The NCLEX tests are required to receive professional licensure in the field of nursing and are created by the National Council of State Boards of Nursing (NCSBN). The NCLEX means National Council Licensure Examination. Both the NCLEX-RN and NCLEX-PN cover a lot of overlapping material; however, the scoring and number of questions vary between the exams.

The NCLEX tests are designed to be one of the final hurdles in your nursing career. Consequently, the questions focus on your ability to make decisions in various patient care scenarios under critical conditions. The NCLEX test requires that you understand the basic principles of nursing and apply this to different elements of patient safety management.

NCLEX Introduction

Many stare at limited funding and the overwhelming task of studying to pass the NCLEX. This website has been created to help students overcome the challenge of the NCLEX test. The key NCLEX testing tips are stated as follows:

1. Assess, Assess, Assess: In almost all cases something can be done before contacting the MD.
2. Prioritize: Delegate to the appropriate support personal and prioritize your tasks.
3. Review Medical Terminology: Understand the definition of all medical abbreviations and terminology used in the NCLEX questions.

The hours of studying and the class work are finally worth it when you are free to practice nursing after passing the NCLEX, and you have highly sought after job skills.

Please take your time to review all of the course notes and links put together on this site about the NCLEX test and the pitfalls that some students fall into with the NCLEX test. Hopefully you can avoid mistakes others have made when preparing for the NCLEX and will find the following information to be helpful and informative on dealing with the NCLEX test.

NCLEX Test Information

You should answer NCLEX questions using "book" knowledge and not practical experience. On the NCLEX hospitals operate on massive budgets and no expense is spared to provide proper care. NCLEX test writers are covering all their bases and focus on patient care that is sometimes unrealistic in today's healthcare world. Generally, **The correct answer** is the answer that identifies the safest approach. It may not be the fastest or the best, but it is the safest. The old medical slogan of "Do No Harm" applies to NCLEX test takers. NCLEX test writers are trying to make sure that you are competent and recognize that safety is the key.

NCLEX Test Information

Another key point on reviewing for the NCLEX, is know your normal laboratory data ranges. Lab test results on the NCLEX will not be flagged with an asterisk if the number is outside of normal ranges. NCLEX test takers must memorize the basic lab values. Focus on the blood gas values. These values in particular can be complicated. If you do not remember the normal ranges you will have no chance of answering lab value questions on the NCLEX. Many times these abnormal values will require further assessment.

It is also important to note that notifying the physician or contacting other health care workers is not **The correct answer** in many cases on the NCLEX. Remember the guidelines: Assess, Assess, Assess. Choose answers that require further assessment before contacting someone else on the NCLEX questions. Basically, collect more data and factual information before calling in other healthcare professionals.

Finally, think safety with all types of patient care on the NCLEX. If equipment breaks down and the patient is in trouble, work on solving the patient's problems before getting someone else to fix the equipment. Let maintenance deal with the equipment mess and focus on getting the patient in a safe environment. The NCLEX is attempting to determine competencies related to all of the above situations.

NCLEX Format

Note: The NCLEX Exam is offered by Pearson VUE. The National Council of State Boards of Nursing has partnered with Pearson VUE to deliver the NCLEX exam. Pearson VUE offers both the NCLEX-RN and NCLEX-PN exams.

The NCLEX CAT testing format stands for a computer adaptive testing format. The computer during the NCLEX test will give you harder questions if you answer a Questioncorrectly or easier questions if you answer a Question-incorrectly. The first Questionon the NCLEX will be below the baseline required passing score. Consequently, a graph could be constructed using questions as points on the graph. The points above and below the passing baseline contribute to your overall testing score. The NCLEX test attempts to match you with questions that are at your level of nursing knowledge and understanding.

The NCLEX does not time each Questionpresented in the CAT format. You are allowed to answer each Question-without time constraints. However, the NCLEX does have a test taking time of 5 hours.

Question1: What is the maximum amount of time allowed to take the NCLEX?
Answer: 5 hours

Question2: How do I prepare for the CAT format on the NCLEX?
Answer: Allow each Questiona reasonable amount of time and thought. Treat each Questionwith the same level of difficulty. Don't be scared if questions are getting "easier," and you think that you are falling below the passing baseline of difficulty.

Question3: What is the maximum amount of time that I could spend on each Questionon the NCLEX?
Answer: If you take the maximum number of questions a safe time would be around 1 minute per Questionon the NCLEX.

Question4: What study aides have you found that help you understand the format better?
Answer: The link on the right of this page offers valuable help with the NCLEX format.

Question5: What if the CAT format offers questions beyond the minimum number required to pass?
Answer: Keep taking the test and don't get nervous. You still have the opportunity to do well and pass.

Learn How to Quickly Solve Difficult
NCLEX Test Questions
NCLEX Flashcard Study System Free Online Sample Practice Test Questions

Click here to see free sample flashcards.

Dear Friend,

Here's a little "secret" about the NCLEX Examination: the NCLEX is what we in the test preparation field call a "content driven" test.

While some tests are looking to see what you are ABLE to learn, the purpose of the National Council Licensure Examination for Registered Nurses (NCLEX-RN) and National Council Licensure Examination for Practical Nurses (NCLEX-PN), offered by the National Council of State Boards of Nursing (NCSBN), is to test your understanding of what you have already learned. The goal of the NCLEX is to make sure you have a minimum competency level to protect the integrity of the testing process.

In other words, it's more about what you know than your ability to solve clever puzzles. This is good news for those who are serious about being prepared, because it boils down to a very

simple strategy:

You can succeed on the NCLEX and become a Registered Nurse (RN) or Practical Nurse (PN) by learning critical concepts on the test so that you are prepared for as many questions as possible.

Repetition and thorough preparation is a process that rewards those who are serious about being prepared, which means that succeeding on the NCLEX is within the reach of virtually anyone interested in learning the material.

This is great news! It means that if you've been worried about your upcoming NCLEX, you can rest easy IF you have a good strategy for knowing what to study and how to effectively use repetition to your advantage.

But it also creates another set of problems.

If you tried to memorize every single possible thing you can for the NCLEX, the field of possible things to review would be so huge that you could not hope to cover everything in a reasonable time.

That's why I created the NCLEX Flashcard Study System: I have taken all of the possible topics and reduced them down to the hundreds of concepts you must know and provided an easy-to-use learning method to guarantee success on the NCLEX.

I wanted this system to be simple, effective, and fast so that you can succeed on your NCLEX with a minimum amount of time spent preparing for it.

Note: This product will also work for the HESI exit exam and help you graduate from your nursing program.
Here Are Some of the Features of Our NCLEX Flashcard Study System

* Study after study has shown that repetition is the most effective form of learning- and nothing beats flashcards when it comes to making repetitive learning fun and fast
* Flashcards engage more of your senses in the learning process- you "compete" with yourself to see if you know the answers to the questions, and the flipping action gets you actively involved in the learning process
* Our cards are printed on heavy, bright white 67 lb. cover stock, and are laser printed at 1200 dpi on our industrial printers- these are professional-quality cards that will not smear or wear out with heavy usage
* We cover all of the major categories of the NCLEX test (see the list below)
* Our flashcards include an edge that is micro-perforated, which means that you are much less likely to have a painful papercut on your fingers when moving quickly through the cards
* Our cards are portable, making it easy for you to grab a few and study while waiting for the bus or the doctor, or anywhere where you have a spare moment that would otherwise be wasted
* Our cards are written in an easy to understand, straightforward style - we don't include any more technical jargon than what you need to pass the test
* The cards are a generous size- 3.67 x 4.25 inches- they fit perfectly in your hands and they aren't so small that you have to use a magnifying glass to read tiny type- all questions and answers are in a normal-size print for easy studying
* Our cards include in-depth explanations- you won't see any "one word" answers on our cards that require you to go get a textbook to understand why your answer was wrong- all of our cards include generous, thorough explanations so you not only get it right or wrong- but you also know why!
* We use a font created by Microsoft to make reading easier- this will enable you to absorb more information painlessly during late night study sessions
* Our system enables you to study in small, digestible bits of information- unlike using boring textbooks, flashcards turn learning into a "game" you can play until you've mastered the material
* It's easy for a friend to help you study- they don't even have to know anything about the NCLEX- if they can read, then they can quiz you with our flashcards!

Now, let me explain what the NCLEX Flashcard Study System is not. It is not a comprehensive review of your education. There's no way we

could fit that onto flashcards- if we claimed to, it would be an insult to what you know.

Don't get us wrong: we're not saying that memorization alone will automatically result in a passing NCLEX score- you have to have the ability to apply it as well. However, without the foundation of the core concepts, you cannot possibly hope to apply the information. After all, you can't apply what you don't know.

NCLEX Flashcard Study System is a compilation of the 615+ critical concepts you must understand to pass the NCLEX. Nothing more, nothing less.
Here's Exactly What You Get With the NCLEX Flashcard Study System

When you order the NCLEX Flashcard Study System, you'll get our set of over 615 flashcards specially selected to give you the most NCLEX performance improvement for the least time. This is just a small sampling of the topics covered:

NCLEX Exam Topics:

* Types of Nosocomial Infections
* Principles of Surgical Asepsis
* Medical Testing and Labs
* TURP Procedure
* Romberg's Test
* Lithotripsy Procedure
* Levels of Consciousness
* Mental Exam Basics
* Grading of Deep Tendon Reflexes
* Glascow Coma Scale
* Normative Values
* Methods of Oxygen Delivery
* Dementia and Delirium
* Types of Injections
* Ethical Duties of Nurses
* Patient Rights
* Bioethical Principles
* Changes Associated with Aging
* Drip Rate Calculations
* Barriers to Communication
* Nutrition and TPN
* Attributes of Nutrients
* Methods of Absorption
* Metabolism and Nutrition
* Medical Nutrition Therapy
* Cultural Aspects of Diets
* Placenta Previa
* Stages of Labor
* Assessing Fetal Lung Maturity
* Pathology of Eclampsia
* PMS and Menopause
* Attributes of Battered Women
* Apgar Scores
* Types of Cardiomyopathies
* Opportunistic Infections
* Classifications of Cancer
* Medical Nutritional Therapy
* Staging of Pressure Ulcers
* Disease Pathology
* Types of Shock
* Lipid Profile Labs
* Coagulation Studies
* CBC Components
* Acne Treatment Medications
* Phases of Adolescence
* Three Types of Jaundice
* Pain Assessment
* Lymphoma Characteristics
* Sexually Transmitted Diseases
* Tanner Staging
* Vaccinations and Immunizations
* Symptoms of Child Abuse
* Performing Newborn Assessments
* Motor Development
* Development of Language
* Pharmacology
* Types of Adrenergic Receptors
* Properties of Decongestants
* Classifications of Drugs
* Antipsychotic Classifications
* Drug Interactions
* Major Injection Sites
* Calcium Channel Blockers
* Phases of Burn Management
* Types of Burns
* Wound Healing Phases

Click here to see 3 free NCLEX Flashcard Study System sample cards.

Remember, this is just a small sampling of the topics covered in our system. Overall, you get over 615 premium-quality flashcards covering everything you'll need to succeed on the NCLEX. The price for this package is only $39.95.
Receive the Following Bonus

Since I know it's 100% to your benefit to use our flashcards, I want to sweeten the pot and give you every possible reason to say YES! With your order, you'll also receive the following:

Special Report- The “Leitner Method” for Maximizing Flashcard Learning- in the 1970’s a German psychologist developed a learning system that turned the humble flashcard into an advanced learning technology. His method teaches you to learn faster by playing a simple game with your flashcards, with the help of a few items you probably have around your home. Simple to learn, but incredibly effective- our free report shows you exactly how to use his method in plain, easy-to-understand language.

Note: we cannot guarantee that this free report will be available indefinitely, so act now to lock in your copy.

By the way, this bonus is yours to keep even in the unlikely event you decide to take advantage of our ironclad money-back guarantee:
You Cannot Lose With My No-Questions-Asked 1-Year Money-Back Guarantee

We stand behind our offer with a no-questions-asked 1-year guarantee on our products.

So go ahead and order your copy of the NCLEX Flashcard Study System today. Read them, study them, and profit from them. If you don’t think they are helping you prepare for your NCLEX exam - you can return them for an immediate 100% refund of your purchase price, no questions asked.

I think that speaks volumes about our confidence in our products. We are also members of the Better Business Bureau of Southeast Texas.

If you think there’s even the smallest chance that these flashcards will help you, you owe it to yourself to try them out. Don’t let fear or doubt stand in the way of what could be your best opportunity to achieve the test score you need to fulfill the dream you deserve.

What I’m saying is, don’t decide now if these flashcards are for you. Just get them and try them out. If they don’t do everything I say and more, if you don’t save money, time and frustration, if they aren’t what you thought they were, if they don’t work for you, you have nothing to worry about because you can get every dime of your money back under our no-loopholes guarantee. So you have nothing to lose and everything to gain.

My belief is simple: either this product helps you or you don’t pay. Period. No gimmicks, no asterisks.

NCLEX Medical Terminology Review

Understanding the medical terminology used on the NCLEX should be a top priority when preparing for the NCLEX. Medical terms can sometimes be confusing due to the use of medical abbreviations.

If you are unable to understand the medical terminology used on the NCLEX then you will have poor chance of picking **The correct answer**. Depending on your clinical rotations you may also be more familiar with certain medical terms in a specific area of nursing. Generally, nurses that have the broadest experience with medical terminology will have a better understanding to answer questions that contain complex medical terminology on the NCLEX test.

Take time to review the following abbreviations on the NCLEX test as well as a more thorough list as found in the NCLEX study guide linked to the right hand side of this page.

ADH antidieuretic hormone
AML acute myelogenous leukemia
APC atrial premature contraction
ASD atrial septal defect
BPH benign prostatic hypertrophy
BUN blood, urea, nitrogen
Ca calcium
CA cancer
CAPD continuous ambulatory peritoneal dialysis
CC chief complaint
CPK creatine phosphokinase
CRP C-reactive protein
DIFF differential blood count
DOE dyspnea on exertion
D/W dextrose in water
ECT electroconvulsive therapy
ESRD end stage renal disease
FUO fever of undetermined origin
GH growth hormone
GSC glascow coma scale
Hg mercury

HLA human leukocyte antigen
Hz hertz
ICS intercostal space
IPG impedance plethysmogram
JRA juvenile rheumatoid arthritis

Practicing nurses have the luxury of being able to look up medial abbreviations and definitions before making patient care decisions. However, the NCLEX test does not allow that option. If you are confused by the medical terminology on the NCLEX, you will not be able to use a medical dictionary for reference purposes.

NCLEX Preparation

The most important thing that you can do preparing for the NCLEX is not stress out. A score in the 90th percentile is not required to pass the NCLEX test. You only have to show a minimum level of competency in the field of nursing.

1. Begin your preparation by sending in your application to the board of licensure.
2. Then schedule with the Chauncey Group for the exam. Finally, you will be sent authorization to test (ATT).
3. Next set-up a time that works for you and show up with all the required documents at the testing center for the NCLEX. If you are recently married with a name change, bring your marriage license. You may not need it, but if you did it could cause you to miss your testing time.

**The testing center will require at least 2 forms of identification to allow you to take the NCLEX test.

Don't make the mistake of altering hair color or facial hair prior to the exam. Your picture has to match the application picture. You will also have to be thumb printed to take the NCLEX. In addition, bring a drink and some snack food for your testing break and wear layered clothing. Students that take the NCLEX in shorts and a tee shirt may find the testing center unbearable cold and be unable to concentrate.

NCLEX-RN vs. NCLEX-PN

One of the primary differences between the NCLEX-RN and NCLEX-PN is the different number of questions. Please review the following chart:

	NCLEX-RN	NCLEX-PN
Minimum Number of Questions	75	85
Maximum Number of Questions	265	205

Both of these tests require the same basic understanding of nursing practice and knowledge. The NCLEX-RN questions and the NCLEX-PN questions are presented with four multiple choice answer scenarios. In some cases, the NCLEX is using a more difficult Questionformat that requires multiple right answers to be selected. However, the material that is covered is the same.

NCLEX-RN vs. NCLEX-PN

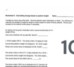
On the NCLEX-RN nursing students are required to concentrate for a longer period of time due to the higher number of questions. If the computer doesn't turn off at the minimum number of questions, continue to answer each Questionin a reasonable amount of time. Do not begin to rush through the questions, because you may have to answer the maximum number of questions on the exam. Anticipate going the distance and concentrating on each question.

Obviously, some of the questions related to delegation of responsibility are different between these exams. Registered nurses will be asked to assign tasks to practical nurses and nursing assistants while prioritizing their patients. Likewise practical nurses will be asked questions that require assigning tasks to nursing assistants and requesting more assistance from registered nurses.

Many of the study guides on the market have questions that help understand the delegation of responsibility task with nursing.

Recommended for you

Document continues below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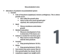
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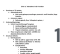
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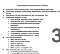
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Pediatric nursing lecture notes exam 1
Child Health Nursing
100% (2)

NCLEX Testing Recommendations

1. Watch out for the words: except, always and not in all NCLEX questions.
2. Answer each question. You are not penalized for taking an educated guess.
3. Get a good night's sleep before the NCLEX.
4. Wear layered clothing to the exam.
5. Practice with a watch and bring a watch to the test.
6. Study for each material section of the NCLEX individually.
7. If you extremely weak in one area of content focus on that area.
8. Don't cram for the NCLEX. Read over a good practice study guide at least one week in advance.
9. Stay away from negative talk about the NCLEX with other students.
10. Know the route to the testing center,
11. Double check that you have the appropriate ID prior to the NCLEX test.
12. Work through several practice tests prior to the exam.

1. A nurse is reviewing a patient's medication during shift change. Which of the following medication would be contraindicated if the patient were pregnant? Note: More than one answer may be correct.

A: Coumadin
B: Finasteride
C: Celebrex
D: Catapress
E: Habitrol
F: Clofazimine

2. A nurse is reviewing a patient's PMH. The history indicates photosensitive reactions to medications. Which of the following drugs has not been associated with photosensitive reactions? Note: More than one answer may be correct.

A: Cipro
B: Sulfonamide
C: Noroxin
D: Bactrim
E: Accutane
F: Nitrodur

3. A patient tells you that her urine is starting to look discolored. If you believe this change is due to medication, which of the following patient's medication does not cause urine discoloration?

A: Sulfasalazine
B: Levodopa
C: Phenolphthalein
D: Aspirin

4. You are responsible for reviewing the nursing unit's refrigerator. If you found the following drug in the refrigerator it should be removed from the refrigerator's contents?

A: Corgard
B: Humulin (injection)
C: Urokinase
D: Epogen (injection)

5. A 34 year old female has recently been diagnosed with an autoimmune disease. She has also recently discovered that she is pregnant. Which of the following is the only immunoglobulin that will provide protection to the fetus in the womb?

A: IgA
B: IgD
C: IgE
D: IgG

6. A second year nursing student has just suffered a needlestick while working with a patient that is positive for AIDS. Which of the following is the most important action that nursing student should take?

A: Immediately see a social worker
B: Start prophylactic AZT treatment
C: Start prophylactic Pentamide treatment
D: Seek counseling

7. A thirty five year old male has been an insulin-dependent diabetic for five years and now is unable to urinate. Which of the following would you most likely suspect?

A: Atherosclerosis
B: Diabetic nephropathy
C: Autonomic neuropathy
D: Somatic neuropathy

8. You are taking the history of a 14 year old girl

who has a (BMI) of 18. The girl reports inability to eat, induced vomiting and severe constipation. Which of the following would you most likely suspect?

A: Multiple sclerosis
B: Anorexia nervosa
C: Bulimia
D: Systemic sclerosis

9. A 24 year old female is admitted to the ER for confusion. This patient has a history of a myeloma diagnosis, constipation, intense abdominal pain, and polyuria. Which of the following would you most likely suspect?

A: Diverticulosis
B: Hypercalcaemia
C: Hypocalcaemia
D: Irritable bowel syndrome

10. Rho gam is most often used to treat____ mothers that have a _____ infant.

A: RH positive, RH positive
B: RH positive, RH negative
C: RH negative, RH positive
D: RH negative, RH negative

Answer Key

1. (A) and (B) are both contraindicated with pregnancy.
2. (F) All of the others have can cause photosensitivity reactions.
3. (D) All of the others can cause urine discoloration.
4. (A) Corgard could be removed from the refigerator.
5. (D) IgG is the only immunoglobulin that can cross the placental barrier.
6. (B) AZT treatment is the most critical innervention.
7. (C) Autonomic neuropathy can cause inability to urinate.
8. (B) All of the clinical signs and systems point to a condition of anorexia nervosa.
9. (B) Hypercalcaemia can cause polyuria, severe abdominal pain, and confusion.
10. (C) Rho gam prevents the production of anti-RH antibodies in the mother that has a Rh positive fetus.

11. A new mother has some questions about (PKU). Which of the following statements made by a nurse is not correct regarding PKU?

A: A Guthrie test can check the necessary lab values.
B: The urine has a high concentration of phenylpyruvic acid
C: Mental deficits are often present with PKU.
D: The effects of PKU are reversible.

12. A patient has taken an overdose of aspirin. Which of the following should a nurse most closely monitor for during acute management of this patient?

A: Onset of pulmonary edema
B: Metabolic alkalosis
C: Respiratory alkalosis
D: Parkinson's disease type symptoms

13. A fifty-year-old blind and deaf patient has been admitted to your floor. As the charge nurse your primary responsibility for this patient is?

A: Let others know about the patient's deficits.
B: Communicate with your supervisor your patient safety concerns.
C: Continuously update the patient on the social environment.
D: Provide a secure environment for the patient.

14. A patient is getting discharged from a SNF facility. The patient has a history of severe COPD and PVD. The patient is primarily concerned about their ability to breath easily. Which of the following would be the best instruction for this patient?

A: Deep breathing techniques to increase O2 levels.
B: Cough regularly and deeply to clear airway passages.
C: Cough following bronchodilator utilization
D: Decrease CO2 levels by increase oxygen take output during meals.

15. A nurse is caring for an infant that has recently been diagnosed with a congenital heart defect. Which of the following clinical signs would most likely be present?

A: Slow pulse rate
B: Weight gain
C: Decreased systolic pressure
D: Irregular WBC lab values

16. A mother has recently been informed that her child has Down's syndrome. You will be assigned to care for the child at shift change. Which of the following characteristics is not associated with Down's syndrome?

A: Simian crease
B: Brachycephaly
C: Oily skin
D: Hypotonicity

17. A patient has recently experienced a (MI) within the last 4 hours. Which of the following medications would most like be administered?

A: Streptokinase
B: Atropine
C: Acetaminophen
D: Coumadin

18. A patient asks a nurse, "My doctor recommended I increase my intake of folic acid. What type of foods contain the highest concentration of folic acids?"

A: Green vegetables and liver
B: Yellow vegetables and red meat
C: Carrots
D: Milk

19. A nurse is putting together a presentation on meningitis. Which of the following microorganisms has noted been linked to meningitis in humans?

A: S. pneumonia
B: H. influenza
C: N. meningitis
D: Cl. difficile

20. A nurse is administering blood to a patient who has a low hemoglobin count. The patient asks how long to RBC's last in my body? The correct response is.

A: The life span of RBC is 45 days.
B: The life span of RBC is 60 days.
C: The life span of RBC is 90 days.
D: The life span of RBC is 120 days.

Answer Key 11-20.

11. (D) The effects of PKU stay with the infant throughout their life.
12. (D) Aspirin overdose can lead to metabolic acidosis and cause pulmonary edema development.
13. (D) This patient's safety is your primary concern.
14. (C) The bronchodilator will allow a more productive cough.
15. (B) Weight gain is associated with CHF and congenital heart deficits.
16. (C) The skin would be dry and not oily.
17. (A) Streptokinase is a clot busting drug and the best choice in this situation.
18. (A) Green vegetables and liver are a great source of folic acid.
19. (D) Cl. difficile has not been linked to meningitis.
20. (D) RBC's last for 120 days in the body.

21. A 65 year old man has been admitted to the hospital for spinal stenosis surgery. When does the discharge training and planning begin for this patient?

A: Following surgery
B: Upon admit
C: Within 48 hours of discharge
D: Preoperative discussion

22. A child is 5 years old and has been recently admitted into the hospital. According to Erickson which of the following stages is the child in?

A: Trust vs. mistrust
B: Initiative vs. guilt
C: Autonomy vs. shame
D: Intimacy vs. isolation

23. A toddler is 16 months old and has been recently admitted into the hospital. According to Erickson which of the following stages is the toddler in?

A: Trust vs. mistrust
B: Initiative vs. guilt
C: Autonomy vs. shame
D: Intimacy vs. isolation

24. A young adult is 20 years old and has been recently admitted into the hospital. According to Erickson which of the following stages is the adult in?

A: Trust vs. mistrust
B: Initiative vs. guilt
C: Autonomy vs. shame
D: Intimacy vs. isolation

25. A nurse is making rounds taking vital signs. Which of the following vital signs is abnormal?

A: 11 year old male – 90 b.p.m, 22 resp/min. , 100/70 mm Hg
B: 13 year old female – 105 b.p.m., 22 resp/min., 105/60 mm Hg
C: 5 year old male- 102 b.p.m, 24 resp/min., 90/65 mm Hg
D: 6 year old female- 100 b.p.m., 26 resp/min., 90/70mm Hg

26. When you are taking a patient's history, she tells you she has been depressed and is dealing with an anxiety disorder. Which of the following medications would the patient most likely be taking?

A: Elavil
B: Calcitonin
C: Pergolide
D: Verapamil

27. Which of the following conditions would a nurse not administer erythromycin?

A: Campylobacterial infection
B: Legionnaire's disease
C: Pneumonia
D: Multiple Sclerosis

28. A patient's chart indicates a history of hyperkalemia. Which of the following would you not expect to see with this patient if this condition were acute?

A: Decreased HR
B: Paresthesias
C: Muscle weakness of the extremities
D: Migranes

29. A patient's chart indicates a history of ketoacidosis. Which of the following would you not expect to see with this patient if this condition were acute?

A: Vomiting
B: Extreme Thirst
C: Weight gain
D: Acetone breath smell

30. A patient's chart indicates a history of meningitis. Which of the following would you not expect to see with this patient if this condition were acute?

A: Increased appetite
B: Vomiting
C: Fever
D: Poor tolerance of light

Answer Key 21-30.

21. (B) Discharge education begins upon admit.
22. (B) Initiative vs. guilt- 3-6 years old
23. (A) Trust vs. Mistrust- 12-18 months old
24. (D) Intimacy vs. isolation- 18-35 years old
25. (B) HR and Respirations are slightly increased. BP is down.
26. (A) Elavil is a tricyclic antidepressant.
27. (D) Erythromycin is used to treat conditions A-C.
28. (D) Answer choices A-C were symptoms of acute hyperkalemia.
29. (C) Weight loss would be expected.
30. (A) Loss of appetite would be expected.

31. A nurse if reviewing a patient's chart and notices that the patient suffers from conjunctivitis. Which of the following microorganisms is related to this condition?

A: Yersinia pestis
B: Helicobacter pyroli
C: Vibrio cholera
D: Hemophilus aegyptius

32. A nurse if reviewing a patient's chart and notices that the patient suffers from Lyme disease. Which of the following microorganisms is related to this condition?

A: Borrelia burgdorferi
B: Streptococcus pyrogens
C: Bacilus anthracis

D: Enterococcus faecalis

33. A fragile 87 year-old female has recently been admitted to the hospital with increased confusion and falls over last 2 weeks. She is also noted to have a mild left hemiparesis. Which of the following tests is most likely to be performed?

A: FBC (full blood count)
B: ECG (electrocardiogram)
C: Thyroid function tests
D: CT scan

34. A 84 year-old male has been loosing mobility and gaining weight over the last 2 months. The patient also has the heater running in his house 24 hours a day, even on warm days. Which of the following tests is most likely to be performed?

A: FBC (full blood count)
B: ECG (electrocardiogram)
C: Thyroid function tests
D: CT scan

35. A 20 year-old female attending college is found unconscious in her dorm room. She has a fever and a noticeable rash. She has just been admitted to the hospital. Which of the following tests is most likely to be performed first?

A: Blood sugar check
B: CT scan
C: Blood cultures
D: Arterial blood gases

36. A 28 year old male has been found wandering around in a confused pattern. The male is sweaty and pale. Which of the following tests is most likely to be performed first?

A: Blood sugar check
B: CT scan
C: Blood cultures
D: Arterial blood gases

37. A mother is inquiring about her child's ability to potty train. Which of the following factors is the most important aspect of toilet training?

A: The age of the child
B: The child ability to understand instruction.
C: The overall mental and physical abilities of the child.
D: Frequent attempts with positive reinforcement.

38. A parent calls the pediatric clinic and is frantic about the bottle of cleaning fluid her child drank 20 minutes. Which of the following is the most important instruction the nurse can give the parent?

A: This too shall pass.
B: Take the child immediately to the ER
C: Contact the Poison Control Center quickly
D: Give the child syrup of ipecac

39. A nurse is administering a shot of Vitamin K to a 30 day-old infant. Which of the following target areas is the most appropriate?

A: Gluteus maximus
B: Gluteus minimus
C: Vastus lateralis
D: Vastus medialis

40. A nurse has just started her rounds delivering medication. A new patient on her rounds is a 4 year-old boy who is non-verbal. This child does not have on any identification. What should the nurse do?

A: Contact the provider
B: Ask the child to write their name on paper.
C: Ask a co-worker about the identification of the child.
D: Ask the father who is in the room the child's name.

Answer Key 31-40.

31. (D) Choice A is linked to Plague, Choice B is linked to peptic ulcers, Choice C is linked to Cholera.
32. (A) Choice B is linked to Rheumatic fever, Choice C is linked to Anthrax, Choice D is linked to Endocarditis.
33. (D) A CT scan would be performed for further investigation of the hemiparesis.
34. (C) Weight gain and poor temperature tolerance indicate something may be wrong with the thyroid function.
35. (C) Blood cultures would be performed to investigate the fever and rash symptoms.
36. (A) With a history of diabetes, the first response should be to check blood sugar levels.

37. (C) Age is not the greatest factor in potty training. The overall mental and physical abilities of the child is the most important factor.
38. (C) The poison control center will have an exact plan of action for this child.
39. (C) Vastus lateralis is the most appropriate location.
40. (D) In this case you are able to determine the name of the child by the father's statement. You should not withhold the medication from the child following identification.

NCLEX Skeletal Muscle Review

In order for the human being to carry out the many intricate movements that must be performed, approximately 650 skeletal muscles of various lengths, shapes, and strength play a part. Each muscle consists of many muscle cells or fibers held together and surrounded by connective tissue that gives functional integrity to the system. Three definite units are commonly referred to:

1. endomysium—connective tissue layer enveloping a single fiber;
2. perimysium—connective tissue layer enveloping a bundle of fibers;
3. epimysium—connective tissue layer enveloping the entire muscle

Muscle Attachment and Function

For coordinated movement to take place, the muscle must attach to either bone or cartilage or, as in the case of the muscles of facial expression, to skin. The portion of a muscle attaching to bone is the tendon. A muscle has two extremities, its origin and its insertion.

NCLEX Four Basic Tissues

1. Muscle Tissue: Muscle tissue is contractile in nature and functions to move the skeletal system and body viscera.

Type	Characteristics	Location
Skeletal	Striated, voluntary	Skeletal muscles of the body
Smooth	Non-striated, involuntary	Walls of digestive tract and blood vessels, uterus, urinary bladder
Cardiac	Striated, involuntary	Heart

2. Nervous Tissue: Nervous tissue is composed of cells (neurons) that respond to external and internal stimuli and have the capability to transmit a message (impulse) from one area of the body to another. This tissue thus induces a response of distant muscles or glands, as well as regulating body processes such as respiration, circulation, and digestion.

3. Epithelial Tissue: Epithelial tissue covers the external surfaces of the body and lines the internal tubes and cavities. It also forms the glands of the body. Characteristics of epithelial tissue (epithelium) are that it

1. has compactly aggregated cells;
2. has limited intercellular spaces and substance;
3. is avascular (no blood vessels);
4. lies on a connective tissue layer—the basal lamina;
5. has cells that form sheets and are polarized;
6. is derived from all three germ layers.

Microvilli—fingerlike projections of plasma membranes.

Cilia—motile organelles extending into the luman consisting of specifically arranged microtubules.

Flagella—similar to cilia. Primary examples are human spermatozoa.

Stereocilia—are actually very elongated Microvilli.

4. Connective Tissue: Connective tissue is the packing and supporting material of the body tissues and organs. It develops from mesoderm (mesenchyme). All connective tissues consist of three distinct components: ground substance, cells and fibers.

* Ground substance. Ground substance is located between the cells and fibers, both of which are embedded in it. It forms an amorphous intercellar material. In the fresh state, it appears as a transparent and homogenous gel. It acts as a route for the passage of nutrients and wastes to and from the cells within or adjacent to the connective tissue.
* Fibers. The fiber components of con-

nective tissue add support and strength. Three types of fibers are present: collagenous, elastic and reticular.

NCLEX Cardiac Review

The heart is a highly specialized blood vessel which pumps 72 times per minute and propels about 4,000 gallons (about 15,000 liters) of blood daily to the tissues. It is composed of:

Endocardium (lining coat; epithelium)

Myocardium (middle coat; cardiac muscle)

Epicardium (external coat or visceral layer of pericardium; epithelium and mostly connective tissue)

Impulse conducting system

Cardiac Nerves: Modification of the intrinsic rhythmicity of the heart muscle is produced by cardiac nerves of the sympathetic and parasympathetic nervous system. Stimulation of the sympathetic system increases the rate and force of the heartbeat and dilates the coronary arteries. Stimulation of the parasympathetic (vagus nerve) reduces the rate and force of the heartbeat and constricts the coronary circulation. Visceral afferent (sensory) fibers from the heart end almost wholly in the first four segments of the thoracic spinal cord.

Cardiac Cycle: Alternating contraction and relaxation is repeated about 75 times per minute; the duration of one cycle is about 0.8 second. Three phases succeed one another during the cycle:

a) atrial systole: 0.1 second,

b) ventricular systole: 0.3 second,

c) diastole: 0.4 second

The actual period of rest for each chamber is 0.7 second for the atria and 0.5 second for the ventricles, so in spite of its activity, the heart is at rest longer than at work.

NCLEX Lesion Review

Occipital Lobe Homonymous hemianopsia, partial seizures with limited visual phenomena
Thalamus Contralateral thalamus pain, contralateral hemisensory loss
Pineal gland Early hydrocephalus, papillary abnormalities, Parinaud’s syndrome
Internal capsule Hemisensory loss, homonymous hemianopsia, contralateral hemiplegia
Basal ganglia Contralateral dystonia, Contralateral choreoathetosis
Pons Diplopia, internal strabismus, VI and VII involvement, contralateral hemisensory and hemiparesis loss, issilateral cerebellar ataxia
Broca’s area Motor dysphasia
Precentral gyrus Jacksonian seizures, generalized seizures, hemiparesis
Superficial parietal lobe Receptive dysphasia

NCLEX Tumor Review

Primary Tumors

* Neuromas- 80-90% of brain tumors, named for what part of nerve cell affected.
* Meningiomas- outside of arachnoidal tissue, usually benign and slow growing
* Glioblastoma Multiform-50% of all primary tumors, linked to specific genetic mutations

Secondary Tumors

* Metastatic carcinomas

Scale –degree of anaplasia: differentiation of mature (good) vs. immature cells (bad)

Grade I: up to 25% anaplasia

Grade II: 26-50% anaplasia

Grade III: 51-75% anaplasia

Grade IV: 76-100% anaplasia

Primary Tumor Effect:

1. Headaches
2. Vomiting

Secondary Tumor Effect:

1. Direct compression/necrosis
2. Herniation of brain tissue

3. Increase ICP

Noteworthy Tumor Markers

1. AFP
2. Alkaline phosphatase
3. b-hCG
4. CA-125
5. PSA

NCLEX Movement Terms

Flexion is bending, most often ventrally to decrease the angle between two parts of the body; it is usually an action at an articulation or joint.

Extension is straightening, or increasing the angle between two parts of the body; a stretching out or making the flexed part straight.

Abduction is a movement away from the midsagittal plane (midline); to adduct is to move medially and bring a part back to the mid-axis.

Circumduction is a circular movement at a ball and socket (shoulder or hip) joint, utilizing the movements of flexion, extension, abduction, and adduction.

Rotation is a movement of a part of the body around its long axis.

Supination refers only to the movement of the radius around the ulna. In supination the palm of the hand is oriented anteriorly; turning the palm dorsally puts it into pronation. The body on its back is in the supine position.

Pronation refers to the palm of the hand being oriented posteriorly. The body on its belly is the prone position.

Inversion refers only to the lower extremity, specifically the ankle joint. When the foot (plantar surface) is turned inward, so that the sole is pointing and directed toward the midline of the body and is parallel with the median plane, we speak of inversion. Its opposite is eversion.

Eversion refers to the foot (plantar surface) being turned outward so that the sole is pointing laterally.

Opposition is one of the most critical movements in humans; it allows us to have pulp-to-pulp opposition, which gives us the great dexterity of our hands. In this movement the thumb pad is brought to a finger pad. A median nerve injury negates this action.

NCLEX Cell Structure Review

Endoplasmic Reticulum (ER)

This cellular organelle was first described using phase microscopy by Porter, Claude and Fallam in 1945. It is an extensive network of interconnecting channels. The endoplasmic reticular membranes are unit membranes (triminar). When ribosomes line the outer surface it is designated as rough endoplasmic reticulum (RER). The primary form of this organelle is the rough variety. The smooth is derived from the rough due to loss of ribosomes. The amount of each depends on the cell type and the cellular activity.

The RER is the synthetic machinery of the cell. It is mainly concerned with protein synthesis.

The Golgi Complex

This structure was discovered by Camillo Golgi in 1898. All eukaryotic cells, except for the red blood cell, possess a Golgi apparatus. Generally speaking the Golgi complex is prominent in glandular cells and is thought to function in the production, concentration packaging, and transportation of secretory material. IN summary one can link the Golgi complex to: secretion, membrane biogenesis, lysosome formation, membrane recycling, hormone modulation.

Lysosome

Lysosomes are described as containing proteolytic enzymes (hydrolases).Lysosomes contain acid phosphatase and other hydrolytic enzymes.. These enzymes are enclosed by a membrane and are released when needed into the cell or into phagocytic vesicles.

Lysosomal enzymes have the capacity to hydrolyze all classes of macromolecules.

A generalized list of substrates acted upon by respective enzymes is given below:

Lipids by lipases and phospholipases;

Proteins by proteases or peptidases;
Polysaccharides by glycosidases;

Nucleic acids by nucleases;

Phosphates (organic-linked) by phosphatases;

Sulphates (organic-linked) by sulfatases.

NCLEX Definitions

Pachyderma-increased thickness of the skin

Paroxysm-sudden attack

Pathogenic-disease causing

Pathologist-individual who studies pathology

Pediculosis-condition of lice

Percutaneous- penetrating the skin

Pleuritis-inflammation of the pleura

Pneumonia-disease of the lung related to infection

Pneumoconiosis-dust in the lung's condition

Pneumothorax-air in the chest resulting in the collapse of a lung

Pneumatocele-hernia associated with the lung

Posterior-related to the rear/back position

Prognosis-opinion of an individual about outcomes

Pruritus-uncontrollable itching

Pyelolithotomy-incision to remove a stone from the renal pelvis

Pyeloplasty-repair of the renal pelvis

Pyosalpinx-pus in the fallopian tube

Pyuria-pus in the urine

NCLEX Cranial Nerve Review

I-Olfactory-Smell

II-Optic-Vision acuity

III-Oculomotor – Eye function

IV-Trochlear – Eye function

V-Trigeminal – Sensory of the face, chewing

VI-Abducens – Eye function

VII-Facial – Facial expression, wrinkle forehead, taste anterior tongue

VIII-Vestibulocochlear – Auditory acuity, balance and postural responses

IX-Glossopharyngeal – Taste on posterior 33% of the scale

X-Vagus – Cardiac, respiratory reflexes

XI-Spinal Accessory - Strength of trapezius and Sternocleidomastoid muscles

XII-Hypoglossal – Motor function of the tongue

NCLEX Cholinomimetrics

1. Muscarinic Agonists

A. Bethanecol (URECHOLINE) – increase GI motility
B. Carbachol (ISOPTO, MIOSTAT, CARBACHOL) – various types of glaucoma
C. Methacholine (PROVOCHOLINE) – test hyperactivity of airways
D. Pilocarpine – used for glaucoma

2. Anticholinesterases

A. Pysostigmine (ANTILIRIUM) – treat glaucoma, crosses BBB, reverse anticholinergic toxicity.
B. Neostigmine (PROSTIGMIN) – synthetic form of Pysostigmine

(Anticholinesterases) – used for Myasthenia gravis, glaucoma, and to increase tone in blad-

der

Symptoms of Anticholinesterase toxicity:

1. Miosis
2. Rhinitis
3. Bradycardia
4. GI spasms
5. brochoconstriction
6. involuntary voiding of urine

NCLEX Drug Distribution Review

Bioavailability dependant on several things:

1. Route of administration
2. The drug's ability to cross membranes
3. The drug's binding to plasma proteins and intracellular component

Membrane Review:

1. Membranes separate the body in components
2. The ability of membranes to act as barriers is related to its structure
3. Lipid Soluable compounds (many drugs) pass through by becoming dissolved in the lipid bylayer.
4. Glucose, H20, electrolytes can't pass on their own. They use pores.
5. In excitable tissues, the pores open and close.

    1. Movement occurs by:
    2. passive diffusion
    3. active transport
    4. facilitated diffusion
    5. endocytosis

Passive Diffusion Review:

1. No energy expended.
2. Weak acids and bases need to be in non-ionized form (no net charge).
3. Drugs can also move between cell junctions. BBB is exception.
4. Must be lipid soluable to pass through pores.
5. Osmosis is a special case of diffusion

    1. A drug dissolved in H2O will move with the water by "bulk flow"
    2. Usually limited to movement through gap junctions because size too large for pores.

Active Transport Review:

1. Requires energy and requires a transport protein
2. Drugs must be similar to some endogenous substance.
3. Can carry substances against a gradient
4. Some drugs may exert their effect by increasing or decreasing transport proteins.

Facilitated Diffusion Review:

1. Requires transport protein
2. Does not require energy
3. Very few drugs move this way

Endocytosis:

1. Drug gets engulfed by cell via invagination
2. Very few drugs move this way and only in certain cells.

Regulation of distribution determined by:

1. Lipid permeability
2. Blood flow
3. Binding to plasma proteins
4. Binding to subcellular components

Volume of Distribution (Vd) - is a calculation of where the drug is distributed.

Vd = amount of drug given (mg)

concentration in plasma (mg/ml)

Calculate the Vd and compare to the total amount of body H20 in a person.

-if Vd = total amount of body (approx. 42) is uniformly distributed

-if Vd is less than 42 – retained in plasma and probably bound to plasma proteins

-if Vd is more than 42 – concentrated in tissues

This is not a "real value" but tells you where the drug is being distributed.

Placental Transfer of Drugs

1. Some drugs cause congenital anomalies
2. Cross placenta by simple diffusion
3. Must be polar or lipid-insoluable Not to Enter
4. Must assume the fetus is subjected to all drugs taken by the mother to some extent.

NCLEX Score Review

Usually, NCLEX scores are sent out 2-6 weeks after the NCLEX test. Each state board is different with score reporting. Don't call the state boards for a score report.

NCLEX Score Review

If you do not pass the NCLEX don't lose hope. Thousands of good nurses have missed a passing score by a few questions. Any given day a good student can make a few mistakes. You will be required to wait 3 months to retest for the NCLEX.

If you don't pass the NCLEX ask yourself the following questions.

1. Did I know the material on the NCLEX?
2. Did I feel comfortable with testing format?
3. Was there something else going on in my life that was a distracter?
4. Did I feel like I was guessing on the NCLEX test?
5. **Did I give each Questionmy best effort?**
6. Did I focus on the practical and not book knowledge regarding patient care?
7. Did I prepare for the minimum number of questions and not the maximum on the NCLEX test?

Use the above questions to improve your focus for your NCLEX preparation. Hundreds if not thousands of nursing students have never gone back to take the NCLEX test the second time. The NCLEX is just another hurdle in a series of qualifying requirements to become a nurse. Don't lose hope and become a better nurse by pursing knowledge that will help you pass the NCLEX.

NCLEX Study Guide Recommendation

The amount of effort required to pass the NCLEX varies between students. There is no magic formula that students can get plugged into to pass the NCLEX test . Consequently, some students may be able pass without reviewing any reference materials, and other will buy 5-7 reference guides and attend NCLEX review courses that are extremely expensive. Obviously, it is foolish to take the NCLEX without any review of potential questions and NCLEX content. The application fee and a failing score simply add up to frustration.

NCLEX Study Guide Recommendation

The NCLEX test takers should be aware of the fact that sometimes too much information on the NCLEX can lead to "overkill". The right study guide offers brevity, precision, and no fluff. NCLEX test takers should be aware of the many pitfalls of NCLEX preparation. The NCLEX will be the most important test nursing students take in the process of becoming a nurse.

If you memorize facts piled upon facts about patient care in a cram course before the NCLEX, you will most likely be distracted by the details and not focus on the concepts. A concise review of the NCLEX that helps you recall details without giving you all the minute details will work the best, because you will be able to think on test day and not be attempting to regurgitate data.

Free NCLEX-RN
Sample Test Questions

1. The correct answer is B.
Question: What are the needs of the patient with acute lymphocytic leukemia and thrombocytopenia?

Needed Info: Lymphocytic leukemia, disease characterized by proliferation of immature WBCs. Immature cells unable to fight infection as competently as mature white cells. Treatment: chemotherapy, antibiotics, blood transfusions, bone marrow transplantation. Nursing responsibilities: private room, no raw fruits or vegs, small frequent meals, O2, good skin care.

(A) to a private room so she will not infect other patients and health care workers — poses little or no threat
(B) to a private room so she will not be infected by other patients and health care workers — CORRECT: protects patient from exogenous bacteria, risk for developing infection from others due to depressed WBC count, alters ability to fight infection
(C) to a semiprivate room so she will have stimulation during her hospitalization — should be placed in a room alone
(D) to a semiprivate room so she will have the opportunity to express her feelings about her illness — ensure that patient is provided with opportunities to express feelings about illness

2. The correct answer is A.
Question: What is the BEST way to prevent accidental poisoning in children?

Strategy: Picture toddlers at play.

(A) Lock all medications in a cabinet — CORRECT: improper storage most common cause of poisoning; highest incidence in two-year-olds
(B) Child proof all the caps to medication bottles — children can open
(C) Store medications on the highest shelf in a cupboard — toddlers climb
(D) Place medications in different containers — keep in original container

3. The correct answer is C.
Question: What is the correct universal precaution?

Strategy: Think about each answer choice. How is each measure protecting the nurse?

Needed Info: Mask, eye protection, face shield protect mucous membrane exposure; used if activities are likely to generate splash or sprays. Gowns used if activities are likely to generate splashes or sprays.

(A) Gloves, gown, goggles, and surgical cap — surgical caps offer protection to hair but aren>t required.
(B) Sterile gloves, mask, plastic bags, and gown — plastic bags provide no direct protection and aren>t part of universal precautions
(C) Gloves, gown, mask, and goggles — CORRECT: must use universal precautions on ALL patients; prevent skin and mucous membrane exposure when contact with blood or other body fluids is anticipated
(D) Double gloves, goggles, mask, and surgical cap — surgical cap not required; unnecessary to double glove

4. The correct answer is B.
Question: What is the best position after tonsillectomy to help with drainage of oral secretions?

Strategy: Picture the patient as described.

(A) Sims> — on side with top knee flexed and thigh drawn up to chest and lower knee less sharply flexed: used for vaginal or rectal examination
(B) Side-lying — CORRECT: most effective to facilitate drainage of secretions from the mouth and pharynx; reduces possibility of airway obstruction.
(C) Supine — increased risk for aspiration, would not facilitate drainage of oral secretions
(D) Prone — risk for airway obstruction and aspiration, unable to observe the child for signs of bleeding such as increased swallowing

5. The correct answer is A.
Question: Which patient is an appropriate assignment for the LPN/LVN?

Strategy: Think about the skill level involved in each patient>s care.

Needed Info: LPN/LVN: assists with implementation of care; performs procedures; differentiates normal from abnormal; cares for stable patients with predictable conditions; has knowledge of asepsis and dressing changes; administers medications (varies with educational background and

state nurse practice act).

(A) A 72-year-old patient with diabetes who requires a dressing change for a stasis ulcer — CORRECT: stable patient with an expected outcome
(B) A 42-year-old patient with cancer of the bone complaining of pain — requires assessment; RN is the appropriate caregiver
(C) A 55-year-old patient with terminal cancer being transferred to hospice home care — requires nursing judgement; RN is the appropriate caregiver
(D) A 23-year-old patient with a fracture of the right leg who asks to use the urinal — standard unchanging procedure; assign to the nursing assistant

Health Promotion and Maintenance

1. The answer is B.

Question: The fetus is ROA. Where should the nurse listen for the FHT?

Strategy: Picture the situation described. It may be helpful for you to draw this out so that you can imagine where the heartbeat would be found.

Needed Info: Describing fetal position: practice of defining position of baby relative to mother>s pelvis. The point of maximum intensity (PMI) of the fetus: point on the mother>s abdomen where the FHT is the loudest, usually over the fetal back. Divide the mother>s pelvis into 4 parts or quadrants: right and left anterior, which is the front, and right and left posterior, which is the back. Abbreviated: R and L for right and left, and A and P for anterior and posterior. The head, particularly the occiput, is the most common presenting part, and is abbreviated O. LOA is most common fetal position and FHT heard on left side. In a vertex presentation, FHT is heard below the umbilicus. In a breech presentation, FHT is heard above the umbilicus.

(A) Below the umbilicus, on the mother>s left side — found on right not left side
(B) Below the umbilicus, on the mother>s right side — CORRECT: occiput and back are pressing against right side of mother>s abdomen; FHT would be heard below umbilicus on right side
(C) Above the umbilicus, on the mother>s left side — found in breech presentation
(D) Above the umbilicus, on the mother>s right side — found in breech presentation

2. The correct answer is B.

Question: What is a contraindication to receiving flu vaccine?

Strategy: Think about what each answer choice means.

Needed Info: Influenza vaccine: given yearly, preferably Oct.-Nov.; recommended for people age 65 or older; people under 65 with heart disease, lung disease, diabetes, immuno-suppression, chronic care facility residents.

(A) A 45-year-old male who is allergic to shellfish — allergy to eggs is a contraindication
(B) A 60-year-old female who says she has a sore throat — CORRECT: vaccine deferred in presence of acute respiratory disease
(C) A 66-year-old female who lives in a group home — vaccine deferred only if patient has an active immunization
(D) A 70-year-old female with congestive heart failure — no contraindication

3. The correct answer is D.

Question: What is the treatment for thrush?

Strategy: Determine the outcome of each answer choice.

Needed Info: Thrush (oral candidiasis): white plaque on oral mucous membranes, gums, or tongue; treatment includes good handwashing, nystatin (Mycostatin).

(A) Determine the baby>s blood glucose level — thrush in newborns caused by poor handwashing or exposure to an infected vagina during birth
(B) Suggest that the newborn>s formula be changed — not related to thrush
(C) Remind the caretaker not to let the infant sleep with the bottle — not related to thrush
(D) Explain that the newborn will need to receive some medication — CORRECT: thrush most often treated with nystatin (Mycostatin)

4. The correct answer is C.

Question: What will you see with congenital hip dislocation?

Strategy: Form a mental image of the deformity.

Needed Info: Subluxation: most common type of congenital hip dislocation. Head of femur remains in contact with acetabulum but is partially displaced. Diagnosed in infant less than 4 weeks old S/S: unlevel gluteal folds, limited abduction of hip, shortened femur affected side, Ortolani>s sign (click). Treatment: abduction splint, hip spica cast, Bryant>s traction, open reduction.

(A) lengthening of the limb on the affected side — inaccurate
(B) deformities of the foot and ankle — inaccurate
(C) asymmetry of the gluteal and thigh folds — CORRECT: restricted movement on affected side
(D) plantar flexion of the foot — seen with clubfoot

5. The correct answer is D.

Question: How do you determine the frequency of uterine contractions?

Needed Info: There must be at least 3 contractions to establish frequency.

(A) from the beginning of one contraction to the end of the next contraction — not accurate
(B) from the beginning of one contraction to the end of the same contraction — defines duration
(C) by the strength of the contraction at its peak — describes intensity
(D) by the number of contractions that occur within a given period of time — CORRECT

1. The correct answer is C.

Question: What is the goal of family therapy?

Needed Info: Symptoms of depression: a low self-esteem, obsessive thoughts, regressive behavior, unkempt appearance, a lack of energy, weight loss, decreased concentration, withdrawn behavior.

(A) trust the nurse who will solve his problem — not realistic
(B) learn to live with anxiety and tension — minimizes concerns
(C) accept responsibility for his actions and choices — CORRECT
(D) use the members of the therapeutic milieu to solve his problems — must do it himself

2. The correct answer is B.

Question: What is your responsibility concerning informed consent?

Needed Info: Physician>s responsibility to obtain informed consent.

(A) The nurse should explain the procedure to the patient and ask her to sign the consent form — Physician should get patient to sign consent
(B) The nurse should verify that the consent form has been signed by the patient and that it is attached to her chart — CORRECT
(C) The nurse should tell the physician that the patient agrees to have the examination — Physician should explain procedure and get consent form signed
(D) The nurse should verify that the patient or a family member has signed the consent form — must be signed by patient unless unable to do

3. The correct answer is C.

Question: What should you do to communicate with a person with a moderate hearing loss?

Needed Info: Presbycusis: age-related hearing loss due to inner ear changes. Decreased ability to hear high sounds.

(A) Raise your voice until the patient is able to hear you — would result in high tones patient unable to hear
(B) Face the patient and speak quickly using a high voice — usually unable to hear high tones
(C) Face the patient and speak slowly using a slightly lowered voice — CORRECT: also decrease background noise; speak at a slow pace, use nonverbal cues
(D) Use facial expressions and speak as you would normally — nonverbal cues help, but need low tones

4. The correct answer is C.

Question: What is the reason for the wife>s behavior?

Needed Info: Stages of grief: 1) shock and disbelief, 2) awareness of pain and loss, 3) restitution. Acute period: 4-8 weeks, usual resolution: 1 year.

(A) She has already moved through the stages of the grieving process — takes one year
(B) She is repressing anger related to her

husband>s death — not accurate; second stage: crying, regression
(C) She is experiencing shock and disbelief related to her husband>s death — CORRECT: denial first stage; inability to comprehend reality of situation
(D) She is demonstrating resolution of her husband>s death — too soon

5. The correct answer is C.

Question: Is the depression normal, or something to be concerned about?

(A) The treatment plan is not effective; the patient requires a larger dose of lithium — not accurate
(B) This is a normal response to lithium therapy; the patient should continue with the current treatment plan — does not address safety needs
(C) This is a normal response to lithium therapy; the patient should be monitored for suicidal behavior — CORRECT: delay of 1-3 weeks before med benefits seen
(D) The treatment plan is not effective; the patient requires an antidepressant — normal response

Physiological Integrity

1. The correct answer is B.

Question: Which lab values should you monitor for a patient receiving Gentamicin?

Needed Info: Gentamicin: broad spectrum antibiotic. Side effects: neuromuscular blockage, ototoxic to eighth cranial nerve (tinnitus, vertigo, ataxia, nystagmus, hearing loss), nephrotoxic. Nursing responsibilities: monitor renal function, force fluids, monitor hearing acuity. Draw blood for peak levels 1 hr. after IM and 30 min - 1 hr. after IV infusion, draw blood for trough just before next dose.

(A) Hemoglobin and hematocrit — can cause anemia; less common
(B) BUN and creatinine — CORRECT: nephrotoxic; will see proteinuria, oliguria, hematuria, thirst, increased BUN, decreased creatine clearance
(C) Platelet count and clotting time — do not usually change
(D) Sodium and potassium — hypokalemia infrequent problem

2. The correct answer is A.

Question: What nursing diagnosis is seen with acute lymphocytic leukemia and thromocytopenia?

Needed Info: Thromocytopenia: decreased platelet count increases the patient>s risk for injury, normal count: 200,000-400,000 per mm3. Leukemia: group of malignant disorders involving overproduction of immature leukocytes in bone marrow. This shuts down normal bone marrow production of erythrocytes, platelets, normal leukocytes. Causes anemia, leukopenia, and thrombocytopenia leading to infection and hemorrhage. Symptoms: pallor of nail beds and conjunctiva, petechiae (small hemorrhagic spot on skin), tachycardia, dyspnea, weight loss, fatigue. Treatment: chemotherapy, antibiotics, blood transfusions, bone marrow transplantation. Nursing responsibilities: private room, no raw fruits or vegs, small frequent meals, O2, good skin care.

(A) Potential for injury — CORRECT: low platelet increases risk of bleeding from even minor injuries. Safety measures: shave with an electric razor, use soft tooth brush, avoid SQ or IM meds and invasive procedures (urinary drainage catheter or a nasogastric tube), side-rails up, remove sharp objects, frequently assess for signs of bleeding, bruising, hemorrhage.
(B) Self-care deficit — may feel weak, doesn>t address condition
(C) Potential for self-harm — implies risk for purposeful self-injury, not given any info, assumption
(D) Alteration in comfort — patient is not comfortable, and comfort measures would address problem

3. The correct answer is C.

Question: What is the best site for nitroglycerine ointment?

Strategy: Think about each site.

Needed Info: Nitroglycerine: used in treatment of angina pectoris to reduce ischemia and relieve pain by decreasing myocardial oxygen consumption; dilates veins and arteries. Side effects: throbbing headache, flushing, hypotension, tachycardia. Nursing responsibilities: teach appropriate administration, storage, expected pain relief, side effects. Ointment applied to skin; sites rotated to avoid skin irritaion. Prolonged effect up to 24 hours.

(A) muscular — not most important
(B) near the heart — not most important
(C) non-hairy — CORRECT: skin site free of hair will increase absorption; avoid distal part of extremities due to less than maximal absorption
(D) over a bony prominence — most important is that the site be non-hairy

4. The correct answer is B.

Question: Why is a patient defibrillated?

Strategy: Think about each answer choice.

Needed Info: Defibrillation: produces asystole of heart to provide opportunity for natural pacemaker (SA node) to resume as pacer of heart activity.

(A) increase cardiac contractility and cardiac output — inaccurate
(B) cause asystole so the normal pacemaker can recapture — CORRECT: allows SA node to resume as pacer of heart activity
(C) reduce cardiac ischemia and acidosis — inaccurate
(D) provide energy for depleted myocardial cells — inaccurate

5. The correct answer is C.

Question: How should you regulate the IV flow rate?

Strategy: Use formula and avoid making math errors.

Needed Info: total volume x the drop factor divided by the total time in minutes.

(A) 21 — inaccurate
(B) 28 — inaccurate
(C) 31 — CORRECT: 3,000 x 15 divided by 24 x 60
(D) 42 — inaccurate

Question1

A client has been hospitalized after an automobile accident. A full leg cast was applied in the emergency room. The most important reason for the nurse to elevate the casted leg is to
A) Promote the client>s comfort
B) Reduce the drying time
C) Decrease irritation to the skin
D) Improve venous return

Review Information: The correct answer is D: Improve venous return. Elevating the leg both improves venous return and reduces swelling. Client comfort will be improved as well.

Question2

The nurse is reviewing with a client how to collect a clean catch urine specimen. What is the appropriate sequence to teach the client?

A) Clean the meatus, begin voiding, then catch urine stream
B) Void a little, clean the meatus, then collect specimen
C) Clean the meatus, then urinate into container
D) Void continuously and catch some of the urine

Review Information: The correct answer is A: Clean the meatus, begin voiding, then catch urine stream. A clean catch urine is difficult to obtain and requires clear directions. Instructing the client to carefully clean the meatus, then void naturally with a steady stream prevents surface bacteria from contaminating the urine specimen. As starting and stopping flow can be difficult, once the client begins voiding it>>s best to just slip the container into the stream. Other responses do not reflect correct technique.

Question3

Following change-of-shift report on an orthopedic unit, which client should the nurse see first?
A) 16 year-old who had an open reduction of a fractured wrist 10 hours ago
B) 20 year-old in skeletal traction for 2 weeks since a motor cycle accident
C) 72 year-old recovering from surgery after a hip replacement 2 hours ago
D) 75 year-old who is in skin traction prior to planned hip pinning surgery.

Review Information: The correct answer is C: 72 year-old recovering from surgery after a hip replacement 2 hours ago. Look for the client who has the most imminent risks and acute vulnerability. The client who returned from surgery 2 hours ago is at risk for life threatening hemorrhage and should be seen first. The 16 year-old should be seen next because it is still the first post-op day. The 75 year-old is potentially vulnerable to age-related physical and cognitive consequences in

skin traction should be seen next. The client who can safely be seen last is the 20 year-old who is 2 weeks post-injury.

Question4

A client with Guillain Barre is in a nonresponsive state, yet vital signs are stable and breathing is independent. What should the nurse document to most accurately describe the client>s condition?

A) Comatose, breathing unlabored
B) Glascow Coma Scale 8, respirations regular
C) Appears to be sleeping, vital signs stable
D) Glascow Coma Scale 13, no ventilator required

Review Information: The correct answer is B: Glascow Coma Scale 8, respirations regular. The Glascow Coma Scale provides a standard reference for assessing or monitoring level of consciousness. Any score less than 13 indicates a neurological impairment. Using the term comatose provides too much room for interpretation and is not very precise.

Question5

When caring for a client receiving warfarin sodium (Coumadin), which lab test would the nurse monitor to determine therapeutic response to the drug?

A) Bleeding time
B) Coagulation time
C) Prothrombin time
D) Partial thromboplastin time

Review Information: The correct answer is C: Prothrombin time. Coumadin is ordered daily, based on the client>>s prothrombin time (PT). This test evaluates the adequacy of the extrinsic system and common pathway in the clotting cascade; Coumadin affects the Vitamin K dependent clotting factors.

Question6

A client with moderate persistent asthma is admitted for a minor surgical procedure. On admission the peak flow meter is measured at 480 liters/minute. Post-operatively the client is complaining of chest tightness. The peak flow has dropped to 200 liters/minute. What should the nurse do first?

A) Notify both the surgeon and provider
B) Administer the prn dose of albuterol
C) Apply oxygen at 2 liters per nasal cannula
D) Repeat the peak flow reading in 30 minutes

Review Information: The correct answer is B: Administer the prn dose of albuterol. Peak flow monitoring during exacerbations of asthma is recommended for clients with moderate-to-severe persistent asthma to determine the severity of the exacerbation and to guide the treatment. A peak flow reading of less than 50% of the client>>s baseline reading is a medical alert condition and a short-acting beta-agonist must be taken immediately.

Question7

A client had 20 mg of Lasix (furosemide) PO at 10 AM. Which would be essential for the nurse to include at the change of shift report?

A) The client lost 2 pounds in 24 hours
B) The client's potassium level is 4 mEq/liter.
C) The client's urine output was 1500 cc in 5 hours
D) The client is to receive another dose of Lasix at 10 PM

Review Information: The correct answer is C: The client's urine output was 1500 cc in 5 hours. Although all of these may be correct information to include in report, the essential piece would be the urine output.

Question8

A client has been tentatively diagnosed with Graves> disease (hyperthyroidism). Which of these findings noted on the initial nursing assessment requires quick intervention by the nurse?

A) a report of 10 pounds weight loss in the last month
B) a comment by the client «I just can>t sit still.»
C) the appearance of eyeballs that appear to «pop» out of the client>s eye sockets
D) a report of the sudden onset of irritability in the past 2 weeks

Review Information: The correct answer is C: the appearance of eyeballs that appear to «pop» out of the client>>s eye sockets. Exophthalmos or protruding eyeballs is a distinctive characteristic of Graves>> Disease. It can result in corneal abrasions with severe eye pain or damage when the eyelid is unable to blink down over the protruding eyeball. Eye drops or ointment may be needed.

Question9

The nurse has performed the initial assessments

of 4 clients admitted with an acute episode of asthma. Which assessment finding would cause the nurse to call the provider immediately?
A) prolonged inspiration with each breath
B) expiratory wheezes that are suddenly absent in 1 lobe
C) expectoration of large amounts of purulent mucous
D) appearance of the use of abdominal muscles for breathing

Review Information: The correct answer is B: expiratory wheezes that are suddenly absent in 1 lobe. Acute asthma is characterized by expiratory wheezes caused by obstruction of the airways. Wheezes are a high pitched musical sounds produced by air moving through narrowed airways. Clients often associate wheezes with the feeling of tightness in the chest. However, sudden cessation of wheezing is an ominous or bad sign that indicates an emergency -- the small airways are now collapsed.

Question10

During the initial home visit, a nurse is discussing the care of a client newly diagnosed with Alzheimer>s disease with family members. Which of these interventions would be most helpful at this time?
A) leave a book about relaxation techniques
B) write out a daily exercise routine for them to assist the client to do
C) list actions to improve the client>s daily nutritional intake
D) suggest communication strategies

Review Information: The correct answer is D: suggest communication strategies. Alzheimer>>s disease, a progressive chronic illness, greatly challenges caregivers. The nurse can be of greatest assistance in helping the family to use communication strategies to enhance their ability to relate to the client. By use of select verbal and nonverbal communication strategies the family can best support the client's strengths and cope with any aberrant behavior.

Question11

An 80 year-old client admitted with a diagnosis of possible cerebral vascular accident has had a blood pressure from 160/100 to 180/110 over the past 2 hours. The nurse has also noted increased lethargy. Which assessment finding should the nurse report immediately to the provider?
A) Slurred speech
B) Incontinence
C) Muscle weakness
D) Rapid pulse

Review Information: The correct answer is A: Slurred speech. Changes in speech patterns and level of conscious can be indicators of continued intracranial bleeding or extension of the stroke. Further diagnostic testing may be indicated.

Question12

A school-aged child has had a long leg (hip to ankle) synthetic cast applied 4 hours ago. Which statement from the parent indicates that teaching has been inadequate?
A) «I will keep the cast uncovered for the next day to prevent burning of the skin.»
B) «I can apply an ice pack over the area to relieve itching inside the cast.»
C) «The cast should be propped on at least 2 pillows when my child is lying down.»
D) «I think I remember that my child should not stand until after 72 hours.»

Review Information: The correct answer is D: «I think I remember that my child should not stand until after 72 hours.». Synthetic casts will typically set up in 30 minutes and dry in a few hours. Thus, the client may stand within the initial 24 hours. With plaster casts, the set up and drying time, especially in a long leg cast which is thicker than an arm cast, can take up to 72 hours. Both types of casts give off a lot of heat when drying and it is preferable to keep the cast uncovered for the first 24 hours. Clients may complain of a chill from the wet cast and therefore can simply be covered lightly with a sheet or blanket. Applying ice is a safe method of relieving the itching.

Question13

Which blood serum finding in a client with diabetic ketoacidosis alerts the nurse that immediate action is required?
A) pH below 7.3
B) Potassium of 5.0
C) HCT of 60
D) Pa O2 of 79%

Review Information: The correct answer is C: HCT of 60. This high hematocrit is indicative of severe dehydration which requires priority attention in diabetic ketoacidosis. Without sufficient hydration, all systems of the body are at risk

for hypoxia from a lack of or sluggish circulation. In the absence of insulin, which facilitates the transport of glucose into the cell, the body breaks down fats and proteins to supply energy ketones, a by-product of fat metabolism. These accumulate causing metabolic acidosis (pH < 7.3), which would be the second concern for this client. The potassium and PaO2 levels are near normal.

Question14

The nurse is preparing a client with a deep vein thrombosis (DVT) for a Venous Doppler evaluation. Which of the following would be necessary for preparing the client for this test?

A) Client should be NPO after midnight
B) Client should receive a sedative medication prior to the test
C) Discontinue anti-coagulant therapy prior to the test
D) No special preparation is necessary

Review Information: The correct answer is D: No special preparation is necessary. This is a non-invasive procedure and does not require preparation other than client education.

Question15

A client is admitted with infective endocarditis (IE). Which finding would alert the nurse to a complication of this condition?

A) dyspnea
B) heart murmur
C) macular rash
D) hemorrhage

Review Information: The correct answer is B: heart murmur. Large, soft, rapidly developing vegetations attach to the heart valves. They have a tendency to break off, causing emboli and leaving ulcerations on the valve leaflets. These emboli produce findings of cardiac murmur, fever, anorexia, malaise and neurologic sequelae of emboli. Furthermore, the vegetations may travel to various organs such as spleen, kidney, coronary artery, brain and lungs, and obstruct blood flow.

Question16

The nurse explains an autograft to a client scheduled for excision of a skin tumor. The nurse knows the client understands the procedure when the client says, «I will receive tissue from

A) a tissue bank.»
B) a pig.»
C) my thigh.»
D) synthetic skin.»

Review Information: The correct answer is C: my thigh.». Autografts are done with tissue transplanted from the client>>s own skin.

Question17

A client is admitted to the emergency room following an acute asthma attack. Which of the following assessments would be expected by the nurse?

A) Diffuse expiratory wheezing
B) Loose, productive cough
C) No relief from inhalant
D) Fever and chills

Review Information: The correct answer is A: Diffuse expiratory wheezing. In asthma, the airways are narrowed, creating difficulty getting air in. A wheezing sound results.

Question18

A client has been admitted with a fractured femur and has been placed in skeletal traction. Which of the following nursing interventions should receive priority?

A) Maintaining proper body alignment
B) Frequent neurovascular assessments of the affected leg
C) Inspection of pin sites for evidence of drainage or inflammation
D) Applying an over-bed trapeze to assist the client with movement in bed

Review Information: The correct answer is B: Frequent neurovascular assessments of the affected leg. The most important activity for the nurse is to assess neurovascular status. Compartment syndrome is a serious complication of fractures. Prompt recognition of this neurovascular problem and early intervention may prevent permanent limb damage.

Question19

The nurse is assigned to care for a client who had a myocardial infarction (MI) 2 days ago. The client has many questions about this condition. What area is a priority for the nurse to discuss at this time?

A) Daily needs and concerns
B) The overview cardiac rehabilitation
C) Medication and diet guideline
D) Activity and rest guidelines

Review Information: The correct answer is A:

Daily needs and concerns. At 2 days post-MI, the client's education should be focused on the immediate needs and concerns for the day.

Question20

A 3 year-old child is brought to the clinic by his grandmother to be seen for «scratching his bottom and wetting the bed at night.» Based on these complaints, the nurse would initially assess for which problem?

A) allergies
B) scabies
C) regression
D) pinworms

Review Information: The correct answer is D: pinworms. Signs of pinworm infection include intense perianal itching, poor sleep patterns, general irritability, restlessness, bed-wetting, distractibility and short attention span. Scabies is an itchy skin condition caused by a tiny, eight-legged burrowing mite called Sarcoptes scabiei . The presence of the mite leads to intense itching in the area of its burrows.

Question21

The nurse is caring for a newborn with tracheoesophageal fistula. Which nursing diagnosis is a priority?

A) Risk for dehydration
B) Ineffective airway clearance
C) Altered nutrition
D) Risk for injury

Review Information: The correct answer is B: Ineffective airway clearance. The most common form of TEF is one in which the proximal esophageal segment terminates in a blind pouch and the distal segment is connected to the trachea or primary bronchus by a short fistula at or near the bifurcation. Thus, a priority is maintaining an open airway, preventing aspiration. Other nursing diagnoses are then addressed.

Question22

The nurse is developing a meal plan that would provide the maximum possible amount of iron for a child with anemia. Which dinner menu would be best?

A) Fish sticks, french fries, banana, cookies, milk
B) Ground beef patty, lima beans, wheat roll, raisins, milk
C) Chicken nuggets, macaroni, peas, cantaloupe, milk
D) Peanut butter and jelly sandwich, apple slices, milk

Review Information: The correct answer is B: Ground beef patty, lima beans, wheat roll, raisins, milk. Iron rich foods include red meat, fish, egg yolks, green leafy vegetables, legumes, whole grains, and dried fruits such as raisins. This dinner is the best choice: It is high in iron and is appropriate for a toddler.

Question23

The nurse admitting a 5 month-old who vomited 9 times in the past 6 hours should observe for signs of which overall imbalance?

A) Metabolic acidosis
B) Metabolic alkalosis
C) Some increase in the serum hemoglobin
D) A little decrease in the serum potassium

Review Information: The correct answer is B: Metabolic alkalosis. Vomiting causes loss of acid from the stomach. Prolonged vomiting can result in excess loss of acid and lead to metabolic alkalosis. Findings include irritability, increased activity, hyperactive reflexes, muscle twitching and elevated pulse. Options C and D are correct answers but not the best answers since they are too general.

Question24

A two year-old child is brought to the provider>s office with a chief complaint of mild diarrhea for two days. Nutritional counseling by the nurse should include which statement?

A) Place the child on clear liquids and gelatin for 24 hours
B) Continue with the regular diet and include oral rehydration fluids
C) Give bananas, apples, rice and toast as tolerated
D) Place NPO for 24 hours, then rehydrate with milk and water

Review Information: The correct answer is B: Continue with the regular diet and include oral rehydration fluids. Current recommendations for mild to moderate diarrhea are to maintain a normal diet with fluids to rehydrate.

Question25

The nurse is teaching parents about the appropriate diet for a 4 month-old infant with gastroenteritis and mild dehydration. In addition to oral rehydration fluids, the diet should include

A) formula or breast milk

B) broth and tea
C) rice cereal and apple juice
D) gelatin and ginger ale

Review Information: The correct answer is A: formula or breast milk. The usual diet for a young infant should be followed.

Question26

A child is injured on the school playground and appears to have a fractured leg. The first action the school nurse should take is

A) call for emergency transport to the hospital
B) immobilize the limb and joints above and below the injury
C) assess the child and the extent of the injury
D) apply cold compresses to the injured area

Review Information: The correct answer is C: assess the child and the extent of the injury. When applying the nursing process, assessment is the first step in providing care. The «5 Ps» of vascular impairment can be used as a guide (pain, pulse, pallor, paresthesia, paralysis).

Question27

The mother of a 3 month-old infant tells the nurse that she wants to change from formula to whole milk and add cereal and meats to the diet. What should be emphasized as the nurse teaches about infant nutrition?

A) Solid foods should be introduced at 3-4 months
B) Whole milk is difficult for a young infant to digest
C) Fluoridated tap water should be used to dilute milk
D) Supplemental apple juice can be used between feedings

Review Information: The correct answer is B: Whole milk is difficult for a young infant to digest. Cow>>s milk is not given to infants younger than 1 year because the tough, hard curd is difficult to digest. In addition, it contains little iron and creates a high renal solute load.

Question28

The nurse is preparing a handout on infant feeding to be distributed to families visiting the clinic. Which notation should be included in the teaching materials?

A) Solid foods are introduced one at a time beginning with cereal
B) Finely ground meat should be started early to provide iron
C) Egg white is added early to increase protein intake
D) Solid foods should be mixed with formula in a bottle

Review Information: The correct answer is A: Solid foods are introduced one at a time beginning with cereal. Solid foods should be added one at a time between 4-6 months. If the infant is able to tolerate the food, another may be added in a week. Iron fortified cereal is the recommended first food.

Question29

The nurse planning care for a 12 year-old child with sickle cell disease in a vaso-occlusive crisis of the elbow should include which one of the following as a priority?

A) Limit fluids
B) Client controlled analgesia
C) Cold compresses to elbow
D) Passive range of motion exercise

Review Information: The correct answer is B: Client controlled analgesia. Management of a sickle cell crisis is directed towards supportive and symptomatic treatment. The priority of care is pain relief. In a 12 year-old child, client controlled analgesia promotes maximum comfort.

Question30

The nurse is performing a physical assessment on a toddler. Which of the following actions should be the first?

A) Perform traumatic procedures
B) Use minimal physical contact
C) Proceed from head to toe
D) Explain the exam in detail

Review Information: The correct answer is B: Use minimal physical contact. The nurse should approach the toddler slowly and use minimal physical contact initially so as to gain the toddler>>s cooperation. Be flexible in the sequence of the exam, and give only brief simple explanations just prior to the action.

Question31

What finding signifies that children have attained the stage of concrete operations (Piaget)?

A) Explores the environment with the use of sight and movement
B) Thinks in mental images or word pictures
C) Makes the moral judgment that «stealing is wrong»
D) Reasons that homework is time-consuming yet necessary

Review Information: The correct answer is C: Makes the moral judgment that «stealing is wrong». The stage of concrete operations is depicted by logical thinking and moral judgments.

Question32

The mother of a child with a neural tube defect asks the nurse what she can do to decrease the chances of having another baby with a neural tube defect. What is the best response by the nurse?

A) «Folic acid should be taken before and after conception.»
B) «Multivitamin supplements are recommended during pregnancy.»
C) «A well balanced diet promotes normal fetal development.»
D) «Increased dietary iron improves the health of mother and fetus.»

Review Information: The correct answer is A: «Folic acid should be taken before and after conception.». The American Academy of Pediatrics recommends that all childbearing women increase folic acid from dietary sources and/or supplements. There is evidence that increased amounts of folic acid prevents neural tube defects.

Question33

The provider orders Lanoxin (digoxin) 0.125 mg PO and furosemide 40 mg every day. Which of these foods would the nurse reinforce for the client to eat at least daily?

A) Spaghetti
B) Watermelon
C) Chicken
D) Tomatoes

Review Information: The correct answer is B: Watermelon. Watermelon is high in potassium and will replace potassium lost by the diuretic. The other foods are not high in potassium.

Question34

While teaching the family of a child who will take phenytoin (Dilantin) regularly for seizure control, it is most important for the nurse to teach them about which of the following actions?

A) Maintain good oral hygiene and dental care
B) Omit medication if the child is seizure free
C) Administer acetaminophen to promote sleep
D) Serve a diet that is high in iron

Review Information: The correct answer is A: Maintain good oral hygiene and dental care. Swollen and tender gums occur often with use of phenytoin. Good oral hygiene and regular visits to the dentist should be emphasized.

Question35

The nurse is offering safety instructions to a parent with a four month-old infant and a four year-old child. Which statement by the parent indicates understanding of appropriate precautions to take with the children?

A) «I strap the infant car seat on the front seat to face backwards.»
B) «I place my infant in the middle of the living room floor on a blanket to play with my four year-old while I make supper in the kitchen.»
C) «My sleeping baby lies so cute in the crib with the little buttocks stuck up in the air while the four year-old naps on the sofa.»
D) «I have the four year-old hold and help feed the four month-old a bottle in the kitchen while I make supper.»

Review Information: The correct answer is D: «I have the four year-old hold and help feed the four month-old a bottle in the kitchen while I make supper.». The infant seat is to be placed on the rear seat. Small children and infants are not to be left unsupervised. Infants are

Question36

The nurse admits a 7 year-old to the emergency room after a leg injury. The x-rays show a femur fracture near the epiphysis. The parents ask what will be the outcome of this injury. The appropriate response by the nurse should be which of these

statements?

A) «The injury is expected to heal quickly because of thin periosteum.»
B) «In some instances the result is a retarded bone growth.»
C) «Bone growth is stimulated in the affected leg.»
D) «This type of injury shows more rapid union than that of younger children.»

Review Information: The correct answer is B: «In some instances the result is a retarded bone growth.». An epiphyseal (growth) plate fracture in a 7 year-old often results in retarded bone growth. The leg often will be different in length than the uninjured leg.

Question37

The parents of a 4 year-old hospitalized child tell the nurse, "We are leaving now and will be back at 6 PM." A few hours later the child asks the nurse when the parents will come again. What is the best response by the nurse?

A) «They will be back right after supper.»
B) «In about 2 hours, you will see them.»
C) «After you play awhile, they will be here.»
D) «When the clock hands are on 6 and 12.»

Review Information: The correct answer is A: «They will be back right after supper.». Time is not completely understood by a 4 year-old. Preschoolers interpret time with their own frame of reference. Thus, it is best to explain time in relationship to a known, common event.

Question38

The nurse is giving instructions to the parents of a child with cystic fibrosis. The nurse would emphasize that pancreatic enzymes should be taken
A) once each day
B) 3 times daily after meals
C) with each meal or snack
D) each time carbohydrates are eaten

Review Information: The correct answer is C: with each meal or snack. Pancreatic enzymes should be taken with each meal and every snack to allow for digestion of all foods that are eaten.

Question39

A nurse is providing a parenting class to individuals living in a community of older homes. In discussing formula preparation, which of the following is most important to prevent lead poisoning?

A) Use ready-to-feed commercial infant formula
B) Boil the tap water for 10 minutes prior to preparing the formula
C) Let tap water run for 2 minutes before adding to concentrate
D) Buy bottled water labeled «lead free» to mix the formula

Review Information: The correct answer is C: Let tap water run for 2 minutes before adding to concentrate. Use of lead-contaminated water to prepare formula is a major source of poisoning in infants. Drinking water may be contaminated by lead from old lead pipes or lead solder used in sealing water pipes. Letting tap water run for several minutes will diminish the lead contamination.

Question40

Which of the following manifestations observed by the school nurse confirms the presence of pediculosis capitis in students?

A) Scratching the head more than usual
B) Flakes evident on a student>s shoulders
C) Oval pattern occipital hair loss
D) Whitish oval specks sticking to the hair

Review Information: The correct answer is D: Whitish oval specks sticking to the hair. Diagnosis of pediculosis capitis is made by observation of the white eggs (nits) firmly attached to the hair shafts. Treatment can include application of a medicated shampoo with lindane for children over 2 years of age, and meticulous combing and removal of all nits.

Question41

When interviewing the parents of a child with asthma, it is most important to assess the child>s environment for what factor?

A) Household pets

B) New furniture
C) Lead based paint
D) Plants such as cactus

Review Information: The correct answer is A: Household pets. Animal dander is a very common allergen affecting persons with asthma. Other triggers may include pollens, carpeting and household dust.

Question42

The mother of a 2 month-old baby calls the nurse 2 days after the first DTaP, IPV, Hepatitis B and HIB immunizations. She reports that the baby feels very warm, cries inconsolably for as long as 3 hours, and has had several shaking spells. In addition to referring her to the emergency room, the nurse should document the reaction on the baby>s record and expect which immunization to be most associated with the findings the infant is displaying?

A) DTaP
B) Hepatitis B
C) Polio
D) H. Influenza

Review Information: The correct answer is A: DTaP. The majority of reactions occur with the administration of the DTaP vaccination. Contradictions to giving repeat DTaP immunizations include the occurrence of severe side effects after a previous dose as well as signs of encephalopathy within 7 days of the immunization.

Question43

The mother of a 2 year-old hospitalized child asks the nurse>s advice about the child>s screaming every time the mother gets ready to leave the hospital room. What is the best response by the nurse?

A) «I think you or your partner needs to stay with the child while in the hospital.»
B) «Oh, that behavior will stop in a few days.»
C) «Keep in mind that for the age this is a normal response to being in the hospital.»
D) «You might want to «sneak out» of the room once the child falls asleep.»

Review Information: The correct answer is C: «Keep in mind that for the age this is a normal response to being in the hospital.». The protest phase of separation anxiety is a normal response for a child this age. In toddlers, ages 1 to 3, separation anxiety is at its peak

Question44

A couple experienced the loss of a 7 month-old fetus. In planning for discharge, what should the nurse emphasize?

A) To discuss feelings with each other and use support persons
B) To focus on the other healthy children and move through the loss
C) To seek causes for the fetal death and come to some safe conclusion
D) To plan for another pregnancy within 2 years and maintain physical health

Review Information: The correct answer is A: To discuss feelings with each other and use support persons. To communicate in a therapeutic manner, the nurse>>s goal is to help the couple begin the grief process by suggesting they talk to each other, seek family, friends and support groups to listen to their feelings.

Question45

The nurse is performing a pre-kindergarten physical on a 5 year-old. The last series of vaccines will be administered. What is the preferred site for injection by the nurse?

A) vastus intermedius
B) gluteus maximus
C) vastus lateralis
D) dorsogluteal

Review Information: The correct answer is C: vastus lateralis. Vastus lateralis, a large and well developed muscle, is the preferred site, since it is removed from major nerves and blood vessels.

Question46

A 7 month pregnant woman is admitted with complaints of painless vaginal bleeding over several hours. The nurse should prepare the client for an immediate

A) Non stress test
B) Abdominal ultrasound
C) Pelvic exam
D) X-ray of abdomen

Review Information: The correct answer is B: Abdominal ultrasound. The standard for diagnosis of placenta previa, which is suggested in the client>>s history of painless bleeding, is abdominal ultrasound.

Question47

A nurse entering the room of a postpartum mother observes the baby lying at the edge of the bed while the woman sits in a chair. The mother states «This is not my baby, and I do not want it.» After repositioning the child safely, the nurse>s best response is

A) «This is a common occurrence after birth, but you will come to accept the baby.»
B) «Many women have postpartum blues and need some time to love the baby.»
C) «What a beautiful baby! Her eyes are just like yours.»
D) «You seem upset; tell me what the pregnancy and birth were like for you.»

Review Information: The correct answer is D: «You seem upset; tell me what the pregnancy and birth were like for you.». A non-judgmental, open ended response facilitates dialogue between the client and nurse.

Question48

The nurse notes that a 2 year-old child recovering from a tonsillectomy has an temperature of 98.2 degrees Fahrenheit at 8:00 AM. At 10:00 AM the child>s parent reports that the child «feels very warm» to touch. The first action by the nurse should be to

A) reassure the parent that this is normal
B) offer the child cold oral fluids
C) reassess the child>s temperature
D) administer the prescribed acetaminophen

Review Information: The correct answer is C: reassess the child>>s temperature. A child>>s temperature may have rapid fluctuations. The nurse should listen to and show respect for what parents say. Parental caretakers are often quite sensitive to variations in their children>>s condition that may not be immediately evident to others.

Question49

The nurse is caring for a client who was successfully resuscitated from a pulseless dysrhythmia. Which of the following assessments is critical for the nurse to include in the plan of care?

A) hourly urine output
B) white blood count
C) blood glucose every 4 hours
D) temperature every 2 hours

Review Information: The correct answer is A: hourly urine output. Clients who have had an episode of decreased glomerular perfusion are at risk for pre-renal failure. This is caused by any abnormal decline in kidney perfusion that reduces glomerular perfusion. Pre-renal failure occurs when the effective arterial blood volume falls. Examples of this phenomena include a drop in circulating blood volume as in a cardiac arrest state or in low cardiac perfusion states such as congestive heart failure associated with a cardiomyopathy. Close observation of hourly urinary output is necessary for early detection of this condition.

Question50

A client is admitted to the rehabilitation unit following a cerebral vascular accident (CVA) and mild dysphagia. The most appropriate intervention for this client is to

A) position client in upright position while eating
B) place client on a clear liquid diet
C) tilt head back to facilitate swallowing reflex
D) offer finger foods such as crackers or pretzels

Review Information: The correct answer is A: position client in upright position while eating. An upright position facilitates proper chewing and swallowing.

Question51

A 72 year-old client with osteomyelitis requires a

6 week course of intravenous antibiotics. In planning for home care, what is the most important action by the nurse?

A) Investigating the client>s insurance coverage for home IV antibiotic therapy
B) Determining if there are adequate hand washing facilities in the home
C) Assessing the client>s ability to participate in self care and/or the reliability of a caregiver
D) Selecting the appropriate venous access device

Review Information: The correct answer is C: Assessing the client>>s ability to participate in self care and/or the reliability of a caregiver. The cognitive ability of the client as well as the availability and reliability of a caregiver must be assessed to determine if home care is a feasible option.

Question52

A nurse administers the influenza vaccine to a client in a clinic. Within 15 minutes after the immunization was given, the client complains of itchy and watery eyes, increased anxiety, and difficulty breathing. The nurse expects that the first action in the sequence of care for this client will be to

A) Maintain the airway
B) Administer epinephrine 1:1000 as ordered
C) Monitor for hypotension with shock
D) Administer diphenhydramine as ordered

Review Information: The correct answer is B: Administer epinephrine 1:1000 as ordered. All the answers are correct given the circumstances, but the priority is to administer the epinephrine, then maintain the airway. In the early stages of anaphylaxis, when the patient has not lost consciousness and is normotensive, administering the epinephrine is first, and applying the oxygen, and watching for hypotension and shock, are later responses. The prevention of a severe crisis is maintained by using diphenhydramine.

Question53

The nurse instructs the client taking dexamethasone (Decadron) to take it with food or milk. The physiological basis for this instruction is that the medication
A) retards pepsin production
B) stimulates hydrochloric acid production
C) slows stomach emptying time
D) decreases production of hydrochloric acid

Review Information: The correct answer is B: stimulates hydrochloric acid production. Decadron increases the production of hydrochloric acid, which may cause gastrointestinal ulcers.

Question54

A client receiving chlorpromazine HCL (Thorazine) is in psychiatric home care. During a home visit the nurse observes the client smacking her lips alternately with grinding her teeth. The nurse recognizes this assessment finding as what?
A) Dystonia
B) Akathisia
C) Brady dyskinesia
D) Tardive dyskinesia

Review Information: The correct answer is D: Tardive dyskinesia. Signs of tardive dyskinesia include smacking lips, grinding of teeth and «fly catching» tongue movements. These findings are often described as Parkinsonian.

Question55

Which of the following findings contraindicate the use of haloperidol (Haldol) and warrant withholding the dose?
A) Drowsiness, lethargy, and inactivity
B) Dry mouth, nasal congestion, and blurred vision
C) Rash, blood dyscrasias, severe depression
D) Hyperglycemia, weight gain, and edema

Review Information: The correct answer is C: Rash, blood dyscrasias, severe depression. Rash and blood dyscrasias are side effects of anti-psychotic drugs. A history of severe depression is a contraindication to the use of neuroleptics.

Question56

The nurse is reinforcing teaching to a 24 year-old woman receiving acyclovir (Zovirax) for a Herpes Simplex Virus type 2 infection. Which of these instructions should the nurse give the client?

A) Complete the entire course of the medication

for an effective cure
B) Begin treatment with acyclovir at the onset of symptoms of recurrence
C) Stop treatment if she thinks she may be pregnant to prevent birth defects
D) Continue to take prophylactic doses for at least 5 years after the diagnosis

Review Information: The correct answer is B: Begin treatment with acyclovir at the onset of symptoms of recurrence. When the client is aware of early symptoms, such as pain, itching or tingling, treatment is very effective. Medications for herpes simplex do not cure the disease; they simply decrease the level of symptoms.

Question57

A 14 month-old child ingested half a bottle of aspirin tablets. Which of the following would the nurse expect to see in the child?

A) Hypothermia
B) Edema
C) Dyspnea
D) Epistaxis

Review Information: The correct answer is D: Epistaxis. A large dose of aspirin inhibits prothrombin formation and lowers platelet levels. With an overdose, clotting time is prolonged.

Question58

An 80 year-old client on digitalis (Lanoxin) reports nausea, vomiting, abdominal cramps and halo vision. Which of the following laboratory results should the nurse analyze first?

A) Potassium levels
B) Blood pH
C) Magnesium levels
D) Blood urea nitrogen

Review Information: The correct answer is A: Potassium levels. The most common cause of digitalis toxicity is a low potassium level. Clients must be taught that it is important to have adequate potassium intake especially if taking diuretics that enhance the loss of potassium while they are taking digitalis.

Question59

A 42 year-old male client refuses to take propranolol hydrochloride (Inderal) as prescribed. Which client statement from the assessment data is likely to explain his noncompliance?

A) «I have problems with diarrhea.»
B) «I have difficulty falling asleep.»
C) «I have diminished sexual function.»
D) «I often feel jittery.»

Review Information: The correct answer is C: «I have diminished sexual function.». Inderal, a beta-blocking agent used in hypertension, prohibits the release of epinephrine into the cells; this may result in hypotension which results in decreased libido and impotence.

Question60

The nurse caring for a 9 year-old child with a fractured femur is told that a medication error occurred. The child received twice the ordered dose of morphine an hour ago. Which nursing diagnosis is a priority at this time?

A) Risk for fluid volume deficit related to morphine overdose
B) Decreased gastrointestinal mobility related to mucosal irritation
C) Ineffective breathing patterns related to central nervous system depression
D) Altered nutrition related to inability to control nausea and vomiting

Review Information: The correct answer is C: Ineffective breathing patterns related to central nervous system depression. Respiratory depression is a life-threatening risk in this overdose.

Question61

Lactulose (Chronulac) has been prescribed for a client with advanced liver disease. Which of the following assessments would the nurse use to evaluate the effectiveness of this treatment?

A) An increase in appetite
B) A decrease in fluid retention
C) A decrease in lethargy
D) A reduction in jaundice

Review Information: The correct answer is

C: A decrease in lethargy. Lactulose produces an acid environment in the bowel and traps ammonia in the gut; the laxative effect then aids in removing the ammonia from the body. This decreases the effects of hepatic encephalopathy, including lethargy and confusion.

Question62

The nurse is teaching a class on HIV prevention. Which of the following should be emphasized as increasing risk?

A) Donating blood
B) Using public bathrooms
C) Unprotected sex
D) Touching a person with AIDS

Review Information: The correct answer is C: Unprotected sex. Because HIV is spread through exposure to bodily fluids, unprotected intercourse and shared drug paraphernalia remain the highest risks for infection.

Question63

While interviewing a new admission, the nurse notices that the client is shifting positions, wringing her hands, and avoiding eye contact. It is important for the nurse to
A) ask the client what she is feeling
B) assess the client for auditory hallucinations
C) recognize the behavior as a side effect of medication
D) re-focus the discussion on a less anxiety provoking topic

Review Information: The correct answer is A: ask the client what she is feeling. The initial step in anxiety intervention is observing, identifying, and assessing anxiety. The nurse should seek client validation of the accuracy of nursing assessments and avoid drawing conclusions based on limited data. In the situation above, the client may simply need to use the restroom but be reluctant to communicate her need!

Question64

A young adult seeks treatment in an outpatient mental health center. The client tells the nurse he is a government official being followed by spies. On further questioning, he reveals that his warnings must be heeded to prevent nuclear war. What is the most therapeutic approach by the nurse?

A) Listen quietly without comment
B) Ask for further information on the spies
C) Confront the client's delusion
D) Contact the government agency

Review Information: The correct answer is A: Listen quietly without comment. The client>>s comments demonstrate grandiose ideas. The most therapeutic response is to listen but avoid being incorporated into the client's delusional system.

Question65

The nurse is assessing a 17 year-old female client with bulimia. Which of the following laboratory reports would the nurse anticipate?

A) Increased serum glucose
B) Decreased albumin
C) Decreased potassium
D) Increased sodium retention

Review Information: The correct answer is C: Decreased potassium. In bulimia, loss of electrolytes can occur in addition to other findings of starvation and dehydration.

Question66

A client, recovering from alcoholism, asks the nurse, «What can I do when I start recognizing relapse triggers within myself?» How might the nurse best respond?

A) «When you have the impulse to stop in a bar, contact a sober friend and talk with him.»
B) «Go to an AA meeting when you feel the urge to drink.»
C) «It is important to exercise daily and get involved in activities that will cause you not to think about drug use.»
D) «Let's talk about possible options you have when you recognize relapse triggers in yourself.»

Review Information: The correct answer is D: «Let's talk about possible options you have when you recognize relapse triggers in yourself.». This option encourages the process of self evalua-

tion and problem solving, while avoiding telling the client what to do. Encouraging the client to brainstorm about response options validates the nurse's belief in the client's personal competency and reinforces a coping strategy that will be needed when the nurse may not be available to offer solutions.

Question67

Therapeutic nurse-client interaction occurs when the nurse
A) assists the client to clarify the meaning of what the client has said
B) interprets the client's covert communication
C) praises the client for appropriate feelings and behavior
D) advises the client on ways to resolve problems

Review Information: The correct answer is A: assists the client to clarify the meaning of what the client has said. Clarification is a facilitating/ therapeutic communication strategy. Interpretation, changing the focus/subject, giving approval, and advising are non-therapeutic/barriers to communication.

Question68

Which nursing intervention will be most effective in helping a withdrawn client to develop relationship skills?
A) Offer the client frequent opportunities to interact with 1 person
B) Provide the client with frequent opportunities to interact with other clients
C) Assist the client to analyze the meaning of the withdrawn behavior
D) Discuss with the client the focus that other clients have similar problems

Review Information: The correct answer is A: Offer the client frequent opportunities to interact with 1 person. The withdrawn client is uncomfortable in social interaction. The nurse-client relationship is a corrective relationship in which the client learns both tolerance and skills for relationships.

Question69

An important goal in the development of a therapeutic inpatient milieu is to
A) provide a businesslike atmosphere where clients can work on individual goals
B) provide a group forum in which clients decide on unit rules, regulations, and policies
C) provide a testing ground for new patterns of behavior while the client takes responsibility for his or her own actions
D) discourage expressions of anger because they can be disruptive to other clients

Review Information: The correct answer is C: provide a testing ground for new patterns of behavior while the client takes responsibility for his or her own actions. A therapeutic milieu is purposeful and planned to provide safety and a testing ground for new patterns of behavior.

Question70

A client with paranoid delusions stares at the nurse over a period of several days. The client suddenly walks up to the nurse and shouts «You think you're so perfect and pure and good.» An appropriate response for the nurse is

A) «Is that why you've been staring at me?»
B) «You seem to be in a really bad mood.»
C) «Perfect? I don't quite understand.»
D) «You seem angry right now.»

Review Information: The correct answer is D: «You seem angry right now.». The nurse recognizes the underlying emotion with a matter of fact attitude, but avoids telling the clients how they feel.

Question71

A client who is a former actress enters the day room wearing a sheer nightgown, high heels, numerous bracelets, bright red lipstick and heavily rouged cheeks. Which nursing action is the best in response to the client's attire?

A) Gently remind her that she is no longer on stage
B) Directly assist client to her room for appropriate apparel
C) Quietly point out to her the dress of other clients on the unit
D) Tactfully explain appropriate clothing for the hospital

Review Information: The correct answer is B: Directly assist client to her room for appropriate apparel. It assists the client to maintain self-esteem while modifying behavior.

Question72

When teaching suicide prevention to the parents of a 15 year-old who recently attempted suicide, the nurse describes the following behavioral cue as indicating a need for intervention.

A) Angry outbursts at significant others
B) Fear of being left alone
C) Giving away valued personal items
D) Experiencing the loss of a boyfriend

Review Information: The correct answer is C: Giving away valued personal items. Eighty percent of all potential suicide victims give some type of indication that self-destructiveness should be addressed. These clues might lead one to suspect that a client is having suicidal thoughts or is developing a plan.

Question73

Which statement made by a client indicates to the nurse that the client may have a thought disorder?
A) «I>m so angry about this. Wait until my partner hears about this.»
B) «I>m a little confused. What time is it?»
C) «I can>t find my <mesmer> shoes. Have you seen them?»
D) «I>m fine. It>s my daughter who has the problem.»

Review Information: The correct answer is C: «I can>>t find my <>mesmer>> shoes. Have you seen them?». A neologism is a new word self invented by a person and not readily understood by another. Using neologisms is often associated with a thought disorder.

Question74

In a psychiatric setting, the nurse limits touch or contact used with clients to handshaking because

A) some clients misconstrue hugs as an invitation to sexual advances
B) handshaking keeps the gesture on a professional level
C) refusal to touch a client denotes lack of concern
D) inappropriate touch often results in charges of assault and battery

Review Information: The correct answer is A: some clients misconstrue hugs as an invitation to sexual advances. Touch denotes positive feelings for another person. The client may interpret hugging and holding hands as sexual advances.

Question75

A client with anorexia is hospitalized on a medical unit due to electrolyte imbalance and cardiac dysrhythmias. Additional assessment findings that the nurse would expect to observe are

A) brittle hair, lanugo, amenorrhea
B) diarrhea, nausea, vomiting, dental erosion
C) hyperthermia, tachycardia, increased metabolic rate
D) excessive anxiety about symptoms

Review Information: The correct answer is A: brittle hair, lanugo, amenorrhea. Physical findings associated with anorexia also include reduced metabolic rate and lower vital signs.

NCLEX Study Tips
Jul31,

If you are going to prepare for taking the NCLEX exam and still don>t know what to do i would like to share some effective advices for you.

Picking review courses:

the best choice for review courses is Kaplan or NCSBN (National Council State Boards of Nursing). Kaplan teaches effective techniques on how to answer exam questions with ease and teaches you to land with **The correct answer**.

NCSBN sure is another top choice for review course because the contents are very close to the actual exam itself.

Never Cram

Cramming is never effective in preparing for the NCLEX. Give yourself at least 3 months to study for the exam.

References

Lipincott is known to be the best review book for preparing yourself for the exam.
Some naysayers say that the NCLEX structured questions are based on lipincott.

Do alot of practice testing and never sleep late before the exam day. Just relax you will do fine. NCLEX could be re-taken after 91 days from taking the first exam.

0 comments

Labels: nclex review, nclex study tips

How To Apply For NCLEX Testing

Here are the guidelines on how to apply for NCLEX Testing in the US:

In order to receive a US nursing license, you must pick a state, complete the application and meet their requirements and if they find you eligible, you will have to undergo testing also commonly known as NCLEX, before you can work as an RN in the USA.

Each State Nursing Board has its own fee schedule and specific requirements (e.g. CGFNS, CES, TOEFL, TSE)
The time it takes to approve your credentials and process your application varies from state to state.

All nurses must pass NCLEX .

The Board will supply you with an NCLEX application which could be downlowded in their webpages.

The current fee to register with NCLEX is $200 and you must indicate at the time of application which Board you>ve chosen.Processing times vary from state to state from (4-16 weeks)

After you have met the requirements, been approved by the Board and applied for NCLEX you will be issued an ATT (Authorization to Test) and can schedule your NCLEX exam at your convinience.

You must have an ATT before you can to take the exam.

The NCLEX exam can be scheduled anywhere in the US or it>s territories, and other countries like the Philippines and Hong Kong and is offered year-round.

You do not have to take the NCLEX exam in the State where you applied.

At some testing centers the appointments go very quickly so plan to schedule your appointment early.

0 comments

Labels: how to apply for nclex-rn, nclex testing guidelines

US Boards Of Nursing For NCLEX Application

Here are the list of US Nursing Boards state by state. Click on them and it will link you to each state board webpage and check the guidelines on how you could apply for examination (NCLEX) or reciprocity to practice as a registered nurse in your choice of state.

Alabama Board of Nursing
Alaska Board of Nursing
Arizona State Board of Nursing
Arkansas State Board of Nursing
California Board of Registered Nursing
*California Board of Vocational Nursing and Psychiatric Technicians
Colorado Board of Nursing
Connecticut Board of Examiners for Nursing
Delaware Board of Nursing

District of Columbia Board of Nursing
Florida Board of Nursing
Georgia Board of Nursing
*Georgia State Board of Licensed Practical Nurses
Hawaii Board of Nursing
Idaho Board of Nursing
Illinois Division of Professional Regulation
Indiana State Board of Nursing
Iowa Board of Nursing
Kansas State Board of Nursing
Kentucky Board of Nursing
Louisiana State Board of Nursing
*Louisiana State Board of Practical Nurse Examiners
Maine State Board of Nursing
Maryland Board of Nursing
Massachusetts Board of Registration in Nursing
Michigan CIS/Bureau of Health Professions
Minnesota Board of Nursing
Mississippi Board of Nursing
Missouri Division of Professional Registration
Montana State Board of Nursing
Nebraska Department of Health and Human Services Regulation and Licensure, Nursing and Nursing Support
Nevada State Board of Nursing
New Hampshire Board of Nursing
New Jersey Board of Nursing
New Mexico Board of Nursing
New York State Board of Nursing
North Carolina Board of Nursing
North Dakota Board of Nursing
Ohio Board of Nursing
Oklahoma Board of Nursing
Oregon State Board of Nursing
Pennsylvania State Board of Nursing
Rhode Island Board of Nurse Registration and Nursing Education
South Carolina Board of Nursing
South Dakota Board of Nursing
Tennessee State Board of Nursing
Texas Board of Nurse Examiners
Utah State Board of Nursing
Vermont State Board of Nursing
Virginia Board of Nursing
Washington State Nursing Care Quality Assurance Commission
West Virginia Board of Examiners for Registered Professional Nurses
*West Virginia State Board of Examiners for Licensed Practical Nurses
Wisconsin Department of Regulation and Licensing
Wyoming State Board of Nursing

*Some states have separate Web sites for boards of licensed practical or vocational nursing (LPN/LVN)

Free NCLEX-RN Sample Test Questions For Nursing Review (Pharmacology Set 2)
Jul31,

A nurse is assigned to perform well-child assessments at a day care center. A staff member interrupts the examinations to ask for assistance. They find a crying 3 year-old child on the floor with mouth wide open and gums bleeding. Two unlabeled open bottles lie nearby. The nurse>s first action should be
A) call the poison control center, then 911
B) administer syrup of Ipecac to induce vomiting
C) give the child milk to coat her stomach
D) ask the staff about the contents of the bottles

Review Information: The correct answer is D: ask the staff about the contents of the bottles
The nurse needs to assess what the child ingested before determining the next action. Once the substance is identified, the poison control center and emergency response team should be called.

Question2

A client with atrial fibrillation is receiving digoxin (Lanoxin). Which of these assessments is most important for the nurse to perform?
A) Monitor blood pressure every 4 hours
B) Measure apical pulse prior to administration
C) Maintain accurate intake and output records
D) Record an EKG strip after administration

Review Information: The correct answer is B: Measure apical pulse prior to administration
Digitoxin decreases conduction velocity through the AV node and prolongs the refractory period. If the apical heart rate is less than 60 beats/minute, withhold the drug. The apical pulse should be taken with a stethoscope so that there will be no mistake about what the heart rate actually is.

Question3

The nurse is administering an intravenous vesicant chemotherapeutic agent to a client. Which assessment would require the nurse>s immediate action?

A) Stomatitis lesion in the mouth
B) Severe nausea and vomiting
C) Complaints of pain at site of infusion
D) A rash on the client>s extremities

Review Information: The correct answer is C: Complaints of pain at site of infusion

A vesicant is a chemotherapeutic agent capable of causing blistering of tissues and possible tissue necrosis if there is extravasation. These agents are irritants which cause pain along the vein wall, with or without inflammation.

Question4

The nurse practicing in a long term care facility recognizes that elderly clients are at greater risk for drug toxicity than younger adults because of which of the following physiological changes of advancing age?

A) Drugs are absorbed more readily from the GI tract
B) Elders have less body water and more fat
C) The elderly have more rapid hepatic metabolism
D) Older people are often malnourished and anemic

Review Information: The correct answer is B: Elders have less body water and more fat

Because elderly persons have decreased lean body tissue/water in which to distribute medications, more drug remains in the circulatory system with potential for drug toxicity. Increased body fat results in greater amounts of fat-soluble drugs being absorbed, leaving less in circulation, thus increasing the duration of action of the drug

Question5

The nurse is assessing a client who is on long term glucocorticoid therapy. Which of the following findings would the nurse expect?

A) Buffalo hump
B) Increased muscle mass
C) Peripheral edema
D) Jaundice

Review Information: The correct answer is A: Buffalo hump

With high doses of glucocorticoid, iatrogenic Cushing>>s syndrome develops. The exaggerated physiological action causes abnormal fat distribution which results in a moon-shaped face, a intrascapular pad on the neck (buffalo hump) and truncal obesity with slender limbs.

Question6

The health care provider has written «Morphine sulfate 2 mgs IV every 3-4 hours prn for pain» on the chart of a child weighing 22 lb. (10 kg). What is the nurse>s initial action?

A) Check with the pharmacist
B) Hold the medication and contact the provider
C) Administer the prescribed dose as ordered
D) Give the dose every 6-8 hours

Review Information: The correct answer is B: Hold the medication and contact the provider

The usual pediatric dose of morphine is 0.1 mg/kg every 3 to 4 hours. At 10 kg, this child typically should receive 1.0 mg every 3 to 4 hours.

Question7

A client is ordered atropine to be administered preoperatively. Which physiological effect should the nurse monitor for?

A) Elevate blood pressure
B) Drying up of secretions
C) Reduce heart rate
D) Enhance sedation

Review Information: The correct answer is B: Drying up of secretions

Atropine dries secretions which may get in the way during the operative procedure.

Question8

A client is receiving digitalis. The nurse should instruct the client to report which of the following side effects?

A) Nausea, vomiting, fatigue
B) Rash, dyspnea, edema
C) Polyuria, thirst, dry skin
D) Hunger, dizziness, diaphoresis

Review Information: The correct answer is A: Nausea, vomiting, fatigue
Side effects of digitalis toxicity include fatigue, nausea, vomiting, anorexia, and bradycardia. Digitalis inhibits the sodium potassium ATPase, which makes more calcium available for contractile proteins, resulting in increased cardiac output.

Question9

A client is receiving dexamethasone (Decadron) therapy. What should the nurse plan to monitor in this client?
A) Urine output every 4 hours
B) Blood glucose levels every 12 hours
C) Neurological signs every 2 hours
D) Oxygen saturation every 8 hours

Review Information: The correct answer is B: Blood glucose levels every 12 hours
The drug Decadron increases glycogenesis. This may lead to hyperglycemia. Therefore the blood sugar level and acetone production must be monitored.

Question10

The nurse is caring for a client with schizophrenia who has been treated with quetiapine (Seroquel) for 1 month. Today the client is increasingly agitated and complains of muscle stiffness. Which of these findings should be reported to the health care provider?
A) Elevated temperature and sweating.
B) Decreased pulse and blood pressure.
C) Mental confusion and general weakness.
D) Muscle spasms and seizures.

Review Information: The correct answer is A: Elevated temperature and sweating.
Neuroleptic malignant syndrome (NMS) is a rare disorder that can occur as a side effect of antipsychotic medications. It is characterized by muscular rigidity, tachycardia, hyperthermia, sweating, altered consciousness, autonomic dysfunction, and increase in CPK. This is a life-threatening complication.

Question11

A child presents to the Emergency Department with documented acetaminophen poisoning. In order to provide counseling and education for the parents, which principle must the nurse understand?
A) The problem occurs in stages with recovery within 12-24 hours
B) Hepatic problems may occur and may be life-threatening
C) Full and rapid recovery can be expected in most children
D) This poisoning is usually fatal, as no antidote is available

Review Information: The correct answer is B: Hepatic problems may occur and may be life-threatening
Clinical manifestations associated with acetaminophen poisoning occurs in 4 stages. The third stage is hepatic involvement which may last up to 7 days and be permanent. Clients who do not die in the hepatic stage gradually recover.

Question12

A client has been receiving dexamethasone (Decadron) for control of cerebral edema. Which of the following assessments would indicate that the treatment is effective?
A) A positive Babinski>s reflex
B) Increased response to motor stimuli
C) A widening pulse pressure
D) Temperature of 37 degrees Celsius

Review Information: The correct answer is B: Increased response to motor stimuli
Decadron is a corticosteroid that acts on the cell membrane to decrease inflammatory responses as well as stabilize the blood-brain barrier. Once Decadron reaches a therapeutic level, there should be a decrease in symptomology with improvement in motor skills.

Question13

The provider has ordered transdermal nitroglycerin patches for a client. Which of these instructions should be included when teaching a client about how to use the patches?
A) Remove the patch when swimming or bathing
B) Apply the patch to any non-hairy area of the body
C) Apply a second patch with chest pain
D) Remove the patch if ankle edema occurs

Review Information: The correct answer is B: Apply the patch to any non-hairy area of the body
The patch application sites should be rotated.

Question14

A newly admitted client has a diagnosis of depression. She complains of "twitching muscles" and a "racing heart", and states she stopped taking Zoloft a few days ago because it was not helping her depression. Instead, she began to take her partner>s Parnate. The nurse should immediately assess for which of these adverse reactions?
A) Pulmonary edema
B) Atrial fibrillation
C) Mental status changes
D) Muscle weakness

Review Information: The correct answer is C: Mental status changes
Use of serotonergic agents may result in Serotonin Syndrome with confusion, nausea, palpitations, increased muscle tone with twitching muscles, and agitation. Serotonin syndrome is most often reported in patients taking 2 or more medications that increase CNS serotonin levels by different mechanisms. The most common drug combinations associated with serotonin syndrome involve the MAOIs, SSRIs, and the tricyclic antidepressants.

Question15

A client with bi-polar disorder is taking lithium (Lithane). What should the nurse emphasize when teaching about this medication?
A) Take the medication before meals
B) Maintain adequate daily salt intake
C) Reduce fluid intake to minimize diuresis
D) Use antacids to prevent heartburn

Review Information: The correct answer is B: Maintain adequate daily salt intake
Salt intake affects fluid volume, which can affect lithium (Lithane) levels; therefore, maintaining adequate salt intake is advised.

Question16

A client with anemia has a new prescription for ferrous sulfate. In teaching the client about diet and iron supplements, the nurse should emphasize that absorption of iron is enhanced if taken with which substance?
A) Acetaminophen
B) Orange juice
C) Low fat milk
D) An antacid

Review Information: The correct answer is B: Orange juice
Ascorbic acid enhances the absorption of iron.

Question17

A client with an aplastic sickle cell crisis is receiving a blood transfusion and begins to complain of «feeling hot.» Almost immediately, the client begins to wheeze. What is the nurse>s first action?
A) Stop the blood infusion
B) Notify the health care provider
C) Take/record vital signs
D) Send blood samples to lab

Review Information: The correct answer is A: Stop the blood infusion
If a reaction of any type is suspected during administration of blood products, stop the infusion immediately, keep the line open with saline, notify the health care provider, monitor vital signs and other changes, and then send a blood sample to the lab.

Question18

A client confides in the RN that a friend has told her the medication she takes for depression, Wellbutrin, was taken off the market because it caused seizures. What is an appropriate response by the nurse?
A) «Ask your friend about the source of this information.»
B) «Omit the next doses until you talk with the doctor.»
C) «There were problems, but the recommended dose is changed.»
D) «Your health care provider knows the best drug for your condition.»

Review Information: The correct answer is C: «There were problems, but the recommended dose is changed.»
Wellbutrin was introduced in the U.S. in 1985 and then withdrawn because of the occurrence of seizures in some patients taking the drug. The drug was reintroduced in 1989 with specific rec-

ommendations regarding dose ranges to limit the occurrence of seizures. The risk of seizure appears to be strongly associated with dose.

Question19

When providing discharge teaching to a client with asthma, the nurse will warn against the use of which of the following over-the-counter medications?

A) Cortisone ointments for skin rashes
B) Aspirin products for pain relief
C) Cough medications containing guaifenesin
D) Histamine blockers for gastric distress

Review Information: The correct answer is B: Aspirin products for pain relief
Aspirin is known to induce asthma attacks. Aspirin can also cause nasal polyps and rhinitis. Warn individuals with asthma about signs and symptoms resulting from complications due to aspirin ingestion.

Question20

The nurse is caring for a client who is receiving procainamide (Pronestyl) intravenously. It is important for the nurse to monitor which of the following parameters?

A) Hourly urinary output
B) Serum potassium levels
* C) Continuous EKG readings
D) Neurological signs

Review Information: The correct answer is C: Continuous EKG readings
Procainamide (Pronestyl) is used to suppress cardiac arrhythmias. When administered intravenously, it must be accompanied by continuous cardiac monitoring by ECG.

Question21

The nurse is providing education for a client with newly diagnosed tuberculosis. Which statement should be included in the information that is given to the client?

A) «Isolate yourself from others until you are finished taking your medication.»
B) «Follow up with your primary care provider in 3 months.»
C) «Continue to take your medications even when you are feeling fine.»
D) «Continue to get yearly tuberculin skin tests.»

Review Information: The correct answer is C: «Continue to take your medications even when you are feeling fine.»
The most important piece of information the tuberculosis client needs is to understand the importance of medication compliance, even if no longer experiencing symptoms. Clients are most infectious early in the course of therapy. The numbers of acid-fast bacilli are greatly reduced as early as 2 weeks after therapy begins.

Question22

The nurse is applying silver sulfadiazine (Silvadene) to a child with severe burns to arms and legs. Which side effect should the nurse be monitoring for?

A) Skin discoloration
B) Hardened eschar
C) Increased neutrophils
D) Urine sulfa crystals

Review Information: The correct answer is D: Urine sulfa crystals
Silver sulfadiazine is a broad spectrum antimicrobial, especially effective against pseudomonas. When applied to extensive areas, however, it may cause a transient neutropenia, as well as renal function changes with sulfa crystals production and kernicterus.

Question23

The nurse is monitoring a client receiving a thrombolytic agent, alteplase (Activase tissue plasminogen activator), for treatment of a myocardial infarction. What outcome indicates the client is receiving adequate therapy within the first hours of treatment?

A) Absence of a dysrhythmia (or arrhythmia)
B) Blood pressure reduction
C) Cardiac enzymes are within normal limits
D) Return of ST segment to baseline on ECG

Review Information: The correct answer is D: Return of ST segment to baseline on ECG
Improved perfusion should result from this medication, along with the reduction of ST segment elevation.

Question24
The provider has ordered daily high doses of aspirin for a client with rheumatoid arthritis. The nurse instructs the client to discontinue the medication and contact the provider if which of the following symptoms occur?
A) Infection of the gums
B) Diarrhea for more than one day
C) Numbness in the lower extremities
D) Ringing in the ears

Review Information: The correct answer is D: Ringing in the ears
Aspirin stimulates the central nervous system which may result in ringing in the ears.
Deglin, J.D. and Vallerand, A.H. (2001). Davis' drug guide for nurses. (7th edition). Philadelphia: F.A. Davis Company.
Key, J.L. and Hayes, E.R. (2003). Pharmacology, a nursing process approach. (4th edition). Philadelphia: Saunders.

Question25
A nurse is caring for a client who is receiving methyldopa hydrochloride (Aldomet) intravenously. Which of the following assessment findings would indicate to the nurse that the client may be having an adverse reaction to the medication?
A) Headache
B) Mood changes
C) Hyperkalemia
D) Palpitations

Review Information: The correct answer is B: Mood changes
The nurse should assess the client for alterations in mental status such as mood changes. These symptoms should be reported promptly.
Deglin, J.D. and Vallerand, A.H. (2001). Davis' drug guide for nurses. (7th edition). Philadelphia: F.A. Davis Company.
Wilson, B.A., Shannon, M.T., and Stang, C.L. (2004). Nurse's drug guide. Upper Saddle River, New Jersey: Pearson Prentice Hall.

Question26
The nurse is teaching a child and the family about the medication phenytoin (Dilantin) prescribed for seizure control. Which of the following side effects is most likely to occur?
A) Vertigo
B) Drowsiness
C) Gingival hyperplasia
D) Vomiting

Review Information: The correct answer is C: Gingival hyperplasia
Swollen and tender gums occur often with use of phenytoin. Good oral hygiene and regular visits to the dentist should be emphasized.

Question27
The use of atropine for treatment of symptomatic bradycardia is contraindicated for a client with which of the following conditions?
A) Urinary incontinence
B) Glaucoma
C) Increased intracranial pressure
D) Right sided heart failure

Review Information: The correct answer is B: Glaucoma
Atropine is contraindicated in clients with angle-closure glaucoma because it can cause pupillary dilation with an increase in aqueous humor, leading to a resultant increase in optic pressure.

Question28
A pregnant woman is hospitalized for treatment of pregnancy induced hypertension (PIH) in the third trimester. She is receiving magnesium sulfate intravenously. The nurse understands that this medication is used mainly for what purpose?
A) Maintain normal blood pressure
B) Prevent convulsive seizures
C) Decrease the respiratory rate
D) Increase uterine blood flow

Review Information: The correct answer is B: Prevent convulsive seizures
Magnesium sulfate is a central nervous system depressant. While it has many systemic effects, it is used in the client with pregnancy induced hypertension (PIH) to prevent seizures.

Question29
The nurse is teaching a group of women in a com-

munity clinic about prevention of osteoporosis. Which of the following over-the-counter medications should the nurse recognize as having the most elemental calcium per tablet?
A) Calcium chloride
B) Calcium citrate
C) Calcium gluconate
D) Calcium carbonate

Review Information: The correct answer is D: Calcium carbonate
Calcium carbonate contains 400mg of elemental calcium in 1 gram of calcium carbonate.

Question30

The nurse is administering diltiazem (Cardizem) to a client. Prior to administration, it is important for the nurse to assess which parameter?
A) Temperature
B) Blood pressure
C) Vision
D) Bowel sounds

Review Information: The correct answer is B: Blood pressure
Diltiazem (Cardizem) is a calcium channel blocker that causes systemic vasodilation resulting in decreased blood pressure.

Question31

The nurse is instructing a client with moderate persistent asthma on the proper method for using MDIs (multi-dose inhalers). Which medication should be administered first?
A) Steroid
B) Anticholinergic
C) Mast cell stabilizer
D) Beta agonist

Review Information: The correct answer is D: Beta agonist
The beta-agonist drugs help to relieve bronchospasm by relaxing the smooth muscle of the airway. These drugs should be taken first so that other medications can reach the lungs.

Question32

A post-operative client has a prescription for acetaminophen with codeine. What should the nurse recognizes as a primary effect of this combination?
A) Enhanced pain relief
B) Minimized side effects
C) Prevention of drug tolerance
D) Increased onset of action

Review Information: The correct answer is A: Enhanced pain relief
Combination of analgesics with different mechanisms of action can afford greater pain relief.

Question33

A client is receiving erythromycin 500mg IV every 6 hours to treat a pneumonia. Which of the following is the most common side effect of the medication?
A) Blurred vision
B) Nausea and vomiting
C) Severe headache
D) Insomnia

Review Information: The correct answer is B: Nausea and vomiting
Nausea is a common side-effect of erythromycin in both oral and intravenous forms.

Question34

The health care provider orders an IV aminophylline infusion at 30 mg/hr. The pharmacy sends a 1,000 ml bag of D5W containing 500 mg of aminophylline. In order to administer 30 mg per hour, the RN will set the infusion rate at:
A) 20 ml per hour
B) 30 ml per hour
C) 50 ml per hour
D) 60 ml per hour

Review Information: The correct answer is D: 60 ml per hour
Using the ratio method to calculate infusion rate: mg to be given (30) : ml to be infused (X) :: mg available (500) : ml of solution (1,000). Solve for X by cross-multiplying: 30 x 1,000 = 500 x X (or cancel), 30,000 = 500 X, X = 30,000/500, X = 60ml per hour.

Question35

The nurse is assessing a 7 year-old after several days of treatment for a documented strep throat.

Which of the following statements suggests that further teaching is needed?
A) «Sometimes I take my medicine with fruit juice.»
B) «My mother makes me take my medicine right after school.»
C) «Sometimes I take the pills in the morning and other times at night.»
D) «I am feeling much better than I did last week.»

Review Information: The correct answer is C: «Sometimes I take the pills in the morning and other times at night.»
Inconsistency in taking the prescribed medication indicates more teaching is needed.

Question36

The nurse is caring for a 10 year-old client who will be placed on heparin therapy. Which assessment is critical for the nurse to make before initiating therapy
A) Vital signs
B) Weight
C) Lung sounds
D) Skin turgor

Review Information: The correct answer is B: Weight
Check the client>>s weight because dosage is calculated on the basis of weight.

Question37

In providing care for a client with pain from a sickle cell crisis, which one of the following medication orders for pain control should be questioned by the nurse?
A) Demerol
B) Morphine
C) Methadone
D) Codeine

Review Information: The correct answer is A: Demerol
Meperidine is not recommended in clients with sickle cell disease. Normeperidine, a metabolite of meperidine, is a central nervous system stimulant that produces anxiety, tremors, myoclonus, and generalized seizures when it accumulates with repetitive dosing. Clients with sickle cell disease are particularly at risk for normeperidine-induced seizures.

Question38

A 5 year-old has been rushed to the emergency room several hours after acetaminophen poisoning. Which laboratory result should receive attention by the nurse?
A) Sedimentation rate
B) Profile 2
C) Bilirubin
D) Neutrophils

Review Information: The correct answer is C: Bilirubin
Bilirubin, along with liver enzymes ALT and AST, may rise in the second stage (1-3 days) after a significant overdose, indicating cellular necrosis and liver dysfunction. A prolonged prothrombin time may also be found.

Question39

An elderly client is on an anticholinergic metered dose inhaler (MDI) for chronic obstructive pulmonary disease. The nurse would suggest a spacer to
A) enhance the administration of the medication
B) increase client compliance
C) improve aerosol delivery in clients who are not able to coordinate the MDI
D) prevent exacerbation of COPD

Review Information: The correct answer is C: improve aerosol delivery in clients who are not able to coordinate the MDI
Spacers improve the medication delivery in clients who are unable to coordinate the movements of administering a dose with an MDI.

Question40

The nurse is teaching a parent how to administer oral iron supplements to a 2 year-old child. Which of the following interventions should be included in the teaching?
A) Stop the medication if the stools become tarry green
B) Give the medicine with orange juice and through a straw
C) Add the medicine to a bottle of formula
D) Administer the iron with your child>s meals

Review Information: The correct answer is B: Give the medicine with orange juice and through a straw
Absorption of iron is facilitated in an environment rich in Vitamin C. Since liquid iron preparation will stain teeth, a straw is preferred.

Free NCLEX-RN Sample Test Questions For Nursing Review (Pharmacology Set 1)
Jul31,

Question1
A client has an order for antibiotic therapy after hospital treatment of a staph infection. Which of the following should the nurse emphasize?
A) Scheduling follow-up blood cultures
B) Completing the full course of medications
C) Visiting the provider in a few weeks
D) Monitoring for signs of recurrent infection

Review Information: The correct answer is B: Completing the full course of medications
In order for antibiotic therapy to be effective in eradicating an infection, the client must compete the entire course of prescribed therapy. When findings subside, stopping the medication early may lead to recurrence or subsequent drug resistance.

Question2
A 72 year-old client is admitted for possible dehydration. The nurse knows that older adults are particularly at risk for dehydration because they have
A) an increased need for extravascular fluid
B) a decreased sensation of thirst
C) an increase in diaphoresis
D) higher metabolic demands

Review Information: The correct answer is B: a decreased sensation of thirst
The elderly have a reduction in thirst sensation causing them to consume less fluid. Other risk factors may include fear of incontinence, inability to drink fluids independently and lack of motivation.

Question3
A male client is admitted with a spinal cord injury at level C4. The client asks the nurse how the injury is going to affect his sexual function. The nurse would respond
A) «Normal sexual function is not possible.»
B) «Sexual functioning will not be impaired at all.»
C) «Erections will be possible.»
D) «Ejaculation will be normal.»

Review Information: The correct answer is C: «Erections will be possible.»
Because they are a reflex reaction, erections can be stimulated by stroking the genitalia.

Question4
An 82 year-old client complains of chronic constipation. To improve bowel function, the nurse should first suggest
A) Increasing fiber intake to 20-30 grams daily
B) Daily use of laxatives
C) Avoidance of binding foods such as cheese and chocolate
D) Monitoring a balance between activity and rest

Review Information: The correct answer is A: Increasing fiber intake to 20-30 grams daily
The incorporation of high fiber into the diet is an effective way to promote bowel elimination in the elderly.

Question5
A 4 year-old child is admitted with burns on his legs and lower abdomen. When assessing the child's hydration status, which of the following indicates a less than adequate fluid replacement?
A) Decreasing hematocrit and increasing urine volume
B) Rising hematocrit and decreasing urine volume
C) Falling hematocrit and decreasing urine volume
D) Stable hematocrit and increasing urine volume

Review Information: The correct answer is B: Rising hematocrit and decreasing urine volume
A rising hematocrit indicates a decreased total blood volume, a finding consistent with dehydration.

Question6

A client receiving chemotherapy has developed sores in his mouth. He asks the nurse why this happened. What is the nurse's best response?
A) «It is a sign that the medication is working.»
B) «You need to have better oral hygiene.»
C) «The cells in the mouth are sensitive to the chemotherapy.»
D) «This always happens with chemotherapy.»

Review Information: The correct answer is C: «The cells in the mouth are sensitive to the chemotherapy.»
The epithelial cells in the mouth are very sensitive to chemotherapy due to their high rate of cell turnover.

Question7

You are caring for a client with deep vein thrombosis who is on Heparin IV. The latest APTT is 50 seconds. If the laboratory normal range is 16-24 seconds, you would anticipate
A) maintaining the current heparin dose
B) increasing the heparin as it does not appear therapeutic.
C) giving protamine sulfate as an antidote.
D) repeating the blood test 1 hour after giving heparin.

Review Information: The correct answer is A: maintaining the current heparin dose
The range for a therapeutic APTT is 1.5-2 times the control. Therefore the client is receiving a therapeutic dose of Heparin.

Question8

A client is admitted with a diagnosis of nodal bigeminy. The nurse knows that the atrioventricular (AV) node has an intrinsic rate of
A) 60-100 beats/minute
B) 10-30 beats/minute
C) 40-70 beats/minute
D) 20-50 beats/minute

Review Information: The correct answer is C: 40-70 beats/minute
The intrinsic rate of the AV node is within the range of 40-70 beats per minute.

Question9

A client is to receive 3 doses of potassium chloride 10 mEq in 100cc normal saline to infuse over 30 minutes each. Which of the following is a priority assessment to perform before giving this medication?
A) Oral fluid intake
B) Bowel sounds
C) Grip strength
D) Urine output

Review Information: The correct answer is D: Urine output
Potassium chloride should only be administered after adequate urine output (>20cc/hour for 2 consecutive hours) has been established. Impaired ability to excrete potassium via the kidneys can result in hyperkalemia.

Question10

The unlicensed assistive personnel (UAP) reports to the nurse that a client with cirrhosis who had a paracentesis yesterday has become more lethargic and has musty smelling breath. A critical assessment for increasing encephalopathy is
A) monitor the client>s clotting status
B) assess upper abdomen for bruits
C) assess for flap-like tremors of the hands
D) measure abdominal girth changes

Review Information: The correct answer is C: assess for flap-like tremors of the hands
A client with cirrhosis of the liver who develops subtle changes in mental status and has a musty odor to the breath is at risk for developing more advanced signs of encephalopathy.

Question11

A client is scheduled for an intravenous pyelo-

gram (IVP). After the contrast material is injected, which of the following client reactions should be reported immediately?
A) Feeling warm
B) Face flushing
C) Salty taste
D) Hives

Review Information: The correct answer is D: Hives
This is a sign of anaphylaxis and should be reported immediately. The other reactions are considered normal and the client should be informed that they may occur.
.

Question12
A client is prescribed an inhaler. How should the nurse instruct the client to breathe in the medication?
A) As quickly as possible
B) As slowly as possible
C) Deeply for 3-4 seconds
D) Until hearing whistling by the spacer

Review Information: The correct answer is C: Deeply for 3-4 seconds
The client should be instructed to breath in the medication for 3-4 seconds in order to receive the correct dosage of medication.

Question13
The nurse is caring for clients over the age of 70. The nurse knows that due to age-related changes, the elderly clients tolerate diets that are
A) high protein
B) high carbohydrates
C) low fat
D) high calories

Review Information: The correct answer is C: low fat
Due to age related changes, the diet of the elderly should include a lower quantity and higher quality of food. Fewer carbohydrates and fats are required in their diets.

Question14
A woman with a 28 week pregnancy is on the way to the emergency department by ambulance with a tentative diagnosis of abruptio placenta. Which should the nurse do first when the woman arrives?
A) administer oxygen by mask at 100%
B) start a second IV with an 18 gauge cannula
C) check fetal heart rate every 15 minutes
D) insert urethral catheter with hourly urine outputs

Review Information: The correct answer is A: administer oxygen by mask at 100%
Administering oxygen in this situation would increase the circulating oxygen in the mother's circulation to the fetus's circulation. This action will minimize complications.

Question15
A client in respiratory distress is admitted with arterial blood gas results of: PH 7.30; PO2 58, PCO2 34; and HCO3 19. The nurse determines that the client is in
A) metabolic acidosis
B) metabolic alkalosis
C) respiratory acidosis
D) respiratory alkalosis

Review Information: The correct answer is A: metabolic acidosis
These lab values indicate metabolic acidosis: the PH is low, PCO2 is normal, and bicarbonate level is low.

Question16
A client is diagnosed with gastroesophageal reflux disease (GERD). The nurse>s instruction to the client regarding diet should be to
A) avoid all raw fruits and vegetables
B) increase intake of milk products
C) decrease intake of fatty foods
D) focus on 3 average size meals a day

Review Information: The correct answer is C: decrease intake of fatty foods
GERD may be aggravated by a fatty diet. A diet low in fat would decrease the symptoms of GERD. Other agents which should also be decreased or avoided are: cigarette smoking, caffeine, alco-

hol, chocolate, and meperidine (Demerol).

Question17

After surgery, a client with a nasogastric tube complains of nausea. What action would the nurse take?
A) Call the health care provider
B) Administer an antiemetic
C) Put the bed in Fowler's position
D) Check the patency of the tube

Review Information: The correct answer is D: Check the patency of the tube
An indication that the nasogastric tube is obstructed is a client's complaint of nausea. Nasogastric tubes may become obstructed with mucus or sediment.

Question18

A client with testicular cancer has had an orchiectomy. Prior to discharge the client expresses his fears related to his prognosis. Which principle should the nurse base the response on?
A) Testicular cancer has a cure rate of 90% with early diagnosis
B) Testicular cancer has a cure rate of 50% with early diagnosis
C) Intensive chemotherapy is the treatment of choice
D) Testicular cancer is usually fatal

Review Information: The correct answer is A: Testicular cancer has a cure rate of 90% with early diagnosis
With aggressive treatment and early detection/diagnosis the cure rate is 90%.

Question19

A client newly diagnosed with Type I Diabetes Mellitus asks the purpose of the test measuring glycosylated hemoglobin. The nurse should explain that the purpose of this test is to determine:
A) The presence of anemia often associated with Diabetes
B) The oxygen carrying capacity of the client>s red cells
C) The average blood glucose for the past 2-3 months
D) The client>s risk for cardiac complications

Review Information: The correct answer is C: The average blood glucose for the past 2-3 months
By testing the portion of the hemoglobin that absorbs glucose, it is possible to determine the average blood glucose over the life span of the red cell, 120 days.

Question20

A client is admitted for a possible pacemaker insertion. What is the intrinsic rate of the heart>s own pacemaker?
A) 30-50 beats/minute
B) 60-100 beats/minute
C) 20-60 beats/minute
D) 90-100 beats/minute

Review Information: The correct answer is B: 60-100 beats/minute
This is the intrinsic rate of the SA node.

Question21

The nurse discusses nutrition with a pregnant woman who is iron deficient and follows a vegetarian diet. The selection of which foods indicates the woman has learned sources of iron?
A) Cereal and dried fruits
B) Whole grains and yellow vegetables
C) Leafy green vegetables and oranges
D) Fish and dairy products

Review Information: The correct answer is A: Cereal and dried fruits
Both of these foods would be a good source of iron.

Question22

Prior to administering Alteplase (TPA) to a client admitted for a cerebral vascular accident (CVA), it is critical that the nurse assess:
A) Neuro signs
B) Mental status
C) Blood pressure
D) PT/PTT

Review Information: The correct answer is D:

PT/PTT
TPA is a potent thrombolytic enzyme. Because bleeding is the most common side effect, it is most essential to evaluate clotting studies including PT, PTT, APTT, platelets, and hematocrit before beginning therapy.

Question23

The nurse enters the room of a client diagnosed with COPD. The client's skin is pink, and respirations are 8 per minute. The client's oxygen is running at 6 liters per minute. What should be the nurse's first action?
A) Call the health care provider
B) Put the client in Fowler's position
C) Lower the oxygen rate
D) Take the vital signs

Review Information: The correct answer is C: Lower the oxygen rate
In client's diagnosed with COPD, the drive to breathe is hypoxia. If oxygen is delivered at too high of a concentration, this drive will be eliminated and the client's depth and rate of respirations will decrease. Therefore the first action should be to lower the oxygen rate.

Question24

The client with goiter is treated with potassium iodide preoperatively. What should the nurse recognize as the purpose of this medication?
A) Reduce vascularity of the thyroid
B) Correct chronic hyperthyroidism
C) Destroy the thyroid gland function
D) Balance enzymes and electrolytes

Review Information: The correct answer is A: Reduce vascularity of the thyroid
Potassium iodide solution, or Lugol>>s solution may be used preoperatively to reduce the size and vascularity of the thyroid gland.

Question25

One hour before the first treatment is scheduled, the client becomes anxious and states he does not wish to go through with electroconvulsive therapy. Which response by the nurse is most appropriate?
A) «I'll go with you and will be there with you during the treatment.»
B) «You'll be asleep and won't remember anything.»
C) «You have the right to change your mind. You seem anxious. Can we talk about it?»
D) «I'll call the health care provider to notify them of your decision.»

Review Information: The correct answer is C: «You have the right to change your mind. You seem anxious. Can we talk about it?»
This response indicates acknowledgment of the client's rights and the opportunity for the client to clarify and ventilate concerns. After this, if the client continues to refuse, the provider should be notified.

Question26

A nurse who has been named in a lawsuit can use which of these factors for the best protection in a court of law?
A) Clinical specialty certification in the associated area of practice
B) Documentation on the specific client record with a focus on the nursing process
C) Yearly evaluations and proficiency reports prepared by nurse's manager
D) Verification of provider>s orders for the plan of care with identification of outcomes

Review Information: The correct answer is B: Documentation on the specific client record with a focus on the nursing process
Documentation is the key to protect nurses when a lawsuit is filed. The thorough documentation should include all steps of the nursing process – assessment, analysis, plan, intervention, evaluation. In addition, it should include pertinent data such as times, dosages and sites of actions, assessment data, the nurse's response to a change in the client's condition, specific actions taken, if and when the notification occurred to the provider or other health care team members, and what was prescribed along with the client's outcomes.

Question27

The nurse is caring for clients over the age of 70. The nurse is aware that when giving medications to older clients, it is best to
A) start low, go slow
B) avoid stopping a medication entirely
C) avoid drugs with side effects that impact cognition
D) review the drug regimen yearly

Review Information: The correct answer is A: start low, go slow
Due to physiological changes in the elderly, as well as conditions such as dehydration, hyper-

thermia, immobility and liver disease, the effective metabolism of drugs may decrease. As a result, drugs can accumulate to toxic levels and cause serious adverse reactions.

Question28

You are caring for a hypertensive client with a new order for captopril (Capoten). Which information should the nurse include in client teaching?

A) Avoid green leafy vegetables
B) Restrict fluids to 1000cc/day
C) Avoid the use of salt substitutes
D) Take the medication with meals

Review Information: The correct answer is C: Avoid the use of salt substitutes
Captopril can cause an accumulation of potassium or hyperkalemia. Clients should avoid the use of salt substitutes, which are generally potassium-based.

Question29

A client has bilateral knee pain from osteoarthritis. In addition to taking the prescribed non-steroidal anti-inflammatory drug (NSAID), the nurse should instruct the client to

A) start a regular exercise program
B) rest the knees as much as possible to decrease inflammation
C) avoid foods high in citric acid
D) keep the legs elevated when sitting

Review Information: The correct answer is A: start a regular exercise program
A regular exercise program is beneficial in treating osteoarthritis. It can restore self-esteem and improve physical functioning.

Question30

An arterial blood gases test (ABG) is ordered for a confused client. The respiratory therapist draws the blood and then asks the nurse to apply pressure to the area so the therapist can take the specimen to the lab. How long should the nurse apply pressure to the area?

A) 3 minutes
B) 5 minutes
C) 8 minutes
D) 10 minutes

Review Information: The correct answer is B: 5 minutes
It is necessary to apply pressure to the area for 5 minutes to prevent bleeding and the formation of hematomas.

Question31

Which of these clients should the charge nurse assign to the registered nurse (RN)?

A) A 56 year-old with atrial fibrillation receiving digoxin
B) A 60 year-old client with COPD on oxygen at 2 L/min
C) A 24 year-old post-op client with type 1 diabetes in the process of discharge
D) An 80 year-old client recovering 24 hours post right hip replacement

Review Information: The correct answer is C: A 24 year-old post-op client with type 1 diabetes in the process of discharge
Discharge teaching must be done by an RN. Practical nurses (PNs) or unlicensed assistive personnel (UAPs) can reinforce education after the RN does the initial teaching.

Question32

A hypertensive client is started on atenolol (Tenormin). The nurse instructs the client to immediately report which of these findings?

A) Rapid breathing
B) Slow, bounding pulse
C) Jaundiced sclera
D) Weight gain

Review Information: The correct answer is B: Slow, bounding pulse
Atenolol (Tenormin) is a beta-blocker that can cause side effects including bradycardia and hypotension.

Question33

An 80 year-old client is admitted with a diagnosis of malnutrition. In addition to physical assessments, which of the following lab tests should be closely monitored?

A) Urine protein
B) Urine creatinine
C) Serum calcium
D) Serum albumin

Review Information: The correct answer is D: Serum albumin
Serum albumin is a valuable indicator of protein deficiency and, later, nutritional status in adults. A normal reading for an elder's serum albumin is between 3.0-5.0 g/dl.

Question34

Upon admission to an intensive care unit, a client diagnosed with an acute myocardial infarction is ordered oxygen. The nurse knows that the major

reason that oxygen is administered in this situation is to
A) saturate the red blood cells
B) relieve dyspnea
C) decrease cyanosis
D) increase oxygen level in the myocardium

Review Information: The correct answer is D: increase oxygen level in the myocardium
Anoxia of the myocardium occurs in myocardial infarction. Oxygen administration will help relieve dyspnea and cyanosis associated with the condition but the major purpose is to increase the oxygen concentration in the damaged myocardial tissue.

Question35

The nurse is teaching a client with chronic renal failure (CRF) about medications. The client questions the purpose of aluminum hydroxide (Amphojel) in her medication regimen. What is the best explanation for the nurse to give the client about the therapeutic effects of this medication?
A) It decreases serum phosphate
B) It will reduce serum calcium
C) Amphojel increases urine output
D) The drug is taken to control gastric acid secretion

Review Information: The correct answer is A: It decreases serum phosphate
Aluminum binds phosphates that tend to accumulate in the patient with chronic renal failure due to decreased filtration capacity of the kidney. Antacids such as Amphojel are commonly used to accomplish this.

Question36

A 66 year-old client is admitted for mitral valve replacement surgery. The client has a history of mitral valve regurgitation and mitral stenosis since her teenage years. During the admission assessment, the nurse should ask the client if as a child she had
A) measles
B) rheumatic fever
C) hay fever
D) encephalitis

Review Information: The correct answer is B: rheumatic fever
Clients that present with mitral stenosis often have a history of rheumatic fever or bacterial endocarditis.

Question37

During nursing rounds which of these assessments would require immediate corrective action and further instruction to the practical nurse (PN) about proper care?
A) The weights of the skin traction of a client are hanging about 2 inches from the floor
B) A client with a hip prosthesis 1 day post operatively is lying in bed with internal rotation and adduction of the affected leg
C) The nurse observes that the PN moves the extremity of a client with an external fixation device by picking up the frame
D) A client with skeletal traction states «The other nurse said that the clear, yellow and crusty drainage around the pin site is a good sign»

Review Information: The correct answer is B: A client with a hip prosthesis 1 day post operatively is lying in bed with internal rotation and adduction of the affected leg
This position should be prevented in order to prevent dislodgment of the hip prosthesis, especially in the first 48 to 72 hours post-op. The other assessments are not of concern.

Question38

A client diagnosed with gouty arthritis is admitted with severe pain and edema in the right foot. When the nurse develops a plan of care, which intervention should be included?
A) high protein diet
B) salicylates
C) hot compresses to affected joints
D) intake of at least 3000cc/day

Review Information: The correct answer is D: intake of at least 3000cc/day
Fluid intake should be increased to prevent precipitation of urate in the kidneys.

Question39

A 55 year-old woman is taking Prednisone and aspirin (ASA) as part of her treatment for rheumatoid arthritis. Which of the following would be an appropriate intervention for the nurse?
A) Assess the pulse rate q 4 hours
B) Monitor her level of consciousness q shift
C) Test her stools for occult blood
D) Discuss fiber in the diet to prevent constipation

Review Information: The correct answer is C: Test her stools for occult blood
Both Prednisone and ASA can lead to GI bleeding, therefore monitoring for occult blood would

be appropriate.

Question40

A client with testicular cancer is scheduled for a right orchiectomy. The nurse knows that an orchiectomy is the

A) surgical removal of the entire scrotum
B) surgical removal of a testicle
C) dissection of related lymph nodes
D) partial surgical removal of the penis

Review Information: The correct answer is B: surgical removal of a testicle
The affected testicle is surgically removed along with its tunica and spermatic cord.

Free NCLEX-RN Sample Test Questions For Nursing Review (Part 5)

Jul31,

Question1

A client complains of some discomfort after a below the knee amputation. Which action by the nurse is most appropriate initially?

A) Conduct guided imagery or distraction
B) Ensure that the stump is elevated the first day post-op
C) Wrap the stump snugly in an elastic bandage
D) Administer opioid narcotics as ordered

Review Information: The correct answer is B: Ensure that the stump is elevated the first day post-op
This priority intervention prevents pressure caused by pooling of blood, thus minimizing the pain. Without this measure, a firm elastic bandage, opioid narcotics, or guided imagery will have little effect. Opioid narcotics are given for severe pain.

Question2

A 78 year-old client with pneumonia has a productive cough, but is confused. Safety protective devices (restraints) have been ordered for this client. How can the nurse prevent aspiration?

A) Suction the client frequently while restrained
B) Secure all 4 restraints to 1 side of bed
C) Obtain a sitter for the client while restrained
D) Request an order for a cough suppressant

Review Information: The correct answer is C: Obtain a sitter for the client while restrained
The plan to use safety devices (restraints) should be rethought. Restraints are used to protect the client from harm caused by removing tubes or getting out of bed. In the event that this restricted movement could cause more harm, such as aspiration, then a sitter should be requested. These are to be provided by the facility in the event the family cannot do so. This client needs to cough and be watched rather than restricted. Suctioning will not prevent aspiration in this situation. Cough suppressants should be avoided for this client.

Question3

A couple trying to conceive asks the nurse when ovulation occurs. The woman reports a regular 32 day cycle. Which response by the nurse is correct?

A) Days 7-10
B) Days 10-13
C) Days 14-16
D) Days 17-19

Review Information: The correct answer is D: Days 17-19
Ovulation occurs 14 days prior to menses. Considering that the woman>>s cycle is 32 days, subtracting 14 from 32 suggests ovulation is at about the 18th day.

Question4

A newborn is having difficulty maintaining a temperature above 98 degrees Fahrenheit and has been placed in an incubator. Which action is a nursing priority?

A) Protect the eyes of the neonate from the heat lamp
B) Monitor the neonate's temperature
C) Warm all medications and liquids before giving
D) Avoid touching the neonate with cold hands

Review Information: The correct answer is B: Monitor the neonate's temperature
When using a warming device the neonate's temperature should be continuously monitored for undesired elevations. The use of heat lamps is not safe as there is no way to regulate their temperature. Warming medications and fluids is not indicated. While touching with cold hands can startle the infant it does not pose a safety risk.

Question5

Which oxygen delivery system would the nurse apply that would provide the highest concentrations of oxygen to the client?

A) Venturi mask
B) Partial rebreather mask
C) Non-rebreather mask

D) Simple face mask

Review Information: The correct answer is C: Non-rebreather mask
The non-rebreather mask has a one-way valve that prevents exhales air from entering the reservoir bag and one or more valves covering the air holes on the face mask itself to prevent inhalation of room air but to allow exhalation of air. When a tight seal is achieved around the mask up to 100% of the oxygen is available.

Question6

At a senior citizens meeting a nurse talks with a client who has Type 1 diabetes mellitus. Which statement by the client during the conversation is most predictive of a potential for impaired skin integrity?
A) «I give my insulin to myself in my thighs.»
B) «Sometimes when I put my shoes on I don>t know where my toes are.»
C) «Here are my up and down glucose readings that I wrote on my calendar.»
D) «If I bathe more than once a week my skin feels too dry.»

Review Information: The correct answer is B: «Sometimes when I put my shoes on I don>>t know where my toes are.»
Peripheral neuropathy can lead to lack of sensation in the lower extremities. Clients who do not feel pressure and/or pain are at high risk for skin impairment.

Question7

A client returns from surgery after an open reduction of a femur fracture. There is a small bloodstain on the cast. Four hours later, the nurse observes that the stain has doubled in size. What is the best action for the nurse to take?
A) Call the health care provider
B) Access the site by cutting a window in the cast
C) Simply record the findings in the nurse>s notes only
D) Outline the spot with a pencil and note the time and date on the cast

Review Information: The correct answer is D: Outline the spot with a pencil and note the time and date on the cast
This is a good way to assess the amount of bleeding over a period of time. The bleeding does not appear to be excessive and some bleeding is expected with this type of surgery. The bleeding should also be documented in the nurse's notes.

Question8

The nurse is caring for a 1 year-old child who has 6 teeth. What is the best way for the nurse to give mouth care to this child?
A) Using a moist soft brush or cloth to clean teeth and gums
B) Swabbing teeth and gums with flavored mouthwash
C) Offering a bottle of water for the child to drink
D) Brushing with toothpaste and flossing each tooth

Review Information: The correct answer is A: Using a moist soft brush or cloth to clean teeth and gums
The nurse should use a soft cloth or soft brush to do mouth care so that the child can adjust to the routine of cleaning the mouth and teeth.

Question9

In addition to standard precautions, a nurse should implement contact precautions for which client?
A) 60 year-old with herpes simplex
B) 6 year-old with mononucleosis
C) 45 year-old with pneumonia
D) 3 year-old with scarlet fever

Review Information: The correct answer is A: 60 year-old with herpes simplex
Clients who have herpes simplex infections must have contact precautions in addition to standard precautions because of the associated, potentially weeping, skin lesions. Contact precautions are used for clients who are infected by microorganisms that are transmitted by direct contact with the client, including hand or skin-to-skin contact.

Question10

Which of the following situations is most likely to produce sepsis in the neonate?
A) Maternal diabetes
B) Prolonged rupture of membranes
C) Cesarean delivery
D) Precipitous vaginal birth

Review Information: The correct answer is B: Prolonged rupture of membranes
Premature rupture of the membranes (PROM) is a leading cause of newborn sepsis. After 12-24

hours of leaking fluid, measures are taken to reduce the risk to mother and the fetus/newborn.

Question11

The nurse is teaching a parent about side effects of routine immunizations. Which of the following must be reported immediately?

A) Irritability

B) Slight edema at site

C) Local tenderness

D) Seizure activity

Review Information: The correct answer is D: Seizure activity

Other reactions that should be reported include crying for >3 hours, temperature over 104.8 degrees Fahrenheit following DPT immunization, and tender, swollen, reddened areas.

Question12

The nurse is at the community center speaking with retired people about glaucoma. Which comment by one of the retirees would the nurse support to reinforce correct information?

A) «I usually avoid driving at night since lights sometimes seem to make things blur.»

B) «I take half of the usual dose for my sinuses to maintain my blood pressure.»

C) «I have to sit at the side of the pool with the grandchildren since I can>t swim with this eye problem.»

D) «I take extra fiber and drink lots of water to avoid getting constipated.»

Review Information: The correct answer is D: «I take extra fiber and drink lots of water to avoid getting constipated.»

Any activity that involves straining should be avoided in clients with glaucoma. Such activities would increase intraocular pressure.

Question13

A newborn has hyperbilirubinemia and is undergoing phototherapy with a fiberoptic blanket. Which safety measure is most important during this process?

A) Regulate the neonate's temperature using a radiant heater

B) Withhold feedings while under the phototherapy

C) Provide water feedings at least every 2 hours

D) Protect the eyes of neonate from the phototherapy lights

Review Information: The correct answer is C: Provide water feedings at least every 2 hours

Protecting the eyes of the neonates is very important to prevent damage when under the ultraviolet lights, but since the blanket is used, extra protection of the eyes is unnecessary. It is recommended that the neonate remain under the lights for extended periods. The neonate's skin is exposed to the light and the temperature is monitored, but a heater may not be necessary. There is no reason to withhold feedings. Frequent water or feedings are given to help with the excretion of the bilirubin in the stool.

Question14

A nurse is performing the routine daily cleaning of a tracheostomy. During the procedure, the client coughs and displaces the tracheostomy tube. This negative outcome could have avoided by

A) placing an obturator at the client's bedside

B) having another nurse assist with the procedure

C) fastening clean tracheostomy ties before removing old ties

D) placing the client in a flat, supine position

Review Information: The correct answer is C: fastening clean tracheostomy ties before removing old ties

Fastening clean tracheostomy ties before removing old ones will ensure that the tracheostomy is secured during the entire cleaning procedure. The obturator is useful to keep the airway open only after the tracheostomy outer tube is coughed out. A second nurse is not needed. Changing the position may not prevent a dislodged tracheostomy.

Question15

A 4 year-old hospitalized child begins to have a seizure while playing with hard plastic toys in the hallway. Of the following nursing actions, which one should the nurse do first?

A) Place the child in the nearest bed

B) Administer IV medication to slow down the seizure

C) Place a padded tongue blade in the child>s mouth

D) Remove the child>s toys from the immediate area

Review Information: The correct answer is D: Remove the child>>s toys from the immediate area

Nursing care for a child having a seizure includes, maintaining airway patency, ensuring safety, ad-

ministering medications, and providing emotional support. Since the seizure has already started, nothing should be forced into the child>>s mouth and the child should not be moved. Of the choices given, the first priority would be to provide a safe environment.

Question16

The nurse is teaching home care to the parents of a child with acute spasmodic croup. The most important aspects of this care is/are

A) sedation as needed to prevent exhaustion
B) antibiotic therapy for 10 to 14 days
C) humidified air and increased oral fluids
D) antihistamines to decrease allergic response

Review Information: The correct answer is C: humidified air and increased oral fluids
The most important aspects of home care for a child with acute spasmodic croup are humidified air and increased oral fluids. Moisture soothes inflamed membranes. Adequate systemic hydration aids is mucociliary clearance and keeps secretions thin, white, watery, and easily removed with minimal coughing.

Question17

The nurse is assigned to care for a client who has a leaking intracranial aneurysm. To minimize the risk of rebleeding, the nurse should plan to

A) restrict visitors to immediate family
B) avoid arousal of the client except for family visits
C) keep client>s hips flexed at no less than 90 degrees
D) apply a warming blanket for temperatures of 98 degrees Fahrenheit or less

Review Information: The correct answer is A: restrict visitors to immediate family
Maintaining a quiet environment will assist in minimizing cerebral rebleeding. When family visit, the client should not be disturbed. If the client is awake, topics of a general nature are better choices for discussion than topics that result in emotional or physiological stimulation.

Question18

A client who is 12 hour post-op becomes confused and says: “Giant sharks are swimming across the ceiling.” Which assessment is necessary to adequately identify the source of this client>s behavior?

A) Cardiac rhythm strip
B) Pupillary response
C) Pulse oximetry
D) Peripheral glucose stick

Review Information: The correct answer is C: Pulse oximetry
A sudden change in mental status in any post-op client should trigger a nursing intervention directed toward respiratory evaluation. Pulse oximetry would be the initial assessment. If available, arterial blood gases would be better. Acute respiratory failure is the sudden inability of the respiratory system to maintain adequate gas exchange which may result in hypercapnia and/or hypoxemia. Clinical findings of hypoxemia include these finding which are listed in order of initial to later findings: restlessness, irritability, agitation, dyspnea, disorientation, confusion, delirium, hallucinations, and loss of consciousness. While there may be other factors influencing the client>>s behavior, the first nursing action should be directed toward maintaining oxygenation. Once respiratory or oxygenation issues are ruled out then significant changes in glucose would be evaluated.

Question19

A newborn delivered at home without a birth attendant is admitted to the hospital for observation. The initial temperature is 95 degrees Fahrenheit (35 degrees Celsius) axillary. The nurse recognizes that cold stress may lead to what complication?

A) Lowered BMR
B) Reduced PaO2
C) Lethargy
D) Metabolic alkalosis

Review Information: The correct answer is B: Reduced PaO2
Cold stress causes increased risk for respiratory distress. The baby delivered in such circumstances needs careful monitoring. In this situation, the newborn must be warmed immediately to increase its temperature to at least 97 degrees Fahrenheit (36 degrees Celsius).

Question20

Which contraindication should the nurse assess for prior to giving a child immunizations?

A) Mild cold symptoms
B) Chronic asthma
C) Depressed immune system
D) Allergy to eggs

Review Information: The correct answer is C: Depressed immune system

Children who have a depressed immune system related to HIV or chemotherapy should not be given routine immunizations.

Question21

The nurse is caring for a client with a myocardial infarction. Which finding requires the nurse>s immediate action?
A) Periorbital edema
B) Dizzy spells
C) Lethargy
D) Shortness of breath

Review Information: The correct answer is B: Dizzy spells
Cardiac dysrhythmias may cause a transient drop in cardiac output and decreased blood flow to the brain. Near syncope refers to lightheartedness, dizziness, temporary confusion. Such «spells» may indicate runs of ventricular tachycardia or periods of asystole and should be reported immediately.

Question22

Decentralized scheduling is used on a nursing unit. A chief advantage of this management strategy is that it:
A) considers client and staff needs
B) conserves time spent on planning
C) frees the nurse manager to handle other priorities
D) allows requests for special privileges

Review Information: The correct answer is A: considers client and staff needs
Decentralized staffing takes into consideration specific client needs and staff interests and abilities.

Question23

Included in teaching the client with tuberculosis taking isoniazid (INH) about follow-up home care, the nurse should emphasize that a laboratory appointment for which of the following lab tests is critical?
A) Liver function
B) Kidney function
C) Blood sugar
D) Cardiac enzymes

Review Information: The correct answer is A: Liver function
INH can cause hepatocellular injury and hepatitis. This side effect is age-related and can be detected with regular assessment of liver enzymes, which are released into the blood from damaged liver cells.

Question24

A woman in her third trimester complains of severe heartburn. What is appropriate teaching by the nurse to help the woman alleviate these symptoms?
A) Drink small amounts of liquids frequently
B) Eat the evening meal just before retiring
C) Take sodium bicarbonate after each meal
D) Sleep with head propped on several pillows

Review Information: The correct answer is D: Sleep with head propped on several pillows
Heartburn is a burning sensation caused by regurgitation of gastric contents. It is best relieved by sleeping position, eating small meals, and not eating before bedtime.

Question25

A 16 year-old boy is admitted for Ewing>s sarcoma of the tibia. In discussing his care with the parents, the nurse understands that the initial treatment most often includes
A) amputation just above the tumor
B) surgical excision of the mass
C) bone marrow graft in the affected leg
D) radiation and chemotherapy

Review Information: The correct answer is D: radiation and chemotherapy
The initial treatment of choice for Ewing>>s sarcoma is a combination of radiation and chemotherapy.

Question26

A new nurse manager is responsible for interviewing applicants for a staff nurse position. Which interview strategy would be the best approach?
A) Vary the interview style for each candidate to learn different techniques
B) Use simple questions requiring «yes» and «no» answers to gain definitive information
C) Obtain an interview guide from human resources for consistency in interviewing each candidate
D) Ask personal information of each applicant to assure he/she can meet job demands

Review Information: The correct answer is C: Obtain an interview guide from human resources

for consistency in interviewing each candidate
An interview guide used for each candidate enables the nurse manager to be more objective in the decision making. The nurse should use resources available in the agency before attempts to develop one from scratch. Certain personal questions are prohibited, and HR can identify these for novice managers.

Question27

What is the best way that parents of pre-schoolers can begin teaching their child about injury prevention?
A) Set good examples themselves
B) Protect their child from outside influences
C) Make sure their child understands all the safety rules
D) Discuss the consequences of not wearing protective devices

Review Information: The correct answer is A: Set good examples themselves
The preschool years are the time for parents to begin emphasizing safety principles as well as providing protection. Setting a good example themselves is crucial because of the imitative behaviors of pre-schoolers; they are quick to notice discrepancies between what they see and what they are told.

Question28

A nurse assessing the newborn of a mother with diabetes understands that hypoglycemia is related to what pathophysiological process?
A) Disruption of fetal glucose supply
B) Pancreatic insufficiency
C) Maternal insulin dependency
D) Reduced glycogen reserves

Review Information: The correct answer is A: Disruption of fetal glucose supply
After delivery, the high glucose levels which crossed the placenta to the fetus are suddenly stopped. The newborn continues to secrete insulin in anticipation of glucose. When oral feedings begin, the newborn will adjust insulin production within a day or two.

Question29

The nurse is caring for a client with extracellular fluid volume deficit. Which of the following assessments would the nurse anticipate finding?
A) bounding pulse
B) rapid respirations
C) oliguria
D) neck veins are distended

Review Information: The correct answer is C: oliguria
Kidneys maintain fluid volume through adjustments in urine volume.

Question30

A 70 year-old woman is evaluated in the emergency department for a wrist fracture of unknown causes. During the process of taking client history, which of these items should the nurse identify as related to the client's greatest risk factors for osteoporosis?
A) History of menopause at age 50
B) Taking high doses of steroids for arthritis for many years
C) Maintaining an inactive lifestyle for the past 10 years
D) Drinking 2 glasses of red wine each day for the past 30 years

Review Information: The correct answer is B: Taking high doses of steroids for arthritis for many years
The use of steroids, especially at high doses over time, increases the risk for osteoporosis. The other options also predispose to osteoporosis, as do low bone mass, poor calcium absorption and moderate to high alcohol ingestion. Long-term steroid treatment is the most significant risk factor, however.

Question31

The nurse is caring for a 2 year-old who is being treated with chelation therapy, calcium disodium edetate, for lead poisoning. The nurse should be alert for which of the following side effects?
A) Neurotoxicity
B) Hepatomegaly
C) Nephrotoxicity
D) Ototoxicity

Review Information: The correct answer is C: Nephrotoxicity
Nephrotoxicity is a common side effect of calcium disodium edetate, in addition to lead poisoning in general.

Question32

The parents of a toddler ask the nurse how long their child will have to sit in a car seat while in the automobile. What is the nurse's best response to the parents?
A) «Your child must use a care seat until he

weighs at least 40 pounds.»
B) «The child must be 5 years of age to use a regular seat belt.»
C) «Your child must reach a height of 50 inches to sit in a seat belt.»
D) «The child can use a regular seat belt when he can sit still.»

Review Information: The correct answer is A: «Your child must use a care seat until he weighs at least 40 pounds.»
Children should use car seats until they weigh 40 pounds.

Question33

A client asks the nurse to explain the basic ideas of homeopathic medicine. The response that best explains this approach is that such remedies
A) destroy organisms causing disease
B) maintain fluid balance
C) boost the immune system
D) increase bodily energy

Review Information: The correct answer is C: boost the immune system
The practitioner treats with minute doses of plant, mineral or animal substances which provide a gentle stimulus to the body>>s own defenses.

Question34

A client with a fractured femur has been in Russell's traction for 24 hours. Which nursing action is associated with this therapy?
A) Check the skin on the sacrum for breakdown
B) Inspect the pin site for signs of infection
C) Auscultate the lungs for atelectasis
D) Perform a neurovascular check for circulation

Information: **The correct answer** is D: Perform a neurovascular check for circulation
While each of these is an important assessment, the neurovascular integrity check is most associated with this type of traction. Russell's traction is Buck's traction with a sling under the knee.

Question35

When suctioning a client>s tracheostomy, the nurse should instill saline in order to
A) decrease the client>s discomfort
B) reduce viscosity of secretions
C) prevent client aspiration
D) remove a mucus plug

Review Information: The correct answer is D: remove a mucus plug
While no longer recommended for routine suctioning, saline may thin and loosen viscous secretions that are very difficult to move, perhaps making them easier to suction.

Question36

The nurse is performing a gestational age assessment on a newborn delivered 2 hours ago. When coming to a conclusion using the Ballard scale, which of these factors may affect the score?
A) Birth weight
B) Racial differences
C) Fetal distress in labor
D) Birth trauma

Review Information: The correct answer is C: Fetal distress in labor
The effects of earlier distress may alter the findings of reflex responses as measured on the Ballard tool. Other physical characteristics that estimate gestational age, such as amount of lanugo, sole creases and ear cartilage are unaffected by the other factors.

Question37

A nurse is caring for a client who had a closed reduction of a fractured right wrist followed by the application of a fiberglass cast 12 hours ago. Which finding requires the nurse's immediate attention?
A) Capillary refill of fingers on right hand is 3 seconds
B) Skin warm to touch and normally colored
C) Client reports prickling sensation in the right hand
D) Slight swelling of fingers of right hand

Review Information: The correct answer is C: Client reports prickling sensation in the right hand
A prickling sensation is an indication of compartment syndrome and requires immediate action by the nurse. The other findings are normal for a client in this situation.

Question38

A client is admitted with the diagnosis of pulmonary embolism. While taking a history, the client tells the nurse he was admitted for the same thing twice before, the last time just 3 months ago. The nurse would anticipate the provider ordering
A) pulmonary embolectomy
B) vena caval interruption

C) increasing the Coumadin therapy to an INR of 3-4
D) thrombolytic therapy

Review Information: The correct answer is B: vena caval interruption
Clients with contraindications to Heparin, recurrent PE or those with complications related to the medical therapy may require vena caval interruption by the placement of a filter device in the inferior vena cava. A filter can be placed transvenously to trap clots before they travel to the pulmonary circulation.

Question39
Which client is at highest risk for developing a pressure ulcer?
A) 23 year-old in traction for fractured femur
B) 72 year-old with peripheral vascular disease, who is unable to walk without assistance
C) 75 year-old with left sided paresthesia who is incontinent of urine and stool
D) 30 year-old who is comatose following a ruptured aneurysm

Review Information: The correct answer is C: 75 year-old with left sided paresthesia who is incontinent of urine and stool
Risk factors for pressure ulcers include: immobility, absence of sensation, decreased LOC, poor nutrition and hydration, skin moisture, incontinence, increased age, decreased immune response. This client has the greatest number of risk factors.

Question40
The nurse is teaching the mother of a 5 month-old about nutrition for her baby. Which statement by the mother indicates the need for further teaching?
A) «I>m going to try feeding my baby some rice cereal.»
B) «When he wakes at night for a bottle, I feed him.»
C) «I dip his pacifier in honey so he>ll take it.»
D) «I keep formula in the refrigerator for 24 hours.»

Review Information: The correct answer is C: «I dip his pacifier in honey so he>>ll take it.»
Honey has been associated with infant botulism and should be avoided. Older children and adults have digestive enzymes that kill the botulism spores.

Free NCLEX-RN Sample Test Questions For Nursing Review (Part 4) Jul31,

Question1
The clinic nurse is counseling a substance-abusing post partum client on the risks of continued cocaine use. In order to provide continuity of care, which nursing diagnosis is a priority?
A) Social isolation
B) Ineffective coping
C) Altered parenting
D) Sexual dysfunction

Review Information: The correct answer is C: Altered parenting
The cocaine abusing mother puts her newborn and other children at risk for neglect and abuse. Continuing to use drugs has the potential to impact parenting behaviors. Social service referrals are indicated.

Question2
The nurse is teaching about nonsteroidal anti-inflammatory drugs (NSAIDs) to a group of arthritic clients. To minimize the side effects, the nurse should emphasize which of the following actions?
A) Reporting joint stiffness in the morning
B) Taking the medication 1 hour before or 2 hours after meals
C) Using alcohol in moderation unless driving
D) Continuing to take aspirin for short term relief

Review Information: The correct answer is B: Taking the medication 1 hour before or 2 hours after meals
Taking the medication 1 hour before or 2 hours after meals will result in a more rapid effect.

Question3
The nurse is preparing to administer a tube feeding to a postoperative client. To accurately assess for a gastrostomy tube placement, the priority is to
A) auscultate the abdomen while instilling 10 cc of air into the tube
B) place the end of the tube in water to check for air bubbles
C) retract the tube several inches to check for resistance
D) measure the length of tubing from nose to epi-

gastrium

Review Information: The correct answer is A: auscultate the abdomen while instilling 10 cc of air into the tube
If a swoosh of air is heard over the abdominal cavity while instilling air into the gastric tube, this indicates that it is accurately placed in the stomach. The feeding can begin after further assessing the client for bowel sounds.

Question4
While assessing the vital signs in children, the nurse should know that the apical heart rate is preferred until the radial pulse can be accurately assessed at about what age?
A) 1 year of age
B) 2 years of age
C) 3 years of age
D) 4 years of age

Review Information: The correct answer is B: 2 years of age
A child should be at least 2 years of age to use the radial pulse to assess heart rate.

Question5
A client is receiving Total Parenteral Nutrition (TPN) via a Hickman catheter. The catheter accidentally becomes dislodged from the site. Which action by the nurse should take priority?
A) Check that the catheter tip is intact
B) Apply a pressure dressing to the site
C) Monitor respiratory status
D) Assess for mental status changes

Question6
A pregnant client who is at 34 weeks gestation is diagnosed with a pulmonary embolism (PE). Which of these medications would the nurse anticipate the provider ordering?
A) Oral Coumadin therapy
B) Heparin 5000 units subcutaneously B.I.D.
C) Heparin infusion to maintain the PTT at 1.5-2.5 times the control value
D) Heparin by subcutaneous injection to maintain the PTT at 1.5 times the control value

Review Information: The correct answer is D: Heparin by subcutaneous injection to maintain the PTT at 1.5 times the control value
Several studies have been conducted in pregnant women where oral anticoagulation agents are contraindicated. Warfarin (Coumadin) is known to cross the placenta and is therefore reported to be teratogenic.

Question7
The nurse is caring for a client with Hodgkin>s disease who will be receiving radiation therapy. The nurse recognizes that, as a result of the radiation therapy, the client is most likely to experience
A) high fever
B) nausea
C) face and neck edema
D) night sweats

Review Information: The correct answer is B: nausea
Because the client with Hodgkin>>s disease is usually healthy when therapy begins, the nausea is especially troubling.

Question8
A client is brought to the emergency room following a motor vehicle accident. When assessing the client one-half hour after admission, the nurse notes several physical changes. Which finding would require the nurse>s immediate attention?
A) increased restlessness
B) tachycardia
C) tracheal deviation
D) tachypnea

Review Information: The correct answer is C: tracheal deviation
The deviated trachea is a sign that a mediastinal shift has occurred. This is a medical emergency.

Question9
An 18 month-old child is on peritoneal dialysis in preparation for a renal transplant in the near future. When the nurse obtains the child>s health history, the mother indicates that the child has not had the first measles, mumps, rubella (MMR) immunization. The nurse understands that which of the following is true in regards to giving immunizations to this child?
A) Live vaccines are withheld in children with renal chronic illness
B) The MMR vaccine should be given now, prior to the transplant
C) An inactivated form of the vaccine can be given at any time
D) The risk of vaccine side effects precludes giving the vaccine

Review Information: The correct answer is B: The MMR vaccine should be given now, prior to the transplant
MMR is a live virus vaccine, and should be given at this time. Post-transplant, immunosuppressive drugs will be given and the administration of the live vaccine at that time would be contraindicated because of the compromised immune system.

Question10

The nurse is preparing to take a toddler>s blood pressure for the first time. Which of the following actions should the nurse perform first?
A) Explain that the procedure will help him to get well
B) Show a cartoon character with a blood pressure cuff
C) Explain that the blood pressure checks the heart pump
D) Permit handling the equipment before putting the cuff in place

Review Information: The correct answer is D: Permit handling the equipment before putting the cuff in place
The best way to gain the toddler>>s cooperation is to encourage handling the equipment. Detailed explanations are not helpful.

Question11

Which statement made by a nurse about the goal of total quality management or continuous quality improvement in a health care setting is correct?
A) It is to observe reactive service and product problem solving
B) Improvement of the processes in a proactive, preventive mode is paramount
C) A chart audits to finds common errors in practice and outcomes associated with goals
D) A flow chart to organize daily tasks is critical to the initial stages

Review Information: The correct answer is B: Improvement of the processes in a proactive, preventive mode is paramount
Total quality management and continuous quality improvement have a major goal of identifying ways to do the right thing at the right time in the right way by proactive problem-solving.

Question12

Which of the following drugs should the nurse anticipate administering to a client before they are to receive electroconvulsive therapy?
A) Benzodiazepines
B) Chlorpromazine (Thorazine)
C) Succinylcholine (Anectine)
D) Thiopental sodium (Pentothal Sodium)

Review Information: The correct answer is C: Succinylcholine (Anectine)
Succinylcholine is given intravenously to promote skeletal muscle relaxation.

Question13

Which approach is a priority for the nurse who works with clients from many different cultures?
A) Speak at least 2 other languages of clients in the neighborhood
B) Learn about the cultures of clients who are most often encountered
C) Have a list of persons for referral when interaction with these clients occur
D) Recognize personal attitudes about cultural differences and real or expected biases

Review Information: The correct answer is D: Recognize personal attitudes about cultural differences and real or expected biases
The nurse must discover personal attitudes, prejudices and biases specific to different cultures. Awareness of these will prevent negative consequences for interactions with clients and families across cultures.

Question14

A client with chronic obstructive pulmonary disease (COPD) and a history of coronary artery disease is receiving aminophylline, 25mg/hour. Which one of the following findings by the nurse would require immediate intervention?
A) Decreased blood pressure and respirations
B) Flushing and headache
C) Restlessness and palpitations
D) Increased heart rate and blood pressure

Review Information: The correct answer is C: Restlessness and palpitations
Side effects of Aminophylline include restlessness and palpitations.

Question15

A client has gastroesophageal reflux. Which recommendation made by the nurse would be most helpful to the client?
A) Avoid liquids unless a thickening agent is used
B) Sit upright for at least 1 hour after eating
C) Maintain a diet of soft foods and cooked veg-

etables
D) Avoid eating 2 hours before going to sleep

Review Information: The correct answer is D: Avoid eating 2 hours before going to sleep
Eating before sleeping enhances the regurgitation of stomach contents, which have increased acidity, into the esophagus. An upright posture should be maintained for about 2 hours after eating to allow for the stomach emptying. Options A and C are interventions for clients with swallowing difficulties.

Question16

A client with a panic disorder has a new prescription for Xanax (alprazolam). In teaching the client about the drug>s actions and side effects, which of the following should the nurse emphasize?
A) Short-term relief can be expected
B) The medication acts as a stimulant
C) Dosage will be increased as tolerated
D) Initial side effects often continue

Review Information: The correct answer is A: Short-term relief can be expected
Xanax is a short-acting benzodiazepine useful in controlling panic symptoms quickly.

Question17

A client being discharged from the cardiac step-down unit following a myocardial infarction (MI), is given a prescription for a beta-blocking drug. A nursing student asks the charge nurse why this drug would be used by a client who is not hypertensive. What is an appropriate response by the charge nurse?
A) «Most people develop hypertension following an MI.»
B) «A beta-Blocker will prevent orthostatic hypotension.»
C) «This drug will decrease the workload on his heart.»
D) «Beta-blockers increase the strength of heart contractions.»

Review Information: The correct answer is C: «This drug will decrease the workload on his heart.»
One action of beta-blockers is to decrease systemic vascular resistance by dilating arterioles. This is useful for the client with coronary artery disease, and will reduce the risk of another MI or sudden death.

Question18

A 35-year-old client of Puerto Rican-American descent is diagnosed with ovarian cancer. The client states, "I refuse both radiation and chemotherapy because they are <hot.>" The next action for the nurse to take is to
A) document the situation in the notes
B) report the situation to the health care provider
C) talk with the client>s family about the situation
D) ask the client to talk about concerns regarding «hot» treatments

Review Information: The correct answer is D: ask the client to talk about concerns regarding «hot» treatments
The «hot-cold» system is found among Mexican-Americans, Puerto Ricans, and other Hispanic-Latinos. Most foods, beverages, herbs, and medicines are categorized as hot or cold, which are symbolic designations and do not necessarily indicate temperature or spiciness. Care and treatment regimens can be negotiated with clients within this framework.

Question19

A 72 year-old client is scheduled to have a cardioversion. A nurse reviews the client's medication administration record. The nurse should notify the health care provider if the client received which medication during the preceding 24 hours?
A) Digoxin (Lanoxin)
B) Diltiazem (Cardizem)
C) Nitroglycerine ointment
D) Metoprolol (Toprol XL)

Review Information: The correct answer is A: Digoxin (Lanoxin)
Digoxin increases ventricular irritability and increases the risk of ventricular fibrillation following cardioversion. The other medications do not increase ventricular irritability.

Question20

Which of these clients, all of whom have the findings of a board-like abdomen, would the nurse suggest that the provider examine first?
A) An elderly client who stated, «My awful pain in my right side suddenly stopped about 3 hours ago.»
B) A pregnant woman of 8 weeks newly diagnosed with an ectopic pregnancy
C) A middle-aged client admitted with diverticulitis who has taken only clear liquids for the past week
D) A teenager with a history of falling off a bicycle

without hitting the handle bars

Review Information: The correct answer is A: An elderly client who stated, «My awful pain in my right side suddenly stopped about 3 hours ago.»
This client has the highest risk for hypovolemic and septic shock since the appendix has most likely ruptured, based on the history of the pain suddenly stopping over three hours ago. Elderly clients have less functional reserve for the body to cope with shock and infection over long periods. The others are at risk for shock also, however given that they fall in younger age groups, they would more likely be able to tolerate an imbalance in circulation. A common complication of falling off a bicycle is hitting the handle bars in the upper abdomen often on the left, resulting in a ruptured spleen.

Question21

The nurse is teaching parents of a 7 month-old about adding table foods. Which of the following is an appropriate finger food?
A) Hot dog pieces
B) Sliced bananas
C) Whole grapes
D) Popcorn

Review Information: The correct answer is B: Sliced bananas
Finger foods should be bite-size pieces of soft food such as bananas. Hot dogs and grapes can accidentally be swallowed whole and can occlude the airway. Popcorn is too difficult to chew at this age and can irritate the airway if swallowed.

Question22

To prevent drug resistance from developing, the nurse is aware that which of the following is a characteristic of the typical treatment plan to eliminate the tuberculosis bacilli?
A) An anti-inflammatory agent
B) High doses of B complex vitamins
C) Aminoglycoside antibiotics
D) Administering two anti-tuberculosis drugs

Review Information: The correct answer is D: Administering two anti-tuberculosis drugs
Resistance of the tubercle bacilli often occurs to a single antimicrobial agent. Therefore, therapy with multiple drugs over a long period of time helps to ensure eradication of the organism.

Question23

The nurse is assessing a comatose client receiving gastric tube feedings. Which of the following assessments requires an immediate response from the nurse?
A) Decreased breath sounds in right lower lobe
B) Aspiration of a residual of 100cc of formula
C) Decrease in bowel sounds
D) Urine output of 250 cc in past 8 hours

Review Information: The correct answer is A: Decreased breath sounds in right lower lobe
The most common problem associated with enteral feedings is atelectasis. Maintain client at 30 degrees of head elevation during feedings and monitor for signs of aspiration. Check for tube placement prior to each feeding or every 4 to 8 hours if the client is receiving continuous feeding.

Question24

A client is prescribed warfarin sodium (Coumadin) to be continued at home. Which focus is critical to be included in the nurse's discharge instruction?
A) Maintain a consistent intake of green leafy foods
B) Report any nose or gum bleeds
C) Take Tylenol for minor pains
D) Use a soft toothbrush

Review Information: The correct answer is B: Report any nose or gum bleeds
The client should notify the health care provider if blood is noted in stools or urine, or any other signs of bleeding occur.

Question25

When teaching a client about the side effects of fluoxetine (Prozac), which of the following will the nurse include?
A) Tachycardia blurred vision, hypotension, anorexia
B) Orthostatic hypotension, vertigo, reactions to tyramine-rich foods
C) Diarrhea, dry mouth, weight loss, reduced libido
D) Photosensitivity, seizures, edema, hyperglycemia

Review Information: The correct answer is C: Diarrhea, dry mouth, weight loss, reduced libido
Commonly reported side effects for fluoxetine (Prozac) are diarrhea, dry mouth, weight loss and reduced libido.

Question26

A newborn weighed 7 pounds 2 ounces at birth. The nurse assesses the newborn at home 2 days later and finds the weight to be 6 pounds 7 ounces. What should the nurse tell the parents about this weight loss?

A) The newborn needs additional assessments
B) The mother should breast feed more often
C) A change to formula is indicated
D) The loss is within normal limits

Review Information: The correct answer is D: The loss is within normal limits

A newborn is expected to lose 5-10% of the birth weight in the first few days post-partum because of changes in elimination and feeding.

Question27

The nurse manager informs the nursing staff at morning report that the clinical nurse specialist will be conducting a research study on staff attitudes toward client care. All staff are invited to participate in the study if they wish. This affirms the ethical principle of

A) Anonymity
B) Beneficence
C) Justice
D) Autonomy

Review Information: The correct answer is D: Autonomy

Individuals must be free to make independent decisions about participation in research without coercion from others.

Question28

The nurse is talking with the family of an 18 months-old newly diagnosed with retinoblastoma. A priority in communicating with the parents is

A) Discuss the need for genetic counseling
B) Inform them that combined therapy is seldom effective
C) Prepare for the child>s permanent disfigurement
D) Suggest that total blindness may follow surgery

Review Information: The correct answer is A: Discuss the need for genetic counseling

The hereditary aspects of this disease are well documented. While the parents focus on the needs of this child, they should be aware that the risk is high for future offspring.

Question29

The nurse is planning care for an 8 year-old child. Which of the following should be included in the plan of care?

A) Encourage child to engage in activities in the playroom
B) Promote independence in activities of daily living
C) Talk with the child and allow him to express his opinions
D) Provide frequent reassurance and cuddling

Review Information: The correct answer is A: Encourage child to engage in activities in the playroom

According to Erikson, the school age child is in the stage of industry versus inferiority. To help them achieve industry, the nurse should encourage them to carry out tasks and activities in their room or in the playroom.

Question30

The nurse is assigned to care for 4 clients. Which of the following should be assessed immediately after hearing the report?

A) The client with asthma who is now ready for discharge
B) The client with a peptic ulcer who has been vomiting all night
C) The client with chronic renal failure returning from dialysis
D) The client with pancreatitis who was admitted yesterday

Review Information: The correct answer is B: The client with a peptic ulcer who has been vomiting all night

A perforated peptic ulcer could cause nausea, vomiting and abdominal distention, and may be a life threatening situation. The client should be assessed immediately and findings reported to the provider.

Question31

During a routine check-up, an insulin-dependent diabetic has his glycosylated hemoglobin checked. The results indicate a level of 11%. Based on this result, what teaching should the nurse emphasize?

A) Rotation of injection sties
B) Insulin mixing and preparation
C) Daily blood sugar monitoring
D) Regular high protein diet

Review Information: The correct answer is C:

Daily blood sugar monitoring
Normal hemoglobin A1C (glycosylated hemoglobin) level is 7 to 9%. Elevation indicates elevated glucose levels over time.

Question32

A client taking isoniazid (INH) for tuberculosis asks the nurse about side effects of the medication. The client should be instructed to immediately report which of these?
A) Double vision and visual halos
B) Extremity tingling and numbness
C) Confusion and lightheadedness
D) Sensitivity of sunlight

Review Information: The correct answer is B: Extremity tingling and numbness
Peripheral neuropathy is the most common side effect of INH and should be reported to the provider. It can be reversed.

Question33

Which of these questions is priority when assessing a client with hypertension?
A) «What over-the-counter medications do you take?»
B) «Describe your usual exercise and activity patterns.»
C) «Tell me about your usual diet.»
D) «Describe your family>s cardiovascular history.»

Review Information: The correct answer is A: «What over-the-counter medications do you take?»
Over-the-counter medications, especially those that contain cold preparations can increase the blood pressure to the point of hypertension.

Question34

The nurse is performing an assessment of the motor function in a client with a head injury. The best technique is
A) touching the trapezius muscle or arm firmly
B) pinching any body part
C) shaking a limb vigorously
D) rubbing the sternum

Review Information: The correct answer is D: rubbing the sternum
The purpose is to assess the non-responsive client's reaction to a painful stimulus after less noxious methods have been tried.

Question35

A nurse admits a client transferred from the emergency room (ER). The client, diagnosed with a myocardial infarction, is complaining of substernal chest pain, diaphoresis and nausea. The first action by the nurse should be to
A) order an EKG
B) administer morphine sulfate
C) start an IV
D) measure vital signs

Review Information: The correct answer is B: administer morphine sulfate
Decreasing the clients pain is the most important priority at this time. As long as pain is present there is danger in extending the infarcted area. Morphine will decrease the oxygen demands of the heart and act as a mild diuretic as well. It is probable that an EKG and IV insertion were performed in the ER.

Question36

The nurse admits a 2 year-old child who has had a seizure. Which of the following statement by the child>s parent would be important in determining the etiology of the seizure?
A) «He has been taking long naps for a week.»
B) «He has had an ear infection for the past 2 days.»
C) «He has been eating more red meat lately.»
D) «He seems to be going to the bathroom more frequently.»
Review Information: The correct answer is B: «He has had an ear infection for the past 2 days.»
Contributing factors to seizures in children include those such as age (more common in first 2 years), infections (late infancy and early childhood), fatigue, not eating properly and excessive fluid intake or fluid retention.

Question37

Which of these clients would the nurse monitor for the complication of C. difficile diarrhea?
A) An adolescent taking medications for acne
B) An elderly client living in a retirement center taking prednisone
C) A young adult at home taking a prescribed aminoglycoside
D) A hospitalized middle aged client receiving clindamycin

Review Information: The correct answer is D: A hospitalized middle aged client receiving clindamycin
Hospitalized patients, especially those receiving antibiotic therapy, are primary targets for C. diffi-

cile. Of clients receiving antibiotics, 5-38% experience antibiotic-associated diarrhea; C. difficile causes 15 to 20% of the cases. Several antibiotic agents have been associated with C. difficile. Broad-spectrum agents, such as clindamycin, ampicillin, amoxicillin, and cephalosporins, are the most frequent sources of C. difficile. Also, C. difficile infection has been caused by the administration of agents containing beta-lactamase inhibitors (i.e., clavulanic acid, sulbactam, tazobactam) and intravenous agents that achieve substantial colonic intraluminal concentrations (i.e., ceftriaxone, nafcillin, oxacillin). Fluoroquinolones, aminoglycosides, vancomycin, and trimethoprim are seldom associated with C. difficile infection or pseudomembranous colitis.

Question38

The nurse is performing an assessment on a client who is cachectic and has developed an enterocutaneous fistula following surgery to relieve a small bowel obstruction. The client>s total protein level is reported as 4.5 g/dl. Which of the following would the nurse anticipate?

A) Additional potassium will be given IV
B) Blood for coagulation studies will be drawn
C) Total parenteral nutrition (TPN) will be started
D) Serum lipase levels will be evaluated

Review Information: The correct answer is C: Total parenteral nutrition (TPN) will be started
The client is not absorbing nutrients adequately as evidenced by the cachexia and low protein levels. (A normal total serum protein level is 6.0-8.0 g/dl.) TPN will promote a positive nitrogen balance in this client who is unable to digest and absorb nutrients adequately.

Question39

During a situation of pain management, which statement is a priority to consider for the ethical guidelines of the nurse?

A) The client>s self-report is the most important consideration
B) Cultural sensitivity is fundamental to pain management
C) Clients have the right to have their pain relieved
D) Nurses should not prejudge a client>s pain using their own values

Review Information: The correct answer is A: The client>>s self-report is the most important consideration
Pain is a complex phenomenon that is perceived differently by each individual. Pain is whatever the client says it is. The other statements are correct but not the most important considerations.

Question40

As a part of a 9 pound full-term newborn>s assessment, the nurse performs a dextro-stick at 1 hour post birth. The serum glucose reading is 45 mg/dl. What action by the nurse is appropriate at this time?

A) Give oral glucose water
B) Notify the pediatrician
C) Repeat the test in 2 hours
D) Check the pulse oximetry reading

Review Information: The correct answer is C: Repeat the test in 2 hours
This blood sugar is within the normal range for a full-term newborn. Normal values are: Premature infant: 20-60 mg/dl or 1.1-3.3 mmol/L, Neonate: 30-60 mg/dl or 1.7-3.3 mmol/L, Infant: 40-90 mg/dl or 2.2-5.0 mmol/L. Critical values are: Infant: <40 mg/dl and in a Newborn: <30 and >300 mg/dl. Because of the increased birth weight which can be associated with diabetes mellitus, repeated blood sugars will be drawn

Free NCLEX-RN Sample Test Questions For Nursing Review (Part 3)

Jul31,

Question1

A client diagnosed with chronic depression is maintained on tranylcypromine (Parnate). An important nursing intervention is to teach the client to avoid which of the following foods?

A) Wine, beer, cheese, liver and chocolate
B) Wine, citrus fruits, yogurt and broccoli
C) Beer, cheese, beef and carrots
D) Wine, apples, sour cream and beef steak

Review Information: The correct answer is A: Wine, beer, cheese, liver and chocolate
These foods are tyramine rich and ingestion of these foods while taking monoamine oxidase inhibitors (MAOIs) can precipitate a life-threatening hypertensive crisis.

Question2

The nurse is working in a high risk antepartum clinic. A 40 year-old woman in the first trimester gives a thorough health history. Which information should receive priority attention by the nurse?

A) Her father and brother are insulin dependent diabetics
B) She has taken 800 mcg of folic acid daily for the past year
C) Her husband was treated for tuberculosis as a child
D) She reports recent use of over-the counter sinus remedies

Review Information: The correct answer is D: She reports recent use of over-the counter sinus remedies
Over-the-counter drugs are a possible danger in early pregnancy. A report by the client that she has taken medications should be followed up immediately.

Question3

What must be the priority consideration for nurses when communicating with children?
A) Present environment
B) Physical condition
C) Nonverbal cues
D) Developmental level

Review Information: The correct answer is D: Developmental level
While each of the factors affect communication, the nurse recognizes that developmental differences have implications for processing and understanding information. Consequently, a child's developmental level must be considered when selecting communication approaches.

Question4

The nurse is assessing a client>s home in preparation for discharge. Which of the following should be given priority consideration?
A) Family understanding of client needs
B) Financial status
C) Location of bathrooms
D) Proximity to emergency services

Review Information: The correct answer is A: Family understanding of client needs
Functional communication patterns between family members are fundamental to meeting the needs of the client and family.

Question5

As a general guide for emergency management of acute alcohol intoxication, it is important for the nurse initially to obtain data regarding which of the following?
A) What and how much the client drinks, according to family and friends
B) The blood alcohol level of the client
C) The blood pressure level of the client
D) The blood glucose level of the client

Review Information: The correct answer is B: The blood alcohol level of the client
Blood alcohol levels are generally obtained to determine the level of intoxication. The amount of alcohol consumed determines how much medication the client needs for detoxification and treatment. Reports of alcohol consumption are notoriously inaccurate.

Question6

Which clinical finding would the nurse expect to assess first in a newborn with spastic cerebral palsy?
A) cognitive impairment
B) hypotonic muscular activity
C) seizures
D) criss-crossing leg movement

Review Information: The correct answer is D: criss-crossing leg movement
Cerebral palsy is a neuromuscular impairment resulting in muscular and reflexive hypertonicity and the criss-crossing, or scissoring leg movements.

Question7

Which medication is more helpful in treating bulimia than anorexia?
A) Amphetamines
B) Sedatives
C) Anticholinergics
D) Narcotics

Review Information: The correct answer is C: Anticholinergics
In contrast to anorexics, individuals with bulimia are troubled by their behavioral characteristics and become depressed. The person feels compelled to binge, purge and fast. Feeling helpless to stop the behavior, feelings of self-disgust occur.

Question8

The nurse is assessing a woman in early labor. While positioning for a vaginal exam, she complains of dizziness and nausea and appears pale. Her blood pressure has dropped slightly. What should be the initial nursing action?
A) Call the health care provider
B) Encourage deep breathing
C) Elevate the foot of the bed
D) Turn her to her left side

Review Information: The correct answer is D: Turn her to her left side
The weight of the uterus can put pressure on the vena cava and aorta when a pregnant woman is flat on her back causing supine hypotension. Action is needed to relieve the pressure on the vena cava and aorta. Turning the woman to the side reduces this pressure and relieves postural hypotension.

Question9

A client has been started on a long term corticosteroid therapy. Which of the following comments by the client indicate the need for further teaching?
A) «I will keep a weekly weight record.»
B) «I will take medication with food.»
C) «I will stop taking the medication for 1 week every month.»
D) «I will eat foods high in potassium.»

Review Information: The correct answer is C: «I will stop taking the medication for 1week every month.»
Emphatically warn against discontinuing steroid dosage abruptly because that may produce a fatal adrenal crisis.

Question10

A male client calls for a nurse because of chest pain. Which statement by the client would require the most immediate action by the nurse?
A) «When I take in a deep breath, it stabs like a knife.»
B) «The pain came on after dinner. That soup seemed very spicy.»
C) «When I turn in bed to reach the remote for the TV, my chest hurts.»
D) «I feel pressure in the middle of my chest, like an elephant is sitting on my chest.»

Review Information: The correct answer is D: «I feel pressure in the middle of my chest, like an elephant is sitting on my chest.»
This is a classic description of chest pain in men caused by myocardial ischemia. Women experience vague feelings of fatigue and back and jaw pain.

Question11

A nurse is caring for a client who has just been admitted with an overdose of aspirin. The following lab data is available: PaO2 95, PaCO2 30, pH 7.5, K 3.2 mEq/l. Which should be the nurse>s first action?
A) Monitor respiratory rate
B) Monitor intake and output every hour
C) Assist the client to breathe into a paper bag
D) Prepare to administer oxygen by mask

Review Information: The correct answer is C: Assist the client to breathe into a paper bag
Side effects of aspirin toxicity include hyperventilation, which can result in respiratory alkalosis in the initial stages. Breathing into a paper bag will prevent further reduction in PaCO2.

Question12

After assessing a 70 year-old male client>s laboratory results during a routine clinic visit, which one of the following findings would indicate an area in which teaching is needed:
A) Serum albumin 2.5 g/dl
B) LDL Cholesterol 140 mg/dl
C) Serum glucose 90 mg/dl
D) RBC 5.0 million/mm3

Review Information: The correct answer is A: Serum albumin 2.5 g/dl
Serum albumin level is low (normal 3.0 – 5.0 g/dl in elders), indicating nutritional counseling to increase dietary protein is needed. Socioeconomic factors may need to be addressed to help the client comply with the recommendation.

Question13

When teaching a client with a new prescription for lithium (Lithane) for treatment of a bi-polar disorder which of these should the nurse emphasize?
A) Maintaining a salt restricted diet
B) Reporting vomiting or diarrhea
C) Taking other medication as usual
D) Substituting generic form if desired

Review Information: The correct answer is B: Reporting vomiting or diarrhea
If dehydration results from vomiting, diarrhea or excessive perspiration, tolerance to the drug may be altered and symptoms may return.

Question14

A client is discharged on warfarin sulfate (Coumadin). Which statement by the client indicated a need for further teaching?
A) «I know I must avoid crowds.»
B) «I will keep all laboratory appointments.»

C) «I plan to use an electric razor for shaving.»
D) «I will report any bruises for bleeding.»

Review Information: The correct answer is A: «I know I must avoid crowds.»
There are no specific reasons for the client on Coumadin to avoid crowds. General instructions for any cardiac surgical client include limiting exposure to infection.

Question15
A client is taking tranylcypromine (Parnate) and has received dietary instruction. Which of the following food selections would be contraindicated for this client?
A) Fresh juice, carrots, vanilla pudding
B) Apple juice, ham salad, fresh pineapple
C) Hamburger, fries, strawberry shake
D) Red wine, fava beans, aged cheese

Review Information: The correct answer is D: Red wine, fava beans, aged cheese
Red wine and cheese contain tyramine (as do chicken liver and ripe bananas) and so are contraindicated when taking MAOIs. Fava beans contain other vasopressors that can interact with MAOIs also causing malignant hypertension.

Question16
A client is admitted with severe injuries from an auto accident. The client>s vital signs are BP 120/50, pulse rate 110, and respiratory rate of 28. The initial nursing intervention would be to
A) begin intravenous therapy
B) initiate continuous blood pressure monitoring
C) administer oxygen therapy
D) institute cardiac monitoring

Review Information: The correct answer is C: administer oxygen therapy
Early findings of shock reveal hypoxia with rapid heart rate and rapid respirations, and oxygen is the most critical initial intervention. The other interventions are secondary to oxygen therapy.

Question17
A client is admitted to the hospital with a diagnosis of deep vein thrombosis. During the initial assessment, the client complains of sudden shortness of breath. The SaO2 is 87. The priority nursing assessment at this time is
A) bowel sounds
B) heart rate
C) peripheral pulses
D) lung sounds

Review Information: The correct answer is D: lung sounds
Lung sounds are critical assessments at this point. The nurse should be alert to crackles or a pleural friction rub, highly suggestive of a pulmonary embolism.

Question18
The nurse is administering lidocaine (Xylocaine) to a client with a myocardial infarction. Which of the following assessment findings requires the nurse>s immediate action?
A) Central venous pressure reading of 11
B) Respiratory rate of 22
C) Pulse rate of 48 BPM
D) Blood pressure of 144/92

Review Information: The correct answer is C: Pulse rate of 48 BPM
One of the side effects of lidocaine is bradycardia, heart block, cardiovascular collapse and cardiac arrest (this drug should never be administered without continuous EKG monitoring).

Question19
The nurse is teaching a group of college students about breast self-examination. A woman asks for the best time to perform the monthly exam. What is the best reply by the nurse?
A) «The first of every month, because it is easiest to remember»
B) «Right after the period, when your breasts are less tender»
C) «Do the exam at the same time every month»
D) «Ovulation, or mid-cycle is the best time to detect changes»

Review Information: The correct answer is B: «Right after the period, when your breasts are less tender»
The best time for a breast self exam (BSE) is a week after a menstrual cycle, when the breasts are no longer swollen and tender due to hormone elevation.

Question20

The nurse is caring for a post-operative client who develops a wound evisceration. The first nursing intervention should be to

A) medicate the client for pain
B) call the provider
C) cover the wound with sterile saline dressing
D) place the bed in a flat position

Review Information: The correct answer is C: cover the wound with sterile saline dressing
When evisceration occurs, the wound should first be quickly covered by sterile dressings soaked in sterile saline. This prevents tissue damage until a repair can be effected.

Question21

The spouse of a client with Alzheimer>s disease expresses concern about the burden of caregiving. Which of the following actions by the nurse should be a priority?

A) Link the caregiver with a support group
B) Ask friends to visit regularly
C) Schedule a home visit each week
D) Request anti-anxiety prescriptions

Review Information: The correct answer is A: Link the caregiver with a support group
Assisting caregivers to locate and join support groups is most helpful. Families share feelings and learn about services such as respite care. Health education is also available through local and national Alzheimer>>s chapters.

Question22

Clients taking lithium must be particularly sure to maintain adequate intake of which of these elements?

A) Potassium
B) Sodium
C) Chloride
D) Calcium

Review Information: The correct answer is B: Sodium
Clients taking lithium need to maintain an adequate intake of sodium. Serum lithium concentrations may increase in the presence of conditions that cause sodium loss.

Question23

A client is receiving lithium carbonate 600 mg T.I.D. to treat bipolar disorder. Which of these indicate early signs of toxicity?

A) Ataxia and course hand tremors
B) Vomiting, diarrhea and lethargy
C) Pruritus, rash and photosensitivity
D) Electrolyte imbalance and cardiac arrhythmias

Review Information: The correct answer is B: Vomiting, diarrhea and lethargy
These are early signs of lithium toxicity.

Question24

The nurse can best ensure the safety of a client suffering from dementia who wanders from the room by which action?

A) Repeatedly remind the client of the time and location
B) Explain the risks of walking with no purpose
C) Use protective devices to keep the client in the bed or chair in the room
D) Attach a wander-guard sensor band to the client>s wrist

Review Information: The correct answer is D: Attach a wander-guard sensor band to the client>>s wrist
This type of identification band easily tracks the client>>s movements and ensures safety while the client wanders on the unit. Restriction of activity is inappropriate for any client unless they are potentially harmful to themselves or others.

Question25

The nurse is teaching a client about the difference between tardive dyskinesia (TD) and neuroleptic malignant syndrome (NMS). Which statement is true with regards to tardive dyskinesia?

A) TD develops within hours or years of continued antipsychotic drug use in people under 20 and over 30
B) It can occur in clients taking antipsychotic drugs longer than 2 years
C) Tardive dyskinesia occurs within minutes of the first dose of antipsychotic drugs and is reversible
D) TD can easily be treated with anticholinergic drugs

Review Information: The correct answer is B: It can occur in clients taking antipsychotic drugs

longer than 2 years
Tardive dyskinesia is a extrapyramidal side effect that appears after prolonged treatment with antipsychotic medication. Early symptoms of tardive dyskinesia are fasciculations of the tongue or constant smacking of the lips.

Question26

The nurse is aware that the effect of antihypertensive drug therapy may be affected by a 75 year-old client>s
A) poor nutritional status
B) decreased gastrointestinal motility
C) increased splanchnic blood flow
D) altered peripheral resistance

Review Information: The correct answer is B: decreased gastrointestinal motility
Together with shrinkage of the gastric mucosa, and changes in the levels of hydrochloric acid, this will decrease absorption of medications and interfere with their actions.

Question27

In response to a call for assistance by a client in labor, the nurse notes that a loop on the umbilical cord protrudes from the vagina. What is the priority nursing action?
A) call the health care provider
B) check fetal heart beat
C) put the client in knee-chest position
D) turn the client to the side

Review Information: The correct answer is C: put the client in knee-chest position
Immediate action is needed to relieve pressure on the cord, which puts the fetus at risk due to hypoxia. The Trendelenburg position accomplishes this. The exposed cord is covered with saline soaked gauze, not reinserted. The fetal heart rate also should be checked, and the provider called. A prolapsed umbilical cord is a medical emergency.

Question28

The nurse is caring for a 2 month-old infant with a congenital heart defect. Which of the following is a priority nursing action?
A) Provide small feedings every 3 hours
B) Maintain intravenous fluids
C) Add strained cereal to the diet
D) Change to reduced calorie formula

Review Information: The correct answer is A: Provide small feedings every 3 hours
Infants with congenital heart defects are at increased risk for developing congestive heart failure. Infants with congestive heart failure have an increased metabolic rate and require additional calories to grow. At the same time, however, rest and conservation of energy for eating is important. Feedings should be smaller and every 3 hours rather than the usual 4 hour schedule.

Question29

The nurse is caring for a client receiving intravenous nitroglycerin for acute angina. What is the most important assessment during treatment?
A) Heart rate
B) Neurologic status
C) Urine output
D) Blood pressure

Review Information: The correct answer is D: Blood pressure
The vasodilatation that occurs as a result of this medication can cause profound hypotension. The client>>s blood pressure must be evaluated every 15 minutes until stable and then every 30 minutes to every hour.

Question30

A client telephones the clinic to ask about a home pregnancy test she used this morning. The nurse understands that the presence of which hormone strongly suggests a woman is pregnant?
A) Estrogen
B) HCG
C) Alpha-fetoprotein
D) Progesterone

Review Information: The correct answer is B: HCG
Human chorionic gonadotropin (HCG) is the biologic marker on which pregnancy tests are based. Reliability is about 98%, but the test does not conclusively confirm pregnancy.

Question31

A client, admitted to the unit because of severe depression and suicidal threats, is placed on suicidal precautions. The nurse should be aware that the danger of the client committing suicide is greatest
A) during the night shift when staffing is limited
B) when the client’s mood improves with an in-

crease in energy level
C) at the time of the client>s greatest despair
D) after a visit from the client>s estranged partner

Review Information: The correct answer is B: when the client's mood improves with an increase in energy level
Suicide potential is often increased when there is an improvement in mood and energy level. At this time ambivalence is often decreased and a decision is made to commit suicide.

Question32
After 4 electroconvulsive treatments over 2 weeks, a client is very upset and states "I am so confused. I lose my money. I just can't remember telephone numbers." The most therapeutic response for the nurse to make is
A) «You were seriously ill and needed the treatments.»
B) «Don>t get upset. The confusion will clear up in a day or two.»
C) «It is to be expected since most clients have the same results.»
D) «I can hear your concern and that your confusion is upsetting to you.»

Review Information: The correct answer is D: «I can hear your concern and that your confusion is upsetting to you.»
Communicating caring and empathy with the acknowledgement of feelings is the initial response. Afterwards, teaching about the expected short term effects would be discussed.

Question33
A woman in labor calls the nurse to assist her in the bathroom. The nurse notices a large amount of clear fluid on the bed linens. The nurse knows that fetal monitoring must now assess for what complication?
A) Early decelerations
B) Late accelerations
C) Variable decelerations
D) Periodic accelerations

Review Information: The correct answer is C: Variable decelerations
When the membranes rupture, there is increased risk initially of cord prolapse. Fetal heart rate patterns may show variable decelerations, which require immediate nursing action to promote gas exchange.

Question34
The nurse is assessing a client with chronic obstructive pulmonary disease receiving oxygen for low PaO2 levels. Which assessment is a nursing priority?
A) Evaluating SaO2 levels frequently
B) Observing skin color changes
C) Assessing for clubbing fingers
D) Identifying tactile fremitus

Review Information: The correct answer is A: Evaluating SaO2 levels frequently
The best method to evaluate a client>>s oxygenation is to evaluate the SaO2. This is just as effective as an arterial blood gas reading to evaluate oxygenation status, and is less traumatic and expensive.

Question35
The visiting nurse makes a postpartum visit to a married female client. Upon arrival, the nurse observes that the client has a black eye and numerous bruises on her arms and legs. The initial nursing intervention would be to
A) call the police to report indications of domestic violence
B) confront the husband about abusing his wife
C) leave the home because of the unsafe environment
D) interview the client alone to determine the origin of the injuries

Review Information: The correct answer is D: interview the client alone to determine the origin of the injuries
It would be wrong to assume domestic violence without further assessment. Separate the suspected victim from the partner until battering has been ruled out.

Question36
When teaching a client about an oral hypoglycemic medication, the nurse should place primary emphasis on
A) recognizing findings of toxicity
B) taking the medication at specified times
C) increasing the dosage based on blood glucose
D) distinguishing hypoglycemia from hyperglyc-

emia

Review Information: The correct answer is B: taking the medication at specified times
A regular interval between doses should be maintained since oral hypoglycemics stimulate the islets of Langerhans to produce insulin.

Question37

Initial postoperative nursing care for an infant who has had a pyloromyotomy would initially include
A) bland diet appropriate for age
B) intravenous fluids for 3-4 days
C) NPO then glucose and electrolyte solutions
D) formula or breast milk as tolerated

Review Information: The correct answer is C: NPO then glucose and electrolyte solutions
Post-operatively, the initial feedings are clear liquids in small quantities to provide calories and electrolytes.

Question38

A client is treated in the emergency room for diabetic ketoacidosis and a glucose level of 650mg.D/L. In assessing the client, the nurse>s review of which of the following tests suggests an understanding of this health problem?
A) Serum calcium
B) Serum magnesium
C) Serum creatinine
D) Serum potassium

Review Information: The correct answer is D: Serum potassium
Potassium is lost in diabetic ketoacidosis during rehydration and insulin administration. Review of this lab finding suggests the nurse has knowledge of this problem.

Question39

A male client is preparing for discharge following an acute myocardial infarction. He asks the nurse about his sexual activity once he is home. What would be the nurse>s initial response?
A) Give him written material from the American Heart Association about sexual activity with heart disease
B) Answer his questions accurately in a private environment
C) Schedule a private, uninterrupted teaching session with both the client and his wife
D) Assess the client>s knowledge about his health problems

Review Information: The correct answer is D: Assess the client>>s knowledge about his health problems
The nursing process is continuous and cyclical in nature. When a client expresses a specific concern, the nurse performs a focused assessment to gather additional data prior to planning and implementing nursing interventions.

Question40

The client asks the nurse how the health care provider could tell she was pregnant "just by looking inside." What is the best explanation by the nurse?
A) Bluish coloration of the cervix and vaginal walls
B) Pronounced softening of the cervix
C) Clot of very thick mucous that obstructs the cervical canal
D) Slight rotation of the uterus to the right

Review Information: The correct answer is A: Bluish coloration of the cervix and vaginal walls
Chadwick>>s sign is a bluish-purple coloration of the cervix and vaginal walls, occurring at 4 weeks of pregnancy, that is caused by vasocongestion.

Free NCLEX-RN Sample Test Questions For Nursing Review (Part 2)

Jul31,

Question1

The feeling of trust can best be established by the nurse during the process of the development of a nurse-client relationship by which of these characteristics?
A) Reliability and kindness
B) Demeanor and sincerity
C) Honesty and consistency
D) Sympathy and appreciativeness

Review Information: The correct answer is C: Honesty and consistency
Characteristics of a trusting relationship include respect, honesty, consistency, faith and caring.

Question2

A nurse has administered several blood transfusions over 3 days to a 12 year-old client with Thalassemia. What lab value should the nurse monitor closely during this therapy?
A) Hemoglobin
B) Red Blood Cell Indices
C) Platelet count
D) Neutrophil percent

Review Information: The correct answer is A: Hemoglobin
Hemoglobin should be in a therapeutic range of approximately 10 g/dl (100gL). «This level is low enough to foster the patient>>s own erythropoiesis without enlarging the spleen.»

Question3
The nurse is providing care to a newly a hospitalized adolescent. What is the major threat experienced by the hospitalized adolescent?
A) Pain management
B) Restricted physical activity
C) Altered body image
D) Separation from family

Review Information: The correct answer is C: Altered body image
The hospitalized adolescent may see each of these as a threat, but the major threat that they feel when hospitalized is the fear of altered body image, because of the emphasis on physical appearance during this developmental stage.

Question4
A 12 year-old child is admitted with a broken arm and is told surgery is required. The nurse finds him crying and unwilling to talk. What is the most appropriate response by the nurse?
A) Give him privacy
B) Tell him he will get through the surgery with no problem
C) Try to distract him
D) Make arrangements for his friends to visit

Review Information: The correct answer is A: Give him privacy
A 12 year-old child needs the opportunity to express his emotions privately.

Question5
In discharge teaching, the nurse should emphasize that which of these is a common side effect of clozapine (Clozaril) therapy?
A) Dry mouth
B) Rhinitis
C) Dry skin
D) Extreme salivation

Review Information: The correct answer is D: Extreme salivation
A significant number of clients receiving Clozapine (Clozaril) therapy experience extreme salivation.

Question6
A client has had a positive reaction to purified protein derivative (PPD). The client asks the nurse what this means. The nurse should indicate that the client has
A) active tuberculosis
B) been exposed to mycobacterium tuberculosis
C) never had tuberculosis
D) never been infected with mycobacterium tuberculosis

Review Information: The correct answer is B: been exposed to mycobacterium tuberculosis
The PPD skin test is used to determine the presence of tuberculosis antibodies and a positive result indicates that the person has been exposed to mycobacterium tuberculosis. Additional tests are needed to determine if active tuberculosis is present.

Question7
A client is receiving and IV antibiotic infusion and is scheduled to have blood drawn at 1:00 pm for a «peak» antibiotic level measurement. The nurse notes that the IV infusion is running behind schedule and will not be competed by 1:00. The nurse should:
A) Notify the client>s health care provider
B) Stop the infusion at 1:00 pm
C) Reschedule the laboratory test
D) Increase the infusion rate

Review Information: The correct answer is C: Reschedule the laboratory test
If the antibiotic infusion will not be completed at the time the peak blood level is due to be drawn, the nurse should ask that the blood sampling time be adjusted

Question8

The nurse is caring for a client with a new order for bupropion (Wellbutrin) for treatment of depression. The order reads “Wellbutrin 175 mg. BID x 4 days.” What is the appropriate action?

A) Give the medication as ordered

B) Questionthis medication dose

C) Observe the client for mood swings

D) Monitor neuro signs frequently

Review Information: The correct answer is B: Questionthis medication dose

Bupropion (Wellbutrin) should be started at 100mg BID for three days then increased to 150mg BID. When used for depression, it may take up to four weeks for results. Common side effects are dry mouth, headache, and agitation. Doses should be administered in equally spaced time increments throughout the day to minimize the risk of seizures.

Question9

The clinic nurse is discussing health promotion with a group of parents. A mother is concerned about Reye>s Syndrome, and asks about prevention. Which of these demonstrates appropriate teaching?

A) «Immunize your child against this disease.»

B) «Seek medical attention for serious injuries.»

C) «Report exposure to this illness.»

D) «Avoid use of aspirin for viral infections.»

Review Information: The correct answer is D: «Avoid use of aspirin for viral infections.»

The link between aspirin use and Reye>>s Syndrome has not been confirmed, but evidence suggests that the risk is sufficiently grave to include the warning on aspirin products.

Question10

A post-operative client is admitted to the post-anesthesia recovery room (PACU). The anesthetist reports that malignant hyperthermia occurred during surgery. The nurse recognizes that this complication is related to what factor?

A) Allergy to general anesthesia

B) Pre-existing bacterial infection

C) A genetic predisposition

D) Selected surgical procedures

Review Information: The correct answer is C: A genetic predisposition

Malignant hyperthermia is a rare, potentially fatal adverse reaction to inhaled anesthetics. There is a genetic predisposition to this disorder.

Question11

A 9 year-old is taken to the emergency room with right lower quadrant pain and vomiting. When preparing the child for an emergency appendectomy, what must the nurse expect to be the child>s greatest fear?

A) Change in body image

B) An unfamiliar environment

C) Perceived loss of control

D) Guilt over being hospitalized

Review Information: The correct answer is C: Perceived loss of control

For school age children, major fears are loss of control and separation from friends/peers.

Question12

A client is to begin taking Fosamax. The nurse must emphasize which of these instructions to the client when taking this medication? «Take Fosamax

A) on an empty stomach.»

B) after meals.»

C) with calcium.»

D) with milk 2 hours after meals.»

Review Information: The correct answer is A: on an empty stomach.»

Fosamax should be taken first thing in the morning with 6-8 ounces of plain water at least 30 minutes before other medication or food. Food and fluids (other than water) greatly decrease the absorption of Fosamax. The client must also be instructed to remain in the upright position for 30 minutes following the dose to facilitate passage into the stomach and minimize irritation of the esophagus.

Question13

An older adult client is to receive and antibiotic, gentamicin. What diagnostic finding indicates the client may have difficult excreting the medication?

A) High gastric pH

B) High serum creatinine

C) Low serum albumin
D) Low serum blood urea nitrogen

Review Information: The correct answer is B: High serum creatinine
An elevated serum creatinine indicates reduced renal function. Reduced renal function will delay the excretion of many mediations.

Question14

A nurse is assigned to care for a comatose diabetic on IV insulin therapy. Which task would be most appropriate to delegate to an unlicensed assistive personnel (UAP)?
A) Check the client>s level of consciousness
B) Obtain the regular blood glucose readings
C) Determine if special skin care is needed
D) Answer questions from the client>s spouse about the plan of care

Review Information: The correct answer is B: Obtain the regular blood glucose readings
The UAP can safely obtain blood glucose readings, which are routine tasks.

Question15

Which of the following laboratory results would suggest to the emergency room nurse that a client admitted after a severe motor vehicle crash is in acidosis?
A) Hemoglobin 15 gm/dl
B) Chloride 100 mEq/L
C) Sodium 130 mEq/L
D) Carbon dioxide 20 mEq/L

Review Information: The correct answer is D: Carbon dioxide 20 mEq/L
Serum carbon dioxide is an indicator of acid-base status. This finding would indicate acidosis.

Question16

The nurse has just received report on a group of clients and plans to delegate care of several of the clients to a practical nurse (PN). The first thing the RN should do before the delegation of care is
A) Provide a time-frame for the completion of the client care
B) Assure the PN that the RN will be available for assistance
C) Ask about prior experience with similar clients
D) Review the specific procedures unique to the assignment

Review Information: The correct answer is C: Ask about prior experience with similar clients.
The first step in delegation is to determine the qualifications of the person to whom one is delegating. By asking about the PN>>s prior experience with similar clients/tasks, the RN can determine whether the PN has the requisite experience to care for the assigned clients.

Question17

The mother of a 4 month-old infant asks the nurse about the dangers of sunburn while they are on vacation at the beach. Which of the following is the best advice about sun protection for this child?
A) «Use a sunscreen with a minimum sun protective factor of 15.»
B) «Applications of sunscreen should be repeated every few hours.»
C) «An infant should be protected by the maximum strength sunscreen.»
D) «Sunscreens are not recommended in children younger than 6 months.»

Review Information: The correct answer is D: «Sunscreens are not recommended in children younger than 6 months.»
Infants under 6 months of age should be kept out of the sun or shielded from it. Even on a cloudy day, the infant can be sunburned while near water. A hat and light protective clothing should be worn.

Question18

The nurse administers cimetidine (Tagamet) to a 79 year-old male with a gastric ulcer. Which parameter may be affected by this drug, and should be closely monitored by the nurse?
A) Blood pressure
B) Liver function
C) Mental status
D) Hemoglobin

Review Information: The correct answer is C: Mental status
The elderly are at risk for developing confusion when taking cimetidine, a drug that interacts with many other medications.

Question19

The nurse assesses the use of coping mechanisms by an adolescent 1 week after the client had a motor vehicle accident resulting in multiple serious injuries. Which of these characteristics are most likely to be displayed?
A) Ambivalence, dependence, demanding
B) Denial, projection, regression
C) Intellectualization, rationalization, repression
D) Identification, assimilation, withdrawal

Review Information: The correct answer is B: Denial, projection, regression
Helplessness and hopelessness may contribute to regressive, dependent behavior which often occurs at any age with hospitalization. Denying or minimizing the seriousness of the illness is used to avoid facing the worst situation. Recall that denial is the initial step in the process of working through any loss.

Question20

A 52 year-old post menopausal woman asks the nurse how frequently she should have a mammogram. What is the nurse>s best response?
A) «Your doctor will advise you about your risks.»
B) «Unless you had previous problems, every 2 years is best.»
C) «Once a woman reaches 50, she should have a mammogram yearly.»
D) «Yearly mammograms are advised for all women over 35.»

Review Information: The correct answer is C: «Once a woman reaches 50, she should have a mammogram yearly.»
The American Cancer Society recommends a screening mammogram by age 40, every 1 - 2 years for women 40-49, and every year from age 50. If there are family or personal health risks, other assessments may be recommended.

Question21

The nurse is planning care for a client who is taking cyclosporin (Neoral). What would be an appropriate nursing diagnosis for this client?
A) Alteration in body image
B) High risk for infection
C) Altered growth and development
D) Impaired physical mobility

Review Information: The correct answer is B: High risk for infection
Cyclosporin (Neoral) inhibits normal immune responses. Clients receiving cyclosporin are at risk for infection.

Question22

A client on telemetry begins having premature ventricular beats (PVBs) at 12 per minute. In reviewing the most recent laboratory results, which would require immediate action by the nurse?
A) Calcium 9 mg/dl
B) Magnesium 2.5 mg/dl
C) Potassium 2.5 mEq/L
D) PTT 70 seconds

Review Information: The correct answer is C: Potassium 2.5 mEq/L
The patient is at risk for ventricular dysrhythmias when the potassium level is low.
Daniels, R. (2003).

Question23

The nurse is caring for a client who is 4 days post-op for a transverse colostomy. The client is ready for discharge and asks the nurse to empty his colostomy pouch. What is the best response by the nurse?
A) «You should be emptying the pouch yourself.»
B) «Let me demonstrate to you how to empty the pouch.»
C) «What have you learned about emptying your pouch?»
D) «Show me what you have learned about emptying your pouch.»

Review Information: The correct answer is D: «Show me what you have learned about emptying your pouch.»
Most adult learners obtain skills by participating in the activities. Anxiety about discharge can be causing the client to forget that they have mastered the skill of emptying the pouch. The client should show the nurse how the pouch is emptied.

Question24

A 3 year-old child has tympanostomy tubes in place. The child>s parent asks the nurse if he can swim in the family pool. The best response from the nurse is

A) «Your child should not swim at all while the tubes are in place.»
B) «Your child may swim in your own pool but not in a lake or ocean.»
C) «Your child may swim if he wears ear plugs.»
D) «Your child may swim anywhere.»

Review Information: The correct answer is C: «Your child may swim if he wears ear plugs.»

Water should not enter the ears. Children should use ear plugs when bathing or swimming and should not put their heads under the water.

Question25

The nurse is caring for a client with asthma who has developed gastroesophageal reflux disease (GERD). Which of the following medications prescribed for the client may aggravate GERD?
A) Anticholinergics
B) Corticosteroids
C) Histamine blocker
D) Antibiotics

Review Information: The correct answer is A: Anticholinergics
An anticholinergic medication will decrease gastric emptying and the pressure on the lower esophageal sphincter.

Question26

A client is receiving a nitroglycerin infusion for unstable angina. What assessment would be a priority when monitoring the effects of this medication?
A) Blood pressure
B) Cardiac enzymes
C) ECG analysis
D) Respiratory rate

Review Information: The correct answer is A: Blood pressure
Since an effect of this drug is vasodilation, the client must be monitored for hypotension.

Question27

The nurse is caring for a 10 year-old child who has just been diagnosed with diabetes insipidus. The parents ask about the treatment prescribed, vasopressin. A What is priority in teaching the child and family about this drug?
A) The child should carry a nasal spray for emergency use
B) The family must observe the child for dehydration
C) Parents should administer the daily intramuscular injections
D) The client needs to take daily injections in the short-term

Review Information: The correct answer is A: The child should carry a nasal spray for emergency use
Diabetes insipidus results from reduced secretion of the antidiuretic hormone, vasopressin. The child will need to administer daily injections of vasopressin, and should have the nasal spray form of the medication readily available. A medical alert tag should be worn.

Question28

A client diagnosed with cirrhosis is started on lactulose (Cephulac). The main purpose of the drug for this client is to
A) add dietary fiber
B) reduce ammonia levels
C) stimulate peristalsis
D) control portal hypertension

Review Information: The correct answer is B: reduce ammonia levels
Lactulose blocks the absorption of ammonia from the GI tract and secondarily stimulates bowel elimination.

Question29

The nurse is explaining the effects of cocaine abuse to a pregnant client. Which of the following must the nurse understand as a basis for teaching?
A) Cocaine use can cause fetal growth retardation
B) The drug has been linked to neural tube defects
C) Newborn withdrawal generally occurs immediately after birth
D) Breast feeding promotes positive parenting behaviors

Review Information: The correct answer is A: Cocaine use can cause fetal growth retardation
Cocaine is vasoconstrictive, and this effect in the placental vessels causes fetal hypoxia and diminished growth. Other risks of continued cocaine use during pregnancy include preterm labor, congenital abnormalities, altered brain de-

velopment and subsequent behavioral problems in the infant.

Question30

A client has just been diagnosed with breast cancer. The nurse enters the room and the client tells the nurse that she is stupid. What is the most therapeutic response by the nurse?

A) Explore what is going on with the client

B) Accept the client’s statement without comment

C) Tell the client that the comment is inappropriate

D) Leave the client>s room

Review Information: The correct answer is A: Explore what is going on with the client

Exploring feelings with the verbally aggressive client helps to put angry feelings into words and then to engage in problem solving.

Question31

A client has many delusions. As the nurse helps the client prepare for breakfast the client comments «Don’t waste good food on me. I’m dying from this disease I have.» The appropriate response would be

A) «You need some nutritious food to help you regain your weight.»

B) «None of the laboratory reports show that you have any physical disease.»

C) «Try to eat a little bit, breakfast is the most important meal of the day.»

D) «I know you believe that you have an incurable disease.»

Review Information: The correct answer is D: «I know you believe that you have an incurable disease.»

This response does not challenge the client’s delusional system and thus forms an alliance by providing reassurance of desire to help the client.

Question32

A client with paranoid thoughts refuses to eat because of the belief that the food is poisoned. The appropriate statement at this time for the nurse to say is

A) «Here, I will pour a little of the juice in a medicine cup to drink it to show you that it is OK.»

B) «The food has been prepared in our kitchen and is not poisoned.»

C) «Let>s see if your partner could bring food from home.»

D) «If you don>t eat, I will have to suggest for you to be tube fed.»

Review Information: The correct answer is C: «Let>>s see if your partner could bring food from home.»

Reassurance is ineffective when a client is actively delusional. This option avoids both arguing with the client and agreeing with the delusional premise. Option D offers a logical response to a primarily affective concern. When the client’s condition has improved, gentle negation of the delusional premise can be employed.

Question33

A client with tuberculosis is started on Rifampin. Which one of the following statements by the nurse would be appropriate to include in teaching? «You may notice:

A) an orange-red color to your urine.»

B) your appetite may increase for the first week.”

C) it is common to experience occasional sleep disturbances.»

D) if you take the medication with food, you may have nausea.»

Review Information: The correct answer is A: an orange-red color to your urine.»

Discoloration of the urine and other body fluids may occur. It is a harmless response to the drug, but the patient needs to be aware it may happen.

Question34

A client tells the RN she has decided to stop taking sertraline (Zoloft) because she doesn’t like the nightmares, sex dreams, and obsessions she’s experiencing since starting on the medication. What is an appropriate response by the nurse?

A) «It is unsafe to abruptly stop taking any prescribed medication.»

B) «Side effects and benefits should be discussed with your health care provider.»

C) «This medication should be continued despite unpleasant symptoms.»

D) «Many medications have potential side effects.»

Review Information: The correct answer is A: «It is unsafe to abruptly stop taking any prescribed medication.»
Abrupt withdrawal may occasionally cause serotonin syndrome, consisting of lethargy, nausea, headache, fever, sweating and chills. A slow withdrawal may be prescribed with sertraline to avoid dizziness, nausea, vomiting, and diarrhea.

Question35

A client is admitted to the hospital with findings of liver failure with ascites. The health care provider orders spironolactone (Aldactone). What is the pharmacological effect of this medication?
A) Promotes sodium and chloride excretion
B) Increases aldosterone levels
C) Depletes potassium reserves
D) Combines safely with antihypertensives

Review Information: The correct answer is A: Promotes sodium and chloride excretion
Spironolactone promotes sodium and chloride excretion while sparing potassium and decreasing aldosterone levels. It had no effect on ammonia levels.

Question36

A client was admitted to the psychiatric unit for severe depression. After several days, the client continues to withdraw from the other clients. Which of these statements by the nurse would be the most appropriate to promote interaction with other clients?
A) «Your team here thinks it>s good for you to spend time with others.»
B) «It is important for you to participate in group activities.»
C) «Come with me so you can paint a picture to help you feel better.»
D) «Come play Chinese Checkers with Gloria and me.»

Review Information: The correct answer is D: «Come play Chinese Checkers with Gloria and me.»
This gradually engages the client in interactions with others in small groups rather than large groups. In addition, focusing on an activity is less anxiety-provoking than unstructured discussion. The statement is an example of a positive behavioral expectation.

Question37

The nurse is teaching a school-aged child and family about the use of inhalers prescribed for asthma. What is the best way to evaluate effectiveness of the treatments?

A) Rely on child>s self-report
B) Use a peak-flow meter
C) Note skin color changes
D) Monitor pulse rate

Review Information: The correct answer is B: Use a peak-flow meter
The peak flowmeter, if used correctly, shows effectiveness of inhalants.

Question38

The nurse is teaching a client about the toxicity of digoxin. Which one of the following statements made by the client to the nurse indicates more teaching is needed?
A) «I may experience a loss of appetite.»
B) «I can expect occasional double vision.»
C) «Nausea and vomiting may last a few days.»
D) «I must report a bounding pulse of 62 immediately.»

Review Information: The correct answer is D: «I must report a bounding pulse of 62 immediately.»
Slow heart rate is related to increased cardiac output and an intended effect of digoxin. The ideal heart rate is above 60 BPM with digoxin. The client needs further teaching.

Question39

Which of the following assessments by the nurse would indicate that the client is having a possible adverse response to the isoniazid (INH)?
A) Severe headache
B) Appearance of jaundice
C) Tachycardia
D) Decreased hearing

Review Information: The correct answer is B: Appearance of jaundice
Clients receiving INH therapy are at risk for developing drug induced hepatitis. The appearance of jaundice may indicate that the client has liver damage.

Question40

The nurse is beginning nutritional counseling/ teaching with a pregnant woman. What is the initial step in this interaction?

A) Teach her how to meet the needs of self and her family
B) Explain the changes in diet necessary for pregnant women
C) Questionher understanding and use of the food pyramid
D) Conduct a diet history to determine her normal eating routines

Review Information: The correct answer is D: Conduct a diet history to determine her normal eating routines.
Assessment is always the first step in planning teaching for any client. A thorough and accurate history is essential for gathering the needed information.

Free NCLEX-RN Sample Test Questions For Nursing Review (Part 1)

Jul31,

These are sample nursing review questions and not actual test questions made for educational and practice test purposes only. 75 questions have been posted here with answer keys.

Question1

A client has been hospitalized after an automobile accident. A full leg cast was applied in the emergency room. The most important reason for the nurse to elevate the casted leg is to
A) Promote the client>s comfort
B) Reduce the drying time
C) Decrease irritation to the skin
D) Improve venous return

Review Information: The correct answer is D: Improve venous return. Elevating the leg both improves venous return and reduces swelling. Client comfort will be improved as well.

Question2

The nurse is reviewing with a client how to collect a clean catch urine specimen. What is the appropriate sequence to teach the client?

A) Clean the meatus, begin voiding, then catch urine stream
B) Void a little, clean the meatus, then collect specimen
C) Clean the meatus, then urinate into container
D) Void continuously and catch some of the urine

Review Information: The correct answer is A: Clean the meatus, begin voiding, then catch urine stream. A clean catch urine is difficult to obtain and requires clear directions. Instructing the client to carefully clean the meatus, then void naturally with a steady stream prevents surface bacteria from contaminating the urine specimen. As starting and stopping flow can be difficult, once the client begins voiding it>>s best to just slip the container into the stream. Other responses do not reflect correct technique.

Question3

Following change-of-shift report on an orthopedic unit, which client should the nurse see first?
A) 16 year-old who had an open reduction of a fractured wrist 10 hours ago
B) 20 year-old in skeletal traction for 2 weeks since a motor cycle accident
C) 72 year-old recovering from surgery after a hip replacement 2 hours ago
D) 75 year-old who is in skin traction prior to planned hip pinning surgery.

Review Information: The correct answer is C: 72 year-old recovering from surgery after a hip replacement 2 hours ago. Look for the client who has the most imminent risks and acute vulnerability. The client who returned from surgery 2 hours ago is at risk for life threatening hemorrhage and should be seen first. The 16 year-old should be seen next because it is still the first post-op day. The 75 year-old is potentially vulnerable to age-related physical and cognitive consequences in skin traction should be seen next. The client who can safely be seen last is the 20 year-old who is 2 weeks post-injury.

Question4

A client with Guillain Barre is in a nonresponsive state, yet vital signs are stable and breathing is independent. What should the nurse document to most accurately describe the client>s condition?
A) Comatose, breathing unlabored
B) Glascow Coma Scale 8, respirations regular
C) Appears to be sleeping, vital signs stable

D) Glascow Coma Scale 13, no ventilator required

Review Information: The correct answer is B: Glascow Coma Scale 8, respirations regular. The Glascow Coma Scale provides a standard reference for assessing or monitoring level of consciousness. Any score less than 13 indicates a neurological impairment. Using the term comatose provides too much room for interpretation and is not very precise.

Question5

When caring for a client receiving warfarin sodium (Coumadin), which lab test would the nurse monitor to determine therapeutic response to the drug?
A) Bleeding time
B) Coagulation time
C) Prothrombin time
D) Partial thromboplastin time

Review Information: The correct answer is C: Prothrombin time. Coumadin is ordered daily, based on the client>>s prothrombin time (PT). This test evaluates the adequacy of the extrinsic system and common pathway in the clotting cascade; Coumadin affects the Vitamin K dependent clotting factors.

Question6

A client with moderate persistent asthma is admitted for a minor surgical procedure. On admission the peak flow meter is measured at 480 liters/minute. Post-operatively the client is complaining of chest tightness. The peak flow has dropped to 200 liters/minute. What should the nurse do first?
A) Notify both the surgeon and provider
B) Administer the prn dose of albuterol
C) Apply oxygen at 2 liters per nasal cannula
D) Repeat the peak flow reading in 30 minutes

Review Information: The correct answer is B: Administer the prn dose of albuterol. Peak flow monitoring during exacerbations of asthma is recommended for clients with moderate-to-severe persistent asthma to determine the severity of the exacerbation and to guide the treatment. A peak flow reading of less than 50% of the client>>s baseline reading is a medical alert condition and a short-acting beta-agonist must be taken immediately.

Question7

A client had 20 mg of Lasix (furosemide) PO at 10 AM. Which would be essential for the nurse to include at the change of shift report?
A) The client lost 2 pounds in 24 hours
B) The client's potassium level is 4 mEq/liter.
C) The client's urine output was 1500 cc in 5 hours
D) The client is to receive another dose of Lasix at 10 PM

Review Information: The correct answer is C: The client's urine output was 1500 cc in 5 hours. Although all of these may be correct information to include in report, the essential piece would be the urine output.

Question8

A client has been tentatively diagnosed with Graves> disease (hyperthyroidism). Which of these findings noted on the initial nursing assessment requires quick intervention by the nurse?
A) a report of 10 pounds weight loss in the last month
B) a comment by the client «I just can>t sit still.»
C) the appearance of eyeballs that appear to «pop» out of the client>s eye sockets
D) a report of the sudden onset of irritability in the past 2 weeks

Review Information: The correct answer is C: the appearance of eyeballs that appear to «pop» out of the client>>s eye sockets. Exophthalmos or protruding eyeballs is a distinctive characteristic of Graves>> Disease. It can result in corneal abrasions with severe eye pain or damage when the eyelid is unable to blink down over the protruding eyeball. Eye drops or ointment may be needed.

Question9

The nurse has performed the initial assessments of 4 clients admitted with an acute episode of asthma. Which assessment finding would cause the nurse to call the provider immediately?
A) prolonged inspiration with each breath
B) expiratory wheezes that are suddenly absent in 1 lobe
C) expectoration of large amounts of purulent mucous
D) appearance of the use of abdominal muscles

for breathing

Review Information: The correct answer is B: expiratory wheezes that are suddenly absent in 1 lobe. Acute asthma is characterized by expiratory wheezes caused by obstruction of the airways. Wheezes are a high pitched musical sounds produced by air moving through narrowed airways. Clients often associate wheezes with the feeling of tightness in the chest. However, sudden cessation of wheezing is an ominous or bad sign that indicates an emergency -- the small airways are now collapsed.

Question10

During the initial home visit, a nurse is discussing the care of a client newly diagnosed with Alzheimer>s disease with family members. Which of these interventions would be most helpful at this time?

A) leave a book about relaxation techniques
B) write out a daily exercise routine for them to assist the client to do
C) list actions to improve the client>s daily nutritional intake
D) suggest communication strategies

Review Information: The correct answer is D: suggest communication strategies. Alzheimer>>s disease, a progressive chronic illness, greatly challenges caregivers. The nurse can be of greatest assistance in helping the family to use communication strategies to enhance their ability to relate to the client. By use of select verbal and nonverbal communication strategies the family can best support the client's strengths and cope with any aberrant behavior.

Question11

An 80 year-old client admitted with a diagnosis of possible cerebral vascular accident has had a blood pressure from 160/100 to 180/110 over the past 2 hours. The nurse has also noted increased lethargy. Which assessment finding should the nurse report immediately to the provider?

A) Slurred speech
B) Incontinence
C) Muscle weakness
D) Rapid pulse

Review Information: The correct answer is A: Slurred speech. Changes in speech patterns and level of conscious can be indicators of continued intracranial bleeding or extension of the stroke. Further diagnostic testing may be indicated.

Question12

A school-aged child has had a long leg (hip to ankle) synthetic cast applied 4 hours ago. Which statement from the parent indicates that teaching has been inadequate?

A) «I will keep the cast uncovered for the next day to prevent burning of the skin.»
B) «I can apply an ice pack over the area to relieve itching inside the cast.»
C) «The cast should be propped on at least 2 pillows when my child is lying down.»
D) «I think I remember that my child should not stand until after 72 hours.»

Review Information: The correct answer is D: «I think I remember that my child should not stand until after 72 hours.». Synthetic casts will typically set up in 30 minutes and dry in a few hours. Thus, the client may stand within the initial 24 hours. With plaster casts, the set up and drying time, especially in a long leg cast which is thicker than an arm cast, can take up to 72 hours. Both types of casts give off a lot of heat when drying and it is preferable to keep the cast uncovered for the first 24 hours. Clients may complain of a chill from the wet cast and therefore can simply be covered lightly with a sheet or blanket. Applying ice is a safe method of relieving the itching.

Question13

Which blood serum finding in a client with diabetic ketoacidosis alerts the nurse that immediate action is required?

A) pH below 7.3
B) Potassium of 5.0
C) HCT of 60
D) Pa O2 of 79%

Review Information: The correct answer is C: HCT of 60. This high hematocrit is indicative of severe dehydration which requires priority attention in diabetic ketoacidosis. Without sufficient hydration, all systems of the body are at risk for hypoxia from a lack of or sluggish circulation. In the absence of insulin, which facilitates the transport of glucose into the cell, the body breaks down fats and proteins to supply energy ketones, a by-product of fat metabolism. These accumulate causing metabolic acidosis ($pH < 7.3$), which would be the second concern for this

client. The potassium and PaO2 levels are near normal.

Question14
The nurse is preparing a client with a deep vein thrombosis (DVT) for a Venous Doppler evaluation. Which of the following would be necessary for preparing the client for this test?
A) Client should be NPO after midnight
B) Client should receive a sedative medication prior to the test
C) Discontinue anti-coagulant therapy prior to the test
D) No special preparation is necessary

Review Information: The correct answer is D: No special preparation is necessary. This is a non-invasive procedure and does not require preparation other than client education.

Question15
A client is admitted with infective endocarditis (IE). Which finding would alert the nurse to a complication of this condition?
A) dyspnea
B) heart murmur
C) macular rash
D) hemorrhage

Review Information: The correct answer is B: heart murmur. Large, soft, rapidly developing vegetations attach to the heart valves. They have a tendency to break off, causing emboli and leaving ulcerations on the valve leaflets. These emboli produce findings of cardiac murmur, fever, anorexia, malaise and neurologic sequelae of emboli. Furthermore, the vegetations may travel to various organs such as spleen, kidney, coronary artery, brain and lungs, and obstruct blood flow.

Question16
The nurse explains an autograft to a client scheduled for excision of a skin tumor. The nurse knows the client understands the procedure when the client says, «I will receive tissue from
A) a tissue bank.»
B) a pig.»
C) my thigh.»
D) synthetic skin.»

Review Information: The correct answer is C: my thigh.». Autografts are done with tissue transplanted from the client>>s own skin.

Question17
A client is admitted to the emergency room following an acute asthma attack. Which of the following assessments would be expected by the nurse?

A) Diffuse expiratory wheezing
B) Loose, productive cough
C) No relief from inhalant
D) Fever and chills

Review Information: The correct answer is A: Diffuse expiratory wheezing. In asthma, the airways are narrowed, creating difficulty getting air in. A wheezing sound results.

Question18
A client has been admitted with a fractured femur and has been placed in skeletal traction. Which of the following nursing interventions should receive priority?
A) Maintaining proper body alignment
B) Frequent neurovascular assessments of the affected leg
C) Inspection of pin sites for evidence of drainage or inflammation
D) Applying an over-bed trapeze to assist the client with movement in bed

Review Information: The correct answer is B: Frequent neurovascular assessments of the affected leg. The most important activity for the nurse is to assess neurovascular status. Compartment syndrome is a serious complication of fractures. Prompt recognition of this neurovascular problem and early intervention may prevent permanent limb damage.

Question19
The nurse is assigned to care for a client who had a myocardial infarction (MI) 2 days ago. The client has many questions about this condition. What area is a priority for the nurse to discuss at this time?
A) Daily needs and concerns
B) The overview cardiac rehabilitation
C) Medication and diet guideline
D) Activity and rest guidelines

Review Information: The correct answer is A: Daily needs and concerns. At 2 days post-MI, the

client's education should be focused on the immediate needs and concerns for the day.

Question20

A 3 year-old child is brought to the clinic by his grandmother to be seen for «scratching his bottom and wetting the bed at night.» Based on these complaints, the nurse would initially assess for which problem?
A) allergies
B) scabies
C) regression
D) pinworms

Review Information: The correct answer is D: pinworms. Signs of pinworm infection include intense perianal itching, poor sleep patterns, general irritability, restlessness, bed-wetting, distractibility and short attention span. Scabies is an itchy skin condition caused by a tiny, eight-legged burrowing mite called Sarcoptes scabiei . The presence of the mite leads to intense itching in the area of its burrows.

Question21

The nurse is caring for a newborn with tracheoesophageal fistula. Which nursing diagnosis is a priority?
A) Risk for dehydration
B) Ineffective airway clearance
C) Altered nutrition
D) Risk for injury

Review Information: The correct answer is B: Ineffective airway clearance. The most common form of TEF is one in which the proximal esophageal segment terminates in a blind pouch and the distal segment is connected to the trachea or primary bronchus by a short fistula at or near the bifurcation. Thus, a priority is maintaining an open airway, preventing aspiration. Other nursing diagnoses are then addressed.

Question22

The nurse is developing a meal plan that would provide the maximum possible amount of iron for a child with anemia. Which dinner menu would be best?
A) Fish sticks, french fries, banana, cookies, milk
B) Ground beef patty, lima beans, wheat roll, raisins, milk
C) Chicken nuggets, macaroni, peas, cantaloupe, milk
D) Peanut butter and jelly sandwich, apple slices, milk

Review Information: The correct answer is B: Ground beef patty, lima beans, wheat roll, raisins, milk. Iron rich foods include red meat, fish, egg yolks, green leafy vegetables, legumes, whole grains, and dried fruits such as raisins. This dinner is the best choice: It is high in iron and is appropriate for a toddler.

Question23

The nurse admitting a 5 month-old who vomited 9 times in the past 6 hours should observe for signs of which overall imbalance?
A) Metabolic acidosis
B) Metabolic alkalosis
C) Some increase in the serum hemoglobin
D) A little decrease in the serum potassium

Review Information: The correct answer is B: Metabolic alkalosis. Vomiting causes loss of acid from the stomach. Prolonged vomiting can result in excess loss of acid and lead to metabolic alkalosis. Findings include irritability, increased activity, hyperactive reflexes, muscle twitching and elevated pulse. Options C and D are correct answers but not the best answers since they are too general.

Question24

A two year-old child is brought to the provider>s office with a chief complaint of mild diarrhea for two days. Nutritional counseling by the nurse should include which statement?
A) Place the child on clear liquids and gelatin for 24 hours
B) Continue with the regular diet and include oral rehydration fluids
C) Give bananas, apples, rice and toast as tolerated
D) Place NPO for 24 hours, then rehydrate with milk and water

Review Information: The correct answer is B: Continue with the regular diet and include oral rehydration fluids. Current recommendations for mild to moderate diarrhea are to maintain a normal diet with fluids to rehydrate.

Question25

The nurse is teaching parents about the appropriate diet for a 4 month-old infant with gastroenteritis and mild dehydration. In addition to oral rehydration fluids, the diet should include

A) formula or breast milk
B) broth and tea
C) rice cereal and apple juice
D) gelatin and ginger ale

Review Information: The correct answer is A: formula or breast milk. The usual diet for a young infant should be followed.

Question26

A child is injured on the school playground and appears to have a fractured leg. The first action the school nurse should take is

A) call for emergency transport to the hospital
B) immobilize the limb and joints above and below the injury
C) assess the child and the extent of the injury
D) apply cold compresses to the injured area

Review Information: The correct answer is C: assess the child and the extent of the injury. When applying the nursing process, assessment is the first step in providing care. The «5 Ps» of vascular impairment can be used as a guide (pain, pulse, pallor, paresthesia, paralysis).

Question27

The mother of a 3 month-old infant tells the nurse that she wants to change from formula to whole milk and add cereal and meats to the diet. What should be emphasized as the nurse teaches about infant nutrition?

A) Solid foods should be introduced at 3-4 months
B) Whole milk is difficult for a young infant to digest
C) Fluoridated tap water should be used to dilute milk
D) Supplemental apple juice can be used between feedings

Review Information: The correct answer is B: Whole milk is difficult for a young infant to digest. Cow>>s milk is not given to infants younger than 1 year because the tough, hard curd is difficult to digest. In addition, it contains little iron and creates a high renal solute load.

Question28

The nurse is preparing a handout on infant feeding to be distributed to families visiting the clinic. Which notation should be included in the teaching materials?

A) Solid foods are introduced one at a time beginning with cereal
B) Finely ground meat should be started early to provide iron
C) Egg white is added early to increase protein intake
D) Solid foods should be mixed with formula in a bottle

Review Information: The correct answer is A: Solid foods are introduced one at a time beginning with cereal. Solid foods should be added one at a time between 4-6 months. If the infant is able to tolerate the food, another may be added in a week. Iron fortified cereal is the recommended first food.

Question29

The nurse planning care for a 12 year-old child with sickle cell disease in a vaso-occlusive crisis of the elbow should include which one of the following as a priority?

A) Limit fluids
B) Client controlled analgesia
C) Cold compresses to elbow
D) Passive range of motion exercise

Review Information: The correct answer is B: Client controlled analgesia. Management of a sickle cell crisis is directed towards supportive and symptomatic treatment. The priority of care is pain relief. In a 12 year-old child, client controlled analgesia promotes maximum comfort.

Question30

The nurse is performing a physical assessment on a toddler. Which of the following actions should be the first?

A) Perform traumatic procedures
B) Use minimal physical contact
C) Proceed from head to toe
D) Explain the exam in detail

Review Information: The correct answer is B: Use minimal physical contact. The nurse should approach the toddler slowly and use minimal physical contact initially so as to gain the toddler>>s cooperation. Be flexible in the sequence of the exam, and give only brief simple explanations just prior to the action.

Question31

What finding signifies that children have attained the stage of concrete operations (Piaget)?

A) Explores the environment with the use of sight and movement
B) Thinks in mental images or word pictures
C) Makes the moral judgment that «stealing is wrong»
D) Reasons that homework is time-consuming yet necessary

Review Information: The correct answer is C: Makes the moral judgment that «stealing is wrong». The stage of concrete operations is depicted by logical thinking and moral judgments.

Question32

The mother of a child with a neural tube defect asks the nurse what she can do to decrease the chances of having another baby with a neural tube defect. What is the best response by the nurse?

A) «Folic acid should be taken before and after conception.»
B) «Multivitamin supplements are recommended during pregnancy.»
C) «A well balanced diet promotes normal fetal development.»
D) «Increased dietary iron improves the health of mother and fetus.»

Review Information: The correct answer is A: «Folic acid should be taken before and after conception.». The American Academy of Pediatrics recommends that all childbearing women increase folic acid from dietary sources and/or supplements. There is evidence that increased amounts of folic acid prevents neural tube defects.

Question33

The provider orders Lanoxin (digoxin) 0.125 mg PO and furosemide 40 mg every day. Which of these foods would the nurse reinforce for the client to eat at least daily?

A) Spaghetti
B) Watermelon
C) Chicken
D) Tomatoes

Review Information: The correct answer is B: Watermelon. Watermelon is high in potassium and will replace potassium lost by the diuretic. The other foods are not high in potassium.

Question34

While teaching the family of a child who will take phenytoin (Dilantin) regularly for seizure control, it is most important for the nurse to teach them about which of the following actions?

A) Maintain good oral hygiene and dental care
B) Omit medication if the child is seizure free
C) Administer acetaminophen to promote sleep
D) Serve a diet that is high in iron

Review Information: The correct answer is A: Maintain good oral hygiene and dental care. Swollen and tender gums occur often with use of phenytoin. Good oral hygiene and regular visits to the dentist should be emphasized.

Question35

The nurse is offering safety instructions to a parent with a four month-old infant and a four year-old child. Which statement by the parent indicates understanding of appropriate precautions to take with the children?

A) «I strap the infant car seat on the front seat to face backwards.»
B) «I place my infant in the middle of the living room floor on a blanket to play with my four year-old while I make supper in the kitchen.»
C) «My sleeping baby lies so cute in the crib with the little buttocks stuck up in the air while the four year-old naps on the sofa.»
D) «I have the four year-old hold and help feed the four month-old a bottle in the kitchen while I make supper.»

Review Information: The correct answer is D: «I have the four year-old hold and help feed the four month-old a bottle in the kitchen while I make supper.». The infant seat is to be placed

on the rear seat. Small children and infants are not to be left unsupervised. Infants are

Question36

The nurse admits a 7 year-old to the emergency room after a leg injury. The x-rays show a femur fracture near the epiphysis. The parents ask what will be the outcome of this injury. The appropriate response by the nurse should be which of these statements?

A) «The injury is expected to heal quickly because of thin periosteum.»
B) «In some instances the result is a retarded bone growth.»
C) «Bone growth is stimulated in the affected leg.»
D) «This type of injury shows more rapid union than that of younger children.»

Review Information: The correct answer is B: «In some instances the result is a retarded bone growth.». An epiphyseal (growth) plate fracture in a 7 year-old often results in retarded bone growth. The leg often will be different in length than the uninjured leg.

Question37

The parents of a 4 year-old hospitalized child tell the nurse, “We are leaving now and will be back at 6 PM.” A few hours later the child asks the nurse when the parents will come again. What is the best response by the nurse?

A) «They will be back right after supper.»
B) «In about 2 hours, you will see them.»
C) «After you play awhile, they will be here.»
D) «When the clock hands are on 6 and 12.»

Review Information: The correct answer is A: «They will be back right after supper.». Time is not completely understood by a 4 year-old. Preschoolers interpret time with their own frame of reference. Thus, it is best to explain time in relationship to a known, common event.

Question38

The nurse is giving instructions to the parents of a child with cystic fibrosis. The nurse would emphasize that pancreatic enzymes should be taken
A) once each day
B) 3 times daily after meals
C) with each meal or snack
D) each time carbohydrates are eaten

Review Information: The correct answer is C: with each meal or snack. Pancreatic enzymes should be taken with each meal and every snack to allow for digestion of all foods that are eaten.

Question39

A nurse is providing a parenting class to individuals living in a community of older homes. In discussing formula preparation, which of the following is most important to prevent lead poisoning?

A) Use ready-to-feed commercial infant formula
B) Boil the tap water for 10 minutes prior to preparing the formula
C) Let tap water run for 2 minutes before adding to concentrate
D) Buy bottled water labeled «lead free» to mix the formula

Review Information: The correct answer is C: Let tap water run for 2 minutes before adding to concentrate. Use of lead-contaminated water to prepare formula is a major source of poisoning in infants. Drinking water may be contaminated by lead from old lead pipes or lead solder used in sealing water pipes. Letting tap water run for several minutes will diminish the lead contamination.

Question40

Which of the following manifestations observed by the school nurse confirms the presence of pediculosis capitis in students?

A) Scratching the head more than usual
B) Flakes evident on a student>s shoulders
C) Oval pattern occipital hair loss
D) Whitish oval specks sticking to the hair

Review Information: The correct answer is D: Whitish oval specks sticking to the hair. Diagnosis of pediculosis capitis is made by observation of the white eggs (nits) firmly attached to the hair shafts. Treatment can include application of a medicated shampoo with lindane for children over 2 years of age, and meticulous combing and removal of all nits.

Question41
When interviewing the parents of a child with asthma, it is most important to assess the child>s environment for what factor?

A) Household pets
B) New furniture
C) Lead based paint
D) Plants such as cactus

Review Information: The correct answer is A: Household pets. Animal dander is a very common allergen affecting persons with asthma. Other triggers may include pollens, carpeting and household dust.

Question42
The mother of a 2 month-old baby calls the nurse 2 days after the first DTaP, IPV, Hepatitis B and HIB immunizations. She reports that the baby feels very warm, cries inconsolably for as long as 3 hours, and has had several shaking spells. In addition to referring her to the emergency room, the nurse should document the reaction on the baby>s record and expect which immunization to be most associated with the findings the infant is displaying?

A) DTaP
B) Hepatitis B
C) Polio
D) H. Influenza

Review Information: The correct answer is A: DTaP. The majority of reactions occur with the administration of the DTaP vaccination. Contradictions to giving repeat DTaP immunizations include the occurrence of severe side effects after a previous dose as well as signs of encephalopathy within 7 days of the immunization.

Question43
The mother of a 2 year-old hospitalized child asks the nurse>s advice about the child>s screaming every time the mother gets ready to leave the hospital room. What is the best response by the nurse?

A) «I think you or your partner needs to stay with the child while in the hospital.»
B) «Oh, that behavior will stop in a few days.»
C) «Keep in mind that for the age this is a normal response to being in the hospital.»
D) «You might want to «sneak out» of the room once the child falls asleep.»

Review Information: The correct answer is C: «Keep in mind that for the age this is a normal response to being in the hospital.». The protest phase of separation anxiety is a normal response for a child this age. In toddlers, ages 1 to 3, separation anxiety is at its peak

Question44
A couple experienced the loss of a 7 month-old fetus. In planning for discharge, what should the nurse emphasize?

A) To discuss feelings with each other and use support persons
B) To focus on the other healthy children and move through the loss
C) To seek causes for the fetal death and come to some safe conclusion
D) To plan for another pregnancy within 2 years and maintain physical health

Review Information: The correct answer is A: To discuss feelings with each other and use support persons. To communicate in a therapeutic manner, the nurse>>s goal is to help the couple begin the grief process by suggesting they talk to each other, seek family, friends and support groups to listen to their feelings.

Question45
The nurse is performing a pre-kindergarten physical on a 5 year-old. The last series of vaccines will be administered. What is the preferred site for injection by the nurse?

A) vastus intermedius
B) gluteus maximus
C) vastus lateralis
D) dorsogluteal

Review Information: The correct answer is C: vastus lateralis. Vastus lateralis, a large and well developed muscle, is the preferred site, since it is removed from major nerves and blood vessels.

Question46
A 7 month pregnant woman is admitted with com-

plaints of painless vaginal bleeding over several hours. The nurse should prepare the client for an immediate

A) Non stress test
B) Abdominal ultrasound
C) Pelvic exam
D) X-ray of abdomen

Review Information: The correct answer is B: Abdominal ultrasound. The standard for diagnosis of placenta previa, which is suggested in the client>>s history of painless bleeding, is abdominal ultrasound.

Question47

A nurse entering the room of a postpartum mother observes the baby lying at the edge of the bed while the woman sits in a chair. The mother states «This is not my baby, and I do not want it.» After repositioning the child safely, the nurse>s best response is

A) «This is a common occurrence after birth, but you will come to accept the baby.»
B) «Many women have postpartum blues and need some time to love the baby.»
C) «What a beautiful baby! Her eyes are just like yours.»
D) «You seem upset; tell me what the pregnancy and birth were like for you.»

Review Information: The correct answer is D: «You seem upset; tell me what the pregnancy and birth were like for you.». A non-judgmental, open ended response facilitates dialogue between the client and nurse.

Question48

The nurse notes that a 2 year-old child recovering from a tonsillectomy has an temperature of 98.2 degrees Fahrenheit at 8:00 AM. At 10:00 AM the child>s parent reports that the child «feels very warm» to touch. The first action by the nurse should be to

A) reassure the parent that this is normal
B) offer the child cold oral fluids
C) reassess the child>s temperature
D) administer the prescribed acetaminophen

Review Information: The correct answer is C: reassess the child>>s temperature. A child>>s temperature may have rapid fluctuations. The nurse should listen to and show respect for what parents say. Parental caretakers are often quite sensitive to variations in their children>>s condition that may not be immediately evident to others.

Question49

The nurse is caring for a client who was successfully resuscitated from a pulseless dysrhythmia. Which of the following assessments is critical for the nurse to include in the plan of care?

A) hourly urine output
B) white blood count
C) blood glucose every 4 hours
D) temperature every 2 hours

Review Information: The correct answer is A: hourly urine output. Clients who have had an episode of decreased glomerular perfusion are at risk for pre-renal failure. This is caused by any abnormal decline in kidney perfusion that reduces glomerular perfusion. Pre-renal failure occurs when the effective arterial blood volume falls. Examples of this phenomena include a drop in circulating blood volume as in a cardiac arrest state or in low cardiac perfusion states such as congestive heart failure associated with a cardiomyopathy. Close observation of hourly urinary output is necessary for early detection of this condition.

Question50

A client is admitted to the rehabilitation unit following a cerebral vascular accident (CVA) and mild dysphagia. The most appropriate intervention for this client is to

A) position client in upright position while eating
B) place client on a clear liquid diet
C) tilt head back to facilitate swallowing reflex
D) offer finger foods such as crackers or pretzels

Review Information: The correct answer is A: position client in upright position while eating. An upright position facilitates proper chewing and swallowing.

Question51

A 72 year-old client with osteomyelitis requires a 6 week course of intravenous antibiotics. In planning for home care, what is the most important action by the nurse?

A) Investigating the client>s insurance coverage for home IV antibiotic therapy
B) Determining if there are adequate hand washing facilities in the home
C) Assessing the client>s ability to participate in self care and/or the reliability of a caregiver
D) Selecting the appropriate venous access device

Review Information: The correct answer is C: Assessing the client>>s ability to participate in self care and/or the reliability of a caregiver. The cognitive ability of the client as well as the availability and reliability of a caregiver must be assessed to determine if home care is a feasible option.

Question52

A nurse administers the influenza vaccine to a client in a clinic. Within 15 minutes after the immunization was given, the client complains of itchy and watery eyes, increased anxiety, and difficulty breathing. The nurse expects that the first action in the sequence of care for this client will be to

A) Maintain the airway
B) Administer epinephrine 1:1000 as ordered
C) Monitor for hypotension with shock
D) Administer diphenhydramine as ordered

Review Information: The correct answer is B: Administer epinephrine 1:1000 as ordered. All the answers are correct given the circumstances, but the priority is to administer the epinephrine, then maintain the airway. In the early stages of anaphylaxis, when the patient has not lost consciousness and is normotensive, administering the epinephrine is first, and applying the oxygen, and watching for hypotension and shock, are later responses. The prevention of a severe crisis is maintained by using diphenhydramine.

Question53

The nurse instructs the client taking dexamethasone (Decadron) to take it with food or milk. The physiological basis for this instruction is that the medication
A) retards pepsin production
B) stimulates hydrochloric acid production
C) slows stomach emptying time
D) decreases production of hydrochloric acid

Review Information: The correct answer is B: stimulates hydrochloric acid production. Decadron increases the production of hydrochloric acid, which may cause gastrointestinal ulcers.

Question54

A client receiving chlorpromazine HCL (Thorazine) is in psychiatric home care. During a home visit the nurse observes the client smacking her lips alternately with grinding her teeth. The nurse recognizes this assessment finding as what?
A) Dystonia
B) Akathisia
C) Brady dyskinesia
D) Tardive dyskinesia

Review Information: The correct answer is D: Tardive dyskinesia. Signs of tardive dyskinesia include smacking lips, grinding of teeth and «fly catching» tongue movements. These findings are often described as Parkinsonian.

Question55

Which of the following findings contraindicate the use of haloperidol (Haldol) and warrant withholding the dose?
A) Drowsiness, lethargy, and inactivity
B) Dry mouth, nasal congestion, and blurred vision
C) Rash, blood dyscrasias, severe depression
D) Hyperglycemia, weight gain, and edema

Review Information: The correct answer is C: Rash, blood dyscrasias, severe depression. Rash and blood dyscrasias are side effects of anti-psychotic drugs. A history of severe depression is a contraindication to the use of neuroleptics.

Question56

The nurse is reinforcing teaching to a 24 year-old woman receiving acyclovir (Zovirax) for a Herpes Simplex Virus type 2 infection. Which of these instructions should the nurse give the client?

A) Complete the entire course of the medication for an effective cure
B) Begin treatment with acyclovir at the onset of symptoms of recurrence
C) Stop treatment if she thinks she may be pregnant to prevent birth defects
D) Continue to take prophylactic doses for at least 5 years after the diagnosis

Review Information: The correct answer is B: Begin treatment with acyclovir at the onset of symptoms of recurrence. When the client is aware of early symptoms, such as pain, itching or tingling, treatment is very effective. Medications for herpes simplex do not cure the disease; they simply decrease the level of symptoms.

Question57

A 14 month-old child ingested half a bottle of aspirin tablets. Which of the following would the nurse expect to see in the child?

A) Hypothermia
B) Edema
C) Dyspnea
D) Epistaxis

Review Information: The correct answer is D: Epistaxis. A large dose of aspirin inhibits prothrombin formation and lowers platelet levels. With an overdose, clotting time is prolonged.

Question58

An 80 year-old client on digitalis (Lanoxin) reports nausea, vomiting, abdominal cramps and halo vision. Which of the following laboratory results should the nurse analyze first?

A) Potassium levels
B) Blood pH
C) Magnesium levels
D) Blood urea nitrogen

Review Information: The correct answer is A: Potassium levels. The most common cause of digitalis toxicity is a low potassium level. Clients must be taught that it is important to have adequate potassium intake especially if taking diuretics that enhance the loss of potassium while they are taking digitalis.

Question59

A 42 year-old male client refuses to take propranolol hydrochloride (Inderal) as prescribed. Which client statement from the assessment data is likely to explain his noncompliance?

A) «I have problems with diarrhea.»
B) «I have difficulty falling asleep.»
C) «I have diminished sexual function.»
D) «I often feel jittery.»

Review Information: The correct answer is C: «I have diminished sexual function.». Inderal, a beta-blocking agent used in hypertension, prohibits the release of epinephrine into the cells; this may result in hypotension which results in decreased libido and impotence.

Question60

The nurse caring for a 9 year-old child with a fractured femur is told that a medication error occurred. The child received twice the ordered dose of morphine an hour ago. Which nursing diagnosis is a priority at this time?

A) Risk for fluid volume deficit related to morphine overdose
B) Decreased gastrointestinal mobility related to mucosal irritation
C) Ineffective breathing patterns related to central nervous system depression
D) Altered nutrition related to inability to control nausea and vomiting

Review Information: The correct answer is C: Ineffective breathing patterns related to central nervous system depression. Respiratory depression is a life-threatening risk in this overdose.

Question61

Lactulose (Chronulac) has been prescribed for a client with advanced liver disease. Which of the following assessments would the nurse use to evaluate the effectiveness of this treatment?

A) An increase in appetite
B) A decrease in fluid retention
C) A decrease in lethargy
D) A reduction in jaundice

Review Information: The correct answer is C: A decrease in lethargy. Lactulose produces an acid environment in the bowel and traps ammonia in the gut; the laxative effect then aids in removing the ammonia from the body. This decreases the effects of hepatic encephalopathy, including lethargy and confusion.

Question62

The nurse is teaching a class on HIV prevention. Which of the following should be emphasized as increasing risk?

A) Donating blood
B) Using public bathrooms
C) Unprotected sex
D) Touching a person with AIDS

Review Information: The correct answer is C: Unprotected sex. Because HIV is spread through exposure to bodily fluids, unprotected intercourse and shared drug paraphernalia remain the highest risks for infection.

Question63

While interviewing a new admission, the nurse notices that the client is shifting positions, wringing her hands, and avoiding eye contact. It is important for the nurse to
A) ask the client what she is feeling
B) assess the client for auditory hallucinations
C) recognize the behavior as a side effect of medication
D) re-focus the discussion on a less anxiety provoking topic

Review Information: The correct answer is A: ask the client what she is feeling. The initial step in anxiety intervention is observing, identifying, and assessing anxiety. The nurse should seek client validation of the accuracy of nursing assessments and avoid drawing conclusions based on limited data. In the situation above, the client may simply need to use the restroom but be reluctant to communicate her need!

Question64

A young adult seeks treatment in an outpatient mental health center. The client tells the nurse he is a government official being followed by spies. On further questioning, he reveals that his warnings must be heeded to prevent nuclear war. What is the most therapeutic approach by the nurse?

A) Listen quietly without comment
B) Ask for further information on the spies
C) Confront the client's delusion
D) Contact the government agency

Review Information: The correct answer is A: Listen quietly without comment. The client>>s comments demonstrate grandiose ideas. The most therapeutic response is to listen but avoid being incorporated into the client's delusional system.

Question65

The nurse is assessing a 17 year-old female client with bulimia. Which of the following laboratory reports would the nurse anticipate?

A) Increased serum glucose
B) Decreased albumin
C) Decreased potassium
D) Increased sodium retention

Review Information: The correct answer is C: Decreased potassium. In bulimia, loss of electrolytes can occur in addition to other findings of starvation and dehydration.

Question66

A client, recovering from alcoholism, asks the nurse, «What can I do when I start recognizing relapse triggers within myself?» How might the nurse best respond?

A) «When you have the impulse to stop in a bar, contact a sober friend and talk with him.»
B) «Go to an AA meeting when you feel the urge to drink.»
C) «It is important to exercise daily and get involved in activities that will cause you not to think about drug use.»
D) «Let's talk about possible options you have

when you recognize relapse triggers in yourself.»

Review Information: The correct answer is D: «Let's talk about possible options you have when you recognize relapse triggers in yourself.». This option encourages the process of self evaluation and problem solving, while avoiding telling the client what to do. Encouraging the client to brainstorm about response options validates the nurse's belief in the client's personal competency and reinforces a coping strategy that will be needed when the nurse may not be available to offer solutions.

Question67

Therapeutic nurse-client interaction occurs when the nurse

A) assists the client to clarify the meaning of what the client has said
B) interprets the client's covert communication
C) praises the client for appropriate feelings and behavior
D) advises the client on ways to resolve problems

Review Information: The correct answer is A: assists the client to clarify the meaning of what the client has said. Clarification is a facilitating/therapeutic communication strategy. Interpretation, changing the focus/subject, giving approval, and advising are non-therapeutic/barriers to communication.

Question68

Which nursing intervention will be most effective in helping a withdrawn client to develop relationship skills?

A) Offer the client frequent opportunities to interact with 1 person
B) Provide the client with frequent opportunities to interact with other clients
C) Assist the client to analyze the meaning of the withdrawn behavior
D) Discuss with the client the focus that other clients have similar problems

Review Information: The correct answer is A: Offer the client frequent opportunities to interact with 1 person. The withdrawn client is uncomfortable in social interaction. The nurse-client relationship is a corrective relationship in which the client learns both tolerance and skills for relationships.

Question69

An important goal in the development of a therapeutic inpatient milieu is to

A) provide a businesslike atmosphere where clients can work on individual goals
B) provide a group forum in which clients decide on unit rules, regulations, and policies
C) provide a testing ground for new patterns of behavior while the client takes responsibility for his or her own actions
D) discourage expressions of anger because they can be disruptive to other clients

Review Information: The correct answer is C: provide a testing ground for new patterns of behavior while the client takes responsibility for his or her own actions. A therapeutic milieu is purposeful and planned to provide safety and a testing ground for new patterns of behavior.

Question70

A client with paranoid delusions stares at the nurse over a period of several days. The client suddenly walks up to the nurse and shouts «You think you're so perfect and pure and good.» An appropriate response for the nurse is

A) «Is that why you've been staring at me?»
B) «You seem to be in a really bad mood.»
C) «Perfect? I don't quite understand.»
D) «You seem angry right now.»

Review Information: The correct answer is D: «You seem angry right now.». The nurse recognizes the underlying emotion with a matter of fact attitude, but avoids telling the clients how they feel.

Question71

A client who is a former actress enters the day room wearing a sheer nightgown, high heels, numerous bracelets, bright red lipstick and heavily rouged cheeks. Which nursing action is the best in response to the client's attire?

A) Gently remind her that she is no longer on

stage
B) Directly assist client to her room for appropriate apparel
C) Quietly point out to her the dress of other clients on the unit
D) Tactfully explain appropriate clothing for the hospital

Review Information: The correct answer is B: Directly assist client to her room for appropriate apparel. It assists the client to maintain self-esteem while modifying behavior.

Question72

When teaching suicide prevention to the parents of a 15 year-old who recently attempted suicide, the nurse describes the following behavioral cue as indicating a need for intervention.

A) Angry outbursts at significant others
B) Fear of being left alone
C) Giving away valued personal items
D) Experiencing the loss of a boyfriend

Review Information: The correct answer is C: Giving away valued personal items. Eighty percent of all potential suicide victims give some type of indication that self-destructiveness should be addressed. These clues might lead one to suspect that a client is having suicidal thoughts or is developing a plan.

Question73

Which statement made by a client indicates to the nurse that the client may have a thought disorder?
A) «I>m so angry about this. Wait until my partner hears about this.»
B) «I>m a little confused. What time is it?»
C) «I can>t find my <mesmer> shoes. Have you seen them?»
D) «I>m fine. It>s my daughter who has the problem.»

Review Information: The correct answer is C: «I can>>t find my <>mesmer>> shoes. Have you seen them?». A neologism is a new word self invented by a person and not readily understood by another. Using neologisms is often associated with a thought disorder.

Question74

In a psychiatric setting, the nurse limits touch or contact used with clients to handshaking because

A) some clients misconstrue hugs as an invitation to sexual advances
B) handshaking keeps the gesture on a professional level
C) refusal to touch a client denotes lack of concern
D) inappropriate touch often results in charges of assault and battery

Review Information: The correct answer is A: some clients misconstrue hugs as an invitation to sexual advances. Touch denotes positive feelings for another person. The client may interpret hugging and holding hands as sexual advances.

Question75

A client with anorexia is hospitalized on a medical unit due to electrolyte imbalance and cardiac dysrhythmias. Additional assessment findings that the nurse would expect to observe are

A) brittle hair, lanugo, amenorrhea
B) diarrhea, nausea, vomiting, dental erosion
C) hyperthermia, tachycardia, increased metabolic rate
D) excessive anxiety about symptoms

Review Information: The correct answer is A: brittle hair, lanugo, amenorrhea. Physical findings associated with anorexia also include reduced metabolic rate and lower vital signs.

Free NCLEX-RN Sample Test Questions For Nursing Review (Pharmacology Set 2)

Jul31,

A nurse is assigned to perform well-child assessments at a day care center. A staff member interrupts the examinations to ask for assistance. They find a crying 3 year-old child on the floor with mouth wide open and gums bleeding. Two unlabeled open bottles lie nearby. The nurse's first action should be

A) call the poison control center, then 911
B) administer syrup of Ipecac to induce vomiting
C) give the child milk to coat her stomach
D) ask the staff about the contents of the bottles

Review Information: The correct answer is D: ask the staff about the contents of the bottles
The nurse needs to assess what the child ingested before determining the next action. Once the substance is identified, the poison control center and emergency response team should be called.

Question2

A client with atrial fibrillation is receiving digoxin (Lanoxin). Which of these assessments is most important for the nurse to perform?
A) Monitor blood pressure every 4 hours
B) Measure apical pulse prior to administration
C) Maintain accurate intake and output records
D) Record an EKG strip after administration

Review Information: The correct answer is B: Measure apical pulse prior to administration
Digitoxin decreases conduction velocity through the AV node and prolongs the refractory period. If the apical heart rate is less than 60 beats/minute, withhold the drug. The apical pulse should be taken with a stethoscope so that there will be no mistake about what the heart rate actually is.

Question3

The nurse is administering an intravenous vesicant chemotherapeutic agent to a client. Which assessment would require the nurse's immediate action?
A) Stomatitis lesion in the mouth
B) Severe nausea and vomiting
C) Complaints of pain at site of infusion
D) A rash on the client's extremities

Review Information: The correct answer is C: Complaints of pain at site of infusion
A vesicant is a chemotherapeutic agent capable of causing blistering of tissues and possible tissue necrosis if there is extravasation. These agents are irritants which cause pain along the vein wall, with or without inflammation.

Question4

The nurse practicing in a long term care facility recognizes that elderly clients are at greater risk for drug toxicity than younger adults because of which of the following physiological changes of advancing age?
A) Drugs are absorbed more readily from the GI tract
B) Elders have less body water and more fat
C) The elderly have more rapid hepatic metabolism
D) Older people are often malnourished and anemic

Review Information: The correct answer is B: Elders have less body water and more fat
Because elderly persons have decreased lean body tissue/water in which to distribute medications, more drug remains in the circulatory system with potential for drug toxicity. Increased body fat results in greater amounts of fat-soluble drugs being absorbed, leaving less in circulation, thus increasing the duration of action of the drug

Question5

The nurse is assessing a client who is on long term glucocorticoid therapy. Which of the following findings would the nurse expect?
A) Buffalo hump
B) Increased muscle mass
C) Peripheral edema
D) Jaundice

Review Information: The correct answer is A: Buffalo hump
With high doses of glucocorticoid, iatrogenic Cushing''s syndrome develops. The exaggerated physiological action causes abnormal fat distribution which results in a moon-shaped face, a intrascapular pad on the neck (buffalo hump) and truncal obesity with slender limbs.

Question6

The health care provider has written "Morphine sulfate 2 mgs IV every 3-4 hours prn for pain" on the chart of a child weighing 22 lb. (10 kg). What is the nurse's initial action?
A) Check with the pharmacist
B) Hold the medication and contact the provider
C) Administer the prescribed dose as ordered
D) Give the dose every 6-8 hours

Review Information: The correct answer is B: Hold the medication and contact the provider
The usual pediatric dose of morphine is 0.1 mg/kg every 3 to 4 hours. At 10 kg, this child typically should receive 1.0 mg every 3 to 4 hours.

Question7

A client is ordered atropine to be administered preoperatively. Which physiological effect should the nurse monitor for?
A) Elevate blood pressure
B) Drying up of secretions
C) Reduce heart rate
D) Enhance sedation

Review Information: The correct answer is B: Drying up of secretions
Atropine dries secretions which may get in the way during the operative procedure.

Question8

A client is receiving digitalis. The nurse should instruct the client to report which of the following side effects?
A) Nausea, vomiting, fatigue
B) Rash, dyspnea, edema
C) Polyuria, thirst, dry skin
D) Hunger, dizziness, diaphoresis

Review Information: The correct answer is A: Nausea, vomiting, fatigue
Side effects of digitalis toxicity include fatigue, nausea, vomiting, anorexia, and bradycardia. Digitalis inhibits the sodium potassium ATPase, which makes more calcium available for contractile proteins, resulting in increased cardiac output.

Question9

A client is receiving dexamethasone (Decadron) therapy. What should the nurse plan to monitor in this client?
A) Urine output every 4 hours
B) Blood glucose levels every 12 hours
C) Neurological signs every 2 hours
D) Oxygen saturation every 8 hours

Review Information: The correct answer is B: Blood glucose levels every 12 hours
The drug Decadron increases glycogenesis. This may lead to hyperglycemia. Therefore the blood sugar level and acetone production must be monitored.

Question10

The nurse is caring for a client with schizophrenia who has been treated with quetiapine (Seroquel) for 1 month. Today the client is increasingly agitated and complains of muscle stiffness. Which of these findings should be reported to the health care provider?
A) Elevated temperature and sweating.
B) Decreased pulse and blood pressure.
C) Mental confusion and general weakness.
D) Muscle spasms and seizures.

Review Information: The correct answer is A: Elevated temperature and sweating.
Neuroleptic malignant syndrome (NMS) is a rare disorder that can occur as a side effect of antipsychotic medications. It is characterized by muscular rigidity, tachycardia, hyperthermia, sweating, altered consciousness, autonomic dysfunction, and increase in CPK. This is a life-threatening complication.

Question11

A child presents to the Emergency Department with documented acetaminophen poisoning. In order to provide counseling and education for the parents, which principle must the nurse understand?
A) The problem occurs in stages with recovery within 12-24 hours
B) Hepatic problems may occur and may be life-threatening
C) Full and rapid recovery can be expected in most children
D) This poisoning is usually fatal, as no antidote is available

Review Information: The correct answer is B: Hepatic problems may occur and may be life-threatening
Clinical manifestations associated with acetaminophen poisoning occurs in 4 stages. The third stage is hepatic involvement which may last up to 7 days and be permanent. Clients who do not die in the hepatic stage gradually recover.

Question12

A client has been receiving dexamethasone (Decadron) for control of cerebral edema. Which of the following assessments would indicate that the treatment is effective?

A) A positive Babinski's reflex
B) Increased response to motor stimuli
C) A widening pulse pressure
D) Temperature of 37 degrees Celsius

Review Information: The correct answer is B: Increased response to motor stimuli

Decadron is a corticosteroid that acts on the cell membrane to decrease inflammatory responses as well as stabilize the blood-brain barrier. Once Decadron reaches a therapeutic level, there should be a decrease in symptomology with improvement in motor skills.

Question13

The provider has ordered transdermal nitroglycerin patches for a client. Which of these instructions should be included when teaching a client about how to use the patches?

A) Remove the patch when swimming or bathing
B) Apply the patch to any non-hairy area of the body
C) Apply a second patch with chest pain
D) Remove the patch if ankle edema occurs

Review Information: The correct answer is B: Apply the patch to any non-hairy area of the body

The patch application sites should be rotated.

Question14

A newly admitted client has a diagnosis of depression. She complains of "twitching muscles" and a "racing heart", and states she stopped taking Zoloft a few days ago because it was not helping her depression. Instead, she began to take her partner's Parnate. The nurse should immediately assess for which of these adverse reactions?

A) Pulmonary edema
B) Atrial fibrillation
C) Mental status changes
D) Muscle weakness

Review Information: The correct answer is C: Mental status changes

Use of serotonergic agents may result in Serotonin Syndrome with confusion, nausea, palpitations, increased muscle tone with twitching muscles, and agitation. Serotonin syndrome is most often reported in patients taking 2 or more medications that increase CNS serotonin levels by different mechanisms. The most common drug combinations associated with serotonin syndrome involve the MAOIs, SSRIs, and the tricyclic antidepressants.

Question15

A client with bi-polar disorder is taking lithium (Lithane). What should the nurse emphasize when teaching about this medication?

A) Take the medication before meals
B) Maintain adequate daily salt intake
C) Reduce fluid intake to minimize diuresis
D) Use antacids to prevent heartburn

Review Information: The correct answer is B: Maintain adequate daily salt intake

Salt intake affects fluid volume, which can affect lithium (Lithane) levels; therefore, maintaining adequate salt intake is advised.

Question16

A client with anemia has a new prescription for ferrous sulfate. In teaching the client about diet and iron supplements, the nurse should emphasize that absorption of iron is enhanced if taken with which substance?

A) Acetaminophen
B) Orange juice
C) Low fat milk
D) An antacid

Review Information: The correct answer is B: Orange juice

Ascorbic acid enhances the absorption of iron.

Question17

A client with an aplastic sickle cell crisis is receiving a blood transfusion and begins to complain of "feeling hot." Almost immediately, the client begins to wheeze. What is the nurse's first action?

A) Stop the blood infusion
B) Notify the health care provider
C) Take/record vital signs
D) Send blood samples to lab

Review Information: The correct answer is A: Stop the blood infusion
If a reaction of any type is suspected during administration of blood products, stop the infusion immediately, keep the line open with saline, notify the health care provider, monitor vital signs and other changes, and then send a blood sample to the lab.

Question18
A client confides in the RN that a friend has told her the medication she takes for depression, Wellbutrin, was taken off the market because it caused seizures. What is an appropriate response by the nurse?
A) "Ask your friend about the source of this information."
B) "Omit the next doses until you talk with the doctor."
C) "There were problems, but the recommended dose is changed."
D) "Your health care provider knows the best drug for your condition."

Review Information: The correct answer is C: "There were problems, but the recommended dose is changed."
Wellbutrin was introduced in the U.S. in 1985 and then withdrawn because of the occurrence of seizures in some patients taking the drug. The drug was reintroduced in 1989 with specific recommendations regarding dose ranges to limit the occurrence of seizures. The risk of seizure appears to be strongly associated with dose.

Question19
When providing discharge teaching to a client with asthma, the nurse will warn against the use of which of the following over-the-counter medications?
A) Cortisone ointments for skin rashes
B) Aspirin products for pain relief
C) Cough medications containing guaifenesin
D) Histamine blockers for gastric distress

Review Information: The correct answer is B: Aspirin products for pain relief
Aspirin is known to induce asthma attacks. Aspirin can also cause nasal polyps and rhinitis. Warn individuals with asthma about signs and symptoms resulting from complications due to aspirin ingestion.

Question20
The nurse is caring for a client who is receiving procainamide (Pronestyl) intravenously. It is important for the nurse to monitor which of the following parameters?
A) Hourly urinary output
B) Serum potassium levels
* C) Continuous EKG readings
D) Neurological signs

Review Information: The correct answer is C: Continuous EKG readings
Procainamide (Pronestyl) is used to suppress cardiac arrhythmias. When administered intravenously, it must be accompanied by continuous cardiac monitoring by ECG.

Question21
The nurse is providing education for a client with newly diagnosed tuberculosis. Which statement should be included in the information that is given to the client?
A) "Isolate yourself from others until you are finished taking your medication."
B) "Follow up with your primary care provider in 3 months."
C) "Continue to take your medications even when you are feeling fine."
D) "Continue to get yearly tuberculin skin tests."

Review Information: The correct answer is C: "Continue to take your medications even when you are feeling fine."
The most important piece of information the tuberculosis client needs is to understand the importance of medication compliance, even if no longer experiencing symptoms. Clients are most infectious early in the course of therapy. The numbers of acid-fast bacilli are greatly reduced as early as 2 weeks after therapy begins.

Question22
The nurse is applying silver sulfadiazine (Silvadene) to a child with severe burns to arms and legs. Which side effect should the nurse be monitoring for?
A) Skin discoloration
B) Hardened eschar

C) Increased neutrophils
D) Urine sulfa crystals

Review Information: The correct answer is D: Urine sulfa crystals
Silver sulfadiazine is a broad spectrum antimicrobial, especially effective against pseudomonas. When applied to extensive areas, however, it may cause a transient neutropenia, as well as renal function changes with sulfa crystals production and kernicterus.

Question23

The nurse is monitoring a client receiving a thrombolytic agent, alteplase (Activase tissue plasminogen activator), for treatment of a myocardial infarction. What outcome indicates the client is receiving adequate therapy within the first hours of treatment?
A) Absence of a dysrhythmia (or arrhythmia)
B) Blood pressure reduction
C) Cardiac enzymes are within normal limits
D) Return of ST segment to baseline on ECG

Review Information: The correct answer is D: Return of ST segment to baseline on ECG
Improved perfusion should result from this medication, along with the reduction of ST segment elevation.

Question24

The provider has ordered daily high doses of aspirin for a client with rheumatoid arthritis. The nurse instructs the client to discontinue the medication and contact the provider if which of the following symptoms occur?
A) Infection of the gums
B) Diarrhea for more than one day
C) Numbness in the lower extremities
D) Ringing in the ears

Review Information: The correct answer is D: Ringing in the ears
Aspirin stimulates the central nervous system which may result in ringing in the ears.
Deglin, J.D. and Vallerand, A.H. (2001). Davis' drug guide for nurses. (7th edition). Philadelphia: F.A. Davis Company.
Key, J.L. and Hayes, E.R. (2003). Pharmacology, a nursing process approach. (4th edition). Philadelphia: Saunders.

Question25

A nurse is caring for a client who is receiving methyldopa hydrochloride (Aldomet) intravenously. Which of the following assessment findings would indicate to the nurse that the client may be having an adverse reaction to the medication?
A) Headache
B) Mood changes
C) Hyperkalemia
D) Palpitations

Review Information: The correct answer is B: Mood changes
The nurse should assess the client for alterations in mental status such as mood changes. These symptoms should be reported promptly.
Deglin, J.D. and Vallerand, A.H. (2001). Davis' drug guide for nurses. (7th edition). Philadelphia: F.A. Davis Company.
Wilson, B.A., Shannon, M.T., and Stang, C.L. (2004). Nurse's drug guide. Upper Saddle River, New Jersey: Pearson Prentice Hall.

Question26

The nurse is teaching a child and the family about the medication phenytoin (Dilantin) prescribed for seizure control. Which of the following side effects is most likely to occur?
A) Vertigo
B) Drowsiness
C) Gingival hyperplasia
D) Vomiting

Review Information: The correct answer is C: Gingival hyperplasia
Swollen and tender gums occur often with use of phenytoin. Good oral hygiene and regular visits to the dentist should be emphasized.

Question27

The use of atropine for treatment of symptomatic bradycardia is contraindicated for a client with which of the following conditions?
A) Urinary incontinence
B) Glaucoma
C) Increased intracranial pressure
D) Right sided heart failure

Review Information: The correct answer is B: Glaucoma
Atropine is contraindicated in clients with angle-closure glaucoma because it can cause pupillary dilation with an increase in aqueous humor, leading to a resultant increase in optic pressure.

Question28
A pregnant woman is hospitalized for treatment of pregnancy induced hypertension (PIH) in the third trimester. She is receiving magnesium sulfate intravenously. The nurse understands that this medication is used mainly for what purpose?
A) Maintain normal blood pressure
B) Prevent convulsive seizures
C) Decrease the respiratory rate
D) Increase uterine blood flow

Review Information: The correct answer is B: Prevent convulsive seizures
Magnesium sulfate is a central nervous system depressant. While it has many systemic effects, it is used in the client with pregnancy induced hypertension (PIH) to prevent seizures.

Question29
The nurse is teaching a group of women in a community clinic about prevention of osteoporosis. Which of the following over-the-counter medications should the nurse recognize as having the most elemental calcium per tablet?
A) Calcium chloride
B) Calcium citrate
C) Calcium gluconate
D) Calcium carbonate

Review Information: The correct answer is D: Calcium carbonate
Calcium carbonate contains 400mg of elemental calcium in 1 gram of calcium carbonate.

Question30
The nurse is administering diltiazem (Cardizem) to a client. Prior to administration, it is important for the nurse to assess which parameter?
A) Temperature
B) Blood pressure
C) Vision
D) Bowel sounds

Review Information: The correct answer is B: Blood pressure
Diltiazem (Cardizem) is a calcium channel blocker that causes systemic vasodilation resulting in decreased blood pressure.

Question31
The nurse is instructing a client with moderate persistent asthma on the proper method for using MDIs (multi-dose inhalers). Which medication should be administered first?
A) Steroid
B) Anticholinergic
C) Mast cell stabilizer
D) Beta agonist

Review Information: The correct answer is D: Beta agonist
The beta-agonist drugs help to relieve bronchospasm by relaxing the smooth muscle of the airway. These drugs should be taken first so that other medications can reach the lungs.

Question32
A post-operative client has a prescription for acetaminophen with codeine. What should the nurse recognizes as a primary effect of this combination?
A) Enhanced pain relief
B) Minimized side effects
C) Prevention of drug tolerance
D) Increased onset of action

Review Information: The correct answer is A: Enhanced pain relief
Combination of analgesics with different mechanisms of action can afford greater pain relief.

Question33
A client is receiving erythromycin 500mg IV every 6 hours to treat a pneumonia. Which of the following is the most common side effect of the medication?
A) Blurred vision
B) Nausea and vomiting
C) Severe headache
D) Insomnia

Review Information: The correct answer is B:

Nausea and vomiting
Nausea is a common side-effect of erythromycin in both oral and intravenous forms.

Question34

The health care provider orders an IV aminophylline infusion at 30 mg/hr. The pharmacy sends a 1,000 ml bag of D5W containing 500 mg of aminophylline. In order to administer 30 mg per hour, the RN will set the infusion rate at:
A) 20 ml per hour
B) 30 ml per hour
C) 50 ml per hour
D) 60 ml per hour

Review Information: The correct answer is D: 60 ml per hour
Using the ratio method to calculate infusion rate: mg to be given (30) : ml to be infused (X) :: mg available (500) : ml of solution (1,000). Solve for X by cross-multiplying: 30 x 1,000 = 500 x X (or cancel), 30,000 = 500 X, X = 30,000/500, X = 60ml per hour.

Question35

The nurse is assessing a 7 year-old after several days of treatment for a documented strep throat. Which of the following statements suggests that further teaching is needed?
A) "Sometimes I take my medicine with fruit juice."
B) "My mother makes me take my medicine right after school."
C) "Sometimes I take the pills in the morning and other times at night."
D) "I am feeling much better than I did last week."

Review Information: The correct answer is C: "Sometimes I take the pills in the morning and other times at night."
Inconsistency in taking the prescribed medication indicates more teaching is needed.

Question36

The nurse is caring for a 10 year-old client who will be placed on heparin therapy. Which assessment is critical for the nurse to make before initiating therapy
A) Vital signs
B) Weight
C) Lung sounds
D) Skin turgor

Review Information: The correct answer is B: Weight
Check the client''s weight because dosage is calculated on the basis of weight.

Question37

In providing care for a client with pain from a sickle cell crisis, which one of the following medication orders for pain control should be questioned by the nurse?
A) Demerol
B) Morphine
C) Methadone
D) Codeine

Review Information: The correct answer is A: Demerol
Meperidine is not recommended in clients with sickle cell disease. Normeperidine, a metabolite of meperidine, is a central nervous system stimulant that produces anxiety, tremors, myoclonus, and generalized seizures when it accumulates with repetitive dosing. Clients with sickle cell disease are particularly at risk for normeperidine-induced seizures.

Question38

A 5 year-old has been rushed to the emergency room several hours after acetaminophen poisoning. Which laboratory result should receive attention by the nurse?
A) Sedimentation rate
B) Profile 2
C) Bilirubin
D) Neutrophils

Review Information: The correct answer is C: Bilirubin
Bilirubin, along with liver enzymes ALT and AST, may rise in the second stage (1-3 days) after a significant overdose, indicating cellular necrosis and liver dysfunction. A prolonged prothrombin time may also be found.

Question39

An elderly client is on an anticholinergic metered dose inhaler (MDI) for chronic obstructive pulmonary disease. The nurse would suggest a spacer

to
A) enhance the administration of the medication
B) increase client compliance
C) improve aerosol delivery in clients who are not able to coordinate the MDI
D) prevent exacerbation of COPD

Review Information: The correct answer is C: improve aerosol delivery in clients who are not able to coordinate the MDI
Spacers improve the medication delivery in clients who are unable to coordinate the movements of administering a dose with an MDI.

Question40

The nurse is teaching a parent how to administer oral iron supplements to a 2 year-old child. Which of the following interventions should be included in the teaching?
A) Stop the medication if the stools become tarry green
B) Give the medicine with orange juice and through a straw
C) Add the medicine to a bottle of formula
D) Administer the iron with your child's meals

Review Information: The correct answer is B: Give the medicine with orange juice and through a straw
Absorption of iron is facilitated in an environment rich in Vitamin C. Since liquid iron preparation will stain teeth, a straw is preferred.

0 comments

Labels: free nclex-rn sample review questions, nclex-rn practice test questions, nursing review

Free NCLEX-RN Sample Test Questions For Nursing Review (Pharmacology Set 1)

Question1

A client has an order for antibiotic therapy after hospital treatment of a staph infection. Which of the following should the nurse emphasize?
A) Scheduling follow-up blood cultures
B) Completing the full course of medications
C) Visiting the provider in a few weeks
D) Monitoring for signs of recurrent infection

Review Information: The correct answer is B: Completing the full course of medications
In order for antibiotic therapy to be effective in eradicating an infection, the client must compete the entire course of prescribed therapy. When findings subside, stopping the medication early may lead to recurrence or subsequent drug resistance.

Question2

A 72 year-old client is admitted for possible dehydration. The nurse knows that older adults are particularly at risk for dehydration because they have
A) an increased need for extravascular fluid
B) a decreased sensation of thirst
C) an increase in diaphoresis
D) higher metabolic demands

Review Information: The correct answer is B: a decreased sensation of thirst
The elderly have a reduction in thirst sensation causing them to consume less fluid. Other risk factors may include fear of incontinence, inability to drink fluids independently and lack of motivation.

Question3

A male client is admitted with a spinal cord injury at level C4. The client asks the nurse how the injury is going to affect his sexual function. The nurse would respond
A) "Normal sexual function is not possible."
B) "Sexual functioning will not be impaired at all."
C) "Erections will be possible."
D) "Ejaculation will be normal."

Review Information: The correct answer is C: "Erections will be possible."
Because they are a reflex reaction, erections can be stimulated by stroking the genitalia.

Question4

An 82 year-old client complains of chronic constipation. To improve bowel function, the nurse should first suggest
A) Increasing fiber intake to 20-30 grams daily
B) Daily use of laxatives
C) Avoidance of binding foods such as cheese and chocolate
D) Monitoring a balance between activity and rest

Review Information: The correct answer is A: Increasing fiber intake to 20-30 grams daily
The incorporation of high fiber into the diet is an effective way to promote bowel elimination in the elderly.

Question5

A 4 year-old child is admitted with burns on his legs and lower abdomen. When assessing the child's hydration status, which of the following indicates a less than adequate fluid replacement?
A) Decreasing hematocrit and increasing urine volume
B) Rising hematocrit and decreasing urine volume
C) Falling hematocrit and decreasing urine volume
D) Stable hematocrit and increasing urine volume

Review Information: The correct answer is B: Rising hematocrit and decreasing urine volume
A rising hematocrit indicates a decreased total blood volume, a finding consistent with dehydration.

Question6

A client receiving chemotherapy has developed sores in his mouth. He asks the nurse why this happened. What is the nurse's best response?
A) "It is a sign that the medication is working."
B) "You need to have better oral hygiene."
C) "The cells in the mouth are sensitive to the chemotherapy."
D) "This always happens with chemotherapy."

Review Information: The correct answer is C: "The cells in the mouth are sensitive to the chemotherapy."
The epithelial cells in the mouth are very sensitive to chemotherapy due to their high rate of cell turnover.

Question7

You are caring for a client with deep vein thrombosis who is on Heparin IV. The latest APTT is 50 seconds. If the laboratory normal range is 16-24 seconds, you would anticipate
A) maintaining the current heparin dose
B) increasing the heparin as it does not appear therapeutic.
C) giving protamine sulfate as an antidote.
D) repeating the blood test 1 hour after giving heparin.

Review Information: The correct answer is A: maintaining the current heparin dose
The range for a therapeutic APTT is 1.5-2 times the control. Therefore the client is receiving a therapeutic dose of Heparin.

Question8

A client is admitted with a diagnosis of nodal bigeminy. The nurse knows that the atrioventricular (AV) node has an intrinsic rate of
A) 60-100 beats/minute
B) 10-30 beats/minute
C) 40-70 beats/minute
D) 20-50 beats/minute

Review Information: The correct answer is C: 40-70 beats/minute
The intrinsic rate of the AV node is within the range of 40-70 beats per minute.

Question9

A client is to receive 3 doses of potassium chloride 10 mEq in 100cc normal saline to infuse over 30 minutes each. Which of the following is a priority assessment to perform before giving this medication?
A) Oral fluid intake
B) Bowel sounds
C) Grip strength
D) Urine output

Review Information: The correct answer is D: Urine output
Potassium chloride should only be administered after adequate urine output (>20cc/hour for 2

consecutive hours) has been established. Impaired ability to excrete potassium via the kidneys can result in hyperkalemia.

Question10

The unlicensed assistive personnel (UAP) reports to the nurse that a client with cirrhosis who had a paracentesis yesterday has become more lethargic and has musty smelling breath. A critical assessment for increasing encephalopathy is

A) monitor the client's clotting status
B) assess upper abdomen for bruits
C) assess for flap-like tremors of the hands
D) measure abdominal girth changes

Review Information: The correct answer is C: assess for flap-like tremors of the hands
A client with cirrhosis of the liver who develops subtle changes in mental status and has a musty odor to the breath is at risk for developing more advanced signs of encephalopathy.

Question11

A client is scheduled for an intravenous pyelogram (IVP). After the contrast material is injected, which of the following client reactions should be reported immediately?

A) Feeling warm
B) Face flushing
C) Salty taste
D) Hives

Review Information: The correct answer is D: Hives
This is a sign of anaphylaxis and should be reported immediately. The other reactions are considered normal and the client should be informed that they may occur.
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Question12

A client is prescribed an inhaler. How should the nurse instruct the client to breathe in the medication?

A) As quickly as possible
B) As slowly as possible
C) Deeply for 3-4 seconds
D) Until hearing whistling by the spacer

Review Information: The correct answer is C: Deeply for 3-4 seconds
The client should be instructed to breath in the medication for 3-4 seconds in order to receive the correct dosage of medication.

Question13

The nurse is caring for clients over the age of 70. The nurse knows that due to age-related changes, the elderly clients tolerate diets that are

A) high protein
B) high carbohydrates
C) low fat
D) high calories

Review Information: The correct answer is C: low fat
Due to age related changes, the diet of the elderly should include a lower quantity and higher quality of food. Fewer carbohydrates and fats are required in their diets.

Question14

A woman with a 28 week pregnancy is on the way to the emergency department by ambulance with a tentative diagnosis of abruptio placenta. Which should the nurse do first when the woman arrives?

A) administer oxygen by mask at 100%
B) start a second IV with an 18 gauge cannula
C) check fetal heart rate every 15 minutes
D) insert urethral catheter with hourly urine outputs

Review Information: The correct answer is A: administer oxygen by mask at 100%
Administering oxygen in this situation would increase the circulating oxygen in the mother's circulation to the fetus's circulation. This action will minimize complications.

Question15

A client in respiratory distress is admitted with arterial blood gas results of: PH 7.30; PO2 58, PCO2 34; and HCO3 19. The nurse determines that the client is in

A) metabolic acidosis
B) metabolic alkalosis
C) respiratory acidosis
D) respiratory alkalosis

Review Information: The correct answer is A: metabolic acidosis
These lab values indicate metabolic acidosis: the PH is low, PCO2 is normal, and bicarbonate level is low.

Question16

A client is diagnosed with gastroesophageal reflux disease (GERD). The nurse's instruction to the client regarding diet should be to
A) avoid all raw fruits and vegetables
B) increase intake of milk products
C) decrease intake of fatty foods
D) focus on 3 average size meals a day

Review Information: The correct answer is C: decrease intake of fatty foods
GERD may be aggravated by a fatty diet. A diet low in fat would decrease the symptoms of GERD. Other agents which should also be decreased or avoided are: cigarette smoking, caffeine, alcohol, chocolate, and meperidine (Demerol).

Question17

After surgery, a client with a nasogastric tube complains of nausea. What action would the nurse take?
A) Call the health care provider
B) Administer an antiemetic
C) Put the bed in Fowler's position
D) Check the patency of the tube

Review Information: The correct answer is D: Check the patency of the tube
An indication that the nasogastric tube is obstructed is a client's complaint of nausea. Nasogastric tubes may become obstructed with mucus or sediment.

Question18

A client with testicular cancer has had an orchiectomy. Prior to discharge the client expresses his fears related to his prognosis. Which principle should the nurse base the response on?
A) Testicular cancer has a cure rate of 90% with early diagnosis
B) Testicular cancer has a cure rate of 50% with early diagnosis
C) Intensive chemotherapy is the treatment of choice
D) Testicular cancer is usually fatal

Review Information: The correct answer is A: Testicular cancer has a cure rate of 90% with early diagnosis
With aggressive treatment and early detection/diagnosis the cure rate is 90%.

Question19

A client newly diagnosed with Type I Diabetes Mellitus asks the purpose of the test measuring glycosylated hemoglobin. The nurse should explain that the purpose of this test is to determine:
A) The presence of anemia often associated with Diabetes
B) The oxygen carrying capacity of the client's red cells
C) The average blood glucose for the past 2-3 months
D) The client's risk for cardiac complications

Review Information: The correct answer is C: The average blood glucose for the past 2-3 months
By testing the portion of the hemoglobin that absorbs glucose, it is possible to determine the average blood glucose over the life span of the red cell, 120 days.

Question20

A client is admitted for a possible pacemaker insertion. What is the intrinsic rate of the heart's own pacemaker?
A) 30-50 beats/minute
B) 60-100 beats/minute
C) 20-60 beats/minute
D) 90-100 beats/minute

Review Information: The correct answer is B: 60-100 beats/minute
This is the intrinsic rate of the SA node.

Question21

The nurse discusses nutrition with a pregnant woman who is iron deficient and follows a vegetarian diet. The selection of which foods indicates the woman has learned sources of iron?

A) Cereal and dried fruits

B) Whole grains and yellow vegetables

C) Leafy green vegetables and oranges

D) Fish and dairy products

Review Information: The correct answer is A: Cereal and dried fruits

Both of these foods would be a good source of iron.

Question22

Prior to administering Alteplase (TPA) to a client admitted for a cerebral vascular accident (CVA), it is critical that the nurse assess:

A) Neuro signs

B) Mental status

C) Blood pressure

D) PT/PTT

Review Information: The correct answer is D: PT/PTT

TPA is a potent thrombolytic enzyme. Because bleeding is the most common side effect, it is most essential to evaluate clotting studies including PT, PTT, APTT, platelets, and hematocrit before beginning therapy.

Question23

The nurse enters the room of a client diagnosed with COPD. The client's skin is pink, and respirations are 8 per minute. The client's oxygen is running at 6 liters per minute. What should be the nurse's first action?

A) Call the health care provider

B) Put the client in Fowler's position

C) Lower the oxygen rate

D) Take the vital signs

Review Information: The correct answer is C: Lower the oxygen rate

In client's diagnosed with COPD, the drive to breathe is hypoxia. If oxygen is delivered at too high of a concentration, this drive will be eliminated and the client's depth and rate of respirations will decrease. Therefore the first action should be to lower the oxygen rate.

Question24

The client with goiter is treated with potassium iodide preoperatively. What should the nurse recognize as the purpose of this medication?

A) Reduce vascularity of the thyroid

B) Correct chronic hyperthyroidism

C) Destroy the thyroid gland function

D) Balance enzymes and electrolytes

Review Information: The correct answer is A: Reduce vascularity of the thyroid

Potassium iodide solution, or Lugol''s solution may be used preoperatively to reduce the size and vascularity of the thyroid gland.

Question25

One hour before the first treatment is scheduled, the client becomes anxious and states he does not wish to go through with electroconvulsive therapy. Which response by the nurse is most appropriate?

A) "I'll go with you and will be there with you during the treatment."

B) "You'll be asleep and won't remember anything."

C) "You have the right to change your mind. You seem anxious. Can we talk about it?"

D) "I'll call the health care provider to notify them of your decision."

Review Information: The correct answer is C: "You have the right to change your mind. You seem anxious. Can we talk about it?"

This response indicates acknowledgment of the client's rights and the opportunity for the client to clarify and ventilate concerns. After this, if the client continues to refuse, the provider should be notified.

Question26

A nurse who has been named in a lawsuit can use which of these factors for the best protection in a court of law?

A) Clinical specialty certification in the associated area of practice

B) Documentation on the specific client record with a focus on the nursing process
C) Yearly evaluations and proficiency reports prepared by nurse's manager
D) Verification of provider's orders for the plan of care with identification of outcomes

Review Information: The correct answer is B: Documentation on the specific client record with a focus on the nursing process
Documentation is the key to protect nurses when a lawsuit is filed. The thorough documentation should include all steps of the nursing process – assessment, analysis, plan, intervention, evaluation. In addition, it should include pertinent data such as times, dosages and sites of actions, assessment data, the nurse's response to a change in the client's condition, specific actions taken, if and when the notification occurred to the provider or other health care team members, and what was prescribed along with the client's outcomes.

Question27

The nurse is caring for clients over the age of 70. The nurse is aware that when giving medications to older clients, it is best to
A) start low, go slow
B) avoid stopping a medication entirely
C) avoid drugs with side effects that impact cognition
D) review the drug regimen yearly

Review Information: The correct answer is A: start low, go slow
Due to physiological changes in the elderly, as well as conditions such as dehydration, hyperthermia, immobility and liver disease, the effective metabolism of drugs may decrease. As a result, drugs can accumulate to toxic levels and cause serious adverse reactions.

Question28

You are caring for a hypertensive client with a new order for captopril (Capoten). Which information should the nurse include in client teaching?
A) Avoid green leafy vegetables
B) Restrict fluids to 1000cc/day
C) Avoid the use of salt substitutes
D) Take the medication with meals

Review Information: The correct answer is C: Avoid the use of salt substitutes
Captopril can cause an accumulation of potassium or hyperkalemia. Clients should avoid the use of salt substitutes, which are generally potassium-based.

Question29

A client has bilateral knee pain from osteoarthritis. In addition to taking the prescribed non-steroidal anti-inflammatory drug (NSAID), the nurse should instruct the client to
A) start a regular exercise program
B) rest the knees as much as possible to decrease inflammation
C) avoid foods high in citric acid
D) keep the legs elevated when sitting

Review Information: The correct answer is A: start a regular exercise program
A regular exercise program is beneficial in treating osteoarthritis. It can restore self-esteem and improve physical functioning.

Question30

An arterial blood gases test (ABG) is ordered for a confused client. The respiratory therapist draws the blood and then asks the nurse to apply pressure to the area so the therapist can take the specimen to the lab. How long should the nurse apply pressure to the area?
A) 3 minutes
B) 5 minutes
C) 8 minutes
D) 10 minutes

Review Information: The correct answer is B: 5 minutes
It is necessary to apply pressure to the area for 5 minutes to prevent bleeding and the formation of hematomas.

Question31

Which of these clients should the charge nurse

assign to the registered nurse (RN)?
A) A 56 year-old with atrial fibrillation receiving digoxin
B) A 60 year-old client with COPD on oxygen at 2 L/min
C) A 24 year-old post-op client with type 1 diabetes in the process of discharge
D) An 80 year-old client recovering 24 hours post right hip replacement

Review Information: The correct answer is C: A 24 year-old post-op client with type 1 diabetes in the process of discharge
Discharge teaching must be done by an RN. Practical nurses (PNs) or unlicensed assistive personnel (UAPs) can reinforce education after the RN does the initial teaching.

Question32
A hypertensive client is started on atenolol (Tenormin). The nurse instructs the client to immediately report which of these findings?
A) Rapid breathing
B) Slow, bounding pulse
C) Jaundiced sclera
D) Weight gain

Review Information: The correct answer is B: Slow, bounding pulse
Atenolol (Tenormin) is a beta-blocker that can cause side effects including bradycardia and hypotension.

Question33
An 80 year-old client is admitted with a diagnosis of malnutrition. In addition to physical assessments, which of the following lab tests should be closely monitored?
A) Urine protein
B) Urine creatinine
C) Serum calcium
D) Serum albumin

Review Information: The correct answer is D: Serum albumin
Serum albumin is a valuable indicator of protein deficiency and, later, nutritional status in adults. A normal reading for an elder's serum albumin is between 3.0-5.0 g/dl.

Question34
Upon admission to an intensive care unit, a client diagnosed with an acute myocardial infarction is ordered oxygen. The nurse knows that the major reason that oxygen is administered in this situation is to
A) saturate the red blood cells
B) relieve dyspnea
C) decrease cyanosis
D) increase oxygen level in the myocardium

Review Information: The correct answer is D: increase oxygen level in the myocardium
Anoxia of the myocardium occurs in myocardial infarction. Oxygen administration will help relieve dyspnea and cyanosis associated with the condition but the major purpose is to increase the oxygen concentration in the damaged myocardial tissue.
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Question35
The nurse is teaching a client with chronic renal failure (CRF) about medications. The client questions the purpose of aluminum hydroxide (Amphojel) in her medication regimen. What is the best explanation for the nurse to give the client about the therapeutic effects of this medication?
A) It decreases serum phosphate
B) It will reduce serum calcium
C) Amphojel increases urine output
D) The drug is taken to control gastric acid secretion

Review Information: The correct answer is A: It decreases serum phosphate
Aluminum binds phosphates that tend to accumulate in the patient with chronic renal failure due to decreased filtration capacity of the kidney. Antacids such as Amphojel are commonly used to accomplish this.

Question36
A 66 year-old client is admitted for mitral valve replacement surgery. The client has a history of mitral valve regurgitation and mitral stenosis since her teenage years. During the admission assessment, the nurse should ask the client if as a child she had
A) measles
B) rheumatic fever
C) hay fever
D) encephalitis

Review Information: The correct answer is B: rheumatic fever
Clients that present with mitral stenosis often have a history of rheumatic fever or bacterial endocarditis.

Question37
During nursing rounds which of these assessments would require immediate corrective action and further instruction to the practical nurse (PN) about proper care?
A) The weights of the skin traction of a client are hanging about 2 inches from the floor
B) A client with a hip prosthesis 1 day post operatively is lying in bed with internal rotation and adduction of the affected leg
C) The nurse observes that the PN moves the extremity of a client with an external fixation device by picking up the frame
D) A client with skeletal traction states "The other nurse said that the clear, yellow and crusty drainage around the pin site is a good sign"

Review Information: The correct answer is B: A client with a hip prosthesis 1 day post operatively is lying in bed with internal rotation and adduction of the affected leg
This position should be prevented in order to prevent dislodgment of the hip prosthesis, especially in the first 48 to 72 hours post-op. The other assessments are not of concern.

Question38
A client diagnosed with gouty arthritis is admitted with severe pain and edema in the right foot. When the nurse develops a plan of care, which intervention should be included?
A) high protein diet
B) salicylates
C) hot compresses to affected joints
D) intake of at least 3000cc/day

Review Information: The correct answer is D: intake of at least 3000cc/day
Fluid intake should be increased to prevent precipitation of urate in the kidneys.

Question39
A 55 year-old woman is taking Prednisone and aspirin (ASA) as part of her treatment for rheumatoid arthritis. Which of the following would be an appropriate intervention for the nurse?
A) Assess the pulse rate q 4 hours
B) Monitor her level of consciousness q shift
C) Test her stools for occult blood
D) Discuss fiber in the diet to prevent constipation

Review Information: The correct answer is C: Test her stools for occult blood
Both Prednisone and ASA can lead to GI bleeding, therefore monitoring for occult blood would be appropriate.

Question40
A client with testicular cancer is scheduled for a right orchiectomy. The nurse knows that an orchiectomy is the
A) surgical removal of the entire scrotum
B) surgical removal of a testicle
C) dissection of related lymph nodes
D) partial surgical removal of the penis

Review Information: The correct answer is B: surgical removal of a testicle
The affected testicle is surgically removed along with its tunica and spermatic cord.

0 comments

Labels: free nclex-rn sample review questions, nclex-rn practice test questions, nursing review

Free NCLEX-RN Sample Test Questions For Nursing Review (Part 5)

Question1
A client complains of some discomfort after a below the knee amputation. Which action by the nurse is most appropriate initially?
A) Conduct guided imagery or distraction
B) Ensure that the stump is elevated the first day post-op
C) Wrap the stump snugly in an elastic bandage
D) Administer opioid narcotics as ordered

Review Information: The correct answer is B: Ensure that the stump is elevated the first day post-op
This priority intervention prevents pressure caused by pooling of blood, thus minimizing the pain. Without this measure, a firm elastic bandage, opioid narcotics, or guided imagery will have little effect. Opioid narcotics are given for

severe pain.

Question2

A 78 year-old client with pneumonia has a productive cough, but is confused. Safety protective devices (restraints) have been ordered for this client. How can the nurse prevent aspiration?
A) Suction the client frequently while restrained
B) Secure all 4 restraints to 1 side of bed
C) Obtain a sitter for the client while restrained
D) Request an order for a cough suppressant

Review Information: The correct answer is C: Obtain a sitter for the client while restrained
The plan to use safety devices (restraints) should be rethought. Restraints are used to protect the client from harm caused by removing tubes or getting out of bed. In the event that this restricted movement could cause more harm, such as aspiration, then a sitter should be requested. These are to be provided by the facility in the event the family cannot do so. This client needs to cough and be watched rather than restricted. Suctioning will not prevent aspiration in this situation. Cough suppressants should be avoided for this client.

Question3

A couple trying to conceive asks the nurse when ovulation occurs. The woman reports a regular 32 day cycle. Which response by the nurse is correct?
A) Days 7-10
B) Days 10-13
C) Days 14-16
D) Days 17-19

Review Information: The correct answer is D: Days 17-19
Ovulation occurs 14 days prior to menses. Considering that the woman''s cycle is 32 days, subtracting 14 from 32 suggests ovulation is at about the 18th day.

Question4

A newborn is having difficulty maintaining a temperature above 98 degrees Fahrenheit and has been placed in an incubator. Which action is a nursing priority?
A) Protect the eyes of the neonate from the heat lamp
B) Monitor the neonate's temperature
C) Warm all medications and liquids before giving
D) Avoid touching the neonate with cold hands

Review Information: The correct answer is B: Monitor the neonate's temperature
When using a warming device the neonate's temperature should be continuously monitored for undesired elevations. The use of heat lamps is not safe as there is no way to regulate their temperature. Warming medications and fluids is not indicated. While touching with cold hands can startle the infant it does not pose a safety risk.

Question5

Which oxygen delivery system would the nurse apply that would provide the highest concentrations of oxygen to the client?
A) Venturi mask
B) Partial rebreather mask
C) Non-rebreather mask
D) Simple face mask

Review Information: The correct answer is C: Non-rebreather mask
The non-rebreather mask has a one-way valve that prevents exhales air from entering the reservoir bag and one or more valves covering the air holes on the face mask itself to prevent inhalation of room air but to allow exhalation of air. When a tight seal is achieved around the mask up to 100% of the oxygen is available.

Question6

At a senior citizens meeting a nurse talks with a client who has Type 1 diabetes mellitus. Which statement by the client during the conversation is most predictive of a potential for impaired skin integrity?
A) "I give my insulin to myself in my thighs."
B) "Sometimes when I put my shoes on I don't know where my toes are."
C) "Here are my up and down glucose readings that I wrote on my calendar."
D) "If I bathe more than once a week my skin feels too dry."

Review Information: The correct answer is B: "Sometimes when I put my shoes on I don''t know where my toes are."
Peripheral neuropathy can lead to lack of sensation in the lower extremities. Clients who do not feel pressure and/or pain are at high risk for skin impairment.

Question7

A client returns from surgery after an open reduction of a femur fracture. There is a small bloodstain on the cast. Four hours later, the nurse observes that the stain has doubled in size. What is the best action for the nurse to take?

A) Call the health care provider

B) Access the site by cutting a window in the cast

C) Simply record the findings in the nurse's notes only

D) Outline the spot with a pencil and note the time and date on the cast

Review Information: The correct answer is D: Outline the spot with a pencil and note the time and date on the cast

This is a good way to assess the amount of bleeding over a period of time. The bleeding does not appear to be excessive and some bleeding is expected with this type of surgery. The bleeding should also be documented in the nurse's notes.

Question8

The nurse is caring for a 1 year-old child who has 6 teeth. What is the best way for the nurse to give mouth care to this child?

A) Using a moist soft brush or cloth to clean teeth and gums

B) Swabbing teeth and gums with flavored mouthwash

C) Offering a bottle of water for the child to drink

D) Brushing with toothpaste and flossing each tooth

Review Information: The correct answer is A: Using a moist soft brush or cloth to clean teeth and gums

The nurse should use a soft cloth or soft brush to do mouth care so that the child can adjust to the routine of cleaning the mouth and teeth.

Question9

In addition to standard precautions, a nurse should implement contact precautions for which client?

A) 60 year-old with herpes simplex

B) 6 year-old with mononucleosis

C) 45 year-old with pneumonia

D) 3 year-old with scarlet fever

Review Information: The correct answer is A: 60 year-old with herpes simplex

Clients who have herpes simplex infections must have contact precautions in addition to standard precautions because of the associated, potentially weeping, skin lesions. Contact precautions are used for clients who are infected by microorganisms that are transmitted by direct contact with the client, including hand or skin-to-skin contact.

Question10

Which of the following situations is most likely to produce sepsis in the neonate?

A) Maternal diabetes

B) Prolonged rupture of membranes

C) Cesarean delivery

D) Precipitous vaginal birth

Review Information: The correct answer is B: Prolonged rupture of membranes

Premature rupture of the membranes (PROM) is a leading cause of newborn sepsis. After 12-24 hours of leaking fluid, measures are taken to reduce the risk to mother and the fetus/newborn.

Question11

The nurse is teaching a parent about side effects of routine immunizations. Which of the following must be reported immediately?

A) Irritability

B) Slight edema at site

C) Local tenderness

D) Seizure activity

Review Information: The correct answer is D: Seizure activity

Other reactions that should be reported include crying for >3 hours, temperature over 104.8 degrees Fahrenheit following DPT immunization, and tender, swollen, reddened areas.

Question12

The nurse is at the community center speaking with retired people about glaucoma. Which comment by one of the retirees would the nurse support to reinforce correct information?

A) "I usually avoid driving at night since lights sometimes seem to make things blur."

B) "I take half of the usual dose for my sinuses to maintain my blood pressure."

C) "I have to sit at the side of the pool with the grandchildren since I can't swim with this eye problem."

D) "I take extra fiber and drink lots of water to

avoid getting constipated."

Review Information: The correct answer is D: "I take extra fiber and drink lots of water to avoid getting constipated."
Any activity that involves straining should be avoided in clients with glaucoma. Such activities would increase intraocular pressure.

Question13

A newborn has hyperbilirubinemia and is undergoing phototherapy with a fiberoptic blanket. Which safety measure is most important during this process?
A) Regulate the neonate's temperature using a radiant heater
B) Withhold feedings while under the phototherapy
C) Provide water feedings at least every 2 hours
D) Protect the eyes of neonate from the phototherapy lights

Review Information: The correct answer is C: Provide water feedings at least every 2 hours
Protecting the eyes of the neonates is very important to prevent damage when under the ultraviolet lights, but since the blanket is used, extra protection of the eyes is unnecessary. It is recommended that the neonate remain under the lights for extended periods. The neonate's skin is exposed to the light and the temperature is monitored, but a heater may not be necessary. There is no reason to withhold feedings. Frequent water or feedings are given to help with the excretion of the bilirubin in the stool.
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Question14

A nurse is performing the routine daily cleaning of a tracheostomy. During the procedure, the client coughs and displaces the tracheostomy tube. This negative outcome could have avoided by
A) placing an obturator at the client's bedside
B) having another nurse assist with the procedure
C) fastening clean tracheostomy ties before removing old ties
D) placing the client in a flat, supine position

Review Information: The correct answer is C: fastening clean tracheostomy ties before removing old ties
Fastening clean tracheostomy ties before removing old ones will ensure that the tracheostomy is secured during the entire cleaning procedure. The obturator is useful to keep the airway open only after the tracheostomy outer tube is coughed out. A second nurse is not needed. Changing the position may not prevent a dislodged tracheostomy.

Question15

A 4 year-old hospitalized child begins to have a seizure while playing with hard plastic toys in the hallway. Of the following nursing actions, which one should the nurse do first?
A) Place the child in the nearest bed
B) Administer IV medication to slow down the seizure
C) Place a padded tongue blade in the child's mouth
D) Remove the child's toys from the immediate area

Review Information: The correct answer is D: Remove the child''s toys from the immediate area
Nursing care for a child having a seizure includes, maintaining airway patency, ensuring safety, administering medications, and providing emotional support. Since the seizure has already started, nothing should be forced into the child''s mouth and the child should not be moved. Of the choices given, the first priority would be to provide a safe environment.

Question16

The nurse is teaching home care to the parents of a child with acute spasmodic croup. The most important aspects of this care is/are
A) sedation as needed to prevent exhaustion
B) antibiotic therapy for 10 to 14 days
C) humidified air and increased oral fluids
D) antihistamines to decrease allergic response

Review Information: The correct answer is C: humidified air and increased oral fluids
The most important aspects of home care for a child with acute spasmodic croup are humidified air and increased oral fluids. Moisture soothes inflamed membranes. Adequate systemic hydration aids is mucociliary clearance and keeps secretions thin, white, watery, and easily removed with minimal coughing.

Question17

The nurse is assigned to care for a client who has a leaking intracranial aneurysm. To minimize the risk of rebleeding, the nurse should plan to
A) restrict visitors to immediate family
B) avoid arousal of the client except for family visits
C) keep client's hips flexed at no less than 90 degrees
D) apply a warming blanket for temperatures of 98 degrees Fahrenheit or less

Review Information: The correct answer is A: restrict visitors to immediate family
Maintaining a quiet environment will assist in minimizing cerebral rebleeding. When family visit, the client should not be disturbed. If the client is awake, topics of a general nature are better choices for discussion than topics that result in emotional or physiological stimulation.

Question18

A client who is 12 hour post-op becomes confused and says: "Giant sharks are swimming across the ceiling." Which assessment is necessary to adequately identify the source of this client's behavior?
A) Cardiac rhythm strip
B) Pupillary response
C) Pulse oximetry
D) Peripheral glucose stick

Review Information: The correct answer is C: Pulse oximetry
A sudden change in mental status in any post-op client should trigger a nursing intervention directed toward respiratory evaluation. Pulse oximetry would be the initial assessment. If available, arterial blood gases would be better. Acute respiratory failure is the sudden inability of the respiratory system to maintain adequate gas exchange which may result in hypercapnia and/or hypoxemia. Clinical findings of hypoxemia include these finding which are listed in order of initial to later findings: restlessness, irritability, agitation, dyspnea, disorientation, confusion, delirium, hallucinations, and loss of consciousness. While there may be other factors influencing the client''s behavior, the first nursing action should be directed toward maintaining oxygenation. Once respiratory or oxygenation issues are ruled out then significant changes in glucose would be evaluated.

Question19

A newborn delivered at home without a birth attendant is admitted to the hospital for observation. The initial temperature is 95 degrees Fahrenheit (35 degrees Celsius) axillary. The nurse recognizes that cold stress may lead to what complication?
A) Lowered BMR
B) Reduced PaO2
C) Lethargy
D) Metabolic alkalosis

Review Information: The correct answer is B: Reduced PaO2
Cold stress causes increased risk for respiratory distress. The baby delivered in such circumstances needs careful monitoring. In this situation, the newborn must be warmed immediately to increase its temperature to at least 97 degrees Fahrenheit (36 degrees Celsius).

Question20

Which contraindication should the nurse assess for prior to giving a child immunizations?
A) Mild cold symptoms
B) Chronic asthma
C) Depressed immune system
D) Allergy to eggs

Review Information: The correct answer is C: Depressed immune system
Children who have a depressed immune system related to HIV or chemotherapy should not be given routine immunizations.

Question21

The nurse is caring for a client with a myocardial infarction. Which finding requires the nurse's immediate action?
A) Periorbital edema
B) Dizzy spells
C) Lethargy
D) Shortness of breath

Review Information: The correct answer is B: Dizzy spells
Cardiac dysrhythmias may cause a transient drop in cardiac output and decreased blood flow to the brain. Near syncope refers to lightheartedness, dizziness, temporary confusion. Such "spells" may indicate runs of ventricular tachy-

cardia or periods of asystole and should be reported immediately.

Question22

Decentralized scheduling is used on a nursing unit. A chief advantage of this management strategy is that it:
A) considers client and staff needs
B) conserves time spent on planning
C) frees the nurse manager to handle other priorities
D) allows requests for special privileges

Review Information: The correct answer is A: considers client and staff needs
Decentralized staffing takes into consideration specific client needs and staff interests and abilities.

Question23

Included in teaching the client with tuberculosis taking isoniazid (INH) about follow-up home care, the nurse should emphasize that a laboratory appointment for which of the following lab tests is critical?
A) Liver function
B) Kidney function
C) Blood sugar
D) Cardiac enzymes

Review Information: The correct answer is A: Liver function
INH can cause hepatocellular injury and hepatitis. This side effect is age-related and can be detected with regular assessment of liver enzymes, which are released into the blood from damaged liver cells.

Question24

A woman in her third trimester complains of severe heartburn. What is appropriate teaching by the nurse to help the woman alleviate these symptoms?
A) Drink small amounts of liquids frequently
B) Eat the evening meal just before retiring
C) Take sodium bicarbonate after each meal
D) Sleep with head propped on several pillows

Review Information: The correct answer is D: Sleep with head propped on several pillows
Heartburn is a burning sensation caused by regurgitation of gastric contents. It is best relieved by sleeping position, eating small meals, and not eating before bedtime.

Question25

A 16 year-old boy is admitted for Ewing's sarcoma of the tibia. In discussing his care with the parents, the nurse understands that the initial treatment most often includes
A) amputation just above the tumor
B) surgical excision of the mass
C) bone marrow graft in the affected leg
D) radiation and chemotherapy

Review Information: The correct answer is D: radiation and chemotherapy
The initial treatment of choice for Ewing''s sarcoma is a combination of radiation and chemotherapy.

Question26

A new nurse manager is responsible for interviewing applicants for a staff nurse position. Which interview strategy would be the best approach?
A) Vary the interview style for each candidate to learn different techniques
B) Use simple questions requiring "yes" and "no" answers to gain definitive information
C) Obtain an interview guide from human resources for consistency in interviewing each candidate
D) Ask personal information of each applicant to assure he/she can meet job demands

Review Information: The correct answer is C: Obtain an interview guide from human resources for consistency in interviewing each candidate
An interview guide used for each candidate enables the nurse manager to be more objective in the decision making. The nurse should use resources available in the agency before attempts to develop one from scratch. Certain personal questions are prohibited, and HR can identify these for novice managers.

Question27

What is the best way that parents of pre-schoolers can begin teaching their child about injury prevention?
A) Set good examples themselves
B) Protect their child from outside influences
C) Make sure their child understands all the safety rules
D) Discuss the consequences of not wearing

protective devices

Review Information: The correct answer is A: Set good examples themselves
The preschool years are the time for parents to begin emphasizing safety principles as well as providing protection. Setting a good example themselves is crucial because of the imitative behaviors of pre-schoolers; they are quick to notice discrepancies between what they see and what they are told.

Question28

A nurse assessing the newborn of a mother with diabetes understands that hypoglycemia is related to what pathophysiological process?
A) Disruption of fetal glucose supply
B) Pancreatic insufficiency
C) Maternal insulin dependency
D) Reduced glycogen reserves

Review Information: The correct answer is A: Disruption of fetal glucose supply
After delivery, the high glucose levels which crossed the placenta to the fetus are suddenly stopped. The newborn continues to secrete insulin in anticipation of glucose. When oral feedings begin, the newborn will adjust insulin production within a day or two.

Question29

The nurse is caring for a client with extracellular fluid volume deficit. Which of the following assessments would the nurse anticipate finding?
A) bounding pulse
B) rapid respirations
C) oliguria
D) neck veins are distended

Review Information: The correct answer is C: oliguria
Kidneys maintain fluid volume through adjustments in urine volume.

Question30

A 70 year-old woman is evaluated in the emergency department for a wrist fracture of unknown causes. During the process of taking client history, which of these items should the nurse identify as related to the client's greatest risk factors for osteoporosis?
A) History of menopause at age 50
B) Taking high doses of steroids for arthritis for many years
C) Maintaining an inactive lifestyle for the past 10 years
D) Drinking 2 glasses of red wine each day for the past 30 years

Review Information: The correct answer is B: Taking high doses of steroids for arthritis for many years
The use of steroids, especially at high doses over time, increases the risk for osteoporosis. The other options also predispose to osteoporosis, as do low bone mass, poor calcium absorption and moderate to high alcohol ingestion. Long-term steroid treatment is the most significant risk factor, however.

Question31

The nurse is caring for a 2 year-old who is being treated with chelation therapy, calcium disodium edetate, for lead poisoning. The nurse should be alert for which of the following side effects?
A) Neurotoxicity
B) Hepatomegaly
C) Nephrotoxicity
D) Ototoxicity

Review Information: The correct answer is C: Nephrotoxicity
Nephrotoxicity is a common side effect of calcium disodium edetate, in addition to lead poisoning in general.

Question32

The parents of a toddler ask the nurse how long their child will have to sit in a car seat while in the automobile. What is the nurse's best response to the parents?
A) "Your child must use a care seat until he weighs at least 40 pounds."
B) "The child must be 5 years of age to use a regular seat belt."
C) "Your child must reach a height of 50 inches

to sit in a seat belt."
D) "The child can use a regular seat belt when he can sit still."

Review Information: The correct answer is A: "Your child must use a care seat until he weighs at least 40 pounds."
Children should use car seats until they weigh 40 pounds.

Question33

A client asks the nurse to explain the basic ideas of homeopathic medicine. The response that best explains this approach is that such remedies
A) destroy organisms causing disease
B) maintain fluid balance
C) boost the immune system
D) increase bodily energy

Review Information: The correct answer is C: boost the immune system
The practitioner treats with minute doses of plant, mineral or animal substances which provide a gentle stimulus to the body''s own defenses.

Question34

A client with a fractured femur has been in Russell's traction for 24 hours. Which nursing action is associated with this therapy?
A) Check the skin on the sacrum for breakdown
B) Inspect the pin site for signs of infection
C) Auscultate the lungs for atelectasis
D) Perform a neurovascular check for circulation

Review Information: The correct answer is D: Perform a neurovascular check for circulation
While each of these is an important assessment, the neurovascular integrity check is most associated with this type of traction. Russell's traction is Buck's traction with a sling under the knee.

Question35

When suctioning a client's tracheostomy, the nurse should instill saline in order to
A) decrease the client's discomfort
B) reduce viscosity of secretions
C) prevent client aspiration
D) remove a mucus plug

Review Information: The correct answer is D: remove a mucus plug
While no longer recommended for routine suctioning, saline may thin and loosen viscous secretions that are very difficult to move, perhaps making them easier to suction.

Question36

The nurse is performing a gestational age assessment on a newborn delivered 2 hours ago. When coming to a conclusion using the Ballard scale, which of these factors may affect the score?
A) Birth weight
B) Racial differences
C) Fetal distress in labor
D) Birth trauma

Review Information: The correct answer is C: Fetal distress in labor
The effects of earlier distress may alter the findings of reflex responses as measured on the Ballard tool. Other physical characteristics that estimate gestational age, such as amount of lanugo, sole creases and ear cartilage are unaffected by the other factors.

Question37

A nurse is caring for a client who had a closed reduction of a fractured right wrist followed by the application of a fiberglass cast 12 hours ago. Which finding requires the nurse's immediate attention?
A) Capillary refill of fingers on right hand is 3 seconds
B) Skin warm to touch and normally colored
C) Client reports prickling sensation in the right hand
D) Slight swelling of fingers of right hand

Review Information: The correct answer is C: Client reports prickling sensation in the right

hand
A prickling sensation is an indication of compartment syndrome and requires immediate action by the nurse. The other findings are normal for a client in this situation.

Question38

A client is admitted with the diagnosis of pulmonary embolism. While taking a history, the client tells the nurse he was admitted for the same thing twice before, the last time just 3 months ago. The nurse would anticipate the provider ordering
A) pulmonary embolectomy
B) vena caval interruption
C) increasing the Coumadin therapy to an INR of 3-4
D) thrombolytic therapy

Review Information: The correct answer is B: vena caval interruption
Clients with contraindications to Heparin, recurrent PE or those with complications related to the medical therapy may require vena caval interruption by the placement of a filter device in the inferior vena cava. A filter can be placed transvenously to trap clots before they travel to the pulmonary circulation.

Question39

Which client is at highest risk for developing a pressure ulcer?
A) 23 year-old in traction for fractured femur
B) 72 year-old with peripheral vascular disease, who is unable to walk without assistance
C) 75 year-old with left sided paresthesia who is incontinent of urine and stool
D) 30 year-old who is comatose following a ruptured aneurysm

Review Information: The correct answer is C: 75 year-old with left sided paresthesia who is incontinent of urine and stool
Risk factors for pressure ulcers include: immobility, absence of sensation, decreased LOC, poor nutrition and hydration, skin moisture, incontinence, increased age, decreased immune response. This client has the greatest number of risk factors.

Question40

The nurse is teaching the mother of a 5 month-old about nutrition for her baby. Which statement by the mother indicates the need for further teaching?
A) “I’m going to try feeding my baby some rice cereal.”
B) “When he wakes at night for a bottle, I feed him.”
C) “I dip his pacifier in honey so he’ll take it.”
D) “I keep formula in the refrigerator for 24 hours.”

Review Information: The correct answer is C: “I dip his pacifier in honey so he’’ll take it.”
Honey has been associated with infant botulism and should be avoided. Older children and adults have digestive enzymes that kill the botulism spores.

0 comments

Labels: free nclex-rn sample review questions, nclex-rn practice test questions, nursing review

Free NCLEX-RN Sample Test Questions For Nursing Review (Part 4)

Question1

The clinic nurse is counseling a substance-abusing post partum client on the risks of continued cocaine use. In order to provide continuity of care, which nursing diagnosis is a priority?
A) Social isolation
B) Ineffective coping
C) Altered parenting
D) Sexual dysfunction

Review Information: The correct answer is C: Altered parenting
The cocaine abusing mother puts her newborn and other children at risk for neglect and abuse. Continuing to use drugs has the potential to impact parenting behaviors. Social service referrals are indicated.

Question2

The nurse is teaching about nonsteroidal anti-inflammatory drugs (NSAIDs) to a group of ar-

thritic clients. To minimize the side effects, the nurse should emphasize which of the following actions?
A) Reporting joint stiffness in the morning
B) Taking the medication 1 hour before or 2 hours after meals
C) Using alcohol in moderation unless driving
D) Continuing to take aspirin for short term relief

Review Information: The correct answer is B: Taking the medication 1 hour before or 2 hours after meals
Taking the medication 1 hour before or 2 hours after meals will result in a more rapid effect.

Question3

The nurse is preparing to administer a tube feeding to a postoperative client. To accurately assess for a gastrostomy tube placement, the priority is to
A) auscultate the abdomen while instilling 10 cc of air into the tube
B) place the end of the tube in water to check for air bubbles
C) retract the tube several inches to check for resistance
D) measure the length of tubing from nose to epigastrium

Review Information: The correct answer is A: auscultate the abdomen while instilling 10 cc of air into the tube
If a swoosh of air is heard over the abdominal cavity while instilling air into the gastric tube, this indicates that it is accurately placed in the stomach. The feeding can begin after further assessing the client for bowel sounds.

Question4

While assessing the vital signs in children, the nurse should know that the apical heart rate is preferred until the radial pulse can be accurately assessed at about what age?
A) 1 year of age
B) 2 years of age
C) 3 years of age
D) 4 years of age

Review Information: The correct answer is B: 2 years of age
A child should be at least 2 years of age to use the radial pulse to assess heart rate.

Question5

A client is receiving Total Parenteral Nutrition (TPN) via a Hickman catheter. The catheter accidentally becomes dislodged from the site. Which action by the nurse should take priority?
A) Check that the catheter tip is intact
B) Apply a pressure dressing to the site
C) Monitor respiratory status
D) Assess for mental status changes

Question6

A pregnant client who is at 34 weeks gestation is diagnosed with a pulmonary embolism (PE). Which of these medications would the nurse anticipate the provider ordering?
A) Oral Coumadin therapy
B) Heparin 5000 units subcutaneously B.I.D.
C) Heparin infusion to maintain the PTT at 1.5-2.5 times the control value
D) Heparin by subcutaneous injection to maintain the PTT at 1.5 times the control value

Review Information: The correct answer is D: Heparin by subcutaneous injection to maintain the PTT at 1.5 times the control value
Several studies have been conducted in pregnant women where oral anticoagulation agents are contraindicated. Warfarin (Coumadin) is known to cross the placenta and is therefore reported to be teratogenic.

Question7

The nurse is caring for a client with Hodgkin's disease who will be receiving radiation therapy. The nurse recognizes that, as a result of the radiation therapy, the client is most likely to experi-

ence
A) high fever
B) nausea
C) face and neck edema
D) night sweats

Review Information: The correct answer is B: nausea
Because the client with Hodgkin''s disease is usually healthy when therapy begins, the nausea is especially troubling.
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Question8
A client is brought to the emergency room following a motor vehicle accident. When assessing the client one-half hour after admission, the nurse notes several physical changes. Which finding would require the nurse's immediate attention?
A) increased restlessness
B) tachycardia
C) tracheal deviation
D) tachypnea

Review Information: The correct answer is C: tracheal deviation
The deviated trachea is a sign that a mediastinal shift has occurred. This is a medical emergency.

Question9
An 18 month-old child is on peritoneal dialysis in preparation for a renal transplant in the near future. When the nurse obtains the child's health history, the mother indicates that the child has not had the first measles, mumps, rubella (MMR) immunization. The nurse understands that which of the following is true in regards to giving immunizations to this child?
A) Live vaccines are withheld in children with renal chronic illness
B) The MMR vaccine should be given now, prior to the transplant
C) An inactivated form of the vaccine can be given at any time
D) The risk of vaccine side effects precludes giving the vaccine

Review Information: The correct answer is B: The MMR vaccine should be given now, prior to the transplant
MMR is a live virus vaccine, and should be given at this time. Post-transplant, immunosuppressive drugs will be given and the administration of the live vaccine at that time would be contraindicated because of the compromised immune system.

Question10
The nurse is preparing to take a toddler's blood pressure for the first time. Which of the following actions should the nurse perform first?
A) Explain that the procedure will help him to get well
B) Show a cartoon character with a blood pressure cuff
C) Explain that the blood pressure checks the heart pump
D) Permit handling the equipment before putting the cuff in place

Review Information: The correct answer is D: Permit handling the equipment before putting the cuff in place
The best way to gain the toddler''s cooperation is to encourage handling the equipment. Detailed explanations are not helpful.

Question11
Which statement made by a nurse about the goal of total quality management or continuous quality improvement in a health care setting is correct?
A) It is to observe reactive service and product problem solving
B) Improvement of the processes in a proactive, preventive mode is paramount
C) A chart audits to finds common errors in practice and outcomes associated with goals
D) A flow chart to organize daily tasks is critical to the initial stages

Review Information: The correct answer is

B: Improvement of the processes in a proactive, preventive mode is paramount
Total quality management and continuous quality improvement have a major goal of identifying ways to do the right thing at the right time in the right way by proactive problem-solving.

Question12

Which of the following drugs should the nurse anticipate administering to a client before they are to receive electroconvulsive therapy?
A) Benzodiazepines
B) Chlorpromazine (Thorazine)
C) Succinylcholine (Anectine)
D) Thiopental sodium (Pentothal Sodium)

Review Information: The correct answer is C: Succinylcholine (Anectine)
Succinylcholine is given intravenously to promote skeletal muscle relaxation.

Question13

Which approach is a priority for the nurse who works with clients from many different cultures?
A) Speak at least 2 other languages of clients in the neighborhood
B) Learn about the cultures of clients who are most often encountered
C) Have a list of persons for referral when interaction with these clients occur
D) Recognize personal attitudes about cultural differences and real or expected biases

Review Information: The correct answer is D: Recognize personal attitudes about cultural differences and real or expected biases
The nurse must discover personal attitudes, prejudices and biases specific to different cultures. Awareness of these will prevent negative consequences for interactions with clients and families across cultures.

Question14

A client with chronic obstructive pulmonary disease (COPD) and a history of coronary artery disease is receiving aminophylline, 25mg/hour. Which one of the following findings by the nurse would require immediate intervention?
A) Decreased blood pressure and respirations
B) Flushing and headache
C) Restlessness and palpitations
D) Increased heart rate and blood pressure

Review Information: The correct answer is C: Restlessness and palpitations
Side effects of Aminophylline include restlessness and palpitations.

Question15

A client has gastroesophageal reflux. Which recommendation made by the nurse would be most helpful to the client?
A) Avoid liquids unless a thickening agent is used
B) Sit upright for at least 1 hour after eating
C) Maintain a diet of soft foods and cooked vegetables
D) Avoid eating 2 hours before going to sleep

Review Information: The correct answer is D: Avoid eating 2 hours before going to sleep
Eating before sleeping enhances the regurgitation of stomach contents, which have increased acidity, into the esophagus. An upright posture should be maintained for about 2 hours after eating to allow for the stomach emptying. Options A and C are interventions for clients with swallowing difficulties.
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Question16

A client with a panic disorder has a new prescription for Xanax (alprazolam). In teaching the client about the drug's actions and side effects, which of the following should the nurse emphasize?
A) Short-term relief can be expected
B) The medication acts as a stimulant
C) Dosage will be increased as tolerated
D) Initial side effects often continue

Review Information: The correct answer is A: Short-term relief can be expected
Xanax is a short-acting benzodiazepine useful in controlling panic symptoms quickly.

Question17

A client being discharged from the cardiac step-down unit following a myocardial infarction (MI), is given a prescription for a beta-blocking drug. A nursing student asks the charge nurse why this drug would be used by a client who is not hypertensive. What is an appropriate response by the charge nurse?

A) "Most people develop hypertension following an MI."

B) "A beta-Blocker will prevent orthostatic hypotension."

C) "This drug will decrease the workload on his heart."

D) "Beta-blockers increase the strength of heart contractions."

Review Information: The correct answer is C: "This drug will decrease the workload on his heart."
One action of beta-blockers is to decrease systemic vascular resistance by dilating arterioles. This is useful for the client with coronary artery disease, and will reduce the risk of another MI or sudden death.

Question18

A 35-year-old client of Puerto Rican-American descent is diagnosed with ovarian cancer. The client states, "I refuse both radiation and chemotherapy because they are 'hot.'" The next action for the nurse to take is to

A) document the situation in the notes

B) report the situation to the health care provider

C) talk with the client's family about the situation

D) ask the client to talk about concerns regarding "hot" treatments

Review Information: The correct answer is D: ask the client to talk about concerns regarding "hot" treatments
The "hot-cold" system is found among Mexican-Americans, Puerto Ricans, and other Hispanic-Latinos. Most foods, beverages, herbs, and medicines are categorized as hot or cold, which are symbolic designations and do not necessarily indicate temperature or spiciness. Care and treatment regimens can be negotiated with clients within this framework.

Question19

A 72 year-old client is scheduled to have a cardioversion. A nurse reviews the client's medication administration record. The nurse should notify the health care provider if the client received which medication during the preceding 24 hours?

A) Digoxin (Lanoxin)

B) Diltiazem (Cardizem)

C) Nitroglycerine ointment

D) Metoprolol (Toprol XL)

Review Information: The correct answer is A: Digoxin (Lanoxin)
Digoxin increases ventricular irritability and increases the risk of ventricular fibrillation following cardioversion. The other medications do not increase ventricular irritability.

Question20

Which of these clients, all of whom have the findings of a board-like abdomen, would the nurse suggest that the provider examine first?

A) An elderly client who stated, "My awful pain in my right side suddenly stopped about 3 hours ago."

B) A pregnant woman of 8 weeks newly diagnosed with an ectopic pregnancy

C) A middle-aged client admitted with diverticulitis who has taken only clear liquids for the past week

D) A teenager with a history of falling off a bicycle without hitting the handle bars

Review Information: The correct answer is A: An elderly client who stated, “My awful pain in my right side suddenly stopped about 3 hours ago.”
This client has the highest risk for hypovolemic and septic shock since the appendix has most likely ruptured, based on the history of the pain suddenly stopping over three hours ago. Elderly clients have less functional reserve for the body to cope with shock and infection over long periods. The others are at risk for shock also, however given that they fall in younger age groups, they would more likely be able to tolerate an imbalance in circulation. A common complication of falling off a bicycle is hitting the handle bars in the upper abdomen often on the left, resulting in a ruptured spleen.

Question21

The nurse is teaching parents of a 7 month-old about adding table foods. Which of the following is an appropriate finger food?
A) Hot dog pieces
B) Sliced bananas
C) Whole grapes
D) Popcorn

Review Information: The correct answer is B: Sliced bananas
Finger foods should be bite-size pieces of soft food such as bananas. Hot dogs and grapes can accidentally be swallowed whole and can occlude the airway. Popcorn is too difficult to chew at this age and can irritate the airway if swallowed.

Question22

To prevent drug resistance from developing, the nurse is aware that which of the following is a characteristic of the typical treatment plan to eliminate the tuberculosis bacilli?
A) An anti-inflammatory agent
B) High doses of B complex vitamins
C) Aminoglycoside antibiotics
D) Administering two anti-tuberculosis drugs

Review Information: The correct answer is D: Administering two anti-tuberculosis drugs
Resistance of the tubercle bacilli often occurs to a single antimicrobial agent. Therefore, therapy with multiple drugs over a long period of time helps to ensure eradication of the organism.

Question23

The nurse is assessing a comatose client receiving gastric tube feedings. Which of the following assessments requires an immediate response from the nurse?
A) Decreased breath sounds in right lower lobe
B) Aspiration of a residual of 100cc of formula
C) Decrease in bowel sounds
D) Urine output of 250 cc in past 8 hours

Review Information: The correct answer is A: Decreased breath sounds in right lower lobe
The most common problem associated with enteral feedings is atelectasis. Maintain client at 30 degrees of head elevation during feedings and monitor for signs of aspiration. Check for tube placement prior to each feeding or every 4 to 8 hours if the client is receiving continuous feeding.

Question24

A client is prescribed warfarin sodium (Coumadin) to be continued at home. Which focus is critical to be included in the nurse’s discharge instruction?
A) Maintain a consistent intake of green leafy foods
B) Report any nose or gum bleeds
C) Take Tylenol for minor pains
D) Use a soft toothbrush

Review Information: The correct answer is B: Report any nose or gum bleeds
The client should notify the health care provider if blood is noted in stools or urine, or any other signs of bleeding occur.

Question25

When teaching a client about the side effects of fluoxetine (Prozac), which of the following will the nurse include?

A) Tachycardia blurred vision, hypotension, anorexia

B) Orthostatic hypotension, vertigo, reactions to tyramine-rich foods

C) Diarrhea, dry mouth, weight loss, reduced libido

D) Photosensitivity, seizures, edema, hyperglycemia

Review Information: The correct answer is C: Diarrhea, dry mouth, weight loss, reduced libido

Commonly reported side effects for fluoxetine (Prozac) are diarrhea, dry mouth, weight loss and reduced libido.

Question26

A newborn weighed 7 pounds 2 ounces at birth. The nurse assesses the newborn at home 2 days later and finds the weight to be 6 pounds 7 ounces. What should the nurse tell the parents about this weight loss?

A) The newborn needs additional assessments

B) The mother should breast feed more often

C) A change to formula is indicated

D) The loss is within normal limits

Review Information: The correct answer is D: The loss is within normal limits

A newborn is expected to lose 5-10% of the birth weight in the first few days post-partum because of changes in elimination and feeding.

Question27

The nurse manager informs the nursing staff at morning report that the clinical nurse specialist will be conducting a research study on staff attitudes toward client care. All staff are invited to participate in the study if they wish. This affirms the ethical principle of

A) Anonymity

B) Beneficence

C) Justice

D) Autonomy

Review Information: The correct answer is D: Autonomy

Individuals must be free to make independent decisions about participation in research without coercion from others.

Question28

The nurse is talking with the family of an 18 months-old newly diagnosed with retinoblastoma. A priority in communicating with the parents is

A) Discuss the need for genetic counseling

B) Inform them that combined therapy is seldom effective

C) Prepare for the child's permanent disfigurement

D) Suggest that total blindness may follow surgery

Review Information: The correct answer is A: Discuss the need for genetic counseling

The hereditary aspects of this disease are well documented. While the parents focus on the needs of this child, they should be aware that the risk is high for future offspring.

Question29

The nurse is planning care for an 8 year-old child. Which of the following should be included in the plan of care?

A) Encourage child to engage in activities in the playroom

B) Promote independence in activities of daily living

C) Talk with the child and allow him to express his opinions

D) Provide frequent reassurance and cuddling

Review Information: The correct answer is A: Encourage child to engage in activities in the playroom

According to Erikson, the school age child is in the stage of industry versus inferiority. To help

them achieve industry, the nurse should encourage them to carry out tasks and activities in their room or in the playroom.

Question30

The nurse is assigned to care for 4 clients. Which of the following should be assessed immediately after hearing the report?
A) The client with asthma who is now ready for discharge
B) The client with a peptic ulcer who has been vomiting all night
C) The client with chronic renal failure returning from dialysis
D) The client with pancreatitis who was admitted yesterday

Review Information: The correct answer is B: The client with a peptic ulcer who has been vomiting all night
A perforated peptic ulcer could cause nausea, vomiting and abdominal distention, and may be a life threatening situation. The client should be assessed immediately and findings reported to the provider.
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Question31

During a routine check-up, an insulin-dependent diabetic has his glycosylated hemoglobin checked. The results indicate a level of 11%. Based on this result, what teaching should the nurse emphasize?
A) Rotation of injection sties
B) Insulin mixing and preparation
C) Daily blood sugar monitoring
D) Regular high protein diet

Review Information: The correct answer is C: Daily blood sugar monitoring
Normal hemoglobin A1C (glycosylated hemoglobin) level is 7 to 9%. Elevation indicates elevated glucose levels over time.

Question32

A client taking isoniazid (INH) for tuberculosis asks the nurse about side effects of the medication. The client should be instructed to immediately report which of these?
A) Double vision and visual halos
B) Extremity tingling and numbness
C) Confusion and lightheadedness
D) Sensitivity of sunlight

Review Information: The correct answer is B: Extremity tingling and numbness
Peripheral neuropathy is the most common side effect of INH and should be reported to the provider. It can be reversed.

Question33

Which of these questions is priority when assessing a client with hypertension?
A) "What over-the-counter medications do you take?"
B) "Describe your usual exercise and activity patterns."
C) "Tell me about your usual diet."
D) "Describe your family's cardiovascular history."

Review Information: The correct answer is A: "What over-the-counter medications do you take?"
Over-the-counter medications, especially those that contain cold preparations can increase the blood pressure to the point of hypertension.

Question34

The nurse is performing an assessment of the motor function in a client with a head injury. The best technique is
A) touching the trapezius muscle or arm firmly
B) pinching any body part
C) shaking a limb vigorously
D) rubbing the sternum

Review Information: The correct answer is D: rubbing the sternum

The purpose is to assess the non-responsive client's reaction to a painful stimulus after less noxious methods have been tried.

Question35

A nurse admits a client transferred from the emergency room (ER). The client, diagnosed with a myocardial infarction, is complaining of substernal chest pain, diaphoresis and nausea. The first action by the nurse should be to

A) order an EKG

B) administer morphine sulfate

C) start an IV

D) measure vital signs

Review Information: The correct answer is B: administer morphine sulfate

Decreasing the clients pain is the most important priority at this time. As long as pain is present there is danger in extending the infarcted area. Morphine will decrease the oxygen demands of the heart and act as a mild diuretic as well. It is probable that an EKG and IV insertion were performed in the ER.

Question36

The nurse admits a 2 year-old child who has had a seizure. Which of the following statement by the child's parent would be important in determining the etiology of the seizure?

A) "He has been taking long naps for a week."

B) "He has had an ear infection for the past 2 days."

C) "He has been eating more red meat lately."

D) "He seems to be going to the bathroom more frequently."

Review Information: The correct answer is B: "He has had an ear infection for the past 2 days."

Contributing factors to seizures in children include those such as age (more common in first 2 years), infections (late infancy and early childhood), fatigue, not eating properly and excessive fluid intake or fluid retention.

Question37

Which of these clients would the nurse monitor for the complication of C. difficile diarrhea?

A) An adolescent taking medications for acne

B) An elderly client living in a retirement center taking prednisone

C) A young adult at home taking a prescribed aminoglycoside

D) A hospitalized middle aged client receiving clindamycin

Review Information: The correct answer is D: A hospitalized middle aged client receiving clindamycin

Hospitalized patients, especially those receiving antibiotic therapy, are primary targets for C. difficile. Of clients receiving antibiotics, 5-38% experience antibiotic-associated diarrhea; C. difficile causes 15 to 20% of the cases. Several antibiotic agents have been associated with C. difficile. Broad-spectrum agents, such as clindamycin, ampicillin, amoxicillin, and cephalosporins, are the most frequent sources of C. difficile. Also, C. difficile infection has been caused by the administration of agents containing beta-lactamase inhibitors (i.e., clavulanic acid, sulbactam, tazobactam) and intravenous agents that achieve substantial colonic intraluminal concentrations (i.e., ceftriaxone, nafcillin, oxacillin). Fluoroquinolones, aminoglycosides, vancomycin, and trimethoprim are seldom associated with C. difficile infection or pseudomembranous colitis.

Question38

The nurse is performing an assessment on a client who is cachectic and has developed an enterocutaneous fistula following surgery to relieve a small bowel obstruction. The client's total protein level is reported as 4.5 g/dl. Which of the following would the nurse anticipate?

A) Additional potassium will be given IV

B) Blood for coagulation studies will be drawn

C) Total parenteral nutrition (TPN) will be started

D) Serum lipase levels will be evaluated

Review Information: The correct answer is C: Total parenteral nutrition (TPN) will be started
The client is not absorbing nutrients adequately as evidenced by the cachexia and low protein levels. (A normal total serum protein level is 6.0-8.0 g/dl.) TPN will promote a positive nitrogen balance in this client who is unable to digest and absorb nutrients adequately.

Question39

During a situation of pain management, which statement is a priority to consider for the ethical guidelines of the nurse?
A) The client's self-report is the most important consideration
B) Cultural sensitivity is fundamental to pain management
C) Clients have the right to have their pain relieved
D) Nurses should not prejudge a client's pain using their own values

Review Information: The correct answer is A: The client''s self-report is the most important consideration
Pain is a complex phenomenon that is perceived differently by each individual. Pain is whatever the client says it is. The other statements are correct but not the most important considerations.

Question40

As a part of a 9 pound full-term newborn's assessment, the nurse performs a dextro-stick at 1 hour post birth. The serum glucose reading is 45 mg/dl. What action by the nurse is appropriate at this time?
A) Give oral glucose water
B) Notify the pediatrician
C) Repeat the test in 2 hours
D) Check the pulse oximetry reading

Review Information: The correct answer is C: Repeat the test in 2 hours
This blood sugar is within the normal range for a full-term newborn. Normal values are: Premature infant: 20-60 mg/dl or 1.1-3.3 mmol/L, Neonate: 30-60 mg/dl or 1.7-3.3 mmol/L, Infant: 40-90 mg/dl or 2.2-5.0 mmol/L. Critical values are: Infant: <40 mg/dl and in a Newborn: <30 and >300 mg/dl. Because of the increased birth weight which can be associated with diabetes mellitus, repeated blood sugars will be drawn

0 comments

Labels: free nclex-rn sample review questions, nclex-rn practice test questions, nursing review

Free NCLEX-RN Sample Test Questions For Nursing Review (Part 3)

Question1

A client diagnosed with chronic depression is maintained on tranylcypromine (Parnate). An important nursing intervention is to teach the client to avoid which of the following foods?
A) Wine, beer, cheese, liver and chocolate
B) Wine, citrus fruits, yogurt and broccoli
C) Beer, cheese, beef and carrots
D) Wine, apples, sour cream and beef steak

Review Information: The correct answer is A: Wine, beer, cheese, liver and chocolate
These foods are tyramine rich and ingestion of these foods while taking monoamine oxidase inhibitors (MAOIs) can precipitate a life-threatening hypertensive crisis.

Question2

The nurse is working in a high risk antepartum clinic. A 40 year-old woman in the first trimester gives a thorough health history. Which information should receive priority attention by the nurse?
A) Her father and brother are insulin dependent diabetics
B) She has taken 800 mcg of folic acid daily for the past year
C) Her husband was treated for tuberculosis as a child
D) She reports recent use of over-the counter sinus remedies

Review Information: The correct answer is D: She reports recent use of over-the counter sinus remedies

Over-the-counter drugs are a possible danger in early pregnancy. A report by the client that she has taken medications should be followed up immediately.

Question3
What must be the priority consideration for nurses when communicating with children?
A) Present environment
B) Physical condition
C) Nonverbal cues
D) Developmental level

Review Information: The correct answer is D: Developmental level
While each of the factors affect communication, the nurse recognizes that developmental differences have implications for processing and understanding information. Consequently, a child's developmental level must be considered when selecting communication approaches.

Question4
The nurse is assessing a client's home in preparation for discharge. Which of the following should be given priority consideration?
A) Family understanding of client needs
B) Financial status
C) Location of bathrooms
D) Proximity to emergency services

Review Information: The correct answer is A: Family understanding of client needs
Functional communication patterns between family members are fundamental to meeting the needs of the client and family.

Question5
As a general guide for emergency management of acute alcohol intoxication, it is important for the nurse initially to obtain data regarding which of the following?
A) What and how much the client drinks, according to family and friends
B) The blood alcohol level of the client
C) The blood pressure level of the client
D) The blood glucose level of the client

Review Information: The correct answer is B: The blood alcohol level of the client
Blood alcohol levels are generally obtained to determine the level of intoxication. The amount of alcohol consumed determines how much medication the client needs for detoxification and treatment. Reports of alcohol consumption are notoriously inaccurate.

Question6
Which clinical finding would the nurse expect to assess first in a newborn with spastic cerebral palsy?
A) cognitive impairment
B) hypotonic muscular activity
C) seizures
D) criss-crossing leg movement

Review Information: The correct answer is D: criss-crossing leg movement
Cerebral palsy is a neuromuscular impairment resulting in muscular and reflexive hypertonicity and the criss-crossing, or scissoring leg movements.

Question7
Which medication is more helpful in treating bulimia than anorexia?
A) Amphetamines
B) Sedatives
C) Anticholinergics
D) Narcotics

Review Information: The correct answer is C: Anticholinergics
In contrast to anorexics, individuals with bulimia are troubled by their behavioral characteristics and become depressed. The person feels compelled to binge, purge and fast. Feeling helpless to stop the behavior, feelings of self-disgust occur.

Question8
The nurse is assessing a woman in early labor. While positioning for a vaginal exam, she complains of dizziness and nausea and appears pale. Her blood pressure has dropped slightly. What should be the initial nursing action?
A) Call the health care provider
B) Encourage deep breathing
C) Elevate the foot of the bed
D) Turn her to her left side

Review Information: The correct answer is D:

Turn her to her left side
The weight of the uterus can put pressure on the vena cava and aorta when a pregnant woman is flat on her back causing supine hypotension. Action is needed to relieve the pressure on the vena cava and aorta. Turning the woman to the side reduces this pressure and relieves postural hypotension.

Question9

A client has been started on a long term corticosteroid therapy. Which of the following comments by the client indicate the need for further teaching?
A) "I will keep a weekly weight record."
B) "I will take medication with food."
C) "I will stop taking the medication for 1 week every month."
D) "I will eat foods high in potassium."

Review Information: The correct answer is C: "I will stop taking the medication for 1week every month."
Emphatically warn against discontinuing steroid dosage abruptly because that may produce a fatal adrenal crisis.

Question10

A male client calls for a nurse because of chest pain. Which statement by the client would require the most immediate action by the nurse?
A) "When I take in a deep breath, it stabs like a knife."
B) "The pain came on after dinner. That soup seemed very spicy."
C) "When I turn in bed to reach the remote for the TV, my chest hurts."
D) "I feel pressure in the middle of my chest, like an elephant is sitting on my chest."

Review Information: The correct answer is D: "I feel pressure in the middle of my chest, like an elephant is sitting on my chest."
This is a classic description of chest pain in men caused by myocardial ischemia. Women experience vague feelings of fatigue and back and jaw pain.

Question11

A nurse is caring for a client who has just been admitted with an overdose of aspirin. The following lab data is available: PaO2 95, PaCO2 30, pH 7.5, K 3.2 mEq/l. Which should be the nurse's first action?
A) Monitor respiratory rate
B) Monitor intake and output every hour
C) Assist the client to breathe into a paper bag
D) Prepare to administer oxygen by mask

Review Information: The correct answer is C: Assist the client to breathe into a paper bag
Side effects of aspirin toxicity include hyperventilation, which can result in respiratory alkalosis in the initial stages. Breathing into a paper bag will prevent further reduction in PaCO2.

Question12

After assessing a 70 year-old male client's laboratory results during a routine clinic visit, which one of the following findings would indicate an area in which teaching is needed:
A) Serum albumin 2.5 g/dl
B) LDL Cholesterol 140 mg/dl
C) Serum glucose 90 mg/dl
D) RBC 5.0 million/mm3

Review Information: The correct answer is A: Serum albumin 2.5 g/dl
Serum albumin level is low (normal 3.0 – 5.0 g/dl in elders), indicating nutritional counseling to increase dietary protein is needed. Socioeconomic factors may need to be addressed to help the client comply with the recommendation.

Question13

When teaching a client with a new prescription for lithium (Lithane) for treatment of a bi-polar disorder which of these should the nurse emphasize?
A) Maintaining a salt restricted diet
B) Reporting vomiting or diarrhea
C) Taking other medication as usual
D) Substituting generic form if desired

Review Information: The correct answer is B: Reporting vomiting or diarrhea
If dehydration results from vomiting, diarrhea or excessive perspiration, tolerance to the drug may be altered and symptoms may return.

Question14

A client is discharged on warfarin sulfate (Coumadin). Which statement by the client indicated a need for further teaching?

A) "I know I must avoid crowds."
B) "I will keep all laboratory appointments."
C) "I plan to use an electric razor for shaving."
D) "I will report any bruises for bleeding."

Review Information: The correct answer is A: "I know I must avoid crowds."

There are no specific reasons for the client on Coumadin to avoid crowds. General instructions for any cardiac surgical client include limiting exposure to infection.

Question15

A client is taking tranylcypromine (Parnate) and has received dietary instruction. Which of the following food selections would be contraindicated for this client?

A) Fresh juice, carrots, vanilla pudding
B) Apple juice, ham salad, fresh pineapple
C) Hamburger, fries, strawberry shake
D) Red wine, fava beans, aged cheese

Review Information: The correct answer is D: Red wine, fava beans, aged cheese

Red wine and cheese contain tyramine (as do chicken liver and ripe bananas) and so are contraindicated when taking MAOIs. Fava beans contain other vasopressors that can interact with MAOIs also causing malignant hypertension.

Question16

A client is admitted with severe injuries from an auto accident. The client's vital signs are BP 120/50, pulse rate 110, and respiratory rate of 28. The initial nursing intervention would be to

A) begin intravenous therapy
B) initiate continuous blood pressure monitoring
C) administer oxygen therapy
D) institute cardiac monitoring

Review Information: The correct answer is C: administer oxygen therapy

Early findings of shock reveal hypoxia with rapid heart rate and rapid respirations, and oxygen is the most critical initial intervention. The other interventions are secondary to oxygen therapy.

Question17

A client is admitted to the hospital with a diagnosis of deep vein thrombosis. During the initial assessment, the client complains of sudden shortness of breath. The SaO2 is 87. The priority nursing assessment at this time is

A) bowel sounds
B) heart rate
C) peripheral pulses
D) lung sounds

Review Information: The correct answer is D: lung sounds

Lung sounds are critical assessments at this point. The nurse should be alert to crackles or a pleural friction rub, highly suggestive of a pulmonary embolism.

Question18

The nurse is administering lidocaine (Xylocaine) to a client with a myocardial infarction. Which of the following assessment findings requires the nurse's immediate action?

A) Central venous pressure reading of 11
B) Respiratory rate of 22
C) Pulse rate of 48 BPM
D) Blood pressure of 144/92

Review Information: The correct answer is C: Pulse rate of 48 BPM

One of the side effects of lidocaine is bradycardia, heart block, cardiovascular collapse and cardiac arrest (this drug should never be administered without continuous EKG monitoring).

Question19

The nurse is teaching a group of college students about breast self-examination. A woman asks for the best time to perform the monthly exam. What is the best reply by the nurse?

A) "The first of every month, because it is easiest to remember"
B) "Right after the period, when your breasts are less tender"
C) "Do the exam at the same time every month"
D) "Ovulation, or mid-cycle is the best time to detect changes"

Review Information: The correct answer is B:

"Right after the period, when your breasts are less tender"
The best time for a breast self exam (BSE) is a week after a menstrual cycle, when the breasts are no longer swollen and tender due to hormone elevation.

Question20

The nurse is caring for a post-operative client who develops a wound evisceration. The first nursing intervention should be to
A) medicate the client for pain
B) call the provider
C) cover the wound with sterile saline dressing
D) place the bed in a flat position

Review Information: The correct answer is C: cover the wound with sterile saline dressing
When evisceration occurs, the wound should first be quickly covered by sterile dressings soaked in sterile saline. This prevents tissue damage until a repair can be effected.

Question21

The spouse of a client with Alzheimer's disease expresses concern about the burden of caregiving. Which of the following actions by the nurse should be a priority?
A) Link the caregiver with a support group
B) Ask friends to visit regularly
C) Schedule a home visit each week
D) Request anti-anxiety prescriptions

Review Information: The correct answer is A: Link the caregiver with a support group
Assisting caregivers to locate and join support groups is most helpful. Families share feelings and learn about services such as respite care. Health education is also available through local and national Alzheimer''s chapters.

Question22

Clients taking lithium must be particularly sure to maintain adequate intake of which of these elements?
A) Potassium
B) Sodium
C) Chloride
D) Calcium

Review Information: The correct answer is B: Sodium
Clients taking lithium need to maintain an adequate intake of sodium. Serum lithium concentrations may increase in the presence of conditions that cause sodium loss.

Question23

A client is receiving lithium carbonate 600 mg T.I.D. to treat bipolar disorder. Which of these indicate early signs of toxicity?
A) Ataxia and course hand tremors
B) Vomiting, diarrhea and lethargy
C) Pruritus, rash and photosensitivity
D) Electrolyte imbalance and cardiac arrhythmias

Review Information: The correct answer is B: Vomiting, diarrhea and lethargy
These are early signs of lithium toxicity.

Question24

The nurse can best ensure the safety of a client suffering from dementia who wanders from the room by which action?
A) Repeatedly remind the client of the time and location
B) Explain the risks of walking with no purpose
C) Use protective devices to keep the client in the bed or chair in the room
D) Attach a wander-guard sensor band to the client's wrist

Review Information: The correct answer is D: Attach a wander-guard sensor band to the client''s wrist
This type of identification band easily tracks the client''s movements and ensures safety while the client wanders on the unit. Restriction of activity is inappropriate for any client unless they are potentially harmful to themselves or others.

Question25

The nurse is teaching a client about the difference between tardive dyskinesia (TD) and neuroleptic malignant syndrome (NMS). Which statement is true with regards to tardive dyskinesia?
A) TD develops within hours or years of continued antipsychotic drug use in people under 20 and over 30
B) It can occur in clients taking antipsychotic drugs longer than 2 years

C) Tardive dyskinesia occurs within minutes of the first dose of antipsychotic drugs and is reversible
D) TD can easily be treated with anticholinergic drugs

Review Information: The correct answer is B: It can occur in clients taking antipsychotic drugs longer than 2 years
Tardive dyskinesia is a extrapyramidal side effect that appears after prolonged treatment with antipsychotic medication. Early symptoms of tardive dyskinesia are fasciculations of the tongue or constant smacking of the lips.

Question26

The nurse is aware that the effect of antihypertensive drug therapy may be affected by a 75 year-old client's
A) poor nutritional status
B) decreased gastrointestinal motility
C) increased splanchnic blood flow
D) altered peripheral resistance

Review Information: The correct answer is B: decreased gastrointestinal motility
Together with shrinkage of the gastric mucosa, and changes in the levels of hydrochloric acid, this will decrease absorption of medications and interfere with their actions.

Question27

In response to a call for assistance by a client in labor, the nurse notes that a loop on the umbilical cord protrudes from the vagina. What is the priority nursing action?
A) call the health care provider
B) check fetal heart beat
C) put the client in knee-chest position
D) turn the client to the side

Review Information: The correct answer is C: put the client in knee-chest position
Immediate action is needed to relieve pressure on the cord, which puts the fetus at risk due to hypoxia. The Trendelenburg position accomplishes this. The exposed cord is covered with saline soaked gauze, not reinserted. The fetal heart rate also should be checked, and the provider called. A prolapsed umbilical cord is a medical emergency.

Question28

The nurse is caring for a 2 month-old infant with a congenital heart defect. Which of the following is a priority nursing action?
A) Provide small feedings every 3 hours
B) Maintain intravenous fluids
C) Add strained cereal to the diet
D) Change to reduced calorie formula

Review Information: The correct answer is A: Provide small feedings every 3 hours
Infants with congenital heart defects are at increased risk for developing congestive heart failure. Infants with congestive heart failure have an increased metabolic rate and require additional calories to grow. At the same time, however, rest and conservation of energy for eating is important. Feedings should be smaller and every 3 hours rather than the usual 4 hour schedule.

Question29

The nurse is caring for a client receiving intravenous nitroglycerin for acute angina. What is the most important assessment during treatment?
A) Heart rate
B) Neurologic status
C) Urine output
D) Blood pressure

Review Information: The correct answer is D: Blood pressure
The vasodilatation that occurs as a result of this medication can cause profound hypotension. The client''s blood pressure must be evaluated every 15 minutes until stable and then every 30 minutes to every hour.

Question30

A client telephones the clinic to ask about a home pregnancy test she used this morning. The nurse understands that the presence of which hormone strongly suggests a woman is pregnant?
A) Estrogen
B) HCG
C) Alpha-fetoprotein
D) Progesterone

Review Information: The correct answer is B: HCG
Human chorionic gonadotropin (HCG) is the

biologic marker on which pregnancy tests are based. Reliability is about 98%, but the test does not conclusively confirm pregnancy.

Question31

A client, admitted to the unit because of severe depression and suicidal threats, is placed on suicidal precautions. The nurse should be aware that the danger of the client committing suicide is greatest

A) during the night shift when staffing is limited

B) when the client's mood improves with an increase in energy level

C) at the time of the client's greatest despair

D) after a visit from the client's estranged partner

Review Information: The correct answer is B: when the client's mood improves with an increase in energy level

Suicide potential is often increased when there is an improvement in mood and energy level. At this time ambivalence is often decreased and a decision is made to commit suicide.

Question32

After 4 electroconvulsive treatments over 2 weeks, a client is very upset and states "I am so confused. I lose my money. I just can't remember telephone numbers." The most therapeutic response for the nurse to make is

A) "You were seriously ill and needed the treatments."

B) "Don't get upset. The confusion will clear up in a day or two."

C) "It is to be expected since most clients have the same results."

D) "I can hear your concern and that your confusion is upsetting to you."

Review Information: The correct answer is D: "I can hear your concern and that your confusion is upsetting to you."

Communicating caring and empathy with the acknowledgement of feelings is the initial response. Afterwards, teaching about the expected short term effects would be discussed.

Question33

A woman in labor calls the nurse to assist her in the bathroom. The nurse notices a large amount of clear fluid on the bed linens. The nurse knows that fetal monitoring must now assess for what complication?

A) Early decelerations

B) Late accelerations

C) Variable decelerations

D) Periodic accelerations

Review Information: The correct answer is C: Variable decelerations

When the membranes rupture, there is increased risk initially of cord prolapse. Fetal heart rate patterns may show variable decelerations, which require immediate nursing action to promote gas exchange.

Question34

The nurse is assessing a client with chronic obstructive pulmonary disease receiving oxygen for low PaO2 levels. Which assessment is a nursing priority?

A) Evaluating SaO2 levels frequently

B) Observing skin color changes

C) Assessing for clubbing fingers

D) Identifying tactile fremitus

Review Information: The correct answer is A: Evaluating SaO2 levels frequently

The best method to evaluate a client"s oxygenation is to evaluate the SaO2. This is just as effective as an arterial blood gas reading to evaluate oxygenation status, and is less traumatic and expensive.

Question35

The visiting nurse makes a postpartum visit to a married female client. Upon arrival, the nurse observes that the client has a black eye and numerous bruises on her arms and legs. The initial nursing intervention would be to

A) call the police to report indications of domestic violence

B) confront the husband about abusing his wife

C) leave the home because of the unsafe environment

D) interview the client alone to determine the origin of the injuries

Review Information: The correct answer is D: interview the client alone to determine the origin

of the injuries
It would be wrong to assume domestic violence without further assessment. Separate the suspected victim from the partner until battering has been ruled out.

Question36

When teaching a client about an oral hypoglycemic medication, the nurse should place primary emphasis on
A) recognizing findings of toxicity
B) taking the medication at specified times
C) increasing the dosage based on blood glucose
D) distinguishing hypoglycemia from hyperglycemia

Review Information: The correct answer is B: taking the medication at specified times
A regular interval between doses should be maintained since oral hypoglycemics stimulate the islets of Langerhans to produce insulin.

Question37

Initial postoperative nursing care for an infant who has had a pyloromyotomy would initially include
A) bland diet appropriate for age
B) intravenous fluids for 3-4 days
C) NPO then glucose and electrolyte solutions
D) formula or breast milk as tolerated

Review Information: The correct answer is C: NPO then glucose and electrolyte solutions
Post-operatively, the initial feedings are clear liquids in small quantities to provide calories and electrolytes.

Question38

A client is treated in the emergency room for diabetic ketoacidosis and a glucose level of 650mg.D/L. In assessing the client, the nurse's review of which of the following tests suggests an understanding of this health problem?
A) Serum calcium
B) Serum magnesium
C) Serum creatinine
D) Serum potassium

Review Information: The correct answer is D: Serum potassium
Potassium is lost in diabetic ketoacidosis during rehydration and insulin administration. Review of this lab finding suggests the nurse has knowledge of this problem.

Question39

A male client is preparing for discharge following an acute myocardial infarction. He asks the nurse about his sexual activity once he is home. What would be the nurse's initial response?
A) Give him written material from the American Heart Association about sexual activity with heart disease
B) Answer his questions accurately in a private environment
C) Schedule a private, uninterrupted teaching session with both the client and his wife
D) Assess the client's knowledge about his health problems

Review Information: The correct answer is D: Assess the client"s knowledge about his health problems
The nursing process is continuous and cyclical in nature. When a client expresses a specific concern, the nurse performs a focused assessment to gather additional data prior to planning and implementing nursing interventions.

Question40

The client asks the nurse how the health care provider could tell she was pregnant "just by looking inside." What is the best explanation by the nurse?
A) Bluish coloration of the cervix and vaginal walls
B) Pronounced softening of the cervix
C) Clot of very thick mucous that obstructs the cervical canal
D) Slight rotation of the uterus to the right

Review Information: The correct answer is A: Bluish coloration of the cervix and vaginal walls
Chadwick"s sign is a bluish-purple coloration of the cervix and vaginal walls, occurring at 4 weeks of pregnancy, that is caused by vasocongestion.

0 comments

Labels: free nclex-rn sample review questions,

Free NCLEX-RN Sample Test Questions For Nursing Review (Part 2)

Question1

The feeling of trust can best be established by the nurse during the process of the development of a nurse-client relationship by which of these characteristics?
A) Reliability and kindness
B) Demeanor and sincerity
C) Honesty and consistency
D) Sympathy and appreciativeness

Review Information: The correct answer is C: Honesty and consistency
Characteristics of a trusting relationship include respect, honesty, consistency, faith and caring.

Question2

A nurse has administered several blood transfusions over 3 days to a 12 year-old client with Thalassemia. What lab value should the nurse monitor closely during this therapy?
A) Hemoglobin
B) Red Blood Cell Indices
C) Platelet count
D) Neutrophil percent

Review Information: The correct answer is A: Hemoglobin
Hemoglobin should be in a therapeutic range of approximately 10 g/dl (100gL). "This level is low enough to foster the patient''s own erythropoiesis without enlarging the spleen."

Question3

The nurse is providing care to a newly a hospitalized adolescent. What is the major threat experienced by the hospitalized adolescent?
A) Pain management
B) Restricted physical activity
C) Altered body image
D) Separation from family

Review Information: The correct answer is C: Altered body image
The hospitalized adolescent may see each of these as a threat, but the major threat that they feel when hospitalized is the fear of altered body image, because of the emphasis on physical appearance during this developmental stage.

Question4

A 12 year-old child is admitted with a broken arm and is told surgery is required. The nurse finds him crying and unwilling to talk. What is the most appropriate response by the nurse?
A) Give him privacy
B) Tell him he will get through the surgery with no problem
C) Try to distract him
D) Make arrangements for his friends to visit

Review Information: The correct answer is A: Give him privacy
A 12 year-old child needs the opportunity to express his emotions privately.

Question5

In discharge teaching, the nurse should emphasize that which of these is a common side effect of clozapine (Clozaril) therapy?
A) Dry mouth
B) Rhinitis
C) Dry skin
D) Extreme salivation

Review Information: The correct answer is D: Extreme salivation
A significant number of clients receiving Clozapine (Clozaril) therapy experience extreme salivation.

Question6

A client has had a positive reaction to purified protein derivative (PPD). The client asks the nurse what this means. The nurse should indicate that the client has
A) active tuberculosis
B) been exposed to mycobacterium tuberculosis
C) never had tuberculosis
D) never been infected with mycobacterium tuberculosis

Review Information: The correct answer is B: been exposed to mycobacterium tuberculosis
The PPD skin test is used to determine the presence of tuberculosis antibodies and a positive result indicates that the person has been exposed to mycobacterium tuberculosis. Additional tests are needed to determine if active tuberculosis is present.

Question7

A client is receiving and IV antibiotic infusion and is scheduled to have blood drawn at 1:00 pm for a “peak” antibiotic level measurement. The nurse notes that the IV infusion is running behind schedule and will not be competed by 1:00. The nurse should:

A) Notify the client’s health care provider
B) Stop the infusion at 1:00 pm
C) Reschedule the laboratory test
D) Increase the infusion rate

Review Information: The correct answer is C: Reschedule the laboratory test
If the antibiotic infusion will not be completed at the time the peak blood level is due to be drawn, the nurse should ask that the blood sampling time be adjusted

Question8

The nurse is caring for a client with a new order for bupropion (Wellbutrin) for treatment of depression. The order reads “Wellbutrin 175 mg. BID x 4 days.” What is the appropriate action?

A) Give the medication as ordered
B) Questionthis medication dose
C) Observe the client for mood swings
D) Monitor neuro signs frequently

Review Information: The correct answer is B: Questionthis medication dose
Bupropion (Wellbutrin) should be started at 100mg BID for three days then increased to 150mg BID. When used for depression, it may take up to four weeks for results. Common side effects are dry mouth, headache, and agitation. Doses should be administered in equally spaced time increments throughout the day to minimize the risk of seizures.

Question9

The clinic nurse is discussing health promotion with a group of parents. A mother is concerned about Reye’s Syndrome, and asks about prevention. Which of these demonstrates appropriate teaching?

A) “Immunize your child against this disease.”
B) “Seek medical attention for serious injuries.”
C) “Report exposure to this illness.”
D) “Avoid use of aspirin for viral infections.”

Review Information: The correct answer is D: “Avoid use of aspirin for viral infections.”
The link between aspirin use and Reye’’s Syndrome has not been confirmed, but evidence suggests that the risk is sufficiently grave to include the warning on aspirin products.

Question10

A post-operative client is admitted to the post-anesthesia recovery room (PACU). The anesthetist reports that malignant hyperthermia occurred during surgery. The nurse recognizes that this complication is related to what factor?

A) Allergy to general anesthesia
B) Pre-existing bacterial infection
C) A genetic predisposition
D) Selected surgical procedures

Review Information: The correct answer is C: A genetic predisposition
Malignant hyperthermia is a rare, potentially fatal adverse reaction to inhaled anesthetics. There is a genetic predisposition to this disorder.

Question11

A 9 year-old is taken to the emergency room with right lower quadrant pain and vomiting. When preparing the child for an emergency appendectomy, what must the nurse expect to be the child’s greatest fear?

A) Change in body image
B) An unfamiliar environment
C) Perceived loss of control
D) Guilt over being hospitalized

Review Information: The correct answer is C: Perceived loss of control
For school age children, major fears are loss of control and separation from friends/peers.

Question12

A client is to begin taking Fosamax. The nurse must emphasize which of these instructions to the client when taking this medication? “Take Fosamax

A) on an empty stomach.”
B) after meals.”

C) with calcium."
D) with milk 2 hours after meals."

Review Information: The correct answer is A: on an empty stomach."
Fosamax should be taken first thing in the morning with 6-8 ounces of plain water at least 30 minutes before other medication or food. Food and fluids (other than water) greatly decrease the absorption of Fosamax. The client must also be instructed to remain in the upright position for 30 minutes following the dose to facilitate passage into the stomach and minimize irritation of the esophagus.

Question13

An older adult client is to receive and antibiotic, gentamicin. What diagnostic finding indicates the client may have difficult excreting the medication?
A) High gastric pH
B) High serum creatinine
C) Low serum albumin
D) Low serum blood urea nitrogen

Review Information: The correct answer is B: High serum creatinine
An elevated serum creatinine indicates reduced renal function. Reduced renal function will delay the excretion of many mediations.

Question14

A nurse is assigned to care for a comatose diabetic on IV insulin therapy. Which task would be most appropriate to delegate to an unlicensed assistive personnel (UAP)?
A) Check the client's level of consciousness
B) Obtain the regular blood glucose readings
C) Determine if special skin care is needed
D) Answer questions from the client's spouse about the plan of care

Review Information: The correct answer is B: Obtain the regular blood glucose readings
The UAP can safely obtain blood glucose readings, which are routine tasks.

Question15

Which of the following laboratory results would suggest to the emergency room nurse that a client admitted after a severe motor vehicle crash is in acidosis?
A) Hemoglobin 15 gm/dl
B) Chloride 100 mEq/L
C) Sodium 130 mEq/L
D) Carbon dioxide 20 mEq/L

Review Information: The correct answer is D: Carbon dioxide 20 mEq/L
Serum carbon dioxide is an indicator of acid-base status. This finding would indicate acidosis.

Question16

The nurse has just received report on a group of clients and plans to delegate care of several of the clients to a practical nurse (PN). The first thing the RN should do before the delegation of care is
A) Provide a time-frame for the completion of the client care
B) Assure the PN that the RN will be available for assistance
C) Ask about prior experience with similar clients
D) Review the specific procedures unique to the assignment

Review Information: The correct answer is C: Ask about prior experience with similar clients.
The first step in delegation is to determine the qualifications of the person to whom one is delegating. By asking about the PN''s prior experience with similar clients/tasks, the RN can determine whether the PN has the requisite experience to care for the assigned clients.

Question17

The mother of a 4 month-old infant asks the nurse about the dangers of sunburn while they are on vacation at the beach. Which of the following is the best advice about sun protection for this child?
A) "Use a sunscreen with a minimum sun protective factor of 15."
B) "Applications of sunscreen should be repeated every few hours."
C) "An infant should be protected by the maximum strength sunscreen."
D) "Sunscreens are not recommended in children younger than 6 months."

Review Information: The correct answer is D: "Sunscreens are not recommended in children younger than 6 months."
Infants under 6 months of age should be kept out of the sun or shielded from it. Even on a cloudy day, the infant can be sunburned while near water. A hat and light protective clothing should be worn.

Question18

The nurse administers cimetidine (Tagamet) to a 79 year-old male with a gastric ulcer. Which parameter may be affected by this drug, and should be closely monitored by the nurse?
A) Blood pressure
B) Liver function
C) Mental status
D) Hemoglobin

Review Information: The correct answer is C: Mental status
The elderly are at risk for developing confusion when taking cimetidine, a drug that interacts with many other medications.

Question19

The nurse assesses the use of coping mechanisms by an adolescent 1 week after the client had a motor vehicle accident resulting in multiple serious injuries. Which of these characteristics are most likely to be displayed?
A) Ambivalence, dependence, demanding
B) Denial, projection, regression
C) Intellectualization, rationalization, repression
D) Identification, assimilation, withdrawal

Review Information: The correct answer is B: Denial, projection, regression
Helplessness and hopelessness may contribute to regressive, dependent behavior which often occurs at any age with hospitalization. Denying or minimizing the seriousness of the illness is used to avoid facing the worst situation. Recall that denial is the initial step in the process of working through any loss.

Question20

A 52 year-old post menopausal woman asks the nurse how frequently she should have a mammogram. What is the nurse's best response?
A) "Your doctor will advise you about your risks."
B) "Unless you had previous problems, every 2 years is best."
C) "Once a woman reaches 50, she should have a mammogram yearly."
D) "Yearly mammograms are advised for all women over 35."

Review Information: The correct answer is C: "Once a woman reaches 50, she should have a mammogram yearly."
The American Cancer Society recommends a screening mammogram by age 40, every 1 - 2 years for women 40-49, and every year from age 50. If there are family or personal health risks, other assessments may be recommended.

Question21

The nurse is planning care for a client who is taking cyclosporin (Neoral). What would be an appropriate nursing diagnosis for this client?
A) Alteration in body image
B) High risk for infection
C) Altered growth and development
D) Impaired physical mobility

Review Information: The correct answer is B: High risk for infection
Cyclosporin (Neoral) inhibits normal immune responses. Clients receiving cyclosporin are at risk for infection.

Question22

A client on telemetry begins having premature ventricular beats (PVBs) at 12 per minute. In reviewing the most recent laboratory results, which would require immediate action by the nurse?
A) Calcium 9 mg/dl
B) Magnesium 2.5 mg/dl
C) Potassium 2.5 mEq/L
D) PTT 70 seconds

Review Information: The correct answer is C: Potassium 2.5 mEq/L
The patient is at risk for ventricular dysrhythmias when the potassium level is low.
Daniels, R. (2003).

Question23

The nurse is caring for a client who is 4 days post-op for a transverse colostomy. The client is

ready for discharge and asks the nurse to empty his colostomy pouch. What is the best response by the nurse?
A) “You should be emptying the pouch yourself.”
B) “Let me demonstrate to you how to empty the pouch.”
C) “What have you learned about emptying your pouch?”
D) “Show me what you have learned about emptying your pouch.”

Review Information: The correct answer is D: “Show me what you have learned about emptying your pouch.”
Most adult learners obtain skills by participating in the activities. Anxiety about discharge can be causing the client to forget that they have mastered the skill of emptying the pouch. The client should show the nurse how the pouch is emptied.

Question24

A 3 year-old child has tympanostomy tubes in place. The child’s parent asks the nurse if he can swim in the family pool. The best response from the nurse is
A) “Your child should not swim at all while the tubes are in place.”
B) “Your child may swim in your own pool but not in a lake or ocean.”
C) “Your child may swim if he wears ear plugs.”
D) “Your child may swim anywhere.”

Review Information: The correct answer is C: “Your child may swim if he wears ear plugs.”

Water should not enter the ears. Children should use ear plugs when bathing or swimming and should not put their heads under the water.

Question25

The nurse is caring for a client with asthma who has developed gastroesophageal reflux disease (GERD). Which of the following medications prescribed for the client may aggravate GERD?
A) Anticholinergics
B) Corticosteroids
C) Histamine blocker
D) Antibiotics

Review Information: The correct answer is A: Anticholinergics
An anticholinergic medication will decrease gastric emptying and the pressure on the lower esophageal sphincter.

Question26

A client is receiving a nitroglycerin infusion for unstable angina. What assessment would be a priority when monitoring the effects of this medication?
A) Blood pressure
B) Cardiac enzymes
C) ECG analysis
D) Respiratory rate

Review Information: The correct answer is A: Blood pressure
Since an effect of this drug is vasodilation, the client must be monitored for hypotension.

Question27

The nurse is caring for a 10 year-old child who has just been diagnosed with diabetes insipidus. The parents ask about the treatment prescribed, vasopressin. A What is priority in teaching the child and family about this drug?
A) The child should carry a nasal spray for emergency use
B) The family must observe the child for dehydration
C) Parents should administer the daily intramuscular injections
D) The client needs to take daily injections in the short-term

Review Information: The correct answer is A: The child should carry a nasal spray for emergency use
Diabetes insipidus results from reduced secretion of the antidiuretic hormone, vasopressin. The child will need to administer daily injections of vasopressin, and should have the nasal spray form of the medication readily available. A medical alert tag should be worn.

Question28

A client diagnosed with cirrhosis is started on lactulose (Cephulac). The main purpose of the drug for this client is to
A) add dietary fiber
B) reduce ammonia levels

C) stimulate peristalsis
D) control portal hypertension

Review Information: The correct answer is B: reduce ammonia levels
Lactulose blocks the absorption of ammonia from the GI tract and secondarily stimulates bowel elimination.

Question29

The nurse is explaining the effects of cocaine abuse to a pregnant client. Which of the following must the nurse understand as a basis for teaching?
A) Cocaine use can cause fetal growth retardation
B) The drug has been linked to neural tube defects
C) Newborn withdrawal generally occurs immediately after birth
D) Breast feeding promotes positive parenting behaviors

Review Information: The correct answer is A: Cocaine use can cause fetal growth retardation
Cocaine is vasoconstrictive, and this effect in the placental vessels causes fetal hypoxia and diminished growth. Other risks of continued cocaine use during pregnancy include preterm labor, congenital abnormalities, altered brain development and subsequent behavioral problems in the infant.

Question30

A client has just been diagnosed with breast cancer. The nurse enters the room and the client tells the nurse that she is stupid. What is the most therapeutic response by the nurse?
A) Explore what is going on with the client
B) Accept the client's statement without comment
C) Tell the client that the comment is inappropriate
D) Leave the client's room

Review Information: The correct answer is A: Explore what is going on with the client
Exploring feelings with the verbally aggressive client helps to put angry feelings into words and then to engage in problem solving.

Question31

A client has many delusions. As the nurse helps the client prepare for breakfast the client comments "Don't waste good food on me. I'm dying from this disease I have." The appropriate response would be
A) "You need some nutritious food to help you regain your weight."
B) "None of the laboratory reports show that you have any physical disease."
C) "Try to eat a little bit, breakfast is the most important meal of the day."
D) "I know you believe that you have an incurable disease."

Review Information: The correct answer is D: "I know you believe that you have an incurable disease."
This response does not challenge the client's delusional system and thus forms an alliance by providing reassurance of desire to help the client.

Question32

A client with paranoid thoughts refuses to eat because of the belief that the food is poisoned. The appropriate statement at this time for the nurse to say is
A) "Here, I will pour a little of the juice in a medicine cup to drink it to show you that it is OK."
B) "The food has been prepared in our kitchen and is not poisoned."
C) "Let's see if your partner could bring food from home."
D) "If you don't eat, I will have to suggest for you to be tube fed."

Review Information: The correct answer is C: "Let''s see if your partner could bring food from home."
Reassurance is ineffective when a client is actively delusional. This option avoids both arguing with the client and agreeing with the delusional premise. Option D offers a logical response to a primarily affective concern. When the client's condition has improved, gentle negation of the delusional premise can be employed.

Question33

A client with tuberculosis is started on Rifampin.

Which one of the following statements by the nurse would be appropriate to include in teaching? "You may notice:
A) an orange-red color to your urine."
B) your appetite may increase for the first week."
C) it is common to experience occasional sleep disturbances."
D) if you take the medication with food, you may have nausea."

Review Information: The correct answer is A: an orange-red color to your urine."
Discoloration of the urine and other body fluids may occur. It is a harmless response to the drug, but the patient needs to be aware it may happen.

Question34

A client tells the RN she has decided to stop taking sertraline (Zoloft) because she doesn't like the nightmares, sex dreams, and obsessions she's experiencing since starting on the medication. What is an appropriate response by the nurse?
A) "It is unsafe to abruptly stop taking any prescribed medication."
B) "Side effects and benefits should be discussed with your health care provider."
C) "This medication should be continued despite unpleasant symptoms."
D) "Many medications have potential side effects."

Review Information: The correct answer is A: "It is unsafe to abruptly stop taking any prescribed medication."
Abrupt withdrawal may occasionally cause serotonin syndrome, consisting of lethargy, nausea, headache, fever, sweating and chills. A slow withdrawal may be prescribed with sertraline to avoid dizziness, nausea, vomiting, and diarrhea.

Question35

A client is admitted to the hospital with findings of liver failure with ascites. The health care provider orders spironolactone (Aldactone). What is the pharmacological effect of this medication?
A) Promotes sodium and chloride excretion
B) Increases aldosterone levels
C) Depletes potassium reserves
D) Combines safely with antihypertensives

Review Information: The correct answer is A: Promotes sodium and chloride excretion
Spironolactone promotes sodium and chloride excretion while sparing potassium and decreasing aldosterone levels. It had no effect on ammonia levels.

Question36

A client was admitted to the psychiatric unit for severe depression. After several days, the client continues to withdraw from the other clients. Which of these statements by the nurse would be the most appropriate to promote interaction with other clients?
A) "Your team here thinks it's good for you to spend time with others."
B) "It is important for you to participate in group activities."
C) "Come with me so you can paint a picture to help you feel better."
D) "Come play Chinese Checkers with Gloria and me."

Review Information: The correct answer is D: "Come play Chinese Checkers with Gloria and me."
This gradually engages the client in interactions with others in small groups rather than large groups. In addition, focusing on an activity is less anxiety-provoking than unstructured discussion. The statement is an example of a positive behavioral expectation.

Question37

The nurse is teaching a school-aged child and family about the use of inhalers prescribed for asthma. What is the best way to evaluate effectiveness of the treatments?

A) Rely on child's self-report
B) Use a peak-flow meter
C) Note skin color changes
D) Monitor pulse rate

Review Information: The correct answer is B: Use a peak-flow meter
The peak flowmeter, if used correctly, shows effectiveness of inhalants.

Question38

The nurse is teaching a client about the toxicity of digoxin. Which one of the following statements made by the client to the nurse indicates more teaching is needed?

A) “I may experience a loss of appetite.”
B) “I can expect occasional double vision.”
C) “Nausea and vomiting may last a few days.”
D) “I must report a bounding pulse of 62 immediately.”

Review Information: The correct answer is D: “I must report a bounding pulse of 62 immediately.”
Slow heart rate is related to increased cardiac output and an intended effect of digoxin. The ideal heart rate is above 60 BPM with digoxin. The client needs further teaching.

Question39

Which of the following assessments by the nurse would indicate that the client is having a possible adverse response to the isoniazid (INH)?

A) Severe headache
B) Appearance of jaundice
C) Tachycardia
D) Decreased hearing

Review Information: The correct answer is B: Appearance of jaundice
Clients receiving INH therapy are at risk for developing drug induced hepatitis. The appearance of jaundice may indicate that the client has liver damage.

Question40

The nurse is beginning nutritional counseling/ teaching with a pregnant woman. What is the initial step in this interaction?

A) Teach her how to meet the needs of self and her family
B) Explain the changes in diet necessary for pregnant women
C) Questionher understanding and use of the food pyramid
D) Conduct a diet history to determine her normal eating routines

Review Information: The correct answer is D: Conduct a diet history to determine her normal eating routines.

Assessment is always the first step in planning teaching for any client. A thorough and accurate history is essential for gathering the needed information.

0 comments

Labels: free nclex-rn sample review questions, nclex-rn practice test questions, nursing review

Free NCLEX-RN Sample Test Questions For Nursing Review (Part 1)

These are sample nursing review questions and not actual test questions made for educational and practice test purposes only. 75 questions have been posted here with answer keys.

Question1

A client has been hospitalized after an automobile accident. A full leg cast was applied in the emergency room. The most important reason for the nurse to elevate the casted leg is to

A) Promote the client’s comfort
B) Reduce the drying time
C) Decrease irritation to the skin
D) Improve venous return

Review Information: The correct answer is D: Improve venous return. Elevating the leg both improves venous return and reduces swelling. Client comfort will be improved as well.

Question2

The nurse is reviewing with a client how to collect a clean catch urine specimen. What is the appropriate sequence to teach the client?

A) Clean the meatus, begin voiding, then catch urine stream
B) Void a little, clean the meatus, then collect specimen
C) Clean the meatus, then urinate into container
D) Void continuously and catch some of the urine

Review Information: The correct answer is A: Clean the meatus, begin voiding, then catch urine stream. A clean catch urine is difficult to

obtain and requires clear directions. Instructing the client to carefully clean the meatus, then void naturally with a steady stream prevents surface bacteria from contaminating the urine specimen. As starting and stopping flow can be difficult, once the client begins voiding it''s best to just slip the container into the stream. Other responses do not reflect correct technique.

Question3

Following change-of-shift report on an orthopedic unit, which client should the nurse see first?
A) 16 year-old who had an open reduction of a fractured wrist 10 hours ago
B) 20 year-old in skeletal traction for 2 weeks since a motor cycle accident
C) 72 year-old recovering from surgery after a hip replacement 2 hours ago
D) 75 year-old who is in skin traction prior to planned hip pinning surgery.

Review Information: The correct answer is C: 72 year-old recovering from surgery after a hip replacement 2 hours ago. Look for the client who has the most imminent risks and acute vulnerability. The client who returned from surgery 2 hours ago is at risk for life threatening hemorrhage and should be seen first. The 16 year-old should be seen next because it is still the first post-op day. The 75 year-old is potentially vulnerable to age-related physical and cognitive consequences in skin traction should be seen next. The client who can safely be seen last is the 20 year-old who is 2 weeks post-injury.

Question4

A client with Guillain Barre is in a nonresponsive state, yet vital signs are stable and breathing is independent. What should the nurse document to most accurately describe the client's condition?
A) Comatose, breathing unlabored
B) Glascow Coma Scale 8, respirations regular
C) Appears to be sleeping, vital signs stable
D) Glascow Coma Scale 13, no ventilator required

Review Information: The correct answer is B: Glascow Coma Scale 8, respirations regular. The Glascow Coma Scale provides a standard reference for assessing or monitoring level of consciousness. Any score less than 13 indicates a neurological impairment. Using the term comatose provides too much room for interpretation and is not very precise.

Question5

When caring for a client receiving warfarin sodium (Coumadin), which lab test would the nurse monitor to determine therapeutic response to the drug?
A) Bleeding time
B) Coagulation time
C) Prothrombin time
D) Partial thromboplastin time

Review Information: The correct answer is C: Prothrombin time. Coumadin is ordered daily, based on the client''s prothrombin time (PT). This test evaluates the adequacy of the extrinsic system and common pathway in the clotting cascade; Coumadin affects the Vitamin K dependent clotting factors.

Question6

A client with moderate persistent asthma is admitted for a minor surgical procedure. On admission the peak flow meter is measured at 480 liters/minute. Post-operatively the client is complaining of chest tightness. The peak flow has dropped to 200 liters/minute. What should the nurse do first?
A) Notify both the surgeon and provider
B) Administer the prn dose of albuterol
C) Apply oxygen at 2 liters per nasal cannula
D) Repeat the peak flow reading in 30 minutes

Review Information: The correct answer is B: Administer the prn dose of albuterol. Peak flow monitoring during exacerbations of asthma is recommended for clients with moderate-to-severe persistent asthma to determine the severity of the exacerbation and to guide the treatment. A peak flow reading of less than 50% of the client''s baseline reading is a medical alert condition and a short-acting beta-agonist must be taken immediately.

Question7

A client had 20 mg of Lasix (furosemide) PO at 10 AM. Which would be essential for the nurse to

include at the change of shift report?
A) The client lost 2 pounds in 24 hours
B) The client's potassium level is 4 mEq/liter.
C) The client's urine output was 1500 cc in 5 hours
D) The client is to receive another dose of Lasix at 10 PM

Review Information: The correct answer is C: The client's urine output was 1500 cc in 5 hours. Although all of these may be correct information to include in report, the essential piece would be the urine output.

Question8

A client has been tentatively diagnosed with Graves' disease (hyperthyroidism). Which of these findings noted on the initial nursing assessment requires quick intervention by the nurse?
A) a report of 10 pounds weight loss in the last month
B) a comment by the client "I just can't sit still."
C) the appearance of eyeballs that appear to "pop" out of the client's eye sockets
D) a report of the sudden onset of irritability in the past 2 weeks

Review Information: The correct answer is C: the appearance of eyeballs that appear to "pop" out of the client''s eye sockets. Exophthalmos or protruding eyeballs is a distinctive characteristic of Graves'' Disease. It can result in corneal abrasions with severe eye pain or damage when the eyelid is unable to blink down over the protruding eyeball. Eye drops or ointment may be needed.

Question9

The nurse has performed the initial assessments of 4 clients admitted with an acute episode of asthma. Which assessment finding would cause the nurse to call the provider immediately?
A) prolonged inspiration with each breath
B) expiratory wheezes that are suddenly absent in 1 lobe
C) expectoration of large amounts of purulent mucous
D) appearance of the use of abdominal muscles for breathing

Review Information: The correct answer is B: expiratory wheezes that are suddenly absent in 1 lobe. Acute asthma is characterized by expiratory wheezes caused by obstruction of the airways. Wheezes are a high pitched musical sounds produced by air moving through narrowed airways. Clients often associate wheezes with the feeling of tightness in the chest. However, sudden cessation of wheezing is an ominous or bad sign that indicates an emergency -- the small airways are now collapsed.

Question10

During the initial home visit, a nurse is discussing the care of a client newly diagnosed with Alzheimer's disease with family members. Which of these interventions would be most helpful at this time?
A) leave a book about relaxation techniques
B) write out a daily exercise routine for them to assist the client to do
C) list actions to improve the client's daily nutritional intake
D) suggest communication strategies

Review Information: The correct answer is D: suggest communication strategies. Alzheimer''s disease, a progressive chronic illness, greatly challenges caregivers. The nurse can be of greatest assistance in helping the family to use communication strategies to enhance their ability to relate to the client. By use of select verbal and nonverbal communication strategies the family can best support the client's strengths and cope with any aberrant behavior.

Question11

An 80 year-old client admitted with a diagnosis of possible cerebral vascular accident has had a blood pressure from 160/100 to 180/110 over the past 2 hours. The nurse has also noted increased lethargy. Which assessment finding should the nurse report immediately to the provider?
A) Slurred speech
B) Incontinence
C) Muscle weakness
D) Rapid pulse

Review Information: The correct answer is A: Slurred speech. Changes in speech patterns and level of conscious can be indicators of continued intracranial bleeding or extension of the stroke. Further diagnostic testing may be indicated.

client. The potassium and PaO2 levels are near normal.

Question12

A school-aged child has had a long leg (hip to ankle) synthetic cast applied 4 hours ago. Which statement from the parent indicates that teaching has been inadequate?
A) "I will keep the cast uncovered for the next day to prevent burning of the skin."
B) "I can apply an ice pack over the area to relieve itching inside the cast."
C) "The cast should be propped on at least 2 pillows when my child is lying down."
D) "I think I remember that my child should not stand until after 72 hours."

Review Information: The correct answer is D: "I think I remember that my child should not stand until after 72 hours.". Synthetic casts will typically set up in 30 minutes and dry in a few hours. Thus, the client may stand within the initial 24 hours. With plaster casts, the set up and drying time, especially in a long leg cast which is thicker than an arm cast, can take up to 72 hours. Both types of casts give off a lot of heat when drying and it is preferable to keep the cast uncovered for the first 24 hours. Clients may complain of a chill from the wet cast and therefore can simply be covered lightly with a sheet or blanket. Applying ice is a safe method of relieving the itching.

Question13

Which blood serum finding in a client with diabetic ketoacidosis alerts the nurse that immediate action is required?
A) pH below 7.3
B) Potassium of 5.0
C) HCT of 60
D) Pa O2 of 79%

Review Information: The correct answer is C: HCT of 60. This high hematocrit is indicative of severe dehydration which requires priority attention in diabetic ketoacidosis. Without sufficient hydration, all systems of the body are at risk for hypoxia from a lack of or sluggish circulation. In the absence of insulin, which facilitates the transport of glucose into the cell, the body breaks down fats and proteins to supply energy ketones, a by-product of fat metabolism. These accumulate causing metabolic acidosis (pH < 7.3), which would be the second concern for this client. The potassium and PaO2 levels are near normal.

Question14

The nurse is preparing a client with a deep vein thrombosis (DVT) for a Venous Doppler evaluation. Which of the following would be necessary for preparing the client for this test?
A) Client should be NPO after midnight
B) Client should receive a sedative medication prior to the test
C) Discontinue anti-coagulant therapy prior to the test
D) No special preparation is necessary

Review Information: The correct answer is D: No special preparation is necessary. This is a non-invasive procedure and does not require preparation other than client education.

Question15

A client is admitted with infective endocarditis (IE). Which finding would alert the nurse to a complication of this condition?
A) dyspnea
B) heart murmur
C) macular rash
D) hemorrhage

Review Information: The correct answer is B: heart murmur. Large, soft, rapidly developing vegetations attach to the heart valves. They have a tendency to break off, causing emboli and leaving ulcerations on the valve leaflets. These emboli produce findings of cardiac murmur, fever, anorexia, malaise and neurologic sequelae of emboli. Furthermore, the vegetations may travel to various organs such as spleen, kidney, coronary artery, brain and lungs, and obstruct blood flow.

Question16

The nurse explains an autograft to a client scheduled for excision of a skin tumor. The nurse knows the client understands the procedure when the client says, "I will receive tissue from
A) a tissue bank."
B) a pig."
C) my thigh."
D) synthetic skin."

Review Information: The correct answer is C: my thigh.”. Autografts are done with tissue transplanted from the client’’s own skin.

Question17

A client is admitted to the emergency room following an acute asthma attack. Which of the following assessments would be expected by the nurse?

A) Diffuse expiratory wheezing
B) Loose, productive cough
C) No relief from inhalant
D) Fever and chills

Review Information: The correct answer is A: Diffuse expiratory wheezing. In asthma, the airways are narrowed, creating difficulty getting air in. A wheezing sound results.

Question18

A client has been admitted with a fractured femur and has been placed in skeletal traction. Which of the following nursing interventions should receive priority?
A) Maintaining proper body alignment
B) Frequent neurovascular assessments of the affected leg
C) Inspection of pin sites for evidence of drainage or inflammation
D) Applying an over-bed trapeze to assist the client with movement in bed

Review Information: The correct answer is B: Frequent neurovascular assessments of the affected leg. The most important activity for the nurse is to assess neurovascular status. Compartment syndrome is a serious complication of fractures. Prompt recognition of this neurovascular problem and early intervention may prevent permanent limb damage.

Question19

The nurse is assigned to care for a client who had a myocardial infarction (MI) 2 days ago. The client has many questions about this condition. What area is a priority for the nurse to discuss at this time?
A) Daily needs and concerns
B) The overview cardiac rehabilitation
C) Medication and diet guideline
D) Activity and rest guidelines

Review Information: The correct answer is A: Daily needs and concerns. At 2 days post-MI, the client’s education should be focused on the immediate needs and concerns for the day.

Question20

A 3 year-old child is brought to the clinic by his grandmother to be seen for “scratching his bottom and wetting the bed at night.” Based on these complaints, the nurse would initially assess for which problem?
A) allergies
B) scabies
C) regression
D) pinworms

Review Information: The correct answer is D: pinworms. Signs of pinworm infection include intense perianal itching, poor sleep patterns, general irritability, restlessness, bed-wetting, distractibility and short attention span. Scabies is an itchy skin condition caused by a tiny, eight-legged burrowing mite called Sarcoptes scabiei . The presence of the mite leads to intense itching in the area of its burrows.

Question21

The nurse is caring for a newborn with tracheoesophageal fistula. Which nursing diagnosis is a priority?
A) Risk for dehydration
B) Ineffective airway clearance
C) Altered nutrition
D) Risk for injury

Review Information: The correct answer is B: Ineffective airway clearance. The most common form of TEF is one in which the proximal esophageal segment terminates in a blind pouch and the distal segment is connected to the trachea or primary bronchus by a short fistula at or near the bifurcation. Thus, a priority is maintaining an open airway, preventing aspiration. Other nursing diagnoses are then addressed.

Question22

The nurse is developing a meal plan that would provide the maximum possible amount of iron for a child with anemia. Which dinner menu would be best?
A) Fish sticks, french fries, banana, cookies, milk
B) Ground beef patty, lima beans, wheat roll, raisins, milk
C) Chicken nuggets, macaroni, peas, cantaloupe, milk
D) Peanut butter and jelly sandwich, apple slices, milk

Review Information: The correct answer is B: Ground beef patty, lima beans, wheat roll, raisins, milk. Iron rich foods include red meat, fish, egg yolks, green leafy vegetables, legumes, whole grains, and dried fruits such as raisins. This dinner is the best choice: It is high in iron and is appropriate for a toddler.

Question23

The nurse admitting a 5 month-old who vomited 9 times in the past 6 hours should observe for signs of which overall imbalance?
A) Metabolic acidosis
B) Metabolic alkalosis
C) Some increase in the serum hemoglobin
D) A little decrease in the serum potassium

Review Information: The correct answer is B: Metabolic alkalosis. Vomiting causes loss of acid from the stomach. Prolonged vomiting can result in excess loss of acid and lead to metabolic alkalosis. Findings include irritability, increased activity, hyperactive reflexes, muscle twitching and elevated pulse. Options C and D are correct answers but not the best answers since they are too general.

Question24

A two year-old child is brought to the provider's office with a chief complaint of mild diarrhea for two days. Nutritional counseling by the nurse should include which statement?
A) Place the child on clear liquids and gelatin for 24 hours
B) Continue with the regular diet and include oral rehydration fluids
C) Give bananas, apples, rice and toast as tolerated
D) Place NPO for 24 hours, then rehydrate with milk and water

Review Information: The correct answer is B: Continue with the regular diet and include oral rehydration fluids. Current recommendations for mild to moderate diarrhea are to maintain a normal diet with fluids to rehydrate.

Question25

The nurse is teaching parents about the appropriate diet for a 4 month-old infant with gastroenteritis and mild dehydration. In addition to oral rehydration fluids, the diet should include

A) formula or breast milk
B) broth and tea
C) rice cereal and apple juice
D) gelatin and ginger ale

Review Information: The correct answer is A: formula or breast milk. The usual diet for a young infant should be followed.

Question26

A child is injured on the school playground and appears to have a fractured leg. The first action the school nurse should take is

A) call for emergency transport to the hospital
B) immobilize the limb and joints above and below the injury
C) assess the child and the extent of the injury
D) apply cold compresses to the injured area

Review Information: The correct answer is C: assess the child and the extent of the injury. When applying the nursing process, assessment is the first step in providing care. The "5 Ps" of vascular impairment can be used as a guide (pain, pulse, pallor, paresthesia, paralysis).

Question27

The mother of a 3 month-old infant tells the nurse that she wants to change from formula to whole milk and add cereal and meats to the diet. What should be emphasized as the nurse teaches about infant nutrition?

A) Solid foods should be introduced at 3-4

months
B) Whole milk is difficult for a young infant to digest
C) Fluoridated tap water should be used to dilute milk
D) Supplemental apple juice can be used between feedings

Review Information: The correct answer is B: Whole milk is difficult for a young infant to digest. Cow''s milk is not given to infants younger than 1 year because the tough, hard curd is difficult to digest. In addition, it contains little iron and creates a high renal solute load.

Question28

The nurse is preparing a handout on infant feeding to be distributed to families visiting the clinic. Which notation should be included in the teaching materials?

A) Solid foods are introduced one at a time beginning with cereal
B) Finely ground meat should be started early to provide iron
C) Egg white is added early to increase protein intake
D) Solid foods should be mixed with formula in a bottle

Review Information: The correct answer is A: Solid foods are introduced one at a time beginning with cereal. Solid foods should be added one at a time between 4-6 months. If the infant is able to tolerate the food, another may be added in a week. Iron fortified cereal is the recommended first food.

Question29

The nurse planning care for a 12 year-old child with sickle cell disease in a vaso-occlusive crisis of the elbow should include which one of the following as a priority?

A) Limit fluids
B) Client controlled analgesia
C) Cold compresses to elbow
D) Passive range of motion exercise

Review Information: The correct answer is B: Client controlled analgesia. Management of a sickle cell crisis is directed towards supportive and symptomatic treatment. The priority of care is pain relief. In a 12 year-old child, client controlled analgesia promotes maximum comfort.

Question30

The nurse is performing a physical assessment on a toddler. Which of the following actions should be the first?

A) Perform traumatic procedures
B) Use minimal physical contact
C) Proceed from head to toe
D) Explain the exam in detail

Review Information: The correct answer is B: Use minimal physical contact. The nurse should approach the toddler slowly and use minimal physical contact initially so as to gain the toddler''s cooperation. Be flexible in the sequence of the exam, and give only brief simple explanations just prior to the action.

Question31

What finding signifies that children have attained the stage of concrete operations (Piaget)?

A) Explores the environment with the use of sight and movement
B) Thinks in mental images or word pictures
C) Makes the moral judgment that "stealing is wrong"
D) Reasons that homework is time-consuming yet necessary

Review Information: The correct answer is C: Makes the moral judgment that "stealing is wrong". The stage of concrete operations is depicted by logical thinking and moral judgments.

Question32

The mother of a child with a neural tube defect asks the nurse what she can do to decrease the chances of having another baby with a neural tube defect. What is the best response by the nurse?

A) "Folic acid should be taken before and after conception."
B) "Multivitamin supplements are recommended during pregnancy."

C) “A well balanced diet promotes normal fetal development.”
D) “Increased dietary iron improves the health of mother and fetus.”

Review Information: The correct answer is A: “Folic acid should be taken before and after conception.”. The American Academy of Pediatrics recommends that all childbearing women increase folic acid from dietary sources and/or supplements. There is evidence that increased amounts of folic acid prevents neural tube defects.

Question33

The provider orders Lanoxin (digoxin) 0.125 mg PO and furosemide 40 mg every day. Which of these foods would the nurse reinforce for the client to eat at least daily?

A) Spaghetti
B) Watermelon
C) Chicken
D) Tomatoes

Review Information: The correct answer is B: Watermelon. Watermelon is high in potassium and will replace potassium lost by the diuretic. The other foods are not high in potassium.

Question34

While teaching the family of a child who will take phenytoin (Dilantin) regularly for seizure control, it is most important for the nurse to teach them about which of the following actions?

A) Maintain good oral hygiene and dental care
B) Omit medication if the child is seizure free
C) Administer acetaminophen to promote sleep
D) Serve a diet that is high in iron

Review Information: The correct answer is A: Maintain good oral hygiene and dental care. Swollen and tender gums occur often with use of phenytoin. Good oral hygiene and regular visits to the dentist should be emphasized.

Question35

The nurse is offering safety instructions to a parent with a four month-old infant and a four year-old child. Which statement by the parent indicates understanding of appropriate precautions to take with the children?

A) “I strap the infant car seat on the front seat to face backwards.”
B) “I place my infant in the middle of the living room floor on a blanket to play with my four year-old while I make supper in the kitchen.”
C) “My sleeping baby lies so cute in the crib with the little buttocks stuck up in the air while the four year-old naps on the sofa.”
D) “I have the four year-old hold and help feed the four month-old a bottle in the kitchen while I make supper.”

Review Information: The correct answer is D: “I have the four year-old hold and help feed the four month-old a bottle in the kitchen while I make supper.”. The infant seat is to be placed on the rear seat. Small children and infants are not to be left unsupervised. Infants are

Question36

The nurse admits a 7 year-old to the emergency room after a leg injury. The x-rays show a femur fracture near the epiphysis. The parents ask what will be the outcome of this injury. The appropriate response by the nurse should be which of these statements?

A) “The injury is expected to heal quickly because of thin periosteum.”
B) “In some instances the result is a retarded bone growth.”
C) “Bone growth is stimulated in the affected leg.”
D) “This type of injury shows more rapid union than that of younger children.”

Review Information: The correct answer is B: “In some instances the result is a retarded bone growth.”. An epiphyseal (growth) plate fracture in a 7 year-old often results in retarded bone growth. The leg often will be different in length than the uninjured leg.

Question37

The parents of a 4 year-old hospitalized child tell the nurse, “We are leaving now and will be back at 6 PM.” A few hours later the child asks the

nurse when the parents will come again. What is the best response by the nurse?

A) “They will be back right after supper.”
B) “In about 2 hours, you will see them.”
C) “After you play awhile, they will be here.”
D) “When the clock hands are on 6 and 12.”

Review Information: The correct answer is A: “They will be back right after supper.”. Time is not completely understood by a 4 year-old. Preschoolers interpret time with their own frame of reference. Thus, it is best to explain time in relationship to a known, common event.

Question38

The nurse is giving instructions to the parents of a child with cystic fibrosis. The nurse would emphasize that pancreatic enzymes should be taken
A) once each day
B) 3 times daily after meals
C) with each meal or snack
D) each time carbohydrates are eaten

Review Information: The correct answer is C: with each meal or snack. Pancreatic enzymes should be taken with each meal and every snack to allow for digestion of all foods that are eaten.

Question39

A nurse is providing a parenting class to individuals living in a community of older homes. In discussing formula preparation, which of the following is most important to prevent lead poisoning?

A) Use ready-to-feed commercial infant formula
B) Boil the tap water for 10 minutes prior to preparing the formula
C) Let tap water run for 2 minutes before adding to concentrate
D) Buy bottled water labeled “lead free” to mix the formula

Review Information: The correct answer is C: Let tap water run for 2 minutes before adding to concentrate. Use of lead-contaminated water to prepare formula is a major source of poisoning in infants. Drinking water may be contaminated by lead from old lead pipes or lead solder used in sealing water pipes. Letting tap water run for several minutes will diminish the lead contamination.

Question40

Which of the following manifestations observed by the school nurse confirms the presence of pediculosis capitis in students?

A) Scratching the head more than usual
B) Flakes evident on a student’s shoulders
C) Oval pattern occipital hair loss
D) Whitish oval specks sticking to the hair

Review Information: The correct answer is D: Whitish oval specks sticking to the hair. Diagnosis of pediculosis capitis is made by observation of the white eggs (nits) firmly attached to the hair shafts. Treatment can include application of a medicated shampoo with lindane for children over 2 years of age, and meticulous combing and removal of all nits.

Question41

When interviewing the parents of a child with asthma, it is most important to assess the child’s environment for what factor?

A) Household pets
B) New furniture
C) Lead based paint
D) Plants such as cactus

Review Information: The correct answer is A: Household pets. Animal dander is a very common allergen affecting persons with asthma. Other triggers may include pollens, carpeting and household dust.

Question42

The mother of a 2 month-old baby calls the nurse 2 days after the first DTaP, IPV, Hepatitis B and HIB immunizations. She reports that the baby feels very warm, cries inconsolably for as long as 3 hours, and has had several shaking spells. In addition to referring her to the emergency room, the nurse should document the reaction on the baby’s record and expect which immunization to be most associated with the findings the infant is displaying?

A) DTaP
B) Hepatitis B
C) Polio
D) H. Influenza

Review Information: The correct answer is A: DTaP. The majority of reactions occur with the administration of the DTaP vaccination. Contradictions to giving repeat DTaP immunizations include the occurrence of severe side effects after a previous dose as well as signs of encephalopathy within 7 days of the immunization.

Question43

The mother of a 2 year-old hospitalized child asks the nurse's advice about the child's screaming every time the mother gets ready to leave the hospital room. What is the best response by the nurse?

A) "I think you or your partner needs to stay with the child while in the hospital."
B) "Oh, that behavior will stop in a few days."
C) "Keep in mind that for the age this is a normal response to being in the hospital."
D) "You might want to "sneak out" of the room once the child falls asleep."

Review Information: The correct answer is C: "Keep in mind that for the age this is a normal response to being in the hospital.". The protest phase of separation anxiety is a normal response for a child this age. In toddlers, ages 1 to 3, separation anxiety is at its peak

Question44

A couple experienced the loss of a 7 month-old fetus. In planning for discharge, what should the nurse emphasize?

A) To discuss feelings with each other and use support persons
B) To focus on the other healthy children and move through the loss
C) To seek causes for the fetal death and come to some safe conclusion
D) To plan for another pregnancy within 2 years and maintain physical health

Review Information: The correct answer is A: To discuss feelings with each other and use support persons. To communicate in a therapeutic manner, the nurse''s goal is to help the couple begin the grief process by suggesting they talk to each other, seek family, friends and support groups to listen to their feelings.

Question45

The nurse is performing a pre-kindergarten physical on a 5 year-old. The last series of vaccines will be administered. What is the preferred site for injection by the nurse?

A) vastus intermedius
B) gluteus maximus
C) vastus lateralis
D) dorsogluteal

Review Information: The correct answer is C: vastus lateralis. Vastus lateralis, a large and well developed muscle, is the preferred site, since it is removed from major nerves and blood vessels.

Question46

A 7 month pregnant woman is admitted with complaints of painless vaginal bleeding over several hours. The nurse should prepare the client for an immediate

A) Non stress test
B) Abdominal ultrasound
C) Pelvic exam
D) X-ray of abdomen

Review Information: The correct answer is B: Abdominal ultrasound. The standard for diagnosis of placenta previa, which is suggested in the client''s history of painless bleeding, is abdominal ultrasound.

Question47

A nurse entering the room of a postpartum mother observes the baby lying at the edge of the bed while the woman sits in a chair. The mother states "This is not my baby, and I do not want it." After repositioning the child safely, the nurse's best response is

A) "This is a common occurrence after birth, but you will come to accept the baby."
B) "Many women have postpartum blues and

need some time to love the baby."
C) "What a beautiful baby! Her eyes are just like yours."
D) "You seem upset; tell me what the pregnancy and birth were like for you."

Review Information: The correct answer is D: "You seem upset; tell me what the pregnancy and birth were like for you.". A non-judgmental, open ended response facilitates dialogue between the client and nurse.

Question48

The nurse notes that a 2 year-old child recovering from a tonsillectomy has an temperature of 98.2 degrees Fahrenheit at 8:00 AM. At 10:00 AM the child's parent reports that the child "feels very warm" to touch. The first action by the nurse should be to

A) reassure the parent that this is normal
B) offer the child cold oral fluids
C) reassess the child's temperature
D) administer the prescribed acetaminophen

Review Information: The correct answer is C: reassess the child''s temperature. A child''s temperature may have rapid fluctuations. The nurse should listen to and show respect for what parents say. Parental caretakers are often quite sensitive to variations in their children''s condition that may not be immediately evident to others.

Question49

The nurse is caring for a client who was successfully resuscitated from a pulseless dysrhythmia. Which of the following assessments is critical for the nurse to include in the plan of care?

A) hourly urine output
B) white blood count
C) blood glucose every 4 hours
D) temperature every 2 hours

Review Information: The correct answer is A: hourly urine output. Clients who have had an episode of decreased glomerular perfusion are at risk for pre-renal failure. This is caused by any abnormal decline in kidney perfusion that reduces glomerular perfusion. Pre-renal failure occurs when the effective arterial blood volume falls. Examples of this phenomena include a drop in circulating blood volume as in a cardiac arrest state or in low cardiac perfusion states such as congestive heart failure associated with a cardiomyopathy. Close observation of hourly urinary output is necessary for early detection of this condition.

Question50

A client is admitted to the rehabilitation unit following a cerebral vascular accident (CVA) and mild dysphagia. The most appropriate intervention for this client is to

A) position client in upright position while eating
B) place client on a clear liquid diet
C) tilt head back to facilitate swallowing reflex
D) offer finger foods such as crackers or pretzels

Review Information: The correct answer is A: position client in upright position while eating. An upright position facilitates proper chewing and swallowing.

Question51

A 72 year-old client with osteomyelitis requires a 6 week course of intravenous antibiotics. In planning for home care, what is the most important action by the nurse?

A) Investigating the client's insurance coverage for home IV antibiotic therapy
B) Determining if there are adequate hand washing facilities in the home
C) Assessing the client's ability to participate in self care and/or the reliability of a caregiver
D) Selecting the appropriate venous access device

Review Information: The correct answer is C: Assessing the client''s ability to participate in self care and/or the reliability of a caregiver. The cognitive ability of the client as well as the availability and reliability of a caregiver must be assessed to determine if home care is a feasible option.

Question52

A nurse administers the influenza vaccine to a

client in a clinic. Within 15 minutes after the immunization was given, the client complains of itchy and watery eyes, increased anxiety, and difficulty breathing. The nurse expects that the first action in the sequence of care for this client will be to

A) Maintain the airway
B) Administer epinephrine 1:1000 as ordered
C) Monitor for hypotension with shock
D) Administer diphenhydramine as ordered

Review Information: The correct answer is B: Administer epinephrine 1:1000 as ordered. All the answers are correct given the circumstances, but the priority is to administer the epinephrine, then maintain the airway. In the early stages of anaphylaxis, when the patient has not lost consciousness and is normotensive, administering the epinephrine is first, and applying the oxygen, and watching for hypotension and shock, are later responses. The prevention of a severe crisis is maintained by using diphenhydramine.

Question53

The nurse instructs the client taking dexamethasone (Decadron) to take it with food or milk. The physiological basis for this instruction is that the medication
A) retards pepsin production
B) stimulates hydrochloric acid production
C) slows stomach emptying time
D) decreases production of hydrochloric acid

Review Information: The correct answer is B: stimulates hydrochloric acid production. Decadron increases the production of hydrochloric acid, which may cause gastrointestinal ulcers.

Question54

A client receiving chlorpromazine HCL (Thorazine) is in psychiatric home care. During a home visit the nurse observes the client smacking her lips alternately with grinding her teeth. The nurse recognizes this assessment finding as what?
A) Dystonia
B) Akathisia
C) Brady dyskinesia
D) Tardive dyskinesia

Review Information: The correct answer is D: Tardive dyskinesia. Signs of tardive dyskinesia include smacking lips, grinding of teeth and "fly catching" tongue movements. These findings are often described as Parkinsonian.

Question55

Which of the following findings contraindicate the use of haloperidol (Haldol) and warrant withholding the dose?
A) Drowsiness, lethargy, and inactivity
B) Dry mouth, nasal congestion, and blurred vision
C) Rash, blood dyscrasias, severe depression
D) Hyperglycemia, weight gain, and edema

Review Information: The correct answer is C: Rash, blood dyscrasias, severe depression. Rash and blood dyscrasias are side effects of anti-psychotic drugs. A history of severe depression is a contraindication to the use of neuroleptics.

Question56

The nurse is reinforcing teaching to a 24 year-old woman receiving acyclovir (Zovirax) for a Herpes Simplex Virus type 2 infection. Which of these instructions should the nurse give the client?

A) Complete the entire course of the medication for an effective cure
B) Begin treatment with acyclovir at the onset of symptoms of recurrence
C) Stop treatment if she thinks she may be pregnant to prevent birth defects
D) Continue to take prophylactic doses for at least 5 years after the diagnosis

Review Information: The correct answer is B: Begin treatment with acyclovir at the onset of symptoms of recurrence. When the client is aware of early symptoms, such as pain, itching or tingling, treatment is very effective. Medications for herpes simplex do not cure the disease; they simply decrease the level of symptoms.

Question57

A 14 month-old child ingested half a bottle of aspirin tablets. Which of the following would the nurse expect to see in the child?

A) Hypothermia
B) Edema
C) Dyspnea
D) Epistaxis

Review Information: The correct answer is D: Epistaxis. A large dose of aspirin inhibits prothrombin formation and lowers platelet levels. With an overdose, clotting time is prolonged.

Question58

An 80 year-old client on digitalis (Lanoxin) reports nausea, vomiting, abdominal cramps and halo vision. Which of the following laboratory results should the nurse analyze first?

A) Potassium levels
B) Blood pH
C) Magnesium levels
D) Blood urea nitrogen

Review Information: The correct answer is A: Potassium levels. The most common cause of digitalis toxicity is a low potassium level. Clients must be taught that it is important to have adequate potassium intake especially if taking diuretics that enhance the loss of potassium while they are taking digitalis.

Question59

A 42 year-old male client refuses to take propranolol hydrochloride (Inderal) as prescribed. Which client statement from the assessment data is likely to explain his noncompliance?

A) "I have problems with diarrhea."
B) "I have difficulty falling asleep."
C) "I have diminished sexual function."
D) "I often feel jittery."

Review Information: The correct answer is C: "I have diminished sexual function.". Inderal, a beta-blocking agent used in hypertension, prohibits the release of epinephrine into the cells; this may result in hypotension which results in decreased libido and impotence.

Question60

The nurse caring for a 9 year-old child with a fractured femur is told that a medication error occurred. The child received twice the ordered dose of morphine an hour ago. Which nursing diagnosis is a priority at this time?

A) Risk for fluid volume deficit related to morphine overdose
B) Decreased gastrointestinal mobility related to mucosal irritation
C) Ineffective breathing patterns related to central nervous system depression
D) Altered nutrition related to inability to control nausea and vomiting

Review Information: The correct answer is C: Ineffective breathing patterns related to central nervous system depression. Respiratory depression is a life-threatening risk in this overdose.

Question61

Lactulose (Chronulac) has been prescribed for a client with advanced liver disease. Which of the following assessments would the nurse use to evaluate the effectiveness of this treatment?

A) An increase in appetite
B) A decrease in fluid retention
C) A decrease in lethargy
D) A reduction in jaundice

Review Information: The correct answer is C: A decrease in lethargy. Lactulose produces an acid environment in the bowel and traps ammonia in the gut; the laxative effect then aids in removing the ammonia from the body. This decreases the effects of hepatic encephalopathy, including lethargy and confusion.

Question62

The nurse is teaching a class on HIV prevention. Which of the following should be emphasized as increasing risk?

A) Donating blood
B) Using public bathrooms
C) Unprotected sex
D) Touching a person with AIDS

Review Information: The correct answer is C: Unprotected sex. Because HIV is spread through exposure to bodily fluids, unprotected intercourse and shared drug paraphernalia remain the high-

est risks for infection.

Question63

While interviewing a new admission, the nurse notices that the client is shifting positions, wringing her hands, and avoiding eye contact. It is important for the nurse to
A) ask the client what she is feeling
B) assess the client for auditory hallucinations
C) recognize the behavior as a side effect of medication
D) re-focus the discussion on a less anxiety provoking topic

Review Information: The correct answer is A: ask the client what she is feeling. The initial step in anxiety intervention is observing, identifying, and assessing anxiety. The nurse should seek client validation of the accuracy of nursing assessments and avoid drawing conclusions based on limited data. In the situation above, the client may simply need to use the restroom but be reluctant to communicate her need!

Question64

A young adult seeks treatment in an outpatient mental health center. The client tells the nurse he is a government official being followed by spies. On further questioning, he reveals that his warnings must be heeded to prevent nuclear war. What is the most therapeutic approach by the nurse?

A) Listen quietly without comment
B) Ask for further information on the spies
C) Confront the client's delusion
D) Contact the government agency

Review Information: The correct answer is A: Listen quietly without comment. The client''s comments demonstrate grandiose ideas. The most therapeutic response is to listen but avoid being incorporated into the client's delusional system.

Question65

The nurse is assessing a 17 year-old female client with bulimia. Which of the following laboratory reports would the nurse anticipate?

A) Increased serum glucose
B) Decreased albumin
C) Decreased potassium
D) Increased sodium retention

Review Information: The correct answer is C: Decreased potassium. In bulimia, loss of electrolytes can occur in addition to other findings of starvation and dehydration.

Question66

A client, recovering from alcoholism, asks the nurse, "What can I do when I start recognizing relapse triggers within myself?" How might the nurse best respond?

A) "When you have the impulse to stop in a bar, contact a sober friend and talk with him."
B) "Go to an AA meeting when you feel the urge to drink."
C) "It is important to exercise daily and get involved in activities that will cause you not to think about drug use."
D) "Let's talk about possible options you have when you recognize relapse triggers in yourself."

Review Information: The correct answer is D: "Let's talk about possible options you have when you recognize relapse triggers in yourself.". This option encourages the process of self evaluation and problem solving, while avoiding telling the client what to do. Encouraging the client to brainstorm about response options validates the nurse's belief in the client's personal competency and reinforces a coping strategy that will be needed when the nurse may not be available to offer solutions.

Question67

Therapeutic nurse-client interaction occurs when the nurse
A) assists the client to clarify the meaning of what the client has said
B) interprets the client's covert communication
C) praises the client for appropriate feelings and behavior
D) advises the client on ways to resolve problems

Review Information: The correct answer is A: assists the client to clarify the meaning of what the client has said. Clarification is a facilitating/

therapeutic communication strategy. Interpretation, changing the focus/subject, giving approval, and advising are non-therapeutic/barriers to communication.

Question68

Which nursing intervention will be most effective in helping a withdrawn client to develop relationship skills?

A) Offer the client frequent opportunities to interact with 1 person
B) Provide the client with frequent opportunities to interact with other clients
C) Assist the client to analyze the meaning of the withdrawn behavior
D) Discuss with the client the focus that other clients have similar problems

Review Information: The correct answer is A: Offer the client frequent opportunities to interact with 1 person. The withdrawn client is uncomfortable in social interaction. The nurse-client relationship is a corrective relationship in which the client learns both tolerance and skills for relationships.

Question69

An important goal in the development of a therapeutic inpatient milieu is to

A) provide a businesslike atmosphere where clients can work on individual goals
B) provide a group forum in which clients decide on unit rules, regulations, and policies
C) provide a testing ground for new patterns of behavior while the client takes responsibility for his or her own actions
D) discourage expressions of anger because they can be disruptive to other clients

Review Information: The correct answer is C: provide a testing ground for new patterns of behavior while the client takes responsibility for his or her own actions. A therapeutic milieu is purposeful and planned to provide safety and a testing ground for new patterns of behavior.

Question70

A client with paranoid delusions stares at the nurse over a period of several days. The client suddenly walks up to the nurse and shouts "You think you're so perfect and pure and good." An appropriate response for the nurse is

A) "Is that why you've been staring at me?"
B) "You seem to be in a really bad mood."
C) "Perfect? I don't quite understand."
D) "You seem angry right now."

Review Information: The correct answer is D: "You seem angry right now.". The nurse recognizes the underlying emotion with a matter of fact attitude, but avoids telling the clients how they feel.

Question71

A client who is a former actress enters the day room wearing a sheer nightgown, high heels, numerous bracelets, bright red lipstick and heavily rouged cheeks. Which nursing action is the best in response to the client's attire?

A) Gently remind her that she is no longer on stage
B) Directly assist client to her room for appropriate apparel
C) Quietly point out to her the dress of other clients on the unit
D) Tactfully explain appropriate clothing for the hospital

Review Information: The correct answer is B: Directly assist client to her room for appropriate apparel. It assists the client to maintain self-esteem while modifying behavior.

Question72

When teaching suicide prevention to the parents of a 15 year-old who recently attempted suicide, the nurse describes the following behavioral cue as indicating a need for intervention.

A) Angry outbursts at significant others
B) Fear of being left alone
C) Giving away valued personal items
D) Experiencing the loss of a boyfriend

Review Information: The correct answer is C: Giving away valued personal items. Eighty percent of all potential suicide victims give some type of indication that self-destructiveness should be

addressed. These clues might lead one to suspect that a client is having suicidal thoughts or is developing a plan.

Question73

Which statement made by a client indicates to the nurse that the client may have a thought disorder?
A) “I’m so angry about this. Wait until my partner hears about this.”
B) “I’m a little confused. What time is it?”
C) “I can’t find my ‘mesmer’ shoes. Have you seen them?”
D) “I’m fine. It’s my daughter who has the problem.”

Review Information: The correct answer is C: “I can’’t find my ‘’mesmer’’ shoes. Have you seen them?”. A neologism is a new word self invented by a person and not readily understood by another. Using neologisms is often associated with a thought disorder.

Question74

In a psychiatric setting, the nurse limits touch or contact used with clients to handshaking because

A) some clients misconstrue hugs as an invitation to sexual advances
B) handshaking keeps the gesture on a professional level
C) refusal to touch a client denotes lack of concern
D) inappropriate touch often results in charges of assault and battery

Review Information: The correct answer is A: some clients misconstrue hugs as an invitation to sexual advances. Touch denotes positive feelings for another person. The client may interpret hugging and holding hands as sexual advances.

Question75

A client with anorexia is hospitalized on a medical unit due to electrolyte imbalance and cardiac dysrhythmias. Additional assessment findings that the nurse would expect to observe are
A) brittle hair, lanugo, amenorrhea
B) diarrhea, nausea, vomiting, dental erosion
C) hyperthermia, tachycardia, increased metabolic rate
D) excessive anxiety about symptoms

Review Information: The correct answer is A: brittle hair, lanugo, amenorrhea. Physical findings associated with anorexia also include reduced metabolic rate and lower vital signs.

Free NCLEX-RN Sample Test Questions For Nursing Review (Pharmacology Set 2)

Jul31,

A nurse is assigned to perform well-child assessments at a day care center. A staff member interrupts the examinations to ask for assistance. They find a crying 3 year-old child on the floor with mouth wide open and gums bleeding. Two unlabeled open bottles lie nearby. The nurse’s first action should be
A) call the poison control center, then 911
B) administer syrup of Ipecac to induce vomiting
C) give the child milk to coat her stomach
D) ask the staff about the contents of the bottles

Review Information: The correct answer is D: ask the staff about the contents of the bottles
The nurse needs to assess what the child ingested before determining the next action. Once the substance is identified, the poison control center and emergency response team should be called.

Question2

A client with atrial fibrillation is receiving digoxin (Lanoxin). Which of these assessments is most important for the nurse to perform?
A) Monitor blood pressure every 4 hours
B) Measure apical pulse prior to administration
C) Maintain accurate intake and output records
D) Record an EKG strip after administration

Review Information: The correct answer is B: Measure apical pulse prior to administration
Digitoxin decreases conduction velocity through the AV node and prolongs the refractory period. If the apical heart rate is less than 60 beats/minute, withhold the drug. The apical pulse should be

taken with a stethoscope so that there will be no mistake about what the heart rate actually is.

Question3

The nurse is administering an intravenous vesicant chemotherapeutic agent to a client. Which assessment would require the nurse's immediate action?
A) Stomatitis lesion in the mouth
B) Severe nausea and vomiting
C) Complaints of pain at site of infusion
D) A rash on the client's extremities

Review Information: The correct answer is C: Complaints of pain at site of infusion
A vesicant is a chemotherapeutic agent capable of causing blistering of tissues and possible tissue necrosis if there is extravasation. These agents are irritants which cause pain along the vein wall, with or without inflammation.

Question4

The nurse practicing in a long term care facility recognizes that elderly clients are at greater risk for drug toxicity than younger adults because of which of the following physiological changes of advancing age?
A) Drugs are absorbed more readily from the GI tract
B) Elders have less body water and more fat
C) The elderly have more rapid hepatic metabolism
D) Older people are often malnourished and anemic

Review Information: The correct answer is B: Elders have less body water and more fat
Because elderly persons have decreased lean body tissue/water in which to distribute medications, more drug remains in the circulatory system with potential for drug toxicity. Increased body fat results in greater amounts of fat-soluble drugs being absorbed, leaving less in circulation, thus increasing the duration of action of the drug

Question5

The nurse is assessing a client who is on long term glucocorticoid therapy. Which of the following findings would the nurse expect?
A) Buffalo hump
B) Increased muscle mass
C) Peripheral edema
D) Jaundice

Review Information: The correct answer is A: Buffalo hump
With high doses of glucocorticoid, iatrogenic Cushing>>s syndrome develops. The exaggerated physiological action causes abnormal fat distribution which results in a moon-shaped face, a intrascapular pad on the neck (buffalo hump) and truncal obesity with slender limbs.

Question6

The health care provider has written «Morphine sulfate 2 mgs IV every 3-4 hours prn for pain» on the chart of a child weighing 22 lb. (10 kg). What is the nurse>s initial action?
A) Check with the pharmacist
B) Hold the medication and contact the provider
C) Administer the prescribed dose as ordered
D) Give the dose every 6-8 hours

Review Information: The correct answer is B: Hold the medication and contact the provider
The usual pediatric dose of morphine is 0.1 mg/kg every 3 to 4 hours. At 10 kg, this child typically should receive 1.0 mg every 3 to 4 hours.

Question7

A client is ordered atropine to be administered preoperatively. Which physiological effect should the nurse monitor for?
A) Elevate blood pressure
B) Drying up of secretions
C) Reduce heart rate
D) Enhance sedation

Review Information: The correct answer is B: Drying up of secretions
Atropine dries secretions which may get in the way during the operative procedure.

Question8

A client is receiving digitalis. The nurse should instruct the client to report which of the following side effects?
A) Nausea, vomiting, fatigue
B) Rash, dyspnea, edema
C) Polyuria, thirst, dry skin

D) Hunger, dizziness, diaphoresis

Review Information: The correct answer is A: Nausea, vomiting, fatigue
Side effects of digitalis toxicity include fatigue, nausea, vomiting, anorexia, and bradycardia. Digitalis inhibits the sodium potassium ATPase, which makes more calcium available for contractile proteins, resulting in increased cardiac output.

Question9

A client is receiving dexamethasone (Decadron) therapy. What should the nurse plan to monitor in this client?
A) Urine output every 4 hours
B) Blood glucose levels every 12 hours
C) Neurological signs every 2 hours
D) Oxygen saturation every 8 hours

Review Information: The correct answer is B: Blood glucose levels every 12 hours
The drug Decadron increases glycogenesis. This may lead to hyperglycemia. Therefore the blood sugar level and acetone production must be monitored.

Question10

The nurse is caring for a client with schizophrenia who has been treated with quetiapine (Seroquel) for 1 month. Today the client is increasingly agitated and complains of muscle stiffness. Which of these findings should be reported to the health care provider?
A) Elevated temperature and sweating.
B) Decreased pulse and blood pressure.
C) Mental confusion and general weakness.
D) Muscle spasms and seizures.

Review Information: The correct answer is A: Elevated temperature and sweating.
Neuroleptic malignant syndrome (NMS) is a rare disorder that can occur as a side effect of antipsychotic medications. It is characterized by muscular rigidity, tachycardia, hyperthermia, sweating, altered consciousness, autonomic dysfunction, and increase in CPK. This is a life-threatening complication.

Question11

A child presents to the Emergency Department with documented acetaminophen poisoning. In order to provide counseling and education for the parents, which principle must the nurse understand?
A) The problem occurs in stages with recovery within 12-24 hours
B) Hepatic problems may occur and may be life-threatening
C) Full and rapid recovery can be expected in most children
D) This poisoning is usually fatal, as no antidote is available

Review Information: The correct answer is B: Hepatic problems may occur and may be life-threatening
Clinical manifestations associated with acetaminophen poisoning occurs in 4 stages. The third stage is hepatic involvement which may last up to 7 days and be permanent. Clients who do not die in the hepatic stage gradually recover.

Question12

A client has been receiving dexamethasone (Decadron) for control of cerebral edema. Which of the following assessments would indicate that the treatment is effective?
A) A positive Babinski>s reflex
B) Increased response to motor stimuli
C) A widening pulse pressure
D) Temperature of 37 degrees Celsius

Review Information: The correct answer is B: Increased response to motor stimuli
Decadron is a corticosteroid that acts on the cell membrane to decrease inflammatory responses as well as stabilize the blood-brain barrier. Once Decadron reaches a therapeutic level, there should be a decrease in symptomology with improvement in motor skills.

Question13

The provider has ordered transdermal nitroglycerin patches for a client. Which of these instructions should be included when teaching a client about how to use the patches?
A) Remove the patch when swimming or bathing
B) Apply the patch to any non-hairy area of the body

C) Apply a second patch with chest pain
D) Remove the patch if ankle edema occurs

Review Information: The correct answer is B: Apply the patch to any non-hairy area of the body
The patch application sites should be rotated.

Question14

A newly admitted client has a diagnosis of depression. She complains of "twitching muscles" and a "racing heart", and states she stopped taking Zoloft a few days ago because it was not helping her depression. Instead, she began to take her partner>s Parnate. The nurse should immediately assess for which of these adverse reactions?
A) Pulmonary edema
B) Atrial fibrillation
C) Mental status changes
D) Muscle weakness

Review Information: The correct answer is C: Mental status changes
Use of serotonergic agents may result in Serotonin Syndrome with confusion, nausea, palpitations, increased muscle tone with twitching muscles, and agitation. Serotonin syndrome is most often reported in patients taking 2 or more medications that increase CNS serotonin levels by different mechanisms. The most common drug combinations associated with serotonin syndrome involve the MAOIs, SSRIs, and the tricyclic antidepressants.

Question15

A client with bi-polar disorder is taking lithium (Lithane). What should the nurse emphasize when teaching about this medication?
A) Take the medication before meals
B) Maintain adequate daily salt intake
C) Reduce fluid intake to minimize diuresis
D) Use antacids to prevent heartburn

Review Information: The correct answer is B: Maintain adequate daily salt intake
Salt intake affects fluid volume, which can affect lithium (Lithane) levels; therefore, maintaining adequate salt intake is advised.

Question16

A client with anemia has a new prescription for ferrous sulfate. In teaching the client about diet and iron supplements, the nurse should emphasize that absorption of iron is enhanced if taken with which substance?
A) Acetaminophen
B) Orange juice
C) Low fat milk
D) An antacid

Review Information: The correct answer is B: Orange juice
Ascorbic acid enhances the absorption of iron.

Question17

A client with an aplastic sickle cell crisis is receiving a blood transfusion and begins to complain of «feeling hot.» Almost immediately, the client begins to wheeze. What is the nurse>s first action?
A) Stop the blood infusion
B) Notify the health care provider
C) Take/record vital signs
D) Send blood samples to lab

Review Information: The correct answer is A: Stop the blood infusion
If a reaction of any type is suspected during administration of blood products, stop the infusion immediately, keep the line open with saline, notify the health care provider, monitor vital signs and other changes, and then send a blood sample to the lab.

Question18

A client confides in the RN that a friend has told her the medication she takes for depression, Wellbutrin, was taken off the market because it caused seizures. What is an appropriate response by the nurse?
A) «Ask your friend about the source of this information.»
B) «Omit the next doses until you talk with the doctor.»
C) «There were problems, but the recommended dose is changed.»
D) «Your health care provider knows the best drug for your condition.»

Review Information: The correct answer is C: «There were problems, but the recommended

dose is changed.»
Wellbutrin was introduced in the U.S. in 1985 and then withdrawn because of the occurrence of seizures in some patients taking the drug. The drug was reintroduced in 1989 with specific recommendations regarding dose ranges to limit the occurrence of seizures. The risk of seizure appears to be strongly associated with dose.

Question19

When providing discharge teaching to a client with asthma, the nurse will warn against the use of which of the following over-the-counter medications?
A) Cortisone ointments for skin rashes
B) Aspirin products for pain relief
C) Cough medications containing guaifenesin
D) Histamine blockers for gastric distress

Review Information: The correct answer is B: Aspirin products for pain relief
Aspirin is known to induce asthma attacks. Aspirin can also cause nasal polyps and rhinitis. Warn individuals with asthma about signs and symptoms resulting from complications due to aspirin ingestion.

Question20

The nurse is caring for a client who is receiving procainamide (Pronestyl) intravenously. It is important for the nurse to monitor which of the following parameters?
A) Hourly urinary output
B) Serum potassium levels
* C) Continuous EKG readings
D) Neurological signs

Review Information: The correct answer is C: Continuous EKG readings
Procainamide (Pronestyl) is used to suppress cardiac arrhythmias. When administered intravenously, it must be accompanied by continuous cardiac monitoring by ECG.

Question21

The nurse is providing education for a client with newly diagnosed tuberculosis. Which statement should be included in the information that is given to the client?
A) «Isolate yourself from others until you are finished taking your medication.»
B) «Follow up with your primary care provider in 3 months.»
C) «Continue to take your medications even when you are feeling fine.»
D) «Continue to get yearly tuberculin skin tests.»

Review Information: The correct answer is C: «Continue to take your medications even when you are feeling fine.»
The most important piece of information the tuberculosis client needs is to understand the importance of medication compliance, even if no longer experiencing symptoms. Clients are most infectious early in the course of therapy. The numbers of acid-fast bacilli are greatly reduced as early as 2 weeks after therapy begins.

Question22

The nurse is applying silver sulfadiazine (Silvadene) to a child with severe burns to arms and legs. Which side effect should the nurse be monitoring for?
A) Skin discoloration
B) Hardened eschar
C) Increased neutrophils
D) Urine sulfa crystals

Review Information: The correct answer is D: Urine sulfa crystals
Silver sulfadiazine is a broad spectrum antimicrobial, especially effective against pseudomonas. When applied to extensive areas, however, it may cause a transient neutropenia, as well as renal function changes with sulfa crystals production and kernicterus.

Question23

The nurse is monitoring a client receiving a thrombolytic agent, alteplase (Activase tissue plasminogen activator), for treatment of a myocardial infarction. What outcome indicates the client is receiving adequate therapy within the first hours of treatment?
A) Absence of a dysrhythmia (or arrhythmia)
B) Blood pressure reduction
C) Cardiac enzymes are within normal limits
D) Return of ST segment to baseline on ECG

Review Information: The correct answer is D:

Return of ST segment to baseline on ECG
Improved perfusion should result from this medication, along with the reduction of ST segment elevation.

Question24

The provider has ordered daily high doses of aspirin for a client with rheumatoid arthritis. The nurse instructs the client to discontinue the medication and contact the provider if which of the following symptoms occur?
A) Infection of the gums
B) Diarrhea for more than one day
C) Numbness in the lower extremities
D) Ringing in the ears

Review Information: The correct answer is D: Ringing in the ears
Aspirin stimulates the central nervous system which may result in ringing in the ears.
Deglin, J.D. and Vallerand, A.H. (2001). Davis' drug guide for nurses. (7th edition). Philadelphia: F.A. Davis Company.
Key, J.L. and Hayes, E.R. (2003). Pharmacology, a nursing process approach. (4th edition). Philadelphia: Saunders.

Question25

A nurse is caring for a client who is receiving methyldopa hydrochloride (Aldomet) intravenously. Which of the following assessment findings would indicate to the nurse that the client may be having an adverse reaction to the medication?
A) Headache
B) Mood changes
C) Hyperkalemia
D) Palpitations

Review Information: The correct answer is B: Mood changes
The nurse should assess the client for alterations in mental status such as mood changes. These symptoms should be reported promptly.
Deglin, J.D. and Vallerand, A.H. (2001). Davis' drug guide for nurses. (7th edition). Philadelphia: F.A. Davis Company.
Wilson, B.A., Shannon, M.T., and Stang, C.L. (2004). Nurse's drug guide. Upper Saddle River, New Jersey: Pearson Prentice Hall.

Question26

The nurse is teaching a child and the family about the medication phenytoin (Dilantin) prescribed for seizure control. Which of the following side effects is most likely to occur?
A) Vertigo
B) Drowsiness
C) Gingival hyperplasia
D) Vomiting

Review Information: The correct answer is C: Gingival hyperplasia
Swollen and tender gums occur often with use of phenytoin. Good oral hygiene and regular visits to the dentist should be emphasized.

Question27

The use of atropine for treatment of symptomatic bradycardia is contraindicated for a client with which of the following conditions?
A) Urinary incontinence
B) Glaucoma
C) Increased intracranial pressure
D) Right sided heart failure

Review Information: The correct answer is B: Glaucoma
Atropine is contraindicated in clients with angle-closure glaucoma because it can cause pupillary dilation with an increase in aqueous humor, leading to a resultant increase in optic pressure.

Question28

A pregnant woman is hospitalized for treatment of pregnancy induced hypertension (PIH) in the third trimester. She is receiving magnesium sulfate intravenously. The nurse understands that this medication is used mainly for what purpose?
A) Maintain normal blood pressure
B) Prevent convulsive seizures
C) Decrease the respiratory rate
D) Increase uterine blood flow

Review Information: The correct answer is B: Prevent convulsive seizures
Magnesium sulfate is a central nervous system depressant. While it has many systemic effects, it is used in the client with pregnancy induced

hypertension (PIH) to prevent seizures.

Question29

The nurse is teaching a group of women in a community clinic about prevention of osteoporosis. Which of the following over-the-counter medications should the nurse recognize as having the most elemental calcium per tablet?

A) Calcium chloride
B) Calcium citrate
C) Calcium gluconate
D) Calcium carbonate

Review Information: The correct answer is D: Calcium carbonate
Calcium carbonate contains 400mg of elemental calcium in 1 gram of calcium carbonate.

Question30

The nurse is administering diltiazem (Cardizem) to a client. Prior to administration, it is important for the nurse to assess which parameter?

A) Temperature
B) Blood pressure
C) Vision
D) Bowel sounds

Review Information: The correct answer is B: Blood pressure
Diltiazem (Cardizem) is a calcium channel blocker that causes systemic vasodilation resulting in decreased blood pressure.

Question31

The nurse is instructing a client with moderate persistent asthma on the proper method for using MDIs (multi-dose inhalers). Which medication should be administered first?

A) Steroid
B) Anticholinergic
C) Mast cell stabilizer
D) Beta agonist

Review Information: The correct answer is D: Beta agonist
The beta-agonist drugs help to relieve bronchospasm by relaxing the smooth muscle of the airway. These drugs should be taken first so that other medications can reach the lungs.

Question32

A post-operative client has a prescription for acetaminophen with codeine. What should the nurse recognizes as a primary effect of this combination?

A) Enhanced pain relief
B) Minimized side effects
C) Prevention of drug tolerance
D) Increased onset of action

Review Information: The correct answer is A: Enhanced pain relief
Combination of analgesics with different mechanisms of action can afford greater pain relief.

Question33

A client is receiving erythromycin 500mg IV every 6 hours to treat a pneumonia. Which of the following is the most common side effect of the medication?

A) Blurred vision
B) Nausea and vomiting
C) Severe headache
D) Insomnia

Review Information: The correct answer is B: Nausea and vomiting
Nausea is a common side-effect of erythromycin in both oral and intravenous forms.

Question34

The health care provider orders an IV aminophylline infusion at 30 mg/hr. The pharmacy sends a 1,000 ml bag of D5W containing 500 mg of aminophylline. In order to administer 30 mg per hour, the RN will set the infusion rate at:

A) 20 ml per hour
B) 30 ml per hour
C) 50 ml per hour
D) 60 ml per hour

Review Information: The correct answer is D: 60 ml per hour
Using the ratio method to calculate infusion rate: mg to be given (30) : ml to be infused (X) :: mg available (500) : ml of solution (1,000). Solve for X by cross-multiplying: 30 x 1,000 = 500 x X (or cancel), 30,000 = 500 X, X = 30,000/500, X =

60ml per hour.

Question35

The nurse is assessing a 7 year-old after several days of treatment for a documented strep throat. Which of the following statements suggests that further teaching is needed?
A) «Sometimes I take my medicine with fruit juice.»
B) «My mother makes me take my medicine right after school.»
C) «Sometimes I take the pills in the morning and other times at night.»
D) «I am feeling much better than I did last week.»

Review Information: The correct answer is C: «Sometimes I take the pills in the morning and other times at night.»
Inconsistency in taking the prescribed medication indicates more teaching is needed.

Question36

The nurse is caring for a 10 year-old client who will be placed on heparin therapy. Which assessment is critical for the nurse to make before initiating therapy
A) Vital signs
B) Weight
C) Lung sounds
D) Skin turgor

Review Information: The correct answer is B: Weight
Check the client>>s weight because dosage is calculated on the basis of weight.

Question37

In providing care for a client with pain from a sickle cell crisis, which one of the following medication orders for pain control should be questioned by the nurse?
A) Demerol
B) Morphine
C) Methadone
D) Codeine

Review Information: The correct answer is A: Demerol
Meperidine is not recommended in clients with sickle cell disease. Normeperidine, a metabolite of meperidine, is a central nervous system stimulant that produces anxiety, tremors, myoclonus, and generalized seizures when it accumulates with repetitive dosing. Clients with sickle cell disease are particularly at risk for normeperidine-induced seizures.

Question38

A 5 year-old has been rushed to the emergency room several hours after acetaminophen poisoning. Which laboratory result should receive attention by the nurse?
A) Sedimentation rate
B) Profile 2
C) Bilirubin
D) Neutrophils

Review Information: The correct answer is C: Bilirubin
Bilirubin, along with liver enzymes ALT and AST, may rise in the second stage (1-3 days) after a significant overdose, indicating cellular necrosis and liver dysfunction. A prolonged prothrombin time may also be found.

Question39

An elderly client is on an anticholinergic metered dose inhaler (MDI) for chronic obstructive pulmonary disease. The nurse would suggest a spacer to
A) enhance the administration of the medication
B) increase client compliance
C) improve aerosol delivery in clients who are not able to coordinate the MDI
D) prevent exacerbation of COPD

Review Information: The correct answer is C: improve aerosol delivery in clients who are not able to coordinate the MDI
Spacers improve the medication delivery in clients who are unable to coordinate the movements of administering a dose with an MDI.

Question40

The nurse is teaching a parent how to administer oral iron supplements to a 2 year-old child. Which of the following interventions should be included in the teaching?
A) Stop the medication if the stools become tarry green

B) Give the medicine with orange juice and through a straw
C) Add the medicine to a bottle of formula
D) Administer the iron with your child>s meals

Review Information: The correct answer is B: Give the medicine with orange juice and through a straw
Absorption of iron is facilitated in an environment rich in Vitamin C. Since liquid iron preparation will stain teeth, a straw is preferred.

0 comments

Labels: free nclex-rn sample review questions, nclex-rn practice test questions, nursing review

Free NCLEX-RN Sample Test Questions For Nursing Review (Pharmacology Set 1)

Question1

A client has an order for antibiotic therapy after hospital treatment of a staph infection. Which of the following should the nurse emphasize?
A) Scheduling follow-up blood cultures
B) Completing the full course of medications
C) Visiting the provider in a few weeks
D) Monitoring for signs of recurrent infection

Review Information: The correct answer is B: Completing the full course of medications
In order for antibiotic therapy to be effective in eradicating an infection, the client must compete the entire course of prescribed therapy. When findings subside, stopping the medication early may lead to recurrence or subsequent drug resistance.

Question2

A 72 year-old client is admitted for possible dehydration. The nurse knows that older adults are particularly at risk for dehydration because they have
A) an increased need for extravascular fluid
B) a decreased sensation of thirst
C) an increase in diaphoresis
D) higher metabolic demands

Review Information: The correct answer is B: a decreased sensation of thirst
The elderly have a reduction in thirst sensation causing them to consume less fluid. Other risk factors may include fear of incontinence, inability to drink fluids independently and lack of motivation.

Question3

A male client is admitted with a spinal cord injury at level C4. The client asks the nurse how the injury is going to affect his sexual function. The nurse would respond
A) «Normal sexual function is not possible.»
B) «Sexual functioning will not be impaired at all.»
C) «Erections will be possible.»
D) «Ejaculation will be normal.»

Review Information: The correct answer is C: «Erections will be possible.»
Because they are a reflex reaction, erections can be stimulated by stroking the genitalia.

Question4

An 82 year-old client complains of chronic constipation. To improve bowel function, the nurse should first suggest
A) Increasing fiber intake to 20-30 grams daily
B) Daily use of laxatives
C) Avoidance of binding foods such as cheese and chocolate
D) Monitoring a balance between activity and rest

Review Information: The correct answer is A: Increasing fiber intake to 20-30 grams daily
The incorporation of high fiber into the diet is an effective way to promote bowel elimination in the elderly.

Question5

A 4 year-old child is admitted with burns on his legs and lower abdomen. When assessing the child's hydration status, which of the following indicates a less than adequate fluid replacement?

A) Decreasing hematocrit and increasing urine volume
B) Rising hematocrit and decreasing urine volume
C) Falling hematocrit and decreasing urine volume
D) Stable hematocrit and increasing urine volume

Review Information: The correct answer is B: Rising hematocrit and decreasing urine volume
A rising hematocrit indicates a decreased total blood volume, a finding consistent with dehydration.

Question6

A client receiving chemotherapy has developed sores in his mouth. He asks the nurse why this happened. What is the nurse's best response?
A) «It is a sign that the medication is working.»
B) «You need to have better oral hygiene.»
C) «The cells in the mouth are sensitive to the chemotherapy.»
D) «This always happens with chemotherapy.»

Review Information: The correct answer is C: «The cells in the mouth are sensitive to the chemotherapy.»
The epithelial cells in the mouth are very sensitive to chemotherapy due to their high rate of cell turnover.

Question7

You are caring for a client with deep vein thrombosis who is on Heparin IV. The latest APTT is 50 seconds. If the laboratory normal range is 16-24 seconds, you would anticipate
A) maintaining the current heparin dose
B) increasing the heparin as it does not appear therapeutic.
C) giving protamine sulfate as an antidote.
D) repeating the blood test 1 hour after giving heparin.

Review Information: The correct answer is A: maintaining the current heparin dose
The range for a therapeutic APTT is 1.5-2 times the control. Therefore the client is receiving a therapeutic dose of Heparin.

Question8

A client is admitted with a diagnosis of nodal bigeminy. The nurse knows that the atrioventricular (AV) node has an intrinsic rate of
A) 60-100 beats/minute
B) 10-30 beats/minute
C) 40-70 beats/minute
D) 20-50 beats/minute

Review Information: The correct answer is C: 40-70 beats/minute
The intrinsic rate of the AV node is within the range of 40-70 beats per minute.

Question9

A client is to receive 3 doses of potassium chloride 10 mEq in 100cc normal saline to infuse over 30 minutes each. Which of the following is a priority assessment to perform before giving this medication?
A) Oral fluid intake
B) Bowel sounds
C) Grip strength
D) Urine output

Review Information: The correct answer is D: Urine output
Potassium chloride should only be administered after adequate urine output (>20cc/hour for 2 consecutive hours) has been established. Impaired ability to excrete potassium via the kidneys can result in hyperkalemia.

Question10

The unlicensed assistive personnel (UAP) reports to the nurse that a client with cirrhosis who had a paracentesis yesterday has become more lethargic and has musty smelling breath. A critical assessment for increasing encephalopathy is
A) monitor the client>s clotting status
B) assess upper abdomen for bruits
C) assess for flap-like tremors of the hands
D) measure abdominal girth changes

Review Information: The correct answer is C: assess for flap-like tremors of the hands
A client with cirrhosis of the liver who develops subtle changes in mental status and has a musty odor to the breath is at risk for developing more advanced signs of encephalopathy.

Question11
A client is scheduled for an intravenous pyelogram (IVP). After the contrast material is injected, which of the following client reactions should be reported immediately?
A) Feeling warm
B) Face flushing
C) Salty taste
D) Hives

Review Information: The correct answer is D: Hives
This is a sign of anaphylaxis and should be reported immediately. The other reactions are considered normal and the client should be informed that they may occur.
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Question12
A client is prescribed an inhaler. How should the nurse instruct the client to breathe in the medication?
A) As quickly as possible
B) As slowly as possible
C) Deeply for 3-4 seconds
D) Until hearing whistling by the spacer

Review Information: The correct answer is C: Deeply for 3-4 seconds
The client should be instructed to breath in the medication for 3-4 seconds in order to receive the correct dosage of medication.

Question13
The nurse is caring for clients over the age of 70. The nurse knows that due to age-related changes, the elderly clients tolerate diets that are
A) high protein
B) high carbohydrates
C) low fat
D) high calories

Review Information: The correct answer is C: low fat
Due to age related changes, the diet of the elderly should include a lower quantity and higher quality of food. Fewer carbohydrates and fats are required in their diets.

Question14
A woman with a 28 week pregnancy is on the way to the emergency department by ambulance with a tentative diagnosis of abruptio placenta. Which should the nurse do first when the woman arrives?
A) administer oxygen by mask at 100%
B) start a second IV with an 18 gauge cannula
C) check fetal heart rate every 15 minutes
D) insert urethral catheter with hourly urine outputs

Review Information: The correct answer is A: administer oxygen by mask at 100%
Administering oxygen in this situation would increase the circulating oxygen in the mother's circulation to the fetus's circulation. This action will minimize complications.

Question15
A client in respiratory distress is admitted with arterial blood gas results of: PH 7.30; PO2 58, PCO2 34; and HCO3 19. The nurse determines that the client is in
A) metabolic acidosis
B) metabolic alkalosis
C) respiratory acidosis
D) respiratory alkalosis

Review Information: The correct answer is A: metabolic acidosis
These lab values indicate metabolic acidosis: the PH is low, PCO2 is normal, and bicarbonate level is low.

Question16

A client is diagnosed with gastroesophageal reflux disease (GERD). The nurse>s instruction to the client regarding diet should be to
A) avoid all raw fruits and vegetables
B) increase intake of milk products
C) decrease intake of fatty foods
D) focus on 3 average size meals a day

Review Information: The correct answer is C: decrease intake of fatty foods
GERD may be aggravated by a fatty diet. A diet low in fat would decrease the symptoms of GERD. Other agents which should also be decreased or avoided are: cigarette smoking, caffeine, alcohol, chocolate, and meperidine (Demerol).

Question17

After surgery, a client with a nasogastric tube complains of nausea. What action would the nurse take?
A) Call the health care provider
B) Administer an antiemetic
C) Put the bed in Fowler's position
D) Check the patency of the tube

Review Information: The correct answer is D: Check the patency of the tube
An indication that the nasogastric tube is obstructed is a client's complaint of nausea. Nasogastric tubes may become obstructed with mucus or sediment.

Question18

A client with testicular cancer has had an orchiectomy. Prior to discharge the client expresses his fears related to his prognosis. Which principle should the nurse base the response on?
A) Testicular cancer has a cure rate of 90% with early diagnosis
B) Testicular cancer has a cure rate of 50% with early diagnosis
C) Intensive chemotherapy is the treatment of choice
D) Testicular cancer is usually fatal

Review Information: The correct answer is A: Testicular cancer has a cure rate of 90% with early diagnosis
With aggressive treatment and early detection/ diagnosis the cure rate is 90%.

Question19

A client newly diagnosed with Type I Diabetes Mellitus asks the purpose of the test measuring glycosylated hemoglobin. The nurse should explain that the purpose of this test is to determine:
A) The presence of anemia often associated with Diabetes
B) The oxygen carrying capacity of the client>s red cells
C) The average blood glucose for the past 2-3 months
D) The client>s risk for cardiac complications

Review Information: The correct answer is C: The average blood glucose for the past 2-3 months
By testing the portion of the hemoglobin that absorbs glucose, it is possible to determine the average blood glucose over the life span of the red cell, 120 days.

Question20

A client is admitted for a possible pacemaker insertion. What is the intrinsic rate of the heart>s own pacemaker?
A) 30-50 beats/minute
B) 60-100 beats/minute
C) 20-60 beats/minute
D) 90-100 beats/minute

Review Information: The correct answer is B: 60-100 beats/minute
This is the intrinsic rate of the SA node.

Question21

The nurse discusses nutrition with a pregnant woman who is iron deficient and follows a vegetarian diet. The selection of which foods indicates the woman has learned sources of iron?
A) Cereal and dried fruits
B) Whole grains and yellow vegetables
C) Leafy green vegetables and oranges

D) Fish and dairy products

Review Information: The correct answer is A: Cereal and dried fruits
Both of these foods would be a good source of iron.

Question22

Prior to administering Alteplase (TPA) to a client admitted for a cerebral vascular accident (CVA), it is critical that the nurse assess:
A) Neuro signs
B) Mental status
C) Blood pressure
D) PT/PTT

Review Information: The correct answer is D: PT/PTT
TPA is a potent thrombolytic enzyme. Because bleeding is the most common side effect, it is most essential to evaluate clotting studies including PT, PTT, APTT, platelets, and hematocrit before beginning therapy.

Question23

The nurse enters the room of a client diagnosed with COPD. The client's skin is pink, and respirations are 8 per minute. The client's oxygen is running at 6 liters per minute. What should be the nurse's first action?
A) Call the health care provider
B) Put the client in Fowler's position
C) Lower the oxygen rate
D) Take the vital signs

Review Information: The correct answer is C: Lower the oxygen rate
In client's diagnosed with COPD, the drive to breathe is hypoxia. If oxygen is delivered at too high of a concentration, this drive will be eliminated and the client's depth and rate of respirations will decrease. Therefore the first action should be to lower the oxygen rate.

Question24

The client with goiter is treated with potassium iodide preoperatively. What should the nurse recognize as the purpose of this medication?
A) Reduce vascularity of the thyroid
B) Correct chronic hyperthyroidism
C) Destroy the thyroid gland function
D) Balance enzymes and electrolytes

Review Information: The correct answer is A: Reduce vascularity of the thyroid
Potassium iodide solution, or Lugol>>s solution may be used preoperatively to reduce the size and vascularity of the thyroid gland.

Question25

One hour before the first treatment is scheduled, the client becomes anxious and states he does not wish to go through with electroconvulsive therapy. Which response by the nurse is most appropriate?
A) «I'll go with you and will be there with you during the treatment.»
B) «You'll be asleep and won't remember anything.»
C) «You have the right to change your mind. You seem anxious. Can we talk about it?»
D) «I'll call the health care provider to notify them of your decision.»

Review Information: The correct answer is C: «You have the right to change your mind. You seem anxious. Can we talk about it?»
This response indicates acknowledgment of the client's rights and the opportunity for the client to clarify and ventilate concerns. After this, if the client continues to refuse, the provider should be notified.

Question26

A nurse who has been named in a lawsuit can use which of these factors for the best protection in a court of law?
A) Clinical specialty certification in the associated area of practice
B) Documentation on the specific client record with a focus on the nursing process
C) Yearly evaluations and proficiency reports prepared by nurse's manager
D) Verification of provider>s orders for the plan

of care with identification of outcomes

Review Information: The correct answer is B: Documentation on the specific client record with a focus on the nursing process
Documentation is the key to protect nurses when a lawsuit is filed. The thorough documentation should include all steps of the nursing process – assessment, analysis, plan, intervention, evaluation. In addition, it should include pertinent data such as times, dosages and sites of actions, assessment data, the nurse's response to a change in the client's condition, specific actions taken, if and when the notification occurred to the provider or other health care team members, and what was prescribed along with the client's outcomes.

Question27

The nurse is caring for clients over the age of 70. The nurse is aware that when giving medications to older clients, it is best to
A) start low, go slow
B) avoid stopping a medication entirely
C) avoid drugs with side effects that impact cognition
D) review the drug regimen yearly

Review Information: The correct answer is A: start low, go slow
Due to physiological changes in the elderly, as well as conditions such as dehydration, hyperthermia, immobility and liver disease, the effective metabolism of drugs may decrease. As a result, drugs can accumulate to toxic levels and cause serious adverse reactions.

Question28

You are caring for a hypertensive client with a new order for captopril (Capoten). Which information should the nurse include in client teaching?
A) Avoid green leafy vegetables
B) Restrict fluids to 1000cc/day
C) Avoid the use of salt substitutes
D) Take the medication with meals

Review Information: The correct answer is C: Avoid the use of salt substitutes
Captopril can cause an accumulation of potassium or hyperkalemia. Clients should avoid the use of salt substitutes, which are generally potassium-based.

Question29

A client has bilateral knee pain from osteoarthritis. In addition to taking the prescribed non-steroidal anti-inflammatory drug (NSAID), the nurse should instruct the client to
A) start a regular exercise program
B) rest the knees as much as possible to decrease inflammation
C) avoid foods high in citric acid
D) keep the legs elevated when sitting

Review Information: The correct answer is A: start a regular exercise program
A regular exercise program is beneficial in treating osteoarthritis. It can restore self-esteem and improve physical functioning.

Question30

An arterial blood gases test (ABG) is ordered for a confused client. The respiratory therapist draws the blood and then asks the nurse to apply pressure to the area so the therapist can take the specimen to the lab. How long should the nurse apply pressure to the area?
A) 3 minutes
B) 5 minutes
C) 8 minutes
D) 10 minutes

Review Information: The correct answer is B: 5 minutes
It is necessary to apply pressure to the area for 5 minutes to prevent bleeding and the formation of hematomas.

Question31

Which of these clients should the charge nurse assign to the registered nurse (RN)?
A) A 56 year-old with atrial fibrillation receiving digoxin
B) A 60 year-old client with COPD on oxygen at 2 L/min

C) A 24 year-old post-op client with type 1 diabetes in the process of discharge
D) An 80 year-old client recovering 24 hours post right hip replacement

Review Information: The correct answer is C: A 24 year-old post-op client with type 1 diabetes in the process of discharge
Discharge teaching must be done by an RN. Practical nurses (PNs) or unlicensed assistive personnel (UAPs) can reinforce education after the RN does the initial teaching.

Question32

A hypertensive client is started on atenolol (Tenormin). The nurse instructs the client to immediately report which of these findings?
A) Rapid breathing
B) Slow, bounding pulse
C) Jaundiced sclera
D) Weight gain

Review Information: The correct answer is B: Slow, bounding pulse
Atenolol (Tenormin) is a beta-blocker that can cause side effects including bradycardia and hypotension.

Question33

An 80 year-old client is admitted with a diagnosis of malnutrition. In addition to physical assessments, which of the following lab tests should be closely monitored?
A) Urine protein
B) Urine creatinine
C) Serum calcium
D) Serum albumin

Review Information: The correct answer is D: Serum albumin
Serum albumin is a valuable indicator of protein deficiency and, later, nutritional status in adults. A normal reading for an elder's serum albumin is between 3.0-5.0 g/dl.

Question34

Upon admission to an intensive care unit, a client diagnosed with an acute myocardial infarction is ordered oxygen. The nurse knows that the major reason that oxygen is administered in this situation is to
A) saturate the red blood cells
B) relieve dyspnea
C) decrease cyanosis
D) increase oxygen level in the myocardium

Review Information: The correct answer is D: increase oxygen level in the myocardium
Anoxia of the myocardium occurs in myocardial infarction. Oxygen administration will help relieve dyspnea and cyanosis associated with the condition but the major purpose is to increase the oxygen concentration in the damaged myocardial tissue.
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Question35

The nurse is teaching a client with chronic renal failure (CRF) about medications. The client questions the purpose of aluminum hydroxide (Amphojel) in her medication regimen. What is the best explanation for the nurse to give the client about the therapeutic effects of this medication?
A) It decreases serum phosphate
B) It will reduce serum calcium
C) Amphojel increases urine output
D) The drug is taken to control gastric acid secretion

Review Information: The correct answer is A: It decreases serum phosphate
Aluminum binds phosphates that tend to accumulate in the patient with chronic renal failure due to decreased filtration capacity of the kidney. Antacids such as Amphojel are commonly used to accomplish this.

Question36

A 66 year-old client is admitted for mitral valve replacement surgery. The client has a history of mitral valve regurgitation and mitral stenosis since her teenage years. During the admission assessment, the nurse should ask the client if as a child she had

A) measles
B) rheumatic fever
C) hay fever
D) encephalitis

Review Information: The correct answer is B: rheumatic fever
Clients that present with mitral stenosis often have a history of rheumatic fever or bacterial endocarditis.

Question37

During nursing rounds which of these assessments would require immediate corrective action and further instruction to the practical nurse (PN) about proper care?
A) The weights of the skin traction of a client are hanging about 2 inches from the floor
B) A client with a hip prosthesis 1 day post operatively is lying in bed with internal rotation and adduction of the affected leg
C) The nurse observes that the PN moves the extremity of a client with an external fixation device by picking up the frame
D) A client with skeletal traction states «The other nurse said that the clear, yellow and crusty drainage around the pin site is a good sign»

Review Information: The correct answer is B: A client with a hip prosthesis 1 day post operatively is lying in bed with internal rotation and adduction of the affected leg
This position should be prevented in order to prevent dislodgment of the hip prosthesis, especially in the first 48 to 72 hours post-op. The other assessments are not of concern.

Question38

A client diagnosed with gouty arthritis is admitted with severe pain and edema in the right foot. When the nurse develops a plan of care, which intervention should be included?
A) high protein diet
B) salicylates
C) hot compresses to affected joints
D) intake of at least 3000cc/day

Review Information: The correct answer is D: intake of at least 3000cc/day
Fluid intake should be increased to prevent precipitation of urate in the kidneys.

Question39

A 55 year-old woman is taking Prednisone and aspirin (ASA) as part of her treatment for rheumatoid arthritis. Which of the following would be an appropriate intervention for the nurse?
A) Assess the pulse rate q 4 hours
B) Monitor her level of consciousness q shift
C) Test her stools for occult blood
D) Discuss fiber in the diet to prevent constipation

Review Information: The correct answer is C: Test her stools for occult blood
Both Prednisone and ASA can lead to GI bleeding, therefore monitoring for occult blood would be appropriate.

Question40

A client with testicular cancer is scheduled for a right orchiectomy. The nurse knows that an orchiectomy is the
A) surgical removal of the entire scrotum
B) surgical removal of a testicle
C) dissection of related lymph nodes
D) partial surgical removal of the penis

Review Information: The correct answer is B: surgical removal of a testicle
The affected testicle is surgically removed along with its tunica and spermatic cord.

0 comments

Labels: free nclex-rn sample review questions, nclex-rn practice test questions, nursing review

Free NCLEX-RN Sample Test Questions For Nursing Review (Part 5)

Question1

A client complains of some discomfort after a below the knee amputation. Which action by the nurse is most appropriate initially?

A) Conduct guided imagery or distraction
B) Ensure that the stump is elevated the first day post-op
C) Wrap the stump snugly in an elastic bandage
D) Administer opioid narcotics as ordered

Review Information: The correct answer is B: Ensure that the stump is elevated the first day post-op
This priority intervention prevents pressure caused by pooling of blood, thus minimizing the pain. Without this measure, a firm elastic bandage, opioid narcotics, or guided imagery will have little effect. Opioid narcotics are given for severe pain.

Question2

A 78 year-old client with pneumonia has a productive cough, but is confused. Safety protective devices (restraints) have been ordered for this client. How can the nurse prevent aspiration?
A) Suction the client frequently while restrained
B) Secure all 4 restraints to 1 side of bed
C) Obtain a sitter for the client while restrained
D) Request an order for a cough suppressant

Review Information: The correct answer is C: Obtain a sitter for the client while restrained
The plan to use safety devices (restraints) should be rethought. Restraints are used to protect the client from harm caused by removing tubes or getting out of bed. In the event that this restricted movement could cause more harm, such as aspiration, then a sitter should be requested. These are to be provided by the facility in the event the family cannot do so. This client needs to cough and be watched rather than restricted. Suctioning will not prevent aspiration in this situation. Cough suppressants should be avoided for this client.

Question3

A couple trying to conceive asks the nurse when ovulation occurs. The woman reports a regular 32 day cycle. Which response by the nurse is correct?
A) Days 7-10
B) Days 10-13
C) Days 14-16
D) Days 17-19

Review Information: The correct answer is D: Days 17-19
Ovulation occurs 14 days prior to menses. Considering that the woman>>s cycle is 32 days, subtracting 14 from 32 suggests ovulation is at about the 18th day.

Question4

A newborn is having difficulty maintaining a temperature above 98 degrees Fahrenheit and has been placed in an incubator. Which action is a nursing priority?
A) Protect the eyes of the neonate from the heat lamp
B) Monitor the neonate's temperature
C) Warm all medications and liquids before giving
D) Avoid touching the neonate with cold hands

Review Information: The correct answer is B: Monitor the neonate's temperature
When using a warming device the neonate's temperature should be continuously monitored for undesired elevations. The use of heat lamps is not safe as there is no way to regulate their temperature. Warming medications and fluids is not indicated. While touching with cold hands can startle the infant it does not pose a safety risk.

Question5

Which oxygen delivery system would the nurse apply that would provide the highest concentrations of oxygen to the client?
A) Venturi mask
B) Partial rebreather mask
C) Non-rebreather mask
D) Simple face mask

Review Information: The correct answer is C: Non-rebreather mask
The non-rebreather mask has a one-way valve that prevents exhales air from entering the reservoir bag and one or more valves covering the air holes on the face mask itself to prevent inhalation of room air but to allow exhalation of air. When a tight seal is achieved around the mask up to 100% of the oxygen is available.

Question6

At a senior citizens meeting a nurse talks with a client who has Type 1 diabetes mellitus. Which statement by the client during the conversation is most predictive of a potential for impaired skin integrity?
A) «I give my insulin to myself in my thighs.»
B) «Sometimes when I put my shoes on I don>t know where my toes are.»
C) «Here are my up and down glucose readings that I wrote on my calendar.»
D) «If I bathe more than once a week my skin feels too dry.»

Review Information: The correct answer is B: «Sometimes when I put my shoes on I don>>t know where my toes are.»
Peripheral neuropathy can lead to lack of sensation in the lower extremities. Clients who do not feel pressure and/or pain are at high risk for skin impairment.

Question7

A client returns from surgery after an open reduction of a femur fracture. There is a small bloodstain on the cast. Four hours later, the nurse observes that the stain has doubled in size. What is the best action for the nurse to take?
A) Call the health care provider
B) Access the site by cutting a window in the cast
C) Simply record the findings in the nurse>s notes only
D) Outline the spot with a pencil and note the time and date on the cast

Review Information: The correct answer is D: Outline the spot with a pencil and note the time and date on the cast
This is a good way to assess the amount of bleeding over a period of time. The bleeding does not appear to be excessive and some bleeding is expected with this type of surgery. The bleeding should also be documented in the nurse's notes.

Question8

The nurse is caring for a 1 year-old child who has 6 teeth. What is the best way for the nurse to give mouth care to this child?
A) Using a moist soft brush or cloth to clean teeth and gums
B) Swabbing teeth and gums with flavored mouthwash
C) Offering a bottle of water for the child to drink
D) Brushing with toothpaste and flossing each tooth

Review Information: The correct answer is A: Using a moist soft brush or cloth to clean teeth and gums
The nurse should use a soft cloth or soft brush to do mouth care so that the child can adjust to the routine of cleaning the mouth and teeth.

Question9

In addition to standard precautions, a nurse should implement contact precautions for which client?
A) 60 year-old with herpes simplex
B) 6 year-old with mononucleosis
C) 45 year-old with pneumonia
D) 3 year-old with scarlet fever

Review Information: The correct answer is A: 60 year-old with herpes simplex
Clients who have herpes simplex infections must have contact precautions in addition to standard precautions because of the associated, potentially weeping, skin lesions. Contact precautions are

used for clients who are infected by microorganisms that are transmitted by direct contact with the client, including hand or skin-to-skin contact.

Question10

Which of the following situations is most likely to produce sepsis in the neonate?
A) Maternal diabetes
B) Prolonged rupture of membranes
C) Cesarean delivery
D) Precipitous vaginal birth

Review Information: The correct answer is B: Prolonged rupture of membranes
Premature rupture of the membranes (PROM) is a leading cause of newborn sepsis. After 12-24 hours of leaking fluid, measures are taken to reduce the risk to mother and the fetus/newborn.

Question11

The nurse is teaching a parent about side effects of routine immunizations. Which of the following must be reported immediately?
A) Irritability
B) Slight edema at site
C) Local tenderness
D) Seizure activity

Review Information: The correct answer is D: Seizure activity
Other reactions that should be reported include crying for >3 hours, temperature over 104.8 degrees Fahrenheit following DPT immunization, and tender, swollen, reddened areas.

Question12

The nurse is at the community center speaking with retired people about glaucoma. Which comment by one of the retirees would the nurse support to reinforce correct information?
A) «I usually avoid driving at night since lights sometimes seem to make things blur.»
B) «I take half of the usual dose for my sinuses to maintain my blood pressure.»
C) «I have to sit at the side of the pool with the grandchildren since I can>t swim with this eye problem.»
D) «I take extra fiber and drink lots of water to avoid getting constipated.»

Review Information: The correct answer is D: «I take extra fiber and drink lots of water to avoid getting constipated.»
Any activity that involves straining should be avoided in clients with glaucoma. Such activities would increase intraocular pressure.

Question13

A newborn has hyperbilirubinemia and is undergoing phototherapy with a fiberoptic blanket. Which safety measure is most important during this process?
A) Regulate the neonate's temperature using a radiant heater
B) Withhold feedings while under the phototherapy
C) Provide water feedings at least every 2 hours
D) Protect the eyes of neonate from the phototherapy lights

Review Information: The correct answer is C: Provide water feedings at least every 2 hours
Protecting the eyes of the neonates is very important to prevent damage when under the ultraviolet lights, but since the blanket is used, extra protection of the eyes is unnecessary. It is recommended that the neonate remain under the lights for extended periods. The neonate's skin is exposed to the light and the temperature is monitored, but a heater may not be necessary. There is no reason to withhold feedings. Frequent water or feedings are given to help with the excretion of the bilirubin in the stool.
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Question14

A nurse is performing the routine daily cleaning of a tracheostomy. During the procedure, the client coughs and displaces the tracheostomy tube. This negative outcome could have avoided by

A) placing an obturator at the client's bedside
B) having another nurse assist with the procedure
C) fastening clean tracheostomy ties before removing old ties
D) placing the client in a flat, supine position

Review Information: The correct answer is C: fastening clean tracheostomy ties before removing old ties
Fastening clean tracheostomy ties before removing old ones will ensure that the tracheostomy is secured during the entire cleaning procedure. The obturator is useful to keep the airway open only after the tracheostomy outer tube is coughed out. A second nurse is not needed. Changing the position may not prevent a dislodged tracheostomy.

Question15

A 4 year-old hospitalized child begins to have a seizure while playing with hard plastic toys in the hallway. Of the following nursing actions, which one should the nurse do first?
A) Place the child in the nearest bed
B) Administer IV medication to slow down the seizure
C) Place a padded tongue blade in the child>s mouth
D) Remove the child>s toys from the immediate area

Review Information: The correct answer is D: Remove the child>>s toys from the immediate area
Nursing care for a child having a seizure includes, maintaining airway patency, ensuring safety, administering medications, and providing emotional support. Since the seizure has already started, nothing should be forced into the child>>s mouth and the child should not be moved. Of the choices given, the first priority would be to provide a safe environment.

Question16

The nurse is teaching home care to the parents of a child with acute spasmodic croup. The most important aspects of this care is/are
A) sedation as needed to prevent exhaustion
B) antibiotic therapy for 10 to 14 days
C) humidified air and increased oral fluids
D) antihistamines to decrease allergic response

Review Information: The correct answer is C: humidified air and increased oral fluids
The most important aspects of home care for a child with acute spasmodic croup are humidified air and increased oral fluids. Moisture soothes inflamed membranes. Adequate systemic hydration aids is mucociliary clearance and keeps secretions thin, white, watery, and easily removed with minimal coughing.

Question17

The nurse is assigned to care for a client who has a leaking intracranial aneurysm. To minimize the risk of rebleeding, the nurse should plan to
A) restrict visitors to immediate family
B) avoid arousal of the client except for family visits
C) keep client>s hips flexed at no less than 90 degrees
D) apply a warming blanket for temperatures of 98 degrees Fahrenheit or less

Review Information: The correct answer is A: restrict visitors to immediate family
Maintaining a quiet environment will assist in minimizing cerebral rebleeding. When family visit, the client should not be disturbed. If the client is awake, topics of a general nature are better choices for discussion than topics that result in emotional or physiological stimulation.

Question18

A client who is 12 hour post-op becomes confused and says: "Giant sharks are swimming across the ceiling." Which assessment is necessary to adequately identify the source of this client>s behavior?

A) Cardiac rhythm strip
B) Pupillary response
C) Pulse oximetry
D) Peripheral glucose stick

Review Information: The correct answer is C: Pulse oximetry
A sudden change in mental status in any post-op client should trigger a nursing intervention directed toward respiratory evaluation. Pulse oximetry would be the initial assessment. If available, arterial blood gases would be better. Acute respiratory failure is the sudden inability of the respiratory system to maintain adequate gas exchange which may result in hypercapnia and/or hypoxemia. Clinical findings of hypoxemia include these finding which are listed in order of initial to later findings: restlessness, irritability, agitation, dyspnea, disorientation, confusion, delirium, hallucinations, and loss of consciousness. While there may be other factors influencing the client>>s behavior, the first nursing action should be directed toward maintaining oxygenation. Once respiratory or oxygenation issues are ruled out then significant changes in glucose would be evaluated.

Question19
A newborn delivered at home without a birth attendant is admitted to the hospital for observation. The initial temperature is 95 degrees Fahrenheit (35 degrees Celsius) axillary. The nurse recognizes that cold stress may lead to what complication?
A) Lowered BMR
B) Reduced PaO2
C) Lethargy
D) Metabolic alkalosis

Review Information: The correct answer is B: Reduced PaO2
Cold stress causes increased risk for respiratory distress. The baby delivered in such circumstances needs careful monitoring. In this situation, the newborn must be warmed immediately to increase its temperature to at least 97 degrees Fahrenheit (36 degrees Celsius).

Question20
Which contraindication should the nurse assess for prior to giving a child immunizations?
A) Mild cold symptoms
B) Chronic asthma
C) Depressed immune system
D) Allergy to eggs

Review Information: The correct answer is C: Depressed immune system
Children who have a depressed immune system related to HIV or chemotherapy should not be given routine immunizations.

Question21
The nurse is caring for a client with a myocardial infarction. Which finding requires the nurse>s immediate action?
A) Periorbital edema
B) Dizzy spells
C) Lethargy
D) Shortness of breath

Review Information: The correct answer is B: Dizzy spells
Cardiac dysrhythmias may cause a transient drop in cardiac output and decreased blood flow to the brain. Near syncope refers to lightheartedness, dizziness, temporary confusion. Such «spells» may indicate runs of ventricular tachycardia or periods of asystole and should be reported immediately.

Question22
Decentralized scheduling is used on a nursing unit. A chief advantage of this management strategy is that it:
A) considers client and staff needs
B) conserves time spent on planning
C) frees the nurse manager to handle other priorities
D) allows requests for special privileges

Review Information: The correct answer is A: considers client and staff needs
Decentralized staffing takes into consideration specific client needs and staff interests and abilities.

Question23
Included in teaching the client with tuberculosis taking isoniazid (INH) about follow-up home care, the nurse should emphasize that a laboratory appointment for which of the following lab tests is critical?
A) Liver function
B) Kidney function
C) Blood sugar
D) Cardiac enzymes

Review Information: The correct answer is A: Liver function
INH can cause hepatocellular injury and hepatitis. This side effect is age-related and can be detected with regular assessment of liver enzymes, which are released into the blood from damaged liver cells.

Question24
A woman in her third trimester complains of severe heartburn. What is appropriate teaching by the nurse to help the woman alleviate these symptoms?
A) Drink small amounts of liquids frequently
B) Eat the evening meal just before retiring
C) Take sodium bicarbonate after each meal
D) Sleep with head propped on several pillows

Review Information: The correct answer is D: Sleep with head propped on several pillows
Heartburn is a burning sensation caused by regurgitation of gastric contents. It is best relieved by sleeping position, eating small meals, and not eating before bedtime.

Question25
A 16 year-old boy is admitted for Ewing>s sarcoma of the tibia. In discussing his care with the parents, the nurse understands that the initial treatment most often includes
A) amputation just above the tumor
B) surgical excision of the mass
C) bone marrow graft in the affected leg
D) radiation and chemotherapy

Review Information: The correct answer is D: radiation and chemotherapy
The initial treatment of choice for Ewing>>s sarcoma is a combination of radiation and chemotherapy.

Question26
A new nurse manager is responsible for interviewing applicants for a staff nurse position. Which interview strategy would be the best approach?
A) Vary the interview style for each candidate to learn different techniques
B) Use simple questions requiring «yes» and «no» answers to gain definitive information
C) Obtain an interview guide from human resources for consistency in interviewing each candidate
D) Ask personal information of each applicant to assure he/she can meet job demands

Review Information: The correct answer is C: Obtain an interview guide from human resources for consistency in interviewing each candidate
An interview guide used for each candidate enables the nurse manager to be more objective in the decision making. The nurse should use resources available in the agency before attempts to develop one from scratch. Certain personal questions are prohibited, and HR can identify these for novice managers.

Question27
What is the best way that parents of pre-schoolers can begin teaching their child about injury

prevention?
A) Set good examples themselves
B) Protect their child from outside influences
C) Make sure their child understands all the safety rules
D) Discuss the consequences of not wearing protective devices

Review Information: The correct answer is A: Set good examples themselves
The preschool years are the time for parents to begin emphasizing safety principles as well as providing protection. Setting a good example themselves is crucial because of the imitative behaviors of pre-schoolers; they are quick to notice discrepancies between what they see and what they are told.

Question28
A nurse assessing the newborn of a mother with diabetes understands that hypoglycemia is related to what pathophysiological process?
A) Disruption of fetal glucose supply
B) Pancreatic insufficiency
C) Maternal insulin dependency
D) Reduced glycogen reserves

Review Information: The correct answer is A: Disruption of fetal glucose supply
After delivery, the high glucose levels which crossed the placenta to the fetus are suddenly stopped. The newborn continues to secrete insulin in anticipation of glucose. When oral feedings begin, the newborn will adjust insulin production within a day or two.

Question29
The nurse is caring for a client with extracellular fluid volume deficit. Which of the following assessments would the nurse anticipate finding?
A) bounding pulse
B) rapid respirations
C) oliguria
D) neck veins are distended

Review Information: The correct answer is C: oliguria
Kidneys maintain fluid volume through adjustments in urine volume.

Question30
A 70 year-old woman is evaluated in the emergency department for a wrist fracture of unknown causes. During the process of taking client history, which of these items should the nurse identify as related to the client's greatest risk factors for osteoporosis?
A) History of menopause at age 50
B) Taking high doses of steroids for arthritis for many years
C) Maintaining an inactive lifestyle for the past 10 years
D) Drinking 2 glasses of red wine each day for the past 30 years

Review Information: The correct answer is B: Taking high doses of steroids for arthritis for many years
The use of steroids, especially at high doses over time, increases the risk for osteoporosis. The other options also predispose to osteoporosis, as do low bone mass, poor calcium absorption and moderate to high alcohol ingestion. Long-term steroid treatment is the most significant risk factor, however.

Question31
The nurse is caring for a 2 year-old who is being treated with chelation therapy, calcium disodium edetate, for lead poisoning. The nurse should be alert for which of the following side effects?
A) Neurotoxicity
B) Hepatomegaly
C) Nephrotoxicity
D) Ototoxicity

Review Information: The correct answer is C: Nephrotoxicity
Nephrotoxicity is a common side effect of calcium disodium edetate, in addition to lead poisoning in general.

Question32
The parents of a toddler ask the nurse how long

their child will have to sit in a car seat while in the automobile. What is the nurse's best response to the parents?

A) «Your child must use a care seat until he weighs at least 40 pounds.»

B) «The child must be 5 years of age to use a regular seat belt.»

C) «Your child must reach a height of 50 inches to sit in a seat belt.»

D) «The child can use a regular seat belt when he can sit still.»

Review Information: The correct answer is A: «Your child must use a care seat until he weighs at least 40 pounds.»

Children should use car seats until they weigh 40 pounds.

Question33

A client asks the nurse to explain the basic ideas of homeopathic medicine. The response that best explains this approach is that such remedies

A) destroy organisms causing disease

B) maintain fluid balance

C) boost the immune system

D) increase bodily energy

Review Information: The correct answer is C: boost the immune system

The practitioner treats with minute doses of plant, mineral or animal substances which provide a gentle stimulus to the body>>s own defenses.

Question34

A client with a fractured femur has been in Russell's traction for 24 hours. Which nursing action is associated with this therapy?

A) Check the skin on the sacrum for breakdown

B) Inspect the pin site for signs of infection

C) Auscultate the lungs for atelectasis

D) Perform a neurovascular check for circulation

Review Information: The correct answer is D: Perform a neurovascular check for circulation

While each of these is an important assessment, the neurovascular integrity check is most associated with this type of traction. Russell's traction is Buck's traction with a sling under the knee.

Question35

When suctioning a client>s tracheostomy, the nurse should instill saline in order to

A) decrease the client>s discomfort

B) reduce viscosity of secretions

C) prevent client aspiration

D) remove a mucus plug

Review Information: The correct answer is D: remove a mucus plug

While no longer recommended for routine suctioning, saline may thin and loosen viscous secretions that are very difficult to move, perhaps making them easier to suction.

Question36

The nurse is performing a gestational age assessment on a newborn delivered 2 hours ago. When coming to a conclusion using the Ballard scale, which of these factors may affect the score?

A) Birth weight

B) Racial differences

C) Fetal distress in labor

D) Birth trauma

Review Information: The correct answer is C: Fetal distress in labor

The effects of earlier distress may alter the findings of reflex responses as measured on the Ballard tool. Other physical characteristics that estimate gestational age, such as amount of lanugo, sole creases and ear cartilage are unaffected by the other factors.

Question37

A nurse is caring for a client who had a closed reduction of a fractured right wrist followed by the application of a fiberglass cast 12 hours ago. Which finding requires the nurse's immediate at-

tention?

A) Capillary refill of fingers on right hand is 3 seconds
B) Skin warm to touch and normally colored
C) Client reports prickling sensation in the right hand
D) Slight swelling of fingers of right hand

Review Information: The correct answer is C: Client reports prickling sensation in the right hand
A prickling sensation is an indication of compartment syndrome and requires immediate action by the nurse. The other findings are normal for a client in this situation.

Question38

A client is admitted with the diagnosis of pulmonary embolism. While taking a history, the client tells the nurse he was admitted for the same thing twice before, the last time just 3 months ago. The nurse would anticipate the provider ordering
A) pulmonary embolectomy
B) vena caval interruption
C) increasing the Coumadin therapy to an INR of 3-4
D) thrombolytic therapy

Review Information: The correct answer is B: vena caval interruption
Clients with contraindications to Heparin, recurrent PE or those with complications related to the medical therapy may require vena caval interruption by the placement of a filter device in the inferior vena cava. A filter can be placed transvenously to trap clots before they travel to the pulmonary circulation.

Question39

Which client is at highest risk for developing a pressure ulcer?
A) 23 year-old in traction for fractured femur
B) 72 year-old with peripheral vascular disease, who is unable to walk without assistance
C) 75 year-old with left sided paresthesia who is incontinent of urine and stool
D) 30 year-old who is comatose following a ruptured aneurysm

Review Information: The correct answer is C: 75 year-old with left sided paresthesia who is incontinent of urine and stool
Risk factors for pressure ulcers include: immobility, absence of sensation, decreased LOC, poor nutrition and hydration, skin moisture, incontinence, increased age, decreased immune response. This client has the greatest number of risk factors.

Question40

The nurse is teaching the mother of a 5 month-old about nutrition for her baby. Which statement by the mother indicates the need for further teaching?
A) «I>m going to try feeding my baby some rice cereal.»
B) «When he wakes at night for a bottle, I feed him.»
C) «I dip his pacifier in honey so he>ll take it.»
D) «I keep formula in the refrigerator for 24 hours.»

Review Information: The correct answer is C: «I dip his pacifier in honey so he>>ll take it.»
Honey has been associated with infant botulism and should be avoided. Older children and adults have digestive enzymes that kill the botulism spores.

0 comments

Labels: free nclex-rn sample review questions, nclex-rn practice test questions, nursing review

Free NCLEX-RN Sample Test Questions For Nursing Review (Part 4)

Question1

The clinic nurse is counseling a substance-abusing post partum client on the risks of continued cocaine use. In order to provide continuity of care, which nursing diagnosis is a priority?
A) Social isolation
B) Ineffective coping
C) Altered parenting
D) Sexual dysfunction

Review Information: The correct answer is C:

Altered parenting
The cocaine abusing mother puts her newborn and other children at risk for neglect and abuse. Continuing to use drugs has the potential to impact parenting behaviors. Social service referrals are indicated.

Question2

The nurse is teaching about nonsteroidal anti-inflammatory drugs (NSAIDs) to a group of arthritic clients. To minimize the side effects, the nurse should emphasize which of the following actions?
A) Reporting joint stiffness in the morning
B) Taking the medication 1 hour before or 2 hours after meals
C) Using alcohol in moderation unless driving
D) Continuing to take aspirin for short term relief

Review Information: The correct answer is B: Taking the medication 1 hour before or 2 hours after meals
Taking the medication 1 hour before or 2 hours after meals will result in a more rapid effect.

Question3

The nurse is preparing to administer a tube feeding to a postoperative client. To accurately assess for a gastrostomy tube placement, the priority is to
A) auscultate the abdomen while instilling 10 cc of air into the tube
B) place the end of the tube in water to check for air bubbles
C) retract the tube several inches to check for resistance
D) measure the length of tubing from nose to epigastrium

Review Information: The correct answer is A: auscultate the abdomen while instilling 10 cc of air into the tube
If a swoosh of air is heard over the abdominal cavity while instilling air into the gastric tube, this indicates that it is accurately placed in the stomach. The feeding can begin after further assessing the client for bowel sounds.

Question4

While assessing the vital signs in children, the nurse should know that the apical heart rate is preferred until the radial pulse can be accurately assessed at about what age?
A) 1 year of age
B) 2 years of age
C) 3 years of age
D) 4 years of age

Review Information: The correct answer is B: 2 years of age
A child should be at least 2 years of age to use the radial pulse to assess heart rate.

Question5

A client is receiving Total Parenteral Nutrition (TPN) via a Hickman catheter. The catheter accidentally becomes dislodged from the site. Which action by the nurse should take priority?
A) Check that the catheter tip is intact
B) Apply a pressure dressing to the site
C) Monitor respiratory status
D) Assess for mental status changes

Question6

A pregnant client who is at 34 weeks gestation is diagnosed with a pulmonary embolism (PE). Which of these medications would the nurse anticipate the provider ordering?
A) Oral Coumadin therapy
B) Heparin 5000 units subcutaneously B.I.D.
C) Heparin infusion to maintain the PTT at 1.5-2.5 times the control value
D) Heparin by subcutaneous injection to maintain the PTT at 1.5 times the control value

Review Information: The correct answer is D: Heparin by subcutaneous injection to maintain the PTT at 1.5 times the control value
Several studies have been conducted in preg-

nant women where oral anticoagulation agents are contraindicated. Warfarin (Coumadin) is known to cross the placenta and is therefore reported to be teratogenic.

Question7

The nurse is caring for a client with Hodgkin>s disease who will be receiving radiation therapy. The nurse recognizes that, as a result of the radiation therapy, the client is most likely to experience

A) high fever
B) nausea
C) face and neck edema
D) night sweats

Review Information: The correct answer is B: nausea

Because the client with Hodgkin>>s disease is usually healthy when therapy begins, the nausea is especially troubling.

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Question8

A client is brought to the emergency room following a motor vehicle accident. When assessing the client one-half hour after admission, the nurse notes several physical changes. Which finding would require the nurse>s immediate attention?

A) increased restlessness
B) tachycardia
C) tracheal deviation
D) tachypnea

Review Information: The correct answer is C: tracheal deviation

The deviated trachea is a sign that a mediastinal shift has occurred. This is a medical emergency.

Question9

An 18 month-old child is on peritoneal dialysis in preparation for a renal transplant in the near future. When the nurse obtains the child>s health history, the mother indicates that the child has not had the first measles, mumps, rubella (MMR) immunization. The nurse understands that which of the following is true in regards to giving immunizations to this child?

A) Live vaccines are withheld in children with renal chronic illness
B) The MMR vaccine should be given now, prior to the transplant
C) An inactivated form of the vaccine can be given at any time
D) The risk of vaccine side effects precludes giving the vaccine

Review Information: The correct answer is B: The MMR vaccine should be given now, prior to the transplant

MMR is a live virus vaccine, and should be given at this time. Post-transplant, immunosuppressive drugs will be given and the administration of the live vaccine at that time would be contraindicated because of the compromised immune system.

Question10

The nurse is preparing to take a toddler>s blood pressure for the first time. Which of the following actions should the nurse perform first?

A) Explain that the procedure will help him to get well
B) Show a cartoon character with a blood pressure cuff
C) Explain that the blood pressure checks the heart pump
D) Permit handling the equipment before putting the cuff in place

Review Information: The correct answer is D: Permit handling the equipment before putting the cuff in place

The best way to gain the toddler>>s cooperation is to encourage handling the equipment. Detailed explanations are not helpful.

Question11

Which statement made by a nurse about the goal of total quality management or continuous quality improvement in a health care setting is correct?

A) It is to observe reactive service and product problem solving

B) Improvement of the processes in a proactive, preventive mode is paramount
C) A chart audits to finds common errors in practice and outcomes associated with goals
D) A flow chart to organize daily tasks is critical to the initial stages

Review Information: The correct answer is B: Improvement of the processes in a proactive, preventive mode is paramount
Total quality management and continuous quality improvement have a major goal of identifying ways to do the right thing at the right time in the right way by proactive problem-solving.

Question12

Which of the following drugs should the nurse anticipate administering to a client before they are to receive electroconvulsive therapy?
A) Benzodiazepines
B) Chlorpromazine (Thorazine)
C) Succinylcholine (Anectine)
D) Thiopental sodium (Pentothal Sodium)

Review Information: The correct answer is C: Succinylcholine (Anectine)
Succinylcholine is given intravenously to promote skeletal muscle relaxation.

Question13

Which approach is a priority for the nurse who works with clients from many different cultures?
A) Speak at least 2 other languages of clients in the neighborhood
B) Learn about the cultures of clients who are most often encountered
C) Have a list of persons for referral when interaction with these clients occur
D) Recognize personal attitudes about cultural differences and real or expected biases

Review Information: The correct answer is D: Recognize personal attitudes about cultural differences and real or expected biases
The nurse must discover personal attitudes, prejudices and biases specific to different cultures. Awareness of these will prevent negative consequences for interactions with clients and families across cultures.

Question14

A client with chronic obstructive pulmonary disease (COPD) and a history of coronary artery disease is receiving aminophylline, 25mg/hour. Which one of the following findings by the nurse would require immediate intervention?
A) Decreased blood pressure and respirations
B) Flushing and headache
C) Restlessness and palpitations
D) Increased heart rate and blood pressure

Review Information: The correct answer is C: Restlessness and palpitations
Side effects of Aminophylline include restlessness and palpitations.

Question15

A client has gastroesophageal reflux. Which recommendation made by the nurse would be most helpful to the client?
A) Avoid liquids unless a thickening agent is used
B) Sit upright for at least 1 hour after eating
C) Maintain a diet of soft foods and cooked vegetables
D) Avoid eating 2 hours before going to sleep

Review Information: The correct answer is D: Avoid eating 2 hours before going to sleep
Eating before sleeping enhances the regurgitation of stomach contents, which have increased acidity, into the esophagus. An upright posture should be maintained for about 2 hours after eating to allow for the stomach emptying. Options A and C are interventions for clients with swallowing difficulties.
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Question16

A client with a panic disorder has a new prescription for Xanax (alprazolam). In teaching the client about the drug>s actions and side effects, which of the following should the nurse emphasize?
A) Short-term relief can be expected
B) The medication acts as a stimulant
C) Dosage will be increased as tolerated
D) Initial side effects often continue

Review Information: The correct answer is A: Short-term relief can be expected
Xanax is a short-acting benzodiazepine useful in controlling panic symptoms quickly.

Question17

A client being discharged from the cardiac step-down unit following a myocardial infarction (MI), is given a prescription for a beta-blocking drug. A nursing student asks the charge nurse why this drug would be used by a client who is not hypertensive. What is an appropriate response by the charge nurse?
A) «Most people develop hypertension following an MI.»
B) «A beta-Blocker will prevent orthostatic hypotension.»
C) «This drug will decrease the workload on his heart.»
D) «Beta-blockers increase the strength of heart contractions.»

Review Information: The correct answer is C: «This drug will decrease the workload on his heart.»
One action of beta-blockers is to decrease systemic vascular resistance by dilating arterioles. This is useful for the client with coronary artery disease, and will reduce the risk of another MI or sudden death.

Question18

A 35-year-old client of Puerto Rican-American descent is diagnosed with ovarian cancer. The client states, “I refuse both radiation and chemotherapy because they are <hot.>” The next action for the nurse to take is to
A) document the situation in the notes
B) report the situation to the health care provider
C) talk with the client>s family about the situation
D) ask the client to talk about concerns regarding «hot» treatments

Review Information: The correct answer is D: ask the client to talk about concerns regarding «hot» treatments
The «hot-cold» system is found among Mexican-Americans, Puerto Ricans, and other Hispanic-Latinos. Most foods, beverages, herbs, and medicines are categorized as hot or cold, which are symbolic designations and do not necessarily indicate temperature or spiciness. Care and treatment regimens can be negotiated with clients within this framework.

Question19

A 72 year-old client is scheduled to have a cardioversion. A nurse reviews the client’s medication administration record. The nurse should notify the health care provider if the client received which medication during the preceding 24 hours?
A) Digoxin (Lanoxin)
B) Diltiazem (Cardizem)
C) Nitroglycerine ointment
D) Metoprolol (Toprol XL)

Review Information: The correct answer is A: Digoxin (Lanoxin)
Digoxin increases ventricular irritability and increases the risk of ventricular fibrillation following cardioversion. The other medications do not increase ventricular irritability.

Question20

Which of these clients, all of whom have the findings of a board-like abdomen, would the nurse suggest that the provider examine first?

A) An elderly client who stated, «My awful pain in my right side suddenly stopped about 3 hours ago.»
B) A pregnant woman of 8 weeks newly diagnosed with an ectopic pregnancy
C) A middle-aged client admitted with diverticulitis who has taken only clear liquids for the past week
D) A teenager with a history of falling off a bicycle without hitting the handle bars

Review Information: The correct answer is A: An elderly client who stated, «My awful pain in my right side suddenly stopped about 3 hours ago.»
This client has the highest risk for hypovolemic and septic shock since the appendix has most likely ruptured, based on the history of the pain suddenly stopping over three hours ago. Elderly clients have less functional reserve for the body to cope with shock and infection over long periods. The others are at risk for shock also, however given that they fall in younger age groups, they would more likely be able to tolerate an imbalance in circulation. A common complication of falling off a bicycle is hitting the handle bars in the upper abdomen often on the left, resulting in a ruptured spleen.

Question21

The nurse is teaching parents of a 7 month-old about adding table foods. Which of the following is an appropriate finger food?
A) Hot dog pieces
B) Sliced bananas
C) Whole grapes
D) Popcorn

Review Information: The correct answer is B: Sliced bananas
Finger foods should be bite-size pieces of soft food such as bananas. Hot dogs and grapes can accidentally be swallowed whole and can occlude the airway. Popcorn is too difficult to chew at this age and can irritate the airway if swallowed.

Question22

To prevent drug resistance from developing, the nurse is aware that which of the following is a characteristic of the typical treatment plan to eliminate the tuberculosis bacilli?
A) An anti-inflammatory agent
B) High doses of B complex vitamins
C) Aminoglycoside antibiotics
D) Administering two anti-tuberculosis drugs

Review Information: The correct answer is D: Administering two anti-tuberculosis drugs
Resistance of the tubercle bacilli often occurs to a single antimicrobial agent. Therefore, therapy with multiple drugs over a long period of time helps to ensure eradication of the organism.

Question23

The nurse is assessing a comatose client receiving gastric tube feedings. Which of the following assessments requires an immediate response from the nurse?
A) Decreased breath sounds in right lower lobe
B) Aspiration of a residual of 100cc of formula
C) Decrease in bowel sounds
D) Urine output of 250 cc in past 8 hours

Review Information: The correct answer is A: Decreased breath sounds in right lower lobe
The most common problem associated with enteral feedings is atelectasis. Maintain client at 30 degrees of head elevation during feedings and monitor for signs of aspiration. Check for tube placement prior to each feeding or every 4 to 8 hours if the client is receiving continuous feeding.

Question24

A client is prescribed warfarin sodium (Coumadin) to be continued at home. Which focus is critical to be included in the nurse's discharge instruction?
A) Maintain a consistent intake of green leafy foods
B) Report any nose or gum bleeds
C) Take Tylenol for minor pains

D) Use a soft toothbrush

Review Information: The correct answer is B: Report any nose or gum bleeds
The client should notify the health care provider if blood is noted in stools or urine, or any other signs of bleeding occur.

Question25
When teaching a client about the side effects of fluoxetine (Prozac), which of the following will the nurse include?
A) Tachycardia blurred vision, hypotension, anorexia
B) Orthostatic hypotension, vertigo, reactions to tyramine-rich foods
C) Diarrhea, dry mouth, weight loss, reduced libido
D) Photosensitivity, seizures, edema, hyperglycemia

Review Information: The correct answer is C: Diarrhea, dry mouth, weight loss, reduced libido
Commonly reported side effects for fluoxetine (Prozac) are diarrhea, dry mouth, weight loss and reduced libido.

Question26
A newborn weighed 7 pounds 2 ounces at birth. The nurse assesses the newborn at home 2 days later and finds the weight to be 6 pounds 7 ounces. What should the nurse tell the parents about this weight loss?
A) The newborn needs additional assessments
B) The mother should breast feed more often
C) A change to formula is indicated
D) The loss is within normal limits

Review Information: The correct answer is D: The loss is within normal limits
A newborn is expected to lose 5-10% of the birth weight in the first few days post-partum because of changes in elimination and feeding.

Question27
The nurse manager informs the nursing staff at morning report that the clinical nurse specialist will be conducting a research study on staff attitudes toward client care. All staff are invited to participate in the study if they wish. This affirms the ethical principle of
A) Anonymity
B) Beneficence
C) Justice
D) Autonomy

Review Information: The correct answer is D: Autonomy
Individuals must be free to make independent decisions about participation in research without coercion from others.

Question28
The nurse is talking with the family of an 18 months-old newly diagnosed with retinoblastoma. A priority in communicating with the parents is
A) Discuss the need for genetic counseling
B) Inform them that combined therapy is seldom effective
C) Prepare for the child>s permanent disfigurement
D) Suggest that total blindness may follow surgery

Review Information: The correct answer is A: Discuss the need for genetic counseling
The hereditary aspects of this disease are well documented. While the parents focus on the needs of this child, they should be aware that the risk is high for future offspring.

Question29
The nurse is planning care for an 8 year-old child. Which of the following should be included in the plan of care?
A) Encourage child to engage in activities in the playroom
B) Promote independence in activities of daily living

C) Talk with the child and allow him to express his opinions
D) Provide frequent reassurance and cuddling

Review Information: The correct answer is A: Encourage child to engage in activities in the playroom
According to Erikson, the school age child is in the stage of industry versus inferiority. To help them achieve industry, the nurse should encourage them to carry out tasks and activities in their room or in the playroom.

Question30

The nurse is assigned to care for 4 clients. Which of the following should be assessed immediately after hearing the report?
A) The client with asthma who is now ready for discharge
B) The client with a peptic ulcer who has been vomiting all night
C) The client with chronic renal failure returning from dialysis
D) The client with pancreatitis who was admitted yesterday

Review Information: The correct answer is B: The client with a peptic ulcer who has been vomiting all night
A perforated peptic ulcer could cause nausea, vomiting and abdominal distention, and may be a life threatening situation. The client should be assessed immediately and findings reported to the provider.
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Question31

During a routine check-up, an insulin-dependent diabetic has his glycosylated hemoglobin checked. The results indicate a level of 11%. Based on this result, what teaching should the nurse emphasize?
A) Rotation of injection sties
B) Insulin mixing and preparation
C) Daily blood sugar monitoring
D) Regular high protein diet

Review Information: The correct answer is C: Daily blood sugar monitoring
Normal hemoglobin A1C (glycosylated hemoglobin) level is 7 to 9%. Elevation indicates elevated glucose levels over time.

Question32

A client taking isoniazid (INH) for tuberculosis asks the nurse about side effects of the medication. The client should be instructed to immediately report which of these?
A) Double vision and visual halos
B) Extremity tingling and numbness
C) Confusion and lightheadedness
D) Sensitivity of sunlight

Review Information: The correct answer is B: Extremity tingling and numbness
Peripheral neuropathy is the most common side effect of INH and should be reported to the provider. It can be reversed.

Question33

Which of these questions is priority when assessing a client with hypertension?
A) «What over-the-counter medications do you take?»
B) «Describe your usual exercise and activity patterns.»
C) «Tell me about your usual diet.»
D) «Describe your family>s cardiovascular history.»

Review Information: The correct answer is A: «What over-the-counter medications do you take?»
Over-the-counter medications, especially those that contain cold preparations can increase the blood pressure to the point of hypertension.

Question34

The nurse is performing an assessment of the

motor function in a client with a head injury. The best technique is
A) touching the trapezius muscle or arm firmly
B) pinching any body part
C) shaking a limb vigorously
D) rubbing the sternum

Review Information: The correct answer is D: rubbing the sternum
The purpose is to assess the non-responsive client's reaction to a painful stimulus after less noxious methods have been tried.

Question35

A nurse admits a client transferred from the emergency room (ER). The client, diagnosed with a myocardial infarction, is complaining of substernal chest pain, diaphoresis and nausea. The first action by the nurse should be to
A) order an EKG
B) administer morphine sulfate
C) start an IV
D) measure vital signs

Review Information: The correct answer is B: administer morphine sulfate
Decreasing the clients pain is the most important priority at this time. As long as pain is present there is danger in extending the infarcted area. Morphine will decrease the oxygen demands of the heart and act as a mild diuretic as well. It is probable that an EKG and IV insertion were performed in the ER.

Question36

The nurse admits a 2 year-old child who has had a seizure. Which of the following statement by the child>s parent would be important in determining the etiology of the seizure?
A) «He has been taking long naps for a week.»
B) «He has had an ear infection for the past 2 days.»
C) «He has been eating more red meat lately.»
D) «He seems to be going to the bathroom more frequently.»

Review Information: The correct answer is B: «He has had an ear infection for the past 2 days.»
Contributing factors to seizures in children include those such as age (more common in first 2 years), infections (late infancy and early childhood), fatigue, not eating properly and excessive fluid intake or fluid retention.

Question37

Which of these clients would the nurse monitor for the complication of C. difficile diarrhea?
A) An adolescent taking medications for acne
B) An elderly client living in a retirement center taking prednisone
C) A young adult at home taking a prescribed aminoglycoside
D) A hospitalized middle aged client receiving clindamycin

Review Information: The correct answer is D: A hospitalized middle aged client receiving clindamycin
Hospitalized patients, especially those receiving antibiotic therapy, are primary targets for C. difficile. Of clients receiving antibiotics, 5-38% experience antibiotic-associated diarrhea; C. difficile causes 15 to 20% of the cases. Several antibiotic agents have been associated with C. difficile. Broad-spectrum agents, such as clindamycin, ampicillin, amoxicillin, and cephalosporins, are the most frequent sources of C. difficile. Also, C. difficile infection has been caused by the administration of agents containing beta-lactamase inhibitors (i.e., clavulanic acid, sulbactam, tazobactam) and intravenous agents that achieve substantial colonic intraluminal concentrations (i.e., ceftriaxone, nafcillin, oxacillin). Fluoroquinolones, aminoglycosides, vancomycin, and trimethoprim are seldom associated with C. difficile infection or pseudomembranous colitis.

Question38

The nurse is performing an assessment on a cli-

ent who is cachectic and has developed an enterocutaneous fistula following surgery to relieve a small bowel obstruction. The client>s total protein level is reported as 4.5 g/dl. Which of the following would the nurse anticipate?
A) Additional potassium will be given IV
B) Blood for coagulation studies will be drawn
C) Total parenteral nutrition (TPN) will be started
D) Serum lipase levels will be evaluated

Review Information: The correct answer is C: Total parenteral nutrition (TPN) will be started
The client is not absorbing nutrients adequately as evidenced by the cachexia and low protein levels. (A normal total serum protein level is 6.0-8.0 g/dl.) TPN will promote a positive nitrogen balance in this client who is unable to digest and absorb nutrients adequately.

Question39

During a situation of pain management, which statement is a priority to consider for the ethical guidelines of the nurse?
A) The client>s self-report is the most important consideration
B) Cultural sensitivity is fundamental to pain management
C) Clients have the right to have their pain relieved
D) Nurses should not prejudge a client>s pain using their own values

Review Information: The correct answer is A: The client>>s self-report is the most important consideration
Pain is a complex phenomenon that is perceived differently by each individual. Pain is whatever the client says it is. The other statements are correct but not the most important considerations.

Question40

As a part of a 9 pound full-term newborn>s assessment, the nurse performs a dextro-stick at 1 hour post birth. The serum glucose reading is 45 mg/dl. What action by the nurse is appropriate at this time?
A) Give oral glucose water
B) Notify the pediatrician
C) Repeat the test in 2 hours
D) Check the pulse oximetry reading

Review Information: The correct answer is C: Repeat the test in 2 hours
This blood sugar is within the normal range for a full-term newborn. Normal values are: Premature infant: 20-60 mg/dl or 1.1-3.3 mmol/L, Neonate: 30-60 mg/dl or 1.7-3.3 mmol/L, Infant: 40-90 mg/dl or 2.2-5.0 mmol/L. Critical values are: Infant: <40 mg/dl and in a Newborn: <30 and >300 mg/dl. Because of the increased birth weight which can be associated with diabetes mellitus, repeated blood sugars will be drawn

0 comments

Labels: free nclex-rn sample review questions, nclex-rn practice test questions, nursing review

Free NCLEX-RN Sample Test Questions For Nursing Review (Part 3)

Question1

A client diagnosed with chronic depression is maintained on tranylcypromine (Parnate). An important nursing intervention is to teach the client to avoid which of the following foods?
A) Wine, beer, cheese, liver and chocolate
B) Wine, citrus fruits, yogurt and broccoli
C) Beer, cheese, beef and carrots
D) Wine, apples, sour cream and beef steak

Review Information: The correct answer is A: Wine, beer, cheese, liver and chocolate
These foods are tyramine rich and ingestion of these foods while taking monoamine oxidase inhibitors (MAOIs) can precipitate a life-threatening hypertensive crisis.

Question2

The nurse is working in a high risk antepartum clinic. A 40 year-old woman in the first trimester gives a thorough health history. Which information should receive priority attention by the nurse?
A) Her father and brother are insulin dependent

diabetics
B) She has taken 800 mcg of folic acid daily for the past year
C) Her husband was treated for tuberculosis as a child
D) She reports recent use of over-the counter sinus remedies

Review Information: The correct answer is D: She reports recent use of over-the counter sinus remedies
Over-the-counter drugs are a possible danger in early pregnancy. A report by the client that she has taken medications should be followed up immediately.

Question3
What must be the priority consideration for nurses when communicating with children?
A) Present environment
B) Physical condition
C) Nonverbal cues
D) Developmental level

Review Information: The correct answer is D: Developmental level
While each of the factors affect communication, the nurse recognizes that developmental differences have implications for processing and understanding information. Consequently, a child's developmental level must be considered when selecting communication approaches.

Question4
The nurse is assessing a client>s home in preparation for discharge. Which of the following should be given priority consideration?
A) Family understanding of client needs
B) Financial status
C) Location of bathrooms
D) Proximity to emergency services

Review Information: The correct answer is A: Family understanding of client needs
Functional communication patterns between family members are fundamental to meeting the needs of the client and family.

Question5
As a general guide for emergency management of acute alcohol intoxication, it is important for the nurse initially to obtain data regarding which of the following?
A) What and how much the client drinks, according to family and friends
B) The blood alcohol level of the client
C) The blood pressure level of the client
D) The blood glucose level of the client

Review Information: The correct answer is B: The blood alcohol level of the client
Blood alcohol levels are generally obtained to determine the level of intoxication. The amount of alcohol consumed determines how much medication the client needs for detoxification and treatment. Reports of alcohol consumption are notoriously inaccurate.

Question6
Which clinical finding would the nurse expect to assess first in a newborn with spastic cerebral palsy?
A) cognitive impairment
B) hypotonic muscular activity
C) seizures
D) criss-crossing leg movement

Review Information: The correct answer is D: criss-crossing leg movement
Cerebral palsy is a neuromuscular impairment resulting in muscular and reflexive hypertonicity and the criss-crossing, or scissoring leg movements.

Question7
Which medication is more helpful in treating bulimia than anorexia?
A) Amphetamines
B) Sedatives
C) Anticholinergics
D) Narcotics

Review Information: The correct answer is C: Anticholinergics
In contrast to anorexics, individuals with bulimia are troubled by their behavioral characteristics and become depressed. The person feels compelled to binge, purge and fast. Feeling helpless to stop the behavior, feelings of self-disgust occur.

Question8

The nurse is assessing a woman in early labor. While positioning for a vaginal exam, she complains of dizziness and nausea and appears pale. Her blood pressure has dropped slightly. What should be the initial nursing action?

A) Call the health care provider
B) Encourage deep breathing
C) Elevate the foot of the bed
D) Turn her to her left side

Review Information: The correct answer is D: Turn her to her left side

The weight of the uterus can put pressure on the vena cava and aorta when a pregnant woman is flat on her back causing supine hypotension. Action is needed to relieve the pressure on the vena cava and aorta. Turning the woman to the side reduces this pressure and relieves postural hypotension.

Question9

A client has been started on a long term corticosteroid therapy. Which of the following comments by the client indicate the need for further teaching?

A) «I will keep a weekly weight record.»
B) «I will take medication with food.»
C) «I will stop taking the medication for 1 week every month.»
D) «I will eat foods high in potassium.»

Review Information: The correct answer is C: «I will stop taking the medication for 1week every month.»

Emphatically warn against discontinuing steroid dosage abruptly because that may produce a fatal adrenal crisis.

Question10

A male client calls for a nurse because of chest pain. Which statement by the client would require the most immediate action by the nurse?

A) «When I take in a deep breath, it stabs like a knife.»
B) «The pain came on after dinner. That soup seemed very spicy.»
C) «When I turn in bed to reach the remote for the TV, my chest hurts.»
D) «I feel pressure in the middle of my chest, like an elephant is sitting on my chest.»

Review Information: The correct answer is D: «I feel pressure in the middle of my chest, like an elephant is sitting on my chest.»

This is a classic description of chest pain in men caused by myocardial ischemia. Women experience vague feelings of fatigue and back and jaw pain.

Question11

A nurse is caring for a client who has just been admitted with an overdose of aspirin. The following lab data is available: PaO2 95, PaCO2 30, pH 7.5, K 3.2 mEq/l. Which should be the nurse>s first action?

A) Monitor respiratory rate
B) Monitor intake and output every hour
C) Assist the client to breathe into a paper bag
D) Prepare to administer oxygen by mask

Review Information: The correct answer is C: Assist the client to breathe into a paper bag

Side effects of aspirin toxicity include hyperventilation, which can result in respiratory alkalosis in the initial stages. Breathing into a paper bag will prevent further reduction in PaCO2.

Question12

After assessing a 70 year-old male client>s laboratory results during a routine clinic visit, which one of the following findings would indicate an area in which teaching is needed:

A) Serum albumin 2.5 g/dl
B) LDL Cholesterol 140 mg/dl
C) Serum glucose 90 mg/dl
D) RBC 5.0 million/mm3

Review Information: The correct answer is A: Serum albumin 2.5 g/dl

Serum albumin level is low (normal 3.0 – 5.0 g/dl in elders), indicating nutritional counseling to increase dietary protein is needed. Socioeconomic factors may need to be addressed to help the client comply with the recommendation.

Question13

When teaching a client with a new prescription for lithium (Lithane) for treatment of a bi-polar disorder which of these should the nurse emphasize?

A) Maintaining a salt restricted diet

B) Reporting vomiting or diarrhea
C) Taking other medication as usual
D) Substituting generic form if desired

Review Information: The correct answer is B: Reporting vomiting or diarrhea
If dehydration results from vomiting, diarrhea or excessive perspiration, tolerance to the drug may be altered and symptoms may return.

Question14

A client is discharged on warfarin sulfate (Coumadin). Which statement by the client indicated a need for further teaching?
A) «I know I must avoid crowds.»
B) «I will keep all laboratory appointments.»
C) «I plan to use an electric razor for shaving.»
D) «I will report any bruises for bleeding.»

Review Information: The correct answer is A: «I know I must avoid crowds.»
There are no specific reasons for the client on Coumadin to avoid crowds. General instructions for any cardiac surgical client include limiting exposure to infection.

Question15

A client is taking tranylcypromine (Parnate) and has received dietary instruction. Which of the following food selections would be contraindicated for this client?
A) Fresh juice, carrots, vanilla pudding
B) Apple juice, ham salad, fresh pineapple
C) Hamburger, fries, strawberry shake
D) Red wine, fava beans, aged cheese

Review Information: The correct answer is D: Red wine, fava beans, aged cheese
Red wine and cheese contain tyramine (as do chicken liver and ripe bananas) and so are contraindicated when taking MAOIs. Fava beans contain other vasopressors that can interact with MAOIs also causing malignant hypertension.

Question16

A client is admitted with severe injuries from an auto accident. The client>s vital signs are BP 120/50, pulse rate 110, and respiratory rate of 28. The initial nursing intervention would be to
A) begin intravenous therapy
B) initiate continuous blood pressure monitoring
C) administer oxygen therapy
D) institute cardiac monitoring

Review Information: The correct answer is C: administer oxygen therapy
Early findings of shock reveal hypoxia with rapid heart rate and rapid respirations, and oxygen is the most critical initial intervention. The other interventions are secondary to oxygen therapy.

Question17

A client is admitted to the hospital with a diagnosis of deep vein thrombosis. During the initial assessment, the client complains of sudden shortness of breath. The SaO2 is 87. The priority nursing assessment at this time is
A) bowel sounds
B) heart rate
C) peripheral pulses
D) lung sounds

Review Information: The correct answer is D: lung sounds
Lung sounds are critical assessments at this point. The nurse should be alert to crackles or a pleural friction rub, highly suggestive of a pulmonary embolism.

Question18

The nurse is administering lidocaine (Xylocaine) to a client with a myocardial infarction. Which of the following assessment findings requires the nurse>s immediate action?
A) Central venous pressure reading of 11
B) Respiratory rate of 22
C) Pulse rate of 48 BPM
D) Blood pressure of 144/92

Review Information: The correct answer is C: Pulse rate of 48 BPM
One of the side effects of lidocaine is bradycardia, heart block, cardiovascular collapse and cardiac arrest (this drug should never be administered without continuous EKG monitoring).

Question19

The nurse is teaching a group of college students about breast self-examination. A woman asks for

the best time to perform the monthly exam. What is the best reply by the nurse?
A) «The first of every month, because it is easiest to remember»
B) «Right after the period, when your breasts are less tender»
C) «Do the exam at the same time every month»
D) «Ovulation, or mid-cycle is the best time to detect changes»

Review Information: The correct answer is B: «Right after the period, when your breasts are less tender»
The best time for a breast self exam (BSE) is a week after a menstrual cycle, when the breasts are no longer swollen and tender due to hormone elevation.

Question20
The nurse is caring for a post-operative client who develops a wound evisceration. The first nursing intervention should be to
A) medicate the client for pain
B) call the provider
C) cover the wound with sterile saline dressing
D) place the bed in a flat position

Review Information: The correct answer is C: cover the wound with sterile saline dressing
When evisceration occurs, the wound should first be quickly covered by sterile dressings soaked in sterile saline. This prevents tissue damage until a repair can be effected.

Question21
The spouse of a client with Alzheimer>s disease expresses concern about the burden of caregiving. Which of the following actions by the nurse should be a priority?
A) Link the caregiver with a support group
B) Ask friends to visit regularly
C) Schedule a home visit each week
D) Request anti-anxiety prescriptions

Review Information: The correct answer is A: Link the caregiver with a support group
Assisting caregivers to locate and join support groups is most helpful. Families share feelings and learn about services such as respite care. Health education is also available through local and national Alzheimer>>s chapters.

Question22
Clients taking lithium must be particularly sure to maintain adequate intake of which of these elements?
A) Potassium
B) Sodium
C) Chloride
D) Calcium

Review Information: The correct answer is B: Sodium
Clients taking lithium need to maintain an adequate intake of sodium. Serum lithium concentrations may increase in the presence of conditions that cause sodium loss.

Question23
A client is receiving lithium carbonate 600 mg T.I.D. to treat bipolar disorder. Which of these indicate early signs of toxicity?
A) Ataxia and course hand tremors
B) Vomiting, diarrhea and lethargy
C) Pruritus, rash and photosensitivity
D) Electrolyte imbalance and cardiac arrhythmias

Review Information: The correct answer is B: Vomiting, diarrhea and lethargy
These are early signs of lithium toxicity.

Question24
The nurse can best ensure the safety of a client suffering from dementia who wanders from the room by which action?
A) Repeatedly remind the client of the time and location
B) Explain the risks of walking with no purpose
C) Use protective devices to keep the client in the bed or chair in the room
D) Attach a wander-guard sensor band to the client>s wrist

Review Information: The correct answer is D: Attach a wander-guard sensor band to the client>>s wrist
This type of identification band easily tracks the client>>s movements and ensures safety while the client wanders on the unit. Restriction of ac-

tivity is inappropriate for any client unless they are potentially harmful to themselves or others.

Question25

The nurse is teaching a client about the difference between tardive dyskinesia (TD) and neuroleptic malignant syndrome (NMS). Which statement is true with regards to tardive dyskinesia?
A) TD develops within hours or years of continued antipsychotic drug use in people under 20 and over 30
B) It can occur in clients taking antipsychotic drugs longer than 2 years
C) Tardive dyskinesia occurs within minutes of the first dose of antipsychotic drugs and is reversible
D) TD can easily be treated with anticholinergic drugs

Review Information: The correct answer is B: It can occur in clients taking antipsychotic drugs longer than 2 years
Tardive dyskinesia is a extrapyramidal side effect that appears after prolonged treatment with antipsychotic medication. Early symptoms of tardive dyskinesia are fasciculations of the tongue or constant smacking of the lips.

Question26

The nurse is aware that the effect of antihypertensive drug therapy may be affected by a 75 year-old client>s
A) poor nutritional status
B) decreased gastrointestinal motility
C) increased splanchnic blood flow
D) altered peripheral resistance

Review Information: The correct answer is B: decreased gastrointestinal motility
Together with shrinkage of the gastric mucosa, and changes in the levels of hydrochloric acid, this will decrease absorption of medications and interfere with their actions.

Question27

In response to a call for assistance by a client in labor, the nurse notes that a loop on the umbilical cord protrudes from the vagina. What is the priority nursing action?
A) call the health care provider
B) check fetal heart beat
C) put the client in knee-chest position
D) turn the client to the side

Review Information: The correct answer is C: put the client in knee-chest position
Immediate action is needed to relieve pressure on the cord, which puts the fetus at risk due to hypoxia. The Trendelenburg position accomplishes this. The exposed cord is covered with saline soaked gauze, not reinserted. The fetal heart rate also should be checked, and the provider called. A prolapsed umbilical cord is a medical emergency.

Question28

The nurse is caring for a 2 month-old infant with a congenital heart defect. Which of the following is a priority nursing action?
A) Provide small feedings every 3 hours
B) Maintain intravenous fluids
C) Add strained cereal to the diet
D) Change to reduced calorie formula

Review Information: The correct answer is A: Provide small feedings every 3 hours
Infants with congenital heart defects are at increased risk for developing congestive heart failure. Infants with congestive heart failure have an increased metabolic rate and require additional calories to grow. At the same time, however, rest and conservation of energy for eating is important. Feedings should be smaller and every 3 hours rather than the usual 4 hour schedule.

Question29

The nurse is caring for a client receiving intravenous nitroglycerin for acute angina. What is the most important assessment during treatment?
A) Heart rate
B) Neurologic status
C) Urine output
D) Blood pressure

Review Information: The correct answer is D: Blood pressure
The vasodilatation that occurs as a result of this medication can cause profound hypotension. The client>>s blood pressure must be evaluated every 15 minutes until stable and then every 30 minutes to every hour.

Question30

A client telephones the clinic to ask about a home pregnancy test she used this morning. The nurse understands that the presence of which hormone strongly suggests a woman is pregnant?

A) Estrogen
B) HCG
C) Alpha-fetoprotein
D) Progesterone

Review Information: The correct answer is B: HCG
Human chorionic gonadotropin (HCG) is the biologic marker on which pregnancy tests are based. Reliability is about 98%, but the test does not conclusively confirm pregnancy.

Question31

A client, admitted to the unit because of severe depression and suicidal threats, is placed on suicidal precautions. The nurse should be aware that the danger of the client committing suicide is greatest

A) during the night shift when staffing is limited
B) when the client's mood improves with an increase in energy level
C) at the time of the client>s greatest despair
D) after a visit from the client>s estranged partner

Review Information: The correct answer is B: when the client's mood improves with an increase in energy level
Suicide potential is often increased when there is an improvement in mood and energy level. At this time ambivalence is often decreased and a decision is made to commit suicide.

Question32

After 4 electroconvulsive treatments over 2 weeks, a client is very upset and states "I am so confused. I lose my money. I just can't remember telephone numbers." The most therapeutic response for the nurse to make is

A) «You were seriously ill and needed the treatments.»
B) «Don>t get upset. The confusion will clear up in a day or two.»
C) «It is to be expected since most clients have the same results.»
D) «I can hear your concern and that your confusion is upsetting to you.»

Review Information: The correct answer is D: «I can hear your concern and that your confusion is upsetting to you.»
Communicating caring and empathy with the acknowledgement of feelings is the initial response. Afterwards, teaching about the expected short term effects would be discussed.

Question33

A woman in labor calls the nurse to assist her in the bathroom. The nurse notices a large amount of clear fluid on the bed linens. The nurse knows that fetal monitoring must now assess for what complication?

A) Early decelerations
B) Late accelerations
C) Variable decelerations
D) Periodic accelerations

Review Information: The correct answer is C: Variable decelerations
When the membranes rupture, there is increased risk initially of cord prolapse. Fetal heart rate patterns may show variable decelerations, which require immediate nursing action to promote gas exchange.

Question34

The nurse is assessing a client with chronic obstructive pulmonary disease receiving oxygen for low PaO2 levels. Which assessment is a nursing priority?

A) Evaluating SaO2 levels frequently
B) Observing skin color changes
C) Assessing for clubbing fingers
D) Identifying tactile fremitus

Review Information: The correct answer is A: Evaluating SaO2 levels frequently
The best method to evaluate a client>>s oxygenation is to evaluate the SaO2. This is just as effective as an arterial blood gas reading to evaluate oxygenation status, and is less traumatic and expensive.

Question35

The visiting nurse makes a postpartum visit to a married female client. Upon arrival, the nurse observes that the client has a black eye and nu-

merous bruises on her arms and legs. The initial nursing intervention would be to
A) call the police to report indications of domestic violence
B) confront the husband about abusing his wife
C) leave the home because of the unsafe environment
D) interview the client alone to determine the origin of the injuries

Review Information: The correct answer is D: interview the client alone to determine the origin of the injuries
It would be wrong to assume domestic violence without further assessment. Separate the suspected victim from the partner until battering has been ruled out.

Question36
When teaching a client about an oral hypoglycemic medication, the nurse should place primary emphasis on
A) recognizing findings of toxicity
B) taking the medication at specified times
C) increasing the dosage based on blood glucose
D) distinguishing hypoglycemia from hyperglycemia

Review Information: The correct answer is B: taking the medication at specified times
A regular interval between doses should be maintained since oral hypoglycemics stimulate the islets of Langerhans to produce insulin.

Question37
Initial postoperative nursing care for an infant who has had a pyloromyotomy would initially include
A) bland diet appropriate for age
B) intravenous fluids for 3-4 days
C) NPO then glucose and electrolyte solutions
D) formula or breast milk as tolerated

Review Information: The correct answer is C: NPO then glucose and electrolyte solutions
Post-operatively, the initial feedings are clear liquids in small quantities to provide calories and electrolytes.

Question38
A client is treated in the emergency room for diabetic ketoacidosis and a glucose level of 650mg.D/L. In assessing the client, the nurse>s review of which of the following tests suggests an understanding of this health problem?
A) Serum calcium
B) Serum magnesium
C) Serum creatinine
D) Serum potassium

Review Information: The correct answer is D: Serum potassium
Potassium is lost in diabetic ketoacidosis during rehydration and insulin administration. Review of this lab finding suggests the nurse has knowledge of this problem.

Question39
A male client is preparing for discharge following an acute myocardial infarction. He asks the nurse about his sexual activity once he is home. What would be the nurse>s initial response?
A) Give him written material from the American Heart Association about sexual activity with heart disease
B) Answer his questions accurately in a private environment
C) Schedule a private, uninterrupted teaching session with both the client and his wife
D) Assess the client>s knowledge about his health problems

Review Information: The correct answer is D: Assess the client>>s knowledge about his health problems
The nursing process is continuous and cyclical in nature. When a client expresses a specific concern, the nurse performs a focused assessment to gather additional data prior to planning and implementing nursing interventions.

Question40
The client asks the nurse how the health care provider could tell she was pregnant “just by looking inside.” What is the best explanation by the nurse?
A) Bluish coloration of the cervix and vaginal walls
B) Pronounced softening of the cervix
C) Clot of very thick mucous that obstructs the

cervical canal
D) Slight rotation of the uterus to the right

Review Information: The correct answer is A: Bluish coloration of the cervix and vaginal walls
Chadwick>>s sign is a bluish-purple coloration of the cervix and vaginal walls, occurring at 4 weeks of pregnancy, that is caused by vasocongestion.

0 comments

Labels: free nclex-rn sample review questions, nclex-rn practice test questions, nursing review

Free NCLEX-RN Sample Test Questions For Nursing Review (Part 2)

Question1
The feeling of trust can best be established by the nurse during the process of the development of a nurse-client relationship by which of these characteristics?
A) Reliability and kindness
B) Demeanor and sincerity
C) Honesty and consistency
D) Sympathy and appreciativeness

Review Information: The correct answer is C: Honesty and consistency
Characteristics of a trusting relationship include respect, honesty, consistency, faith and caring.

Question2
A nurse has administered several blood transfusions over 3 days to a 12 year-old client with Thalassemia. What lab value should the nurse monitor closely during this therapy?
A) Hemoglobin
B) Red Blood Cell Indices
C) Platelet count
D) Neutrophil percent

Review Information: The correct answer is A: Hemoglobin
Hemoglobin should be in a therapeutic range of approximately 10 g/dl (100gL). «This level is low enough to foster the patient>>s own erythropoiesis without enlarging the spleen.»

Question3
The nurse is providing care to a newly a hospitalized adolescent. What is the major threat experienced by the hospitalized adolescent?
A) Pain management
B) Restricted physical activity
C) Altered body image
D) Separation from family

Review Information: The correct answer is C: Altered body image
The hospitalized adolescent may see each of these as a threat, but the major threat that they feel when hospitalized is the fear of altered body image, because of the emphasis on physical appearance during this developmental stage.

Question4
A 12 year-old child is admitted with a broken arm and is told surgery is required. The nurse finds him crying and unwilling to talk. What is the most appropriate response by the nurse?
A) Give him privacy
B) Tell him he will get through the surgery with no problem
C) Try to distract him
D) Make arrangements for his friends to visit

Review Information: The correct answer is A: Give him privacy
A 12 year-old child needs the opportunity to express his emotions privately.

Question5
In discharge teaching, the nurse should emphasize that which of these is a common side effect of clozapine (Clozaril) therapy?
A) Dry mouth
B) Rhinitis
C) Dry skin
D) Extreme salivation

Review Information: The correct answer is D: Extreme salivation
A significant number of clients receiving Clozapine (Clozaril) therapy experience extreme salivation.

Question6
A client has had a positive reaction to purified protein derivative (PPD). The client asks the nurse what this means. The nurse should indicate that the client has
A) active tuberculosis

B) been exposed to mycobacterium tuberculosis
C) never had tuberculosis
D) never been infected with mycobacterium tuberculosis

Review Information: The correct answer is B: been exposed to mycobacterium tuberculosis
The PPD skin test is used to determine the presence of tuberculosis antibodies and a positive result indicates that the person has been exposed to mycobacterium tuberculosis. Additional tests are needed to determine if active tuberculosis is present.

Question7

A client is receiving and IV antibiotic infusion and is scheduled to have blood drawn at 1:00 pm for a «peak» antibiotic level measurement. The nurse notes that the IV infusion is running behind schedule and will not be competed by 1:00. The nurse should:
A) Notify the client>s health care provider
B) Stop the infusion at 1:00 pm
C) Reschedule the laboratory test
D) Increase the infusion rate

Review Information: The correct answer is C: Reschedule the laboratory test
If the antibiotic infusion will not be completed at the time the peak blood level is due to be drawn, the nurse should ask that the blood sampling time be adjusted

Question8

The nurse is caring for a client with a new order for bupropion (Wellbutrin) for treatment of depression. The order reads “Wellbutrin 175 mg. BID x 4 days.” What is the appropriate action?
A) Give the medication as ordered
B) Questionthis medication dose
C) Observe the client for mood swings
D) Monitor neuro signs frequently

Review Information: The correct answer is B: Questionthis medication dose
Bupropion (Wellbutrin) should be started at 100mg BID for three days then increased to 150mg BID. When used for depression, it may take up to four weeks for results. Common side effects are dry mouth, headache, and agitation. Doses should be administered in equally spaced time increments throughout the day to minimize the risk of seizures.

Question9

The clinic nurse is discussing health promotion with a group of parents. A mother is concerned about Reye>s Syndrome, and asks about prevention. Which of these demonstrates appropriate teaching?
A) «Immunize your child against this disease.»
B) «Seek medical attention for serious injuries.»
C) «Report exposure to this illness.»
D) «Avoid use of aspirin for viral infections.»

Review Information: The correct answer is D: «Avoid use of aspirin for viral infections.»
The link between aspirin use and Reye>>s Syndrome has not been confirmed, but evidence suggests that the risk is sufficiently grave to include the warning on aspirin products.

Question10

A post-operative client is admitted to the post-anesthesia recovery room (PACU). The anesthetist reports that malignant hyperthermia occurred during surgery. The nurse recognizes that this complication is related to what factor?
A) Allergy to general anesthesia
B) Pre-existing bacterial infection
C) A genetic predisposition
D) Selected surgical procedures

Review Information: The correct answer is C: A genetic predisposition
Malignant hyperthermia is a rare, potentially fatal adverse reaction to inhaled anesthetics. There is a genetic predisposition to this disorder.

Question11

A 9 year-old is taken to the emergency room with right lower quadrant pain and vomiting. When preparing the child for an emergency appendectomy, what must the nurse expect to be the child>s greatest fear?
A) Change in body image
B) An unfamiliar environment
C) Perceived loss of control

D) Guilt over being hospitalized

Review Information: The correct answer is C: Perceived loss of control
For school age children, major fears are loss of control and separation from friends/peers.

Question12
A client is to begin taking Fosamax. The nurse must emphasize which of these instructions to the client when taking this medication? «Take Fosamax
A) on an empty stomach.»
B) after meals.»
C) with calcium.»
D) with milk 2 hours after meals.»

Review Information: The correct answer is A: on an empty stomach.»
Fosamax should be taken first thing in the morning with 6-8 ounces of plain water at least 30 minutes before other medication or food. Food and fluids (other than water) greatly decrease the absorption of Fosamax. The client must also be instructed to remain in the upright position for 30 minutes following the dose to facilitate passage into the stomach and minimize irritation of the esophagus.

Question13
An older adult client is to receive and antibiotic, gentamicin. What diagnostic finding indicates the client may have difficult excreting the medication?
A) High gastric pH
B) High serum creatinine
C) Low serum albumin
D) Low serum blood urea nitrogen

Review Information: The correct answer is B: High serum creatinine
An elevated serum creatinine indicates reduced renal function. Reduced renal function will delay the excretion of many mediations.

Question14
A nurse is assigned to care for a comatose diabetic on IV insulin therapy. Which task would be most appropriate to delegate to an unlicensed assistive personnel (UAP)?
A) Check the client>s level of consciousness
B) Obtain the regular blood glucose readings
C) Determine if special skin care is needed
D) Answer questions from the client>s spouse about the plan of care

Review Information: The correct answer is B: Obtain the regular blood glucose readings
The UAP can safely obtain blood glucose readings, which are routine tasks.

Question15
Which of the following laboratory results would suggest to the emergency room nurse that a client admitted after a severe motor vehicle crash is in acidosis?
A) Hemoglobin 15 gm/dl
B) Chloride 100 mEq/L
C) Sodium 130 mEq/L
D) Carbon dioxide 20 mEq/L

Review Information: The correct answer is D: Carbon dioxide 20 mEq/L
Serum carbon dioxide is an indicator of acid-base status. This finding would indicate acidosis.

Question16
The nurse has just received report on a group of clients and plans to delegate care of several of the clients to a practical nurse (PN). The first thing the RN should do before the delegation of care is
A) Provide a time-frame for the completion of the client care
B) Assure the PN that the RN will be available for assistance
C) Ask about prior experience with similar clients
D) Review the specific procedures unique to the assignment

Review Information: The correct answer is C: Ask about prior experience with similar clients.
The first step in delegation is to determine the qualifications of the person to whom one is delegating. By asking about the PN>>s prior experience with similar clients/tasks, the RN can determine whether the PN has the requisite experience to care for the assigned clients.

Question17

The mother of a 4 month-old infant asks the nurse about the dangers of sunburn while they are on vacation at the beach. Which of the following is the best advice about sun protection for this child?
A) «Use a sunscreen with a minimum sun protective factor of 15.»
B) «Applications of sunscreen should be repeated every few hours.»
C) «An infant should be protected by the maximum strength sunscreen.»
D) «Sunscreens are not recommended in children younger than 6 months.»

Review Information: The correct answer is D: «Sunscreens are not recommended in children younger than 6 months.»
Infants under 6 months of age should be kept out of the sun or shielded from it. Even on a cloudy day, the infant can be sunburned while near water. A hat and light protective clothing should be worn.

Question18

The nurse administers cimetidine (Tagamet) to a 79 year-old male with a gastric ulcer. Which parameter may be affected by this drug, and should be closely monitored by the nurse?
A) Blood pressure
B) Liver function
C) Mental status
D) Hemoglobin

Review Information: The correct answer is C: Mental status
The elderly are at risk for developing confusion when taking cimetidine, a drug that interacts with many other medications.

Question19

The nurse assesses the use of coping mechanisms by an adolescent 1 week after the client had a motor vehicle accident resulting in multiple serious injuries. Which of these characteristics are most likely to be displayed?
A) Ambivalence, dependence, demanding
B) Denial, projection, regression
C) Intellectualization, rationalization, repression
D) Identification, assimilation, withdrawal

Review Information: The correct answer is B: Denial, projection, regression
Helplessness and hopelessness may contribute to regressive, dependent behavior which often occurs at any age with hospitalization. Denying or minimizing the seriousness of the illness is used to avoid facing the worst situation. Recall that denial is the initial step in the process of working through any loss.

Question20

A 52 year-old post menopausal woman asks the nurse how frequently she should have a mammogram. What is the nurse>s best response?
A) «Your doctor will advise you about your risks.»
B) «Unless you had previous problems, every 2 years is best.»
C) «Once a woman reaches 50, she should have a mammogram yearly.»
D) «Yearly mammograms are advised for all women over 35.»

Review Information: The correct answer is C: «Once a woman reaches 50, she should have a mammogram yearly.»
The American Cancer Society recommends a screening mammogram by age 40, every 1 - 2 years for women 40-49, and every year from age 50. If there are family or personal health risks, other assessments may be recommended.

Question21

The nurse is planning care for a client who is taking cyclosporin (Neoral). What would be an appropriate nursing diagnosis for this client?
A) Alteration in body image
B) High risk for infection
C) Altered growth and development
D) Impaired physical mobility

Review Information: The correct answer is B: High risk for infection
Cyclosporin (Neoral) inhibits normal immune responses. Clients receiving cyclosporin are at risk for infection.

Question22

A client on telemetry begins having premature ventricular beats (PVBs) at 12 per minute. In reviewing the most recent laboratory results, which would require immediate action by the nurse?
A) Calcium 9 mg/dl

B) Magnesium 2.5 mg/dl
C) Potassium 2.5 mEq/L
D) PTT 70 seconds

Review Information: The correct answer is C: Potassium 2.5 mEq/L
The patient is at risk for ventricular dysrhythmias when the potassium level is low.
Daniels, R. (2003).

Question23
The nurse is caring for a client who is 4 days post-op for a transverse colostomy. The client is ready for discharge and asks the nurse to empty his colostomy pouch. What is the best response by the nurse?
A) «You should be emptying the pouch yourself.»
B) «Let me demonstrate to you how to empty the pouch.»
C) «What have you learned about emptying your pouch?»
D) «Show me what you have learned about emptying your pouch.»

Review Information: The correct answer is D: «Show me what you have learned about emptying your pouch.»
Most adult learners obtain skills by participating in the activities. Anxiety about discharge can be causing the client to forget that they have mastered the skill of emptying the pouch. The client should show the nurse how the pouch is emptied.

Question24
A 3 year-old child has tympanostomy tubes in place. The child>s parent asks the nurse if he can swim in the family pool. The best response from the nurse is
A) «Your child should not swim at all while the tubes are in place.»
B) «Your child may swim in your own pool but not in a lake or ocean.»
C) «Your child may swim if he wears ear plugs.»
D) «Your child may swim anywhere.»

Review Information: The correct answer is C: «Your child may swim if he wears ear plugs.»
Water should not enter the ears. Children should use ear plugs when bathing or swimming and should not put their heads under the water.

Question25
The nurse is caring for a client with asthma who has developed gastroesophageal reflux disease (GERD). Which of the following medications prescribed for the client may aggravate GERD?
A) Anticholinergics
B) Corticosteroids
C) Histamine blocker
D) Antibiotics

Review Information: The correct answer is A: Anticholinergics
An anticholinergic medication will decrease gastric emptying and the pressure on the lower esophageal sphincter.

Question26
A client is receiving a nitroglycerin infusion for unstable angina. What assessment would be a priority when monitoring the effects of this medication?
A) Blood pressure
B) Cardiac enzymes
C) ECG analysis
D) Respiratory rate

Review Information: The correct answer is A: Blood pressure
Since an effect of this drug is vasodilation, the client must be monitored for hypotension.

Question27
The nurse is caring for a 10 year-old child who has just been diagnosed with diabetes insipidus. The parents ask about the treatment prescribed, vasopressin. A What is priority in teaching the child and family about this drug?
A) The child should carry a nasal spray for emergency use
B) The family must observe the child for dehydration
C) Parents should administer the daily intramuscular injections
D) The client needs to take daily injections in the short-term

Review Information: The correct answer is A:

The child should carry a nasal spray for emergency use
Diabetes insipidus results from reduced secretion of the antidiuretic hormone, vasopressin. The child will need to administer daily injections of vasopressin, and should have the nasal spray form of the medication readily available. A medical alert tag should be worn.

Question28

A client diagnosed with cirrhosis is started on lactulose (Cephulac). The main purpose of the drug for this client is to
A) add dietary fiber
B) reduce ammonia levels
C) stimulate peristalsis
D) control portal hypertension

Review Information: The correct answer is B: reduce ammonia levels
Lactulose blocks the absorption of ammonia from the GI tract and secondarily stimulates bowel elimination.

Question29

The nurse is explaining the effects of cocaine abuse to a pregnant client. Which of the following must the nurse understand as a basis for teaching?
A) Cocaine use can cause fetal growth retardation
B) The drug has been linked to neural tube defects
C) Newborn withdrawal generally occurs immediately after birth
D) Breast feeding promotes positive parenting behaviors

Review Information: The correct answer is A: Cocaine use can cause fetal growth retardation
Cocaine is vasoconstrictive, and this effect in the placental vessels causes fetal hypoxia and diminished growth. Other risks of continued cocaine use during pregnancy include preterm labor, congenital abnormalities, altered brain development and subsequent behavioral problems in the infant.

Question30

A client has just been diagnosed with breast cancer. The nurse enters the room and the client tells the nurse that she is stupid. What is the most therapeutic response by the nurse?
A) Explore what is going on with the client
B) Accept the client's statement without comment
C) Tell the client that the comment is inappropriate
D) Leave the client>s room

Review Information: The correct answer is A: Explore what is going on with the client
Exploring feelings with the verbally aggressive client helps to put angry feelings into words and then to engage in problem solving.

Question31

A client has many delusions. As the nurse helps the client prepare for breakfast the client comments «Don't waste good food on me. I'm dying from this disease I have.» The appropriate response would be
A) «You need some nutritious food to help you regain your weight.»
B) «None of the laboratory reports show that you have any physical disease.»
C) «Try to eat a little bit, breakfast is the most important meal of the day.»
D) «I know you believe that you have an incurable disease.»

Review Information: The correct answer is D: «I know you believe that you have an incurable disease.»
This response does not challenge the client's delusional system and thus forms an alliance by providing reassurance of desire to help the client.

Question32

A client with paranoid thoughts refuses to eat because of the belief that the food is poisoned. The appropriate statement at this time for the nurse to say is
A) «Here, I will pour a little of the juice in a medicine cup to drink it to show you that it is OK.»
B) «The food has been prepared in our kitchen and is not poisoned.»
C) «Let>s see if your partner could bring food from home.»
D) «If you don>t eat, I will have to suggest for you to be tube fed.»

Review Information: The correct answer is C: «Let>>s see if your partner could bring food from home.»
Reassurance is ineffective when a client is actively delusional. This option avoids both arguing with the client and agreeing with the delusional premise. Option D offers a logical response to a primarily affective concern. When the client's condition has improved, gentle negation of the delusional premise can be employed.

Question33

A client with tuberculosis is started on Rifampin. Which one of the following statements by the nurse would be appropriate to include in teaching? «You may notice:
A) an orange-red color to your urine.»
B) your appetite may increase for the first week."
C) it is common to experience occasional sleep disturbances.»
D) if you take the medication with food, you may have nausea.»

Review Information: The correct answer is A: an orange-red color to your urine.»
Discoloration of the urine and other body fluids may occur. It is a harmless response to the drug, but the patient needs to be aware it may happen.

Question34

A client tells the RN she has decided to stop taking sertraline (Zoloft) because she doesn't like the nightmares, sex dreams, and obsessions she's experiencing since starting on the medication. What is an appropriate response by the nurse?
A) «It is unsafe to abruptly stop taking any prescribed medication.»
B) «Side effects and benefits should be discussed with your health care provider.»
C) «This medication should be continued despite unpleasant symptoms.»
D) «Many medications have potential side effects.»

Review Information: The correct answer is A: «It is unsafe to abruptly stop taking any prescribed medication.»
Abrupt withdrawal may occasionally cause serotonin syndrome, consisting of lethargy, nausea, headache, fever, sweating and chills. A slow withdrawal may be prescribed with sertraline to avoid dizziness, nausea, vomiting, and diarrhea.

Question35

A client is admitted to the hospital with findings of liver failure with ascites. The health care provider orders spironolactone (Aldactone). What is the pharmacological effect of this medication?
A) Promotes sodium and chloride excretion
B) Increases aldosterone levels
C) Depletes potassium reserves
D) Combines safely with antihypertensives

Review Information: The correct answer is A: Promotes sodium and chloride excretion
Spironolactone promotes sodium and chloride excretion while sparing potassium and decreasing aldosterone levels. It had no effect on ammonia levels.

Question36

A client was admitted to the psychiatric unit for severe depression. After several days, the client continues to withdraw from the other clients. Which of these statements by the nurse would be the most appropriate to promote interaction with other clients?
A) «Your team here thinks it>s good for you to spend time with others.»
B) «It is important for you to participate in group activities.»
C) «Come with me so you can paint a picture to help you feel better.»
D) «Come play Chinese Checkers with Gloria and me.»

Review Information: The correct answer is D: «Come play Chinese Checkers with Gloria and me.»
This gradually engages the client in interactions with others in small groups rather than large groups. In addition, focusing on an activity is less anxiety-provoking than unstructured discussion. The statement is an example of a positive behavioral expectation.

Question37

The nurse is teaching a school-aged child and

family about the use of inhalers prescribed for asthma. What is the best way to evaluate effectiveness of the treatments?

A) Rely on child>s self-report
B) Use a peak-flow meter
C) Note skin color changes
D) Monitor pulse rate

Review Information: The correct answer is B: Use a peak-flow meter
The peak flowmeter, if used correctly, shows effectiveness of inhalants.

Question38

The nurse is teaching a client about the toxicity of digoxin. Which one of the following statements made by the client to the nurse indicates more teaching is needed?
A) «I may experience a loss of appetite.»
B) «I can expect occasional double vision.»
C) «Nausea and vomiting may last a few days.»
D) «I must report a bounding pulse of 62 immediately.»

Review Information: The correct answer is D: «I must report a bounding pulse of 62 immediately.»
Slow heart rate is related to increased cardiac output and an intended effect of digoxin. The ideal heart rate is above 60 BPM with digoxin. The client needs further teaching.

Question39

Which of the following assessments by the nurse would indicate that the client is having a possible adverse response to the isoniazid (INH)?
A) Severe headache
B) Appearance of jaundice
C) Tachycardia
D) Decreased hearing

Review Information: The correct answer is B: Appearance of jaundice
Clients receiving INH therapy are at risk for developing drug induced hepatitis. The appearance of jaundice may indicate that the client has liver damage.

Question40

The nurse is beginning nutritional counseling/teaching with a pregnant woman. What is the initial step in this interaction?

A) Teach her how to meet the needs of self and her family
B) Explain the changes in diet necessary for pregnant women
C) Questionher understanding and use of the food pyramid
D) Conduct a diet history to determine her normal eating routines

Review Information: The correct answer is D: Conduct a diet history to determine her normal eating routines.

Assessment is always the first step in planning teaching for any client. A thorough and accurate history is essential for gathering the needed information.

0 comments

Labels: free nclex-rn sample review questions, nclex-rn practice test questions, nursing review

Free NCLEX-RN Sample Test Questions For Nursing Review (Part 1)

These are sample nursing review questions and not actual test questions made for educational and practice test purposes only. 75 questions have been posted here with answer keys.

Question1

A client has been hospitalized after an automobile accident. A full leg cast was applied in the emergency room. The most important reason for the nurse to elevate the casted leg is to
A) Promote the client>s comfort
B) Reduce the drying time
C) Decrease irritation to the skin
D) Improve venous return

Review Information: The correct answer is D: Improve venous return. Elevating the leg both improves venous return and reduces swelling. Client comfort will be improved as well.

Question2

The nurse is reviewing with a client how to collect a clean catch urine specimen. What is the appropriate sequence to teach the client?

A) Clean the meatus, begin voiding, then catch urine stream
B) Void a little, clean the meatus, then collect specimen
C) Clean the meatus, then urinate into container
D) Void continuously and catch some of the urine

Review Information: The correct answer is A: Clean the meatus, begin voiding, then catch urine stream. A clean catch urine is difficult to obtain and requires clear directions. Instructing the client to carefully clean the meatus, then void naturally with a steady stream prevents surface bacteria from contaminating the urine specimen. As starting and stopping flow can be difficult, once the client begins voiding it>>s best to just slip the container into the stream. Other responses do not reflect correct technique.

Question3

Following change-of-shift report on an orthopedic unit, which client should the nurse see first?
A) 16 year-old who had an open reduction of a fractured wrist 10 hours ago
B) 20 year-old in skeletal traction for 2 weeks since a motor cycle accident
C) 72 year-old recovering from surgery after a hip replacement 2 hours ago
D) 75 year-old who is in skin traction prior to planned hip pinning surgery.

Review Information: The correct answer is C: 72 year-old recovering from surgery after a hip replacement 2 hours ago. Look for the client who has the most imminent risks and acute vulnerability. The client who returned from surgery 2 hours ago is at risk for life threatening hemorrhage and should be seen first. The 16 year-old should be seen next because it is still the first post-op day. The 75 year-old is potentially vulnerable to age-related physical and cognitive consequences in skin traction should be seen next. The client who can safely be seen last is the 20 year-old who is 2 weeks post-injury.

Question4

A client with Guillain Barre is in a nonresponsive state, yet vital signs are stable and breathing is independent. What should the nurse document to most accurately describe the client>s condition?
A) Comatose, breathing unlabored
B) Glascow Coma Scale 8, respirations regular
C) Appears to be sleeping, vital signs stable
D) Glascow Coma Scale 13, no ventilator required

Review Information: The correct answer is B: Glascow Coma Scale 8, respirations regular. The Glascow Coma Scale provides a standard reference for assessing or monitoring level of consciousness. Any score less than 13 indicates a neurological impairment. Using the term comatose provides too much room for interpretation and is not very precise.

Question5

When caring for a client receiving warfarin sodium (Coumadin), which lab test would the nurse monitor to determine therapeutic response to the drug?
A) Bleeding time
B) Coagulation time
C) Prothrombin time
D) Partial thromboplastin time

Review Information: The correct answer is C: Prothrombin time. Coumadin is ordered daily, based on the client>>s prothrombin time (PT). This test evaluates the adequacy of the extrinsic system and common pathway in the clotting cascade; Coumadin affects the Vitamin K dependent clotting factors.

Question6

A client with moderate persistent asthma is admitted for a minor surgical procedure. On admission the peak flow meter is measured at 480 liters/minute. Post-operatively the client is complaining of chest tightness. The peak flow has dropped to 200 liters/minute. What should the nurse do first?
A) Notify both the surgeon and provider
B) Administer the prn dose of albuterol
C) Apply oxygen at 2 liters per nasal cannula
D) Repeat the peak flow reading in 30 minutes

Review Information: The correct answer is B: Administer the prn dose of albuterol. Peak flow monitoring during exacerbations of asthma is recommended for clients with moderate-to-severe persistent asthma to determine the severity of the exacerbation and to guide the treatment. A peak flow reading of less than 50% of the client>>s baseline reading is a medical alert condition and a short-acting beta-agonist must be taken immediately.

Question7

A client had 20 mg of Lasix (furosemide) PO at 10 AM. Which would be essential for the nurse to include at the change of shift report?

A) The client lost 2 pounds in 24 hours

B) The client's potassium level is 4 mEq/liter.

C) The client's urine output was 1500 cc in 5 hours

D) The client is to receive another dose of Lasix at 10 PM

Review Information: The correct answer is C: The client's urine output was 1500 cc in 5 hours. Although all of these may be correct information to include in report, the essential piece would be the urine output.

Question8

A client has been tentatively diagnosed with Graves> disease (hyperthyroidism). Which of these findings noted on the initial nursing assessment requires quick intervention by the nurse?

A) a report of 10 pounds weight loss in the last month

B) a comment by the client «I just can>t sit still.»

C) the appearance of eyeballs that appear to «pop» out of the client>s eye sockets

D) a report of the sudden onset of irritability in the past 2 weeks

Review Information: The correct answer is C: the appearance of eyeballs that appear to «pop» out of the client>>s eye sockets. Exophthalmos or protruding eyeballs is a distinctive characteristic of Graves>> Disease. It can result in corneal abrasions with severe eye pain or damage when the eyelid is unable to blink down over the protruding eyeball. Eye drops or ointment may be needed.

Question9

The nurse has performed the initial assessments of 4 clients admitted with an acute episode of asthma. Which assessment finding would cause the nurse to call the provider immediately?

A) prolonged inspiration with each breath

B) expiratory wheezes that are suddenly absent in 1 lobe

C) expectoration of large amounts of purulent mucous

D) appearance of the use of abdominal muscles for breathing

Review Information: The correct answer is B: expiratory wheezes that are suddenly absent in 1 lobe. Acute asthma is characterized by expiratory wheezes caused by obstruction of the airways. Wheezes are a high pitched musical sounds produced by air moving through narrowed airways. Clients often associate wheezes with the feeling of tightness in the chest. However, sudden cessation of wheezing is an ominous or bad sign that indicates an emergency -- the small airways are now collapsed.

Question10

During the initial home visit, a nurse is discussing the care of a client newly diagnosed with Alzheimer>s disease with family members. Which of these interventions would be most helpful at this time?

A) leave a book about relaxation techniques

B) write out a daily exercise routine for them to assist the client to do

C) list actions to improve the client>s daily nutritional intake

D) suggest communication strategies

Review Information: The correct answer is D: suggest communication strategies. Alzheimer>>s disease, a progressive chronic illness, greatly challenges caregivers. The nurse can be of greatest assistance in helping the family to use communication strategies to enhance their ability to relate to the client. By use of select verbal and nonverbal communication strategies the family can best support the client's strengths and cope with any aberrant behavior.

Question11

An 80 year-old client admitted with a diagnosis of possible cerebral vascular accident has had a blood pressure from 160/100 to 180/110 over the past 2 hours. The nurse has also noted increased lethargy. Which assessment finding should the nurse report immediately to the provider?
A) Slurred speech
B) Incontinence
C) Muscle weakness
D) Rapid pulse

Review Information: The correct answer is A: Slurred speech. Changes in speech patterns and level of conscious can be indicators of continued intracranial bleeding or extension of the stroke. Further diagnostic testing may be indicated.

Question12

A school-aged child has had a long leg (hip to ankle) synthetic cast applied 4 hours ago. Which statement from the parent indicates that teaching has been inadequate?
A) «I will keep the cast uncovered for the next day to prevent burning of the skin.»
B) «I can apply an ice pack over the area to relieve itching inside the cast.»
C) «The cast should be propped on at least 2 pillows when my child is lying down.»
D) «I think I remember that my child should not stand until after 72 hours.»

Review Information: The correct answer is D: «I think I remember that my child should not stand until after 72 hours.». Synthetic casts will typically set up in 30 minutes and dry in a few hours. Thus, the client may stand within the initial 24 hours. With plaster casts, the set up and drying time, especially in a long leg cast which is thicker than an arm cast, can take up to 72 hours. Both types of casts give off a lot of heat when drying and it is preferable to keep the cast uncovered for the first 24 hours. Clients may complain of a chill from the wet cast and therefore can simply be covered lightly with a sheet or blanket. Applying ice is a safe method of relieving the itching.

Question13

Which blood serum finding in a client with diabetic ketoacidosis alerts the nurse that immediate action is required?
A) pH below 7.3
B) Potassium of 5.0
C) HCT of 60
D) Pa O2 of 79%

Review Information: The correct answer is C: HCT of 60. This high hematocrit is indicative of severe dehydration which requires priority attention in diabetic ketoacidosis. Without sufficient hydration, all systems of the body are at risk for hypoxia from a lack of or sluggish circulation. In the absence of insulin, which facilitates the transport of glucose into the cell, the body breaks down fats and proteins to supply energy ketones, a by-product of fat metabolism. These accumulate causing metabolic acidosis (pH < 7.3), which would be the second concern for this client. The potassium and PaO2 levels are near normal.

Question14

The nurse is preparing a client with a deep vein thrombosis (DVT) for a Venous Doppler evaluation. Which of the following would be necessary for preparing the client for this test?
A) Client should be NPO after midnight
B) Client should receive a sedative medication prior to the test
C) Discontinue anti-coagulant therapy prior to the test
D) No special preparation is necessary

Review Information: The correct answer is D: No special preparation is necessary. This is a non-invasive procedure and does not require preparation other than client education.

Question15

A client is admitted with infective endocarditis (IE). Which finding would alert the nurse to a complication of this condition?
A) dyspnea
B) heart murmur
C) macular rash
D) hemorrhage

Review Information: The correct answer is B: heart murmur. Large, soft, rapidly developing vegetations attach to the heart valves. They have a tendency to break off, causing emboli and leav-

ing ulcerations on the valve leaflets. These emboli produce findings of cardiac murmur, fever, anorexia, malaise and neurologic sequelae of emboli. Furthermore, the vegetations may travel to various organs such as spleen, kidney, coronary artery, brain and lungs, and obstruct blood flow.

Question16

The nurse explains an autograft to a client scheduled for excision of a skin tumor. The nurse knows the client understands the procedure when the client says, «I will receive tissue from

A) a tissue bank.»
B) a pig.»
C) my thigh.»
D) synthetic skin.»

Review Information: The correct answer is C: my thigh.». Autografts are done with tissue transplanted from the client>>s own skin.

Question17

A client is admitted to the emergency room following an acute asthma attack. Which of the following assessments would be expected by the nurse?

A) Diffuse expiratory wheezing
B) Loose, productive cough
C) No relief from inhalant
D) Fever and chills

Review Information: The correct answer is A: Diffuse expiratory wheezing. In asthma, the airways are narrowed, creating difficulty getting air in. A wheezing sound results.

Question18

A client has been admitted with a fractured femur and has been placed in skeletal traction. Which of the following nursing interventions should receive priority?

A) Maintaining proper body alignment
B) Frequent neurovascular assessments of the affected leg
C) Inspection of pin sites for evidence of drainage or inflammation
D) Applying an over-bed trapeze to assist the client with movement in bed

Review Information: The correct answer is B: Frequent neurovascular assessments of the affected leg. The most important activity for the nurse is to assess neurovascular status. Compartment syndrome is a serious complication of fractures. Prompt recognition of this neurovascular problem and early intervention may prevent permanent limb damage.

Question19

The nurse is assigned to care for a client who had a myocardial infarction (MI) 2 days ago. The client has many questions about this condition. What area is a priority for the nurse to discuss at this time?

A) Daily needs and concerns
B) The overview cardiac rehabilitation
C) Medication and diet guideline
D) Activity and rest guidelines

Review Information: The correct answer is A: Daily needs and concerns. At 2 days post-MI, the client's education should be focused on the immediate needs and concerns for the day.

Question20

A 3 year-old child is brought to the clinic by his grandmother to be seen for «scratching his bottom and wetting the bed at night.» Based on these complaints, the nurse would initially assess for which problem?

A) allergies
B) scabies
C) regression
D) pinworms

Review Information: The correct answer is D: pinworms. Signs of pinworm infection include intense perianal itching, poor sleep patterns, general irritability, restlessness, bed-wetting, distractibility and short attention span. Scabies is an itchy skin condition caused by a tiny, eight-legged burrowing mite called Sarcoptes scabiei . The presence of the mite leads to intense itching in the area of its burrows.

Question21

The nurse is caring for a newborn with tracheoesophageal fistula. Which nursing diagno-

sis is a priority?
A) Risk for dehydration
B) Ineffective airway clearance
C) Altered nutrition
D) Risk for injury

Review Information: The correct answer is B: Ineffective airway clearance. The most common form of TEF is one in which the proximal esophageal segment terminates in a blind pouch and the distal segment is connected to the trachea or primary bronchus by a short fistula at or near the bifurcation. Thus, a priority is maintaining an open airway, preventing aspiration. Other nursing diagnoses are then addressed.

Question22
The nurse is developing a meal plan that would provide the maximum possible amount of iron for a child with anemia. Which dinner menu would be best?
A) Fish sticks, french fries, banana, cookies, milk
B) Ground beef patty, lima beans, wheat roll, raisins, milk
C) Chicken nuggets, macaroni, peas, cantaloupe, milk
D) Peanut butter and jelly sandwich, apple slices, milk

Review Information: The correct answer is B: Ground beef patty, lima beans, wheat roll, raisins, milk. Iron rich foods include red meat, fish, egg yolks, green leafy vegetables, legumes, whole grains, and dried fruits such as raisins. This dinner is the best choice: It is high in iron and is appropriate for a toddler.

Question23
The nurse admitting a 5 month-old who vomited 9 times in the past 6 hours should observe for signs of which overall imbalance?
A) Metabolic acidosis
B) Metabolic alkalosis
C) Some increase in the serum hemoglobin
D) A little decrease in the serum potassium

Review Information: The correct answer is B: Metabolic alkalosis. Vomiting causes loss of acid from the stomach. Prolonged vomiting can result in excess loss of acid and lead to metabolic alkalosis. Findings include irritability, increased activity, hyperactive reflexes, muscle twitching and elevated pulse. Options C and D are correct answers but not the best answers since they are too general.

Question24
A two year-old child is brought to the provider>s office with a chief complaint of mild diarrhea for two days. Nutritional counseling by the nurse should include which statement?
A) Place the child on clear liquids and gelatin for 24 hours
B) Continue with the regular diet and include oral rehydration fluids
C) Give bananas, apples, rice and toast as tolerated
D) Place NPO for 24 hours, then rehydrate with milk and water

Review Information: The correct answer is B: Continue with the regular diet and include oral rehydration fluids. Current recommendations for mild to moderate diarrhea are to maintain a normal diet with fluids to rehydrate.

Question25
The nurse is teaching parents about the appropriate diet for a 4 month-old infant with gastroenteritis and mild dehydration. In addition to oral rehydration fluids, the diet should include

A) formula or breast milk
B) broth and tea
C) rice cereal and apple juice
D) gelatin and ginger ale

Review Information: The correct answer is A: formula or breast milk. The usual diet for a young infant should be followed.

Question26
A child is injured on the school playground and appears to have a fractured leg. The first action the school nurse should take is

A) call for emergency transport to the hospital
B) immobilize the limb and joints above and below the injury
C) assess the child and the extent of the injury

D) apply cold compresses to the injured area

Review Information: The correct answer is C: assess the child and the extent of the injury. When applying the nursing process, assessment is the first step in providing care. The «5 Ps» of vascular impairment can be used as a guide (pain, pulse, pallor, paresthesia, paralysis).

Question27

The mother of a 3 month-old infant tells the nurse that she wants to change from formula to whole milk and add cereal and meats to the diet. What should be emphasized as the nurse teaches about infant nutrition?

A) Solid foods should be introduced at 3-4 months
B) Whole milk is difficult for a young infant to digest
C) Fluoridated tap water should be used to dilute milk
D) Supplemental apple juice can be used between feedings

Review Information: The correct answer is B: Whole milk is difficult for a young infant to digest. Cow>>s milk is not given to infants younger than 1 year because the tough, hard curd is difficult to digest. In addition, it contains little iron and creates a high renal solute load.

Question28

The nurse is preparing a handout on infant feeding to be distributed to families visiting the clinic. Which notation should be included in the teaching materials?

A) Solid foods are introduced one at a time beginning with cereal
B) Finely ground meat should be started early to provide iron
C) Egg white is added early to increase protein intake
D) Solid foods should be mixed with formula in a bottle

Review Information: The correct answer is A: Solid foods are introduced one at a time beginning with cereal. Solid foods should be added one at a time between 4-6 months. If the infant is able to tolerate the food, another may be added in a week. Iron fortified cereal is the recommended first food.

Question29

The nurse planning care for a 12 year-old child with sickle cell disease in a vaso-occlusive crisis of the elbow should include which one of the following as a priority?

A) Limit fluids
B) Client controlled analgesia
C) Cold compresses to elbow
D) Passive range of motion exercise

Review Information: The correct answer is B: Client controlled analgesia. Management of a sickle cell crisis is directed towards supportive and symptomatic treatment. The priority of care is pain relief. In a 12 year-old child, client controlled analgesia promotes maximum comfort.

Question30

The nurse is performing a physical assessment on a toddler. Which of the following actions should be the first?

A) Perform traumatic procedures
B) Use minimal physical contact
C) Proceed from head to toe
D) Explain the exam in detail

Review Information: The correct answer is B: Use minimal physical contact. The nurse should approach the toddler slowly and use minimal physical contact initially so as to gain the toddler>>s cooperation. Be flexible in the sequence of the exam, and give only brief simple explanations just prior to the action.

Question31

What finding signifies that children have attained the stage of concrete operations (Piaget)?

A) Explores the environment with the use of sight and movement
B) Thinks in mental images or word pictures
C) Makes the moral judgment that «stealing is wrong»
D) Reasons that homework is time-consuming yet necessary

Review Information: The correct answer is C: Makes the moral judgment that «stealing is wrong». The stage of concrete operations is depicted by logical thinking and moral judgments.

Question32

The mother of a child with a neural tube defect asks the nurse what she can do to decrease the chances of having another baby with a neural tube defect. What is the best response by the nurse?

A) «Folic acid should be taken before and after conception.»
B) «Multivitamin supplements are recommended during pregnancy.»
C) «A well balanced diet promotes normal fetal development.»
D) «Increased dietary iron improves the health of mother and fetus.»

Review Information: The correct answer is A: «Folic acid should be taken before and after conception.». The American Academy of Pediatrics recommends that all childbearing women increase folic acid from dietary sources and/or supplements. There is evidence that increased amounts of folic acid prevents neural tube defects.

Question33

The provider orders Lanoxin (digoxin) 0.125 mg PO and furosemide 40 mg every day. Which of these foods would the nurse reinforce for the client to eat at least daily?

A) Spaghetti
B) Watermelon
C) Chicken
D) Tomatoes

Review Information: The correct answer is B: Watermelon. Watermelon is high in potassium and will replace potassium lost by the diuretic. The other foods are not high in potassium.

Question34

While teaching the family of a child who will take phenytoin (Dilantin) regularly for seizure control, it is most important for the nurse to teach them about which of the following actions?

A) Maintain good oral hygiene and dental care
B) Omit medication if the child is seizure free
C) Administer acetaminophen to promote sleep
D) Serve a diet that is high in iron

Review Information: The correct answer is A: Maintain good oral hygiene and dental care. Swollen and tender gums occur often with use of phenytoin. Good oral hygiene and regular visits to the dentist should be emphasized.

Question35

The nurse is offering safety instructions to a parent with a four month-old infant and a four year-old child. Which statement by the parent indicates understanding of appropriate precautions to take with the children?

A) «I strap the infant car seat on the front seat to face backwards.»
B) «I place my infant in the middle of the living room floor on a blanket to play with my four year-old while I make supper in the kitchen.»
C) «My sleeping baby lies so cute in the crib with the little buttocks stuck up in the air while the four year-old naps on the sofa.»
D) «I have the four year-old hold and help feed the four month-old a bottle in the kitchen while I make supper.»

Review Information: The correct answer is D: «I have the four year-old hold and help feed the four month-old a bottle in the kitchen while I make supper.». The infant seat is to be placed on the rear seat. Small children and infants are not to be left unsupervised. Infants are

Question36

The nurse admits a 7 year-old to the emergency room after a leg injury. The x-rays show a femur fracture near the epiphysis. The parents ask what will be the outcome of this injury. The appropriate response by the nurse should be which of these statements?

A) «The injury is expected to heal quickly because of thin periosteum.»
B) «In some instances the result is a retarded

bone growth.»
C) «Bone growth is stimulated in the affected leg.»
D) «This type of injury shows more rapid union than that of younger children.»

Review Information: The correct answer is B: «In some instances the result is a retarded bone growth.». An epiphyseal (growth) plate fracture in a 7 year-old often results in retarded bone growth. The leg often will be different in length than the uninjured leg.

Question37

The parents of a 4 year-old hospitalized child tell the nurse, “We are leaving now and will be back at 6 PM.” A few hours later the child asks the nurse when the parents will come again. What is the best response by the nurse?

A) «They will be back right after supper.»
B) «In about 2 hours, you will see them.»
C) «After you play awhile, they will be here.»
D) «When the clock hands are on 6 and 12.»

Review Information: The correct answer is A: «They will be back right after supper.». Time is not completely understood by a 4 year-old. Preschoolers interpret time with their own frame of reference. Thus, it is best to explain time in relationship to a known, common event.

Question38

The nurse is giving instructions to the parents of a child with cystic fibrosis. The nurse would emphasize that pancreatic enzymes should be taken
A) once each day
B) 3 times daily after meals
C) with each meal or snack
D) each time carbohydrates are eaten

Review Information: The correct answer is C: with each meal or snack. Pancreatic enzymes should be taken with each meal and every snack to allow for digestion of all foods that are eaten.

Question39

A nurse is providing a parenting class to individuals living in a community of older homes. In discussing formula preparation, which of the following is most important to prevent lead poisoning?

A) Use ready-to-feed commercial infant formula
B) Boil the tap water for 10 minutes prior to preparing the formula
C) Let tap water run for 2 minutes before adding to concentrate
D) Buy bottled water labeled «lead free» to mix the formula

Review Information: The correct answer is C: Let tap water run for 2 minutes before adding to concentrate. Use of lead-contaminated water to prepare formula is a major source of poisoning in infants. Drinking water may be contaminated by lead from old lead pipes or lead solder used in sealing water pipes. Letting tap water run for several minutes will diminish the lead contamination.

Question40

Which of the following manifestations observed by the school nurse confirms the presence of pediculosis capitis in students?

A) Scratching the head more than usual
B) Flakes evident on a student>s shoulders
C) Oval pattern occipital hair loss
D) Whitish oval specks sticking to the hair

Review Information: The correct answer is D: Whitish oval specks sticking to the hair. Diagnosis of pediculosis capitis is made by observation of the white eggs (nits) firmly attached to the hair shafts. Treatment can include application of a medicated shampoo with lindane for children over 2 years of age, and meticulous combing and removal of all nits.

Question41

When interviewing the parents of a child with asthma, it is most important to assess the child>s environment for what factor?

A) Household pets
B) New furniture
C) Lead based paint
D) Plants such as cactus

Review Information: The correct answer is A:

Household pets. Animal dander is a very common allergen affecting persons with asthma. Other triggers may include pollens, carpeting and household dust.

Question42

The mother of a 2 month-old baby calls the nurse 2 days after the first DTaP, IPV, Hepatitis B and HIB immunizations. She reports that the baby feels very warm, cries inconsolably for as long as 3 hours, and has had several shaking spells. In addition to referring her to the emergency room, the nurse should document the reaction on the baby>s record and expect which immunization to be most associated with the findings the infant is displaying?

A) DTaP
B) Hepatitis B
C) Polio
D) H. Influenza

Review Information: The correct answer is A: DTaP. The majority of reactions occur with the administration of the DTaP vaccination. Contradictions to giving repeat DTaP immunizations include the occurrence of severe side effects after a previous dose as well as signs of encephalopathy within 7 days of the immunization.

Question43

The mother of a 2 year-old hospitalized child asks the nurse>s advice about the child>s screaming every time the mother gets ready to leave the hospital room. What is the best response by the nurse?

A) «I think you or your partner needs to stay with the child while in the hospital.»
B) «Oh, that behavior will stop in a few days.»
C) «Keep in mind that for the age this is a normal response to being in the hospital.»
D) «You might want to «sneak out» of the room once the child falls asleep.»

Review Information: The correct answer is C: «Keep in mind that for the age this is a normal response to being in the hospital.». The protest phase of separation anxiety is a normal response for a child this age. In toddlers, ages 1 to 3, separation anxiety is at its peak

Question44

A couple experienced the loss of a 7 month-old fetus. In planning for discharge, what should the nurse emphasize?

A) To discuss feelings with each other and use support persons
B) To focus on the other healthy children and move through the loss
C) To seek causes for the fetal death and come to some safe conclusion
D) To plan for another pregnancy within 2 years and maintain physical health

Review Information: The correct answer is A: To discuss feelings with each other and use support persons. To communicate in a therapeutic manner, the nurse>>s goal is to help the couple begin the grief process by suggesting they talk to each other, seek family, friends and support groups to listen to their feelings.

Question45

The nurse is performing a pre-kindergarten physical on a 5 year-old. The last series of vaccines will be administered. What is the preferred site for injection by the nurse?

A) vastus intermedius
B) gluteus maximus
C) vastus lateralis
D) dorsogluteal

Review Information: The correct answer is C: vastus lateralis. Vastus lateralis, a large and well developed muscle, is the preferred site, since it is removed from major nerves and blood vessels.

Question46

A 7 month pregnant woman is admitted with complaints of painless vaginal bleeding over several hours. The nurse should prepare the client for an immediate

A) Non stress test
B) Abdominal ultrasound
C) Pelvic exam
D) X-ray of abdomen

Review Information: The correct answer is B: Abdominal ultrasound. The standard for diagnosis of placenta previa, which is suggested in the client>>s history of painless bleeding, is abdominal ultrasound.

Question47

A nurse entering the room of a postpartum mother observes the baby lying at the edge of the bed while the woman sits in a chair. The mother states «This is not my baby, and I do not want it.» After repositioning the child safely, the nurse>s best response is

A) «This is a common occurrence after birth, but you will come to accept the baby.»
B) «Many women have postpartum blues and need some time to love the baby.»
C) «What a beautiful baby! Her eyes are just like yours.»
D) «You seem upset; tell me what the pregnancy and birth were like for you.»

Review Information: The correct answer is D: «You seem upset; tell me what the pregnancy and birth were like for you.». A non-judgmental, open ended response facilitates dialogue between the client and nurse.

Question48

The nurse notes that a 2 year-old child recovering from a tonsillectomy has an temperature of 98.2 degrees Fahrenheit at 8:00 AM. At 10:00 AM the child>s parent reports that the child «feels very warm» to touch. The first action by the nurse should be to

A) reassure the parent that this is normal
B) offer the child cold oral fluids
C) reassess the child>s temperature
D) administer the prescribed acetaminophen

Review Information: The correct answer is C: reassess the child>>s temperature. A child>>s temperature may have rapid fluctuations. The nurse should listen to and show respect for what parents say. Parental caretakers are often quite sensitive to variations in their children>>s condition that may not be immediately evident to others.

Question49

The nurse is caring for a client who was successfully resuscitated from a pulseless dysrhythmia. Which of the following assessments is critical for the nurse to include in the plan of care?

A) hourly urine output
B) white blood count
C) blood glucose every 4 hours
D) temperature every 2 hours

Review Information: The correct answer is A: hourly urine output. Clients who have had an episode of decreased glomerular perfusion are at risk for pre-renal failure. This is caused by any abnormal decline in kidney perfusion that reduces glomerular perfusion. Pre-renal failure occurs when the effective arterial blood volume falls. Examples of this phenomena include a drop in circulating blood volume as in a cardiac arrest state or in low cardiac perfusion states such as congestive heart failure associated with a cardiomyopathy. Close observation of hourly urinary output is necessary for early detection of this condition.

Question50

A client is admitted to the rehabilitation unit following a cerebral vascular accident (CVA) and mild dysphagia. The most appropriate intervention for this client is to

A) position client in upright position while eating
B) place client on a clear liquid diet
C) tilt head back to facilitate swallowing reflex
D) offer finger foods such as crackers or pretzels

Review Information: The correct answer is A: position client in upright position while eating. An upright position facilitates proper chewing and swallowing.

Question51

A 72 year-old client with osteomyelitis requires a 6 week course of intravenous antibiotics. In planning for home care, what is the most important action by the nurse?

A) Investigating the client>s insurance coverage

for home IV antibiotic therapy
B) Determining if there are adequate hand washing facilities in the home
C) Assessing the client>s ability to participate in self care and/or the reliability of a caregiver
D) Selecting the appropriate venous access device

Review Information: The correct answer is C: Assessing the client>>s ability to participate in self care and/or the reliability of a caregiver. The cognitive ability of the client as well as the availability and reliability of a caregiver must be assessed to determine if home care is a feasible option.

Question52
A nurse administers the influenza vaccine to a client in a clinic. Within 15 minutes after the immunization was given, the client complains of itchy and watery eyes, increased anxiety, and difficulty breathing. The nurse expects that the first action in the sequence of care for this client will be to

A) Maintain the airway
B) Administer epinephrine 1:1000 as ordered
C) Monitor for hypotension with shock
D) Administer diphenhydramine as ordered

Review Information: The correct answer is B: Administer epinephrine 1:1000 as ordered. All the answers are correct given the circumstances, but the priority is to administer the epinephrine, then maintain the airway. In the early stages of anaphylaxis, when the patient has not lost consciousness and is normotensive, administering the epinephrine is first, and applying the oxygen, and watching for hypotension and shock, are later responses. The prevention of a severe crisis is maintained by using diphenhydramine.

Question53
The nurse instructs the client taking dexamethasone (Decadron) to take it with food or milk. The physiological basis for this instruction is that the medication
A) retards pepsin production
B) stimulates hydrochloric acid production
C) slows stomach emptying time
D) decreases production of hydrochloric acid

Review Information: The correct answer is B: stimulates hydrochloric acid production. Decadron increases the production of hydrochloric acid, which may cause gastrointestinal ulcers.

Question54
A client receiving chlorpromazine HCL (Thorazine) is in psychiatric home care. During a home visit the nurse observes the client smacking her lips alternately with grinding her teeth. The nurse recognizes this assessment finding as what?
A) Dystonia
B) Akathisia
C) Brady dyskinesia
D) Tardive dyskinesia

Review Information: The correct answer is D: Tardive dyskinesia. Signs of tardive dyskinesia include smacking lips, grinding of teeth and «fly catching» tongue movements. These findings are often described as Parkinsonian.

Question55
Which of the following findings contraindicate the use of haloperidol (Haldol) and warrant withholding the dose?
A) Drowsiness, lethargy, and inactivity
B) Dry mouth, nasal congestion, and blurred vision
C) Rash, blood dyscrasias, severe depression
D) Hyperglycemia, weight gain, and edema

Review Information: The correct answer is C: Rash, blood dyscrasias, severe depression. Rash and blood dyscrasias are side effects of anti-psychotic drugs. A history of severe depression is a contraindication to the use of neuroleptics.

Question56
The nurse is reinforcing teaching to a 24 year-old woman receiving acyclovir (Zovirax) for a Herpes Simplex Virus type 2 infection. Which of these instructions should the nurse give the client?

A) Complete the entire course of the medication for an effective cure
B) Begin treatment with acyclovir at the onset of symptoms of recurrence

C) Stop treatment if she thinks she may be pregnant to prevent birth defects
D) Continue to take prophylactic doses for at least 5 years after the diagnosis

Review Information: The correct answer is B: Begin treatment with acyclovir at the onset of symptoms of recurrence. When the client is aware of early symptoms, such as pain, itching or tingling, treatment is very effective. Medications for herpes simplex do not cure the disease; they simply decrease the level of symptoms.

Question57
A 14 month-old child ingested half a bottle of aspirin tablets. Which of the following would the nurse expect to see in the child?

A) Hypothermia
B) Edema
C) Dyspnea
D) Epistaxis

Review Information: The correct answer is D: Epistaxis. A large dose of aspirin inhibits prothrombin formation and lowers platelet levels. With an overdose, clotting time is prolonged.

Question58
An 80 year-old client on digitalis (Lanoxin) reports nausea, vomiting, abdominal cramps and halo vision. Which of the following laboratory results should the nurse analyze first?

A) Potassium levels
B) Blood pH
C) Magnesium levels
D) Blood urea nitrogen

Review Information: The correct answer is A: Potassium levels. The most common cause of digitalis toxicity is a low potassium level. Clients must be taught that it is important to have adequate potassium intake especially if taking diuretics that enhance the loss of potassium while they are taking digitalis.

Question59
A 42 year-old male client refuses to take propranolol hydrochloride (Inderal) as prescribed. Which client statement from the assessment data is likely to explain his noncompliance?

A) «I have problems with diarrhea.»
B) «I have difficulty falling asleep.»
C) «I have diminished sexual function.»
D) «I often feel jittery.»

Review Information: The correct answer is C: «I have diminished sexual function.». Inderal, a beta-blocking agent used in hypertension, prohibits the release of epinephrine into the cells; this may result in hypotension which results in decreased libido and impotence.

Question60
The nurse caring for a 9 year-old child with a fractured femur is told that a medication error occurred. The child received twice the ordered dose of morphine an hour ago. Which nursing diagnosis is a priority at this time?

A) Risk for fluid volume deficit related to morphine overdose
B) Decreased gastrointestinal mobility related to mucosal irritation
C) Ineffective breathing patterns related to central nervous system depression
D) Altered nutrition related to inability to control nausea and vomiting

Review Information: The correct answer is C: Ineffective breathing patterns related to central nervous system depression. Respiratory depression is a life-threatening risk in this overdose.

Question61
Lactulose (Chronulac) has been prescribed for a client with advanced liver disease. Which of the following assessments would the nurse use to evaluate the effectiveness of this treatment?

A) An increase in appetite
B) A decrease in fluid retention
C) A decrease in lethargy
D) A reduction in jaundice

Review Information: The correct answer is C: A decrease in lethargy. Lactulose produces an acid environment in the bowel and traps ammonia in the gut; the laxative effect then aids in

removing the ammonia from the body. This decreases the effects of hepatic encephalopathy, including lethargy and confusion.

Question62

The nurse is teaching a class on HIV prevention. Which of the following should be emphasized as increasing risk?

A) Donating blood
B) Using public bathrooms
C) Unprotected sex
D) Touching a person with AIDS

Review Information: The correct answer is C: Unprotected sex. Because HIV is spread through exposure to bodily fluids, unprotected intercourse and shared drug paraphernalia remain the highest risks for infection.

Question63

While interviewing a new admission, the nurse notices that the client is shifting positions, wringing her hands, and avoiding eye contact. It is important for the nurse to
A) ask the client what she is feeling
B) assess the client for auditory hallucinations
C) recognize the behavior as a side effect of medication
D) re-focus the discussion on a less anxiety provoking topic

Review Information: The correct answer is A: ask the client what she is feeling. The initial step in anxiety intervention is observing, identifying, and assessing anxiety. The nurse should seek client validation of the accuracy of nursing assessments and avoid drawing conclusions based on limited data. In the situation above, the client may simply need to use the restroom but be reluctant to communicate her need!

Question64

A young adult seeks treatment in an outpatient mental health center. The client tells the nurse he is a government official being followed by spies. On further questioning, he reveals that his warnings must be heeded to prevent nuclear war. What is the most therapeutic approach by the nurse?

A) Listen quietly without comment
B) Ask for further information on the spies
C) Confront the client's delusion
D) Contact the government agency

Review Information: The correct answer is A: Listen quietly without comment. The client>>s comments demonstrate grandiose ideas. The most therapeutic response is to listen but avoid being incorporated into the client's delusional system.

Question65

The nurse is assessing a 17 year-old female client with bulimia. Which of the following laboratory reports would the nurse anticipate?

A) Increased serum glucose
B) Decreased albumin
C) Decreased potassium
D) Increased sodium retention

Review Information: The correct answer is C: Decreased potassium. In bulimia, loss of electrolytes can occur in addition to other findings of starvation and dehydration.

Question66

A client, recovering from alcoholism, asks the nurse, «What can I do when I start recognizing relapse triggers within myself?» How might the nurse best respond?

A) «When you have the impulse to stop in a bar, contact a sober friend and talk with him.»
B) «Go to an AA meeting when you feel the urge to drink.»
C) «It is important to exercise daily and get involved in activities that will cause you not to think about drug use.»
D) «Let's talk about possible options you have when you recognize relapse triggers in yourself.»

Review Information: The correct answer is D: «Let's talk about possible options you have when you recognize relapse triggers in yourself.». This option encourages the process of self evaluation and problem solving, while avoiding telling the client what to do. Encouraging the client to brainstorm about response options validates the

nurse's belief in the client's personal competency and reinforces a coping strategy that will be needed when the nurse may not be available to offer solutions.

Question67

Therapeutic nurse-client interaction occurs when the nurse
A) assists the client to clarify the meaning of what the client has said
B) interprets the client's covert communication
C) praises the client for appropriate feelings and behavior
D) advises the client on ways to resolve problems

Review Information: The correct answer is A: assists the client to clarify the meaning of what the client has said. Clarification is a facilitating/therapeutic communication strategy. Interpretation, changing the focus/subject, giving approval, and advising are non-therapeutic/barriers to communication.

Question68

Which nursing intervention will be most effective in helping a withdrawn client to develop relationship skills?
A) Offer the client frequent opportunities to interact with 1 person
B) Provide the client with frequent opportunities to interact with other clients
C) Assist the client to analyze the meaning of the withdrawn behavior
D) Discuss with the client the focus that other clients have similar problems

Review Information: The correct answer is A: Offer the client frequent opportunities to interact with 1 person. The withdrawn client is uncomfortable in social interaction. The nurse-client relationship is a corrective relationship in which the client learns both tolerance and skills for relationships.

Question69

An important goal in the development of a therapeutic inpatient milieu is to

A) provide a businesslike atmosphere where clients can work on individual goals
B) provide a group forum in which clients decide on unit rules, regulations, and policies
C) provide a testing ground for new patterns of behavior while the client takes responsibility for his or her own actions
D) discourage expressions of anger because they can be disruptive to other clients

Review Information: The correct answer is C: provide a testing ground for new patterns of behavior while the client takes responsibility for his or her own actions. A therapeutic milieu is purposeful and planned to provide safety and a testing ground for new patterns of behavior.

Question70

A client with paranoid delusions stares at the nurse over a period of several days. The client suddenly walks up to the nurse and shouts «You think you're so perfect and pure and good.» An appropriate response for the nurse is

A) «Is that why you've been staring at me?»
B) «You seem to be in a really bad mood.»
C) «Perfect? I don't quite understand.»
D) «You seem angry right now.»

Review Information: The correct answer is D: «You seem angry right now.». The nurse recognizes the underlying emotion with a matter of fact attitude, but avoids telling the clients how they feel.

Question71

A client who is a former actress enters the day room wearing a sheer nightgown, high heels, numerous bracelets, bright red lipstick and heavily rouged cheeks. Which nursing action is the best in response to the client's attire?

A) Gently remind her that she is no longer on stage
B) Directly assist client to her room for appropriate apparel
C) Quietly point out to her the dress of other clients on the unit
D) Tactfully explain appropriate clothing for the hospital

Review Information: The correct answer is B: Directly assist client to her room for appropriate

apparel. It assists the client to maintain self-esteem while modifying behavior.

Question72

When teaching suicide prevention to the parents of a 15 year-old who recently attempted suicide, the nurse describes the following behavioral cue as indicating a need for intervention.

A) Angry outbursts at significant others
B) Fear of being left alone
C) Giving away valued personal items
D) Experiencing the loss of a boyfriend

Review Information: The correct answer is C: Giving away valued personal items. Eighty percent of all potential suicide victims give some type of indication that self-destructiveness should be addressed. These clues might lead one to suspect that a client is having suicidal thoughts or is developing a plan.

Question73

Which statement made by a client indicates to the nurse that the client may have a thought disorder?
A) «I>m so angry about this. Wait until my partner hears about this.»
B) «I>m a little confused. What time is it?»
C) «I can>t find my <mesmer> shoes. Have you seen them?»
D) «I>m fine. It>s my daughter who has the problem.»

Review Information: The correct answer is C: «I can>>t find my <>mesmer>> shoes. Have you seen them?». A neologism is a new word self invented by a person and not readily understood by another. Using neologisms is often associated with a thought disorder.

Question74

In a psychiatric setting, the nurse limits touch or contact used with clients to handshaking because

A) some clients misconstrue hugs as an invitation to sexual advances
B) handshaking keeps the gesture on a professional level
C) refusal to touch a client denotes lack of concern
D) inappropriate touch often results in charges of assault and battery

Review Information: The correct answer is A: some clients misconstrue hugs as an invitation to sexual advances. Touch denotes positive feelings for another person. The client may interpret hugging and holding hands as sexual advances.

Question75

A client with anorexia is hospitalized on a medical unit due to electrolyte imbalance and cardiac dysrhythmias. Additional assessment findings that the nurse would expect to observe are

A) brittle hair, lanugo, amenorrhea
B) diarrhea, nausea, vomiting, dental erosion
C) hyperthermia, tachycardia, increased metabolic rate
D) excessive anxiety about symptoms

Review Information: The correct answer is A: brittle hair, lanugo, amenorrhea. Physical findings associated with anorexia also include reduced metabolic rate and lower vital signs.