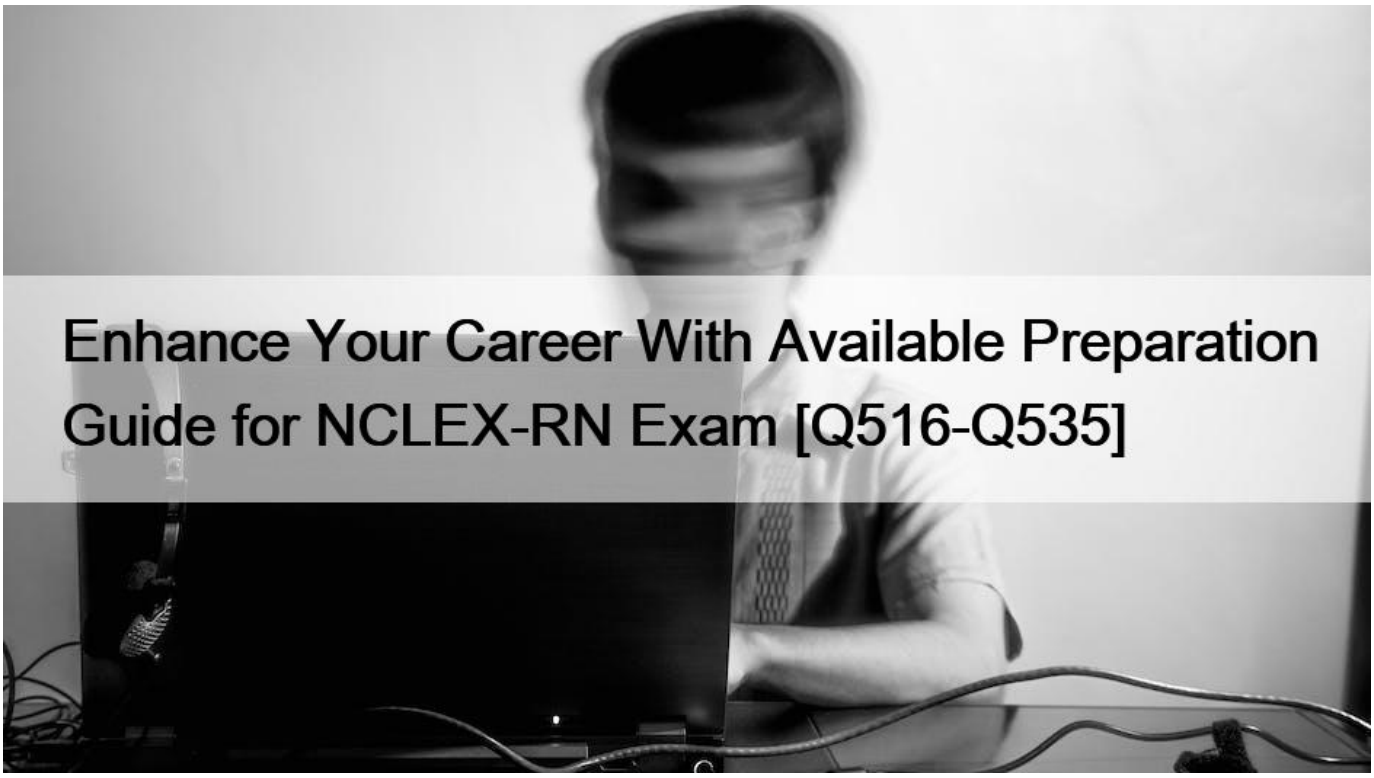
Enhance Your Career With Available Preparation Guide for NCLEX-RN Exam [Q516-Q535



Enhance Your Career With Available Preparation Guide for NCLEX-RN Exam Get Special Discount Offer of NCLEX-RN Certification Exam Sample Questions and Answers

NCLEX-RN exam is a critical step in the journey of becoming a licensed nurse in the United States. NCLEX-RN exam measures a candidate's knowledge and skills in the field of nursing and is designed to ensure that nurses are capable of providing safe and effective patient care. Passing the NCLEX-RN exam is a requirement for obtaining a nursing license in any state in the U.S. and is an important milestone for any aspiring nurse.

Q516. A client was not using his seat belt when involved in a car accident. He fractured ribs 5, 6, and 7 on the left and developed a left pneumothorax. Assessment findings include:
* Crackles and paradoxical chest wall movement
* Decreased breath sounds on the left and chest pain with movement
* Rhonchi and frothy sputum
* Wheezing and dry cough

Section: Questions Set C

Explanation:

(A) Crackles are caused by air moving through moisture in the small airways and occur with pulmonary edema.

Paradoxical chest wall movement occurs with flail chest when a segment of the thorax moves outward on inspiration and inward on expiration. (B) Decreased breath sounds occur when a lung is collapsed or partially collapsed. Chest pain with movement occurs with rib fractures. (C) Rhonchi are caused by air moving through large fluid-filled airways. Frothy sputum may occur with pulmonary edema. (D) Wheezing is caused by fluid in large airways already narrowed by mucus or bronchospasm. Dry cough could indicate a cardiac problem.

Q517. A 16-month-old infant is being prepared for tetralogy of Fallot repair. In the nursing assessment, which lab value should elicit further assessment and requires notification of physician?
* pH 7.39
* White blood cell (WBC) count 10,000 WBCs/mm3
* Hematocrit 60%
* Bleeding time of 4 minutes

Explanation

(A) Normal pH of arterial blood gases for an infant is 7.35-7.45. (B) Normal white blood cell count in an infant is 6,000-17,500 WBCs/mm3. (C) Normal hematocrit in infant is 28%-42%. A 60% hematocrit may indicate polycythemia, a common complication of cyanotic heart disease. (D) Normal bleeding time is 2-7 minutes.

Q518. A 14-year-old boy has had diabetes for 7 years. He takes 30 U of NPH insulin and 10 U of regular insulin every morning at 7 AM. He eats breakfast at 7:30 AM and lunch at noon. What time should he expect the greatest risk for hypoglycemia?
* 9 AM
* 1 PM
* 11 AM
* 3 PM

(A) This time is incorrect because regular insulin would peak after the teenager has eaten breakfast. (B) This time is incorrect because it is after lunch when the NPH peaks. (C) Regular insulin peaks in 2-3 hours and has a duration of 4-6 hours. NPH insulin’s onset is 4-6 hours and peaks in 8-16 hours. Blood sugar would peak after meals and be lowest before meals and during the night. (D) This time is incorrect because it is before the NPH and after the regular insulin peak times.

Q519. A 26-year-old client is admitted to the labor, delivery, recovery, postpartum unit. The nurse completes her assessment and determines the client is in the first stage of labor. The nurse should instruct her:
* To hold her breath during contractions
* To be flat on her back
* Not to push with her contractions
* To push before becoming fully dilated

Explanation/Reference:

Explanation:

(A) This nursing action may cause hyperventilation. (B) This nursing action could cause inferior vena cava syndrome. (C) The client is allowed to push only after complete dilation during the second stage of labor.

The nurse needs to know the stages of labor. (D) If the client pushes before dilation, it could cause cervical edema and/or edema to the fetal scalp; both of these could contribute to increased risk of complications.

Q520. The nurse is teaching a 10-year-old insulin-dependent diabetic how to administer insulin. Which one of the following steps must be taught for insulin administration?
* Never use abdominal site for a rotation site.
* Avoid applying pressure after injection.

* Change needles after injection.
* Pinch the skin up to form a subcutaneous pocket.

Q521. Which of the following would differentiate acute from chronic respiratory acidosis in the assessment of the trauma client?
* Increased PaCO2
* Decreased PaO2
* Increased HCO3
* Decreased base excess

Explanation

(A) Increased CO2 will occur in both acute and chronic respiratory acidosis. (B) Hypoxia does not determine acid-base status. (C) Elevation of HCO3 is a compensatory mechanism in acidosis that occurs almost immediately, but it takes hours to show any effect and days to reach maximum compensation. Renal disease and diuretic therapy may impair the ability of the kidneys to compensate. (D) Base excess is a nonrespiratory contributor to acid-base balance. It would increase to compensate for acidosis.

Q522. A client is hyperactive and not sleeping. She will not remain at the table during mealtime. She is getting very limited calories and is using a lot of energy in her hyperactive state. The most therapeutic nursing action is to:
* Insist that she remain at the table and eat a balanced diet.
* Order a high-calorie diet with supplements.
* Provide nutritious finger foods several times a day.
* Offer to go to the dining room with her and allow her to open the food and inspect what she eats.

Explanation

(A) The client is not able to sit for long periods. Forcing her to remain at the table will increase her anxiety and cause her to become hostile. (B) This action will not ensure that the client eats what is ordered. Dietary orders are not within the nurse’s scope of practice. (C) Providing finger foods increases the likelihood of eating for hyperactive persons. They may be eating “on the run.” (D) These clients are not suspicious of the food or insecure in moving about the unit alone.

Q523. A client on the infectious disease unit is discussing transmission of human immunodeficiency virus (HIV).

The nurse would need to provide more client education based on which client statement?
* “HIV is a virus transmitted by sexual contact.”
* “Condoms reduce the transmission of HIV.”
* “HIV is a virus that is easily transmitted by casual contact.”
* “HIV can be transmitted to an unborn infant.”

(A) HIV is transmitted through unprotected sexual contact. (B) Condoms are an effective barrier to prevent HIV transmission. (C) HIV is not easily transmitted by casual contact. (D) HIV can be transmitted intrauterinely at the time of delivery, and by breast-feeding.

Q524. An 83-year-old client has been hospitalized following a fall in his home. He has developed a possible fecal impaction. Which of the following assessment findings would be most indicative of a fecal impaction?
* Boardlike, rigid abdomen
* Loss of the urge to defecate
* Liquid stool
* Abdominal pain

Section: Questions Set B

Explanation:

(A) A boardlike, rigid abdomen would point to a perforated bowel, not a fecal impaction. (B) When a client is fecally impacted, a

common symptom is the urge to defecate but the inability to do so. (C) When an impaction is present, only liquid stool will be able to pass around the impacted site. (D) Abdominal pain without distention is not a sign of a fecal impaction.

Q525. A 54-year-old client is admitted to the hospital with a possible gastric ulcer. He is a heavy smoker. When discussing his smoking habits with him, the nurse should advise him to:
* Smoke low-tar, filtered cigarettes
* Smoke cigars instead
* Smoke only right after meals
* Chew gum instead

Explanation/Reference:

Explanation:

(A, B, D) Cigarettes, cigars, and chewing gum would stimulate gastric acid secretion. (C) Smoking on a full stomach minimizes effect of nicotine on gastric acid.

Q526. In client teaching, the nurse should emphasize that fetal damage occurs more frequently with ingestion of drugs during:
* First trimester
* Second trimester
* Third trimester
* Every trimester

Explanation

(A) Organogenesis occurs in the first trimester. Fetus is most susceptible to malformation during this period.

(B) Organogenesis has occurred by the second trimester. (C) Fetal development is complete by this time. (D) The dangerous period for fetal damage is the first trimester, not the entire pregnancy.

Q527. A mother continues to breast-feed her 3-month-old infant. She tells the nurse that over the past 3 days she has not been producing enough milk to satisfy the infant. The nurse advises the mother to do which of the following?
* “Start the child on solid food.”
* “Nurse the child more frequently during this growth spurt.”
* “Provide supplements for the child between breastfeeding so you will have enough milk.”
* “Wait 4 hours between feedings so that your breasts will fill up.”

Explanation/Reference:

Explanation:

(A) Solid foods introduced before 4-6 months of age are not compatible with the abilities of the GI tract and the nutritional needs of the infant. (B) Production of milk is supply and demand. A common growth spurt occurs at 3 months of age, and more frequent nursing will increase the milk supply to satisfy the infant. (C) Supplementation will decrease the infant’s appetite and in turn decrease the milk supply. When the infant nurses less often or with less vigor, the amount of milk produced decreases. (D) Rigid feeding schedules lead to a decreased milk supply, whereas frequent nursing signals the mother’s body to produce a correspondingly increased amount of milk.

Q528. The nurse should facilitate bonding during the postpartum period. What should the nurse expect to observe in the taking-hold phase?
* Mother is concerned about her recovery.
* Mother calls infant by name.
* Mother lightly touches infant.

* Mother is concerned about her weight gain.

(A) This observation can be made during the taking-in phase when the mother’s needs are more important. (B) This observation can be made during the taking-hold phase when the mother is actively involved with herself and the infant. (C, D) This observation can be made during the taking-in phase.

Q529. A client who has been diagnosed with anorexia nervosa refuses to eat lunch. The most therapeutic response by the nurse to her refusal is:

* “Okay, missing one meal won’t hurt.”
* “You’ll have to eat lunch, or we’ll force-feed you.”
* “It’s not appropriate for you to try to manipulate the staff into granting your wishes.”
* “We will not allow you to starve yourself. You may choose to eat voluntarily or be fed.”

Explanation

(A) This response reinforces the client’s maladaptive behavior, thereby contributing to the client’s risk. (B) Ultimatums are not therapeutic. (C) This comment invites an argument because it puts the client on the defensive and stabs at her self-esteem, which is already compromised. (D) Setting limits assures the client that staff has genuine concern for her safety and well-being. Giving her an actual choice will give the client an increased sense of control over her life and avoid an argument or power struggle.

Q530. A client with cirrhosis of the liver becomes comatose and is started on neomycin 300 mg q6h via nasogastric tube. The rationale for this therapy is to:

* Prevent systemic infection
* Promote diuresis
* Decrease ammonia formation
* Acidify the small bowel

Section: Questions Set G

Explanation:

(A) Neomycin is an antibiotic, but this is not the Rationale for administering it to a client in hepatic coma. (B) Diuretics and salt-free albumin are used to promote diuresis in clients with cirrhosis of the liver. (C) Neomycin destroys the bacteria in the intestines. It is the bacteria in the bowel that break down protein into ammonia. (D) Lactulose is administered to create an acid environment in the bowel. Ammonia leaves the blood and migrates to this acidic environment where it is trapped and excreted.

Q531. A child becomes neutropenic and is placed on protective isolation. The purpose of protective isolation is to:

* Protect the child from infection
* Provide the child with privacy
* Protect the family from curious visitors
* Isolate the child from other clients and the nursing staff

(A) The child no longer has normal white blood cells and is extremely susceptible to infection. (B) There are more appropriate ways to provide privacy, and there is no need to protect the child from healthy visitors. (C) Visitors and visiting hours may be at the client’s and/or family’s request without regard to the isolation precaution. (D) The child may have strong positive relationships with other clients or staff. As long as proper precautions are observed, there is no reason to isolate her from them.

Q532. A 70-year-old client is almost finished receiving her second unit of packed red blood cells. The client, who weighs 80 lb, has started complaining of being short of breath and now has crackles in the bases of her lungs.

After slowing or stopping the transfusion, the most appropriate initial nursing action would be to:

* Raise the client’s head and place her feet in a dependent position
* Notify the physician

* Place the client on 2 liters of O2 via nasal cannula
* Administer furosemide (Lasix) 20 mg IV push

Section: Questions Set C

Explanation:

(A) Raising the client’s head and placing her feet in a dependent position is an independent nursing action that can be taken to decrease venous return and to reduce pulmonary congestion. (B) Notifying the physician is an appropriate action that should be taken after the client is positioned to maximize her respiratory status. (C) Placing the client on O2may be done with a physician’s order or according to an institution’s standing orders; however, other actions should be taken first. (D) Furosemide 20 mg IV push is an appropriate medication for the client, but it must be ordered by her physician.

Q533. Which of the following would indicate the need for further teaching for the client with COPD? The client verbalizes the need to:

* Eat high-calorie, high-protein foods
* Take vitamin supplementation
* Eliminate intake of milk and milk products
* Eat small, frequent meals

Section: Questions Set B

Explanation:

(A) Protein is vital for the maintenance of muscle to aid in breathing. A high-calorie diet using higher fat than carbohydrate content is given because clients are unable to breathe off the excess CO2that is an end product of carbohydrate metabolism. (B) Inadequate nutritional status, in particular, deficiencies in vitamins A and C, decreases resistance to infection. (C) Milk does not make mucus thicker. It may coat the back of the throat and make it feel thicker. Rinsing the mouth with water after drinking milk will prevent this problem. (D) Small, frequent meals minimize a fullness sensation and reduce pressure on the diaphragm. The work of breathing and SOB are also reduced.

Q534. Which of the following lab data is representative of a client with aplastic anemia?

* Hemoglobin 9.2, hematocrit 27, red blood cells 3.2 million
* White blood cells 4000, erythrocytes 2.5 million, thrombocytes 100,000
* White blood cells 3000, hematocrit 27, red blood cells 2.8 million
* Red blood cells 1 million, white blood cells 1500, thrombocytes 16,000

Explanation

(A, B, C) Although all of the lab data are abnormal and although these values are decreased in aplastic anemia, the disorder is defined by severe deficits in red cell, white cell, and platelet counts. (D) Aplastic anemia is typically defined in terms of abnormalities of red blood cell count, usually <1 million, white cell count <2,000, and thrombocytes <20,000.

Q535. A client is being discharged from the hospital today. The discharge teaching for care of her colostomy included which of the following basic principles for protecting the skin around her stoma:

* Taping a pouch that is leaking
* Cutting the skin barrier 112 inches larger than the stoma
* Changing the pouch only when leakage occurs
* Using a skin sealant under pouch adhesives

Explanation

(A) When a pouch seal leaks, the pouch should be immediately changed, not taped. Stool held against the skin can quickly result in severe irritation. (B) The skin barrier should be cut only slightly larger than the stoma (one-half inch). (C) The client should be

taught to change pouches whenever possible before leakage occurs.

(D) When skin sealant is used under the tape, the outermost layer of the epidermis remains intact. When no skin sealant is used, this layer is removed when the tape is removed.