NCLEX-RN Q&As

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QUESTION 1

The predominant purpose of the first Apgar scoring of a newborn is to:

A. Determine gross abnormal motor function

B. Obtain a baseline for comparison with the infant\\'s future adaptation to the environment

C. Evaluate the infant\\'s vital functions

D. Determine the extent of congenital malformations

Correct Answer: C

(A) Apgar scores are not related to the infant\\'s care, but to the infant\\'s physical condition. (B) Apgar scores assess the current physical condition of the infant and are not related to future environmental adaptation. (C) The purpose of the Apgar system is to evaluate the physical condition of the newborn at birth and to determine if there is an immediate need for resuscitation. (D) Congenital malformations are not one of the areas assessed with Apgar scores.

QUESTION 2

A 19-year-old client fell off a ladder approximately 3 ft to the ground. He did not lose consciousness but was taken to the emergency department by a friend to have a scalp laceration sutured. The nurse instructs the client to:

A. Clean the sutured laceration twice a day with povidone- iodine (Betadine)

B. Remove his scalp sutures after 5 days

C. Return to the hospital immediately if he develops confusion, nausea, or vomiting

D. Take meperidine 50 mg po q4?h prn for headache

Correct Answer: C

(A) Povidone-iodine is very irritating to skin and should not be routinely used. (B) Sutures should not be removed by the client. (C) Confusion, nausea, vomiting, and behavioral changes may indicate increasing intracranial pressure as a result of intracerebral bleeding. (D) Use of a narcotic opiate such as meperidine is not recommended in clients with a possible head injury because it may produce sedation, pupil changes, euphoria, and respiratory depression, which may mask the signs of increasing intracranial pressure.

QUESTION 3

A client was prescribed a major tranquilizer 2 months ago. One month ago she was placed on benztropine (Cogentin). What would indicate that benztropine therapy is effective?

A. Smooth, coordinated voluntary movement

B. Tremors

C. Rigidity

D. Muscle weakness

Correct Answer: A

(A)

Benztropine is prescribed to decrease or alleviate extrapyramidal side effects of major tranquilizers. Smooth, coordinated voluntary movement indicates minimal extrapyramidal side effects. (B) Tremors are an extrapyramidal side effect.

(C)

Rigidity is an extrapyramidal side effect. (D) Muscle weakness is an extrapyramidal side effect.

QUESTION 4

A 3-year-old child was hospitalized for acute laryngotracheobronchitis. During her hospitalization, the child was placed under an oxygen mist tent. The nurse\\'s frequent monitoring of the child\\'s temperature frightened her parents. Which response by the nurse would be most appropriate?

A. Monitoring the temperature prevents undue chilling.

B. Rapid temperature elevations can occur in children.

C. Checking the temperature will prevent febrile seizures.

D. Taking the child\\'s temperature can prevent airway obstruction.

Correct Answer: A

(A) The refrigerated cool mist tent creates a cool, moist environment. The child as well as bedding and clothing may become dampened. Monitoring the temperature of the child will ensure warmth and prevent chilling. (B) Only a low-grade fever is expected in laryngotracheobronchitis. (C) Febrile seizures are not expected with the low-grade fever. (D) Inflammation of the mucosal lining in the respiratory tract can cause airway obstruction. However, monitoring the child\\'s temperature would not prevent airway obstruction.

QUESTION 5

In acute episodes of mania, lithium is effective in 1? weeks, but it may take up to 4 weeks, or even a few months, to treat symptoms fully. Sometimes an antipsychotic agent is prescribed during the first few days or weeks of an acute episode to manage severe behavioral excitement and acute psychotic symptoms. In addition to the lithium, which one of the following medications might the physician prescribe?

A. Diazepam (Valium)

B. Haloperidol (Haldol)

C. Sertraline (Zoloft)

D. Alprazolam (Xanax)

Correct Answer: B

(A) Diazepam is an antianxiety medication and is not designed to reduce psychotic symptoms. (B) Haloperidol is an antipsychotic medication and may be used until the lithium takes effect. (C) Sertraline is an antidepressant and is used primarily to reduce symptoms of depression. (D) Alprazolam is an antianxiety medication and is not designed to reduce psychotic symptoms.

QUESTION 6

A 52-year-old client who underwent an exploratory laparotomy for a bowel obstruction begins to complain of hunger on the third postoperative day. His nasogastric (NG) tube was removed this morning, and he has an IV of D5W with 0.45% normal saline running at 125 mL/hr. He asks when he can get rid of his IV and start eating. The nurse recognizes that he will be able to begin taking oral fluids and nourishment when:

A. It is determined that he has no signs of wound infection

B. He is able to eat a full meal without evidence of nausea or vomiting

C. The nurse can detect bowel sounds in all four quadrants

D. His blood pressure returns to its preoperative baseline level or greater

Correct Answer: C

(A) The absence of wound infection is related to his surgical wound and not to postoperative GI functioning and return of peristalsis. (B) Routine postoperative protocol involves detection of bowel sounds and return of peristalsis before introduction of clear liquids, followed by progression of full liquids and a regular diet versus a full regular meal first. (C) Routine postoperative protocol for bowel obstruction is to assess for the return of bowel sounds within 72 hours after major surgery, because that is when bowel sounds normally return. If unable to detect bowel sounds, the surgeon should be notified immediately and have the client remain NPO. (D) Routine postoperative protocol for bowel obstruction and other major surgeries involves frequent monitoring of vital signs in the immediate postoperative period (in recovery room) and then every 4 hours, or more frequently if the client is unstable, on the nursing unit. This includes assessing for signs of hypovolemic shock. Vital signs usually stabilize within the first 24 hours postoperatively.

QUESTION 7

A mother came to the pediatric clinic with her 17- month-old child. The mother would like to begin toilet training. What should the nurse teach her about implementing toilet training?

A. Take two or three favorite toys with the child.

B. Have a child-sized toilet seat or training potty on hand.

C. Explain to the child she is going to "void" and "defecate."

D. Show disapproval if she does not void or defecate.

Correct Answer: B

(A) Giving her toys will distract her and interfere with toilet training because of inappropriate reinforcement. (B) A child-sized toilet seat or training potty gives a child a feeling of security. (C) She should use words that are age appropriate for the child. (D) Children should be praised for cooperative behavior and/or successful evacuation.

QUESTION 8

A psychiatric client has been stabilized and is to be discharged. The nurse will recognize client insight and behavioral change by which of the following client statements?

A. "When I get home, I will need to take my medicines and call my therapist if I have any side effects or begin to hear voices."

B. "If I have any side effects from my medicines, I will take an extra dose of Cogentin."

C. "When I get home, I should be able to taper myself off the Haldol because the voices are gone now."

D. "As soon as I leave here, I\\'m throwing away my medicines. I never thought I needed them anyway."

Correct Answer: A

(A) The client verbalizes that he is responsible for compliance and keeping the treatment team member informed of progress. This behavior puts him at the lowest risk for relapse. (B) Noncompliance is a major cause of relapse. This statement reflects lack of responsibility for his own health maintenance. (C) This statement reflects lack of insight into the importance of compliance. (D) This statement reflects no insight into his illness or his responsibility in health maintenance.

QUESTION 9

A primigravida is at term. The nurse can recognize the second stage of labor by the client\\'s desire to:

A. Push during contractions

B. Hyperventilate during contractions

C. Walk between contractions

D. Relax during contractions

Correct Answer: A

(A) The second stage of labor is characterized by uterine contractions, which cause the client to bear down. (B) Slow, deep, rhythmic breathing facilitates the laboring process. Hyperventilation is abnormal breathing resulting from loss of pain control. (C) The client should remain on bed rest during labor. (D) Contractions result in discomfort.

QUESTION 10

After performing a sterile vaginal exam on a client who has just been admitted to the unit in active labor and placed on an electronic fetal monitor, the RN assesses that the fetal head is at 21 station. She documents this on the monitor strip. Fetal head at 21 station means that the fetal head is located where in the pelvis?

A. One centimeter below the ischial spines

B. One centimeter above the ischial spines

C. Has not entered the pelvic inlet yet

D. Located in the pelvic outlet

Correct Answer: B

(A) The ischial spines are located on both sides of the midpelvis. These spines mark the diameter of the narrowest part of the pelvis that the fetus will encounter. They are not sharp protrusions that will harm the fetus. Station refers to the relationship between the ischial spines in the pelvis and the fetus. The ischial spines are designated at 0 station. If the presenting part of the fetus is located above the ischial spines, a negative number is assigned, noting the number of centimeters above the ischial spines. Therefore, 1 centimeter below the ischial spines is designated as +1 station. (B) See explanation in A. One centimeter above the ischial spines is designated as +1 station. (C) The pelvic inlet is the first part of the pelvis that the fetus enters in routine delivery. The midpelvis is the second part of the pelvis to be entered by the fetus. The ischial spines are located on both sides of the midpelvis. (D) The pelvic outlet is the last part of the pelvis that the fetus will enter. When the fetus reaches this part of the pelvis, birth is near.

QUESTION 11

A 55-year-old client is unconscious, and his physician has decided to begin tube feeding him using a smallbore silicone feeding tube (Keofeed, Duo-Tube). After the tube is inserted, the nurse identifies the most reliable way to confirm appropriate placement is to:

A. Aspirate gastric contents

B. Auscultate air insufflated through the tube

C. Obtain a chest x-ray

D. Place the tip of the tube under water and observe for air bubbles

Correct Answer: C

(A) Aspiration of gastric contents is usually a reliable way to verify tube placement. However, if the client has dark respiratory secretions from bleeding, tube feedings could be mistaken for respiratory secretions; in other words, aspirating an empty stomach is less reliable in this instance. In addition, it is common for small-bore feeding tubes to collapse when suction pressure is applied. (B) Insufflation of air into large-bore nasogastric tubes can usually be clearly heard. In small-bore tubes, it is more difficult to hear air, and it is difficult to distinguish between air in the stomach and air in the esophagus. (C) A chest x- ray is the most reliable means to determine placement of small-bore nasogastric tubes. (D) Observing for air bubbles when the tip is held under water is an unreliable means to determine correct tube placement for all types of nasogastric tubes. Air may come from both the respiratory tract and the stomach, and the client who is breathing shallowly may not force air out of the tube into the water.

QUESTION 12

A client was admitted to the hospital after falling in her home. At the time of admission, her blood alcohol level was 0.27 mg%. Her family indicates that she has been drinking a fifth of vodka a day for the past 9 months. She had her last drink 30 minutes prior to admission. Alcohol withdrawal symptoms would most likely be exhibited by her:

A. Two to 4 hours after the last drink

B. Six to 8 hours after the last drink

C. Immediately on admission D. Twenty-four hours after the last drink

Correct Answer: B

(A) This answer is incorrect. Alcohol withdrawal usually begins approximately 6? hours after the last drink. (B) This answer is correct. It takes approximately 6? hours for metabolism of alcohol. (C) This answer is incorrect. The alcohol is still in the system, as indicated by the high blood alcohol level. (D) This answer is incorrect. Symptoms of alcohol withdrawal usually begin within 6? hours of the last drink.

QUESTION 13

In the client with a diagnosis of coronary artery disease, the nurse would anticipate the complication of bradycardia with occlusion of which coronary artery?

A. Right coronary artery

B. Left main coronary artery

C. Circumflex coronary artery

D. Left anterior descending coronary artery

Correct Answer: A

(A) Sinus bradycardia and atrioventricular (AV) heart block are usually a result of right coronary artery occlusion. The right coronary artery perfuses the sinoatrial and AV nodes in mostindividuals. (B) Occlusion of the left main coronary artery causes bundle branch blocks and premature ventricular contractions. (C) Occlusion of the circumflex artery does not cause bradycardia. (D) Sinus tachycardia occurs primarily with left anterior descending coronary artery occlusion because this form of occlusion impairs left ventricular function.

QUESTION 14

A 48-year-old client is being seen in her physician\\'s office for complaints of indigestion, heartburn, right upper quadrant pain, and nausea of 4 days\\' duration, especially after meals. The nurse realizes that these symptoms may be associated with cholecystitis and therefore would check for which specific sign during the abdominal assessment?

A. Cullen\\'s sign

B. Rebound tenderness

C. Murphy\\'s sign

D. Turner\\'s sign

Correct Answer: C

(A) This sign is a faint blue discoloration around the umbilicus found in clients who have hemorrhagic pancreatitis. (B) This sign indicates areas of inflammation within the peritoneum, such as with appendicitis. It is a deep palpation technique used on a nontender area of the abdomen, and when the palpating hand is removed suddenly, the client experiences a sharp, stabbing pain at an area of peritoneal inflammation. (C) This sign is considered positive with acute cholecystitis when the client is unable to take a deep breath while the right upper quadrant is being deeply palpated. The client will elicit a sudden, sharp gasp, which means the gallbladder is acutely inflamed. (D) This is a sign of acute hemorrhagic pancreatitis and manifests as a green or purple discoloration in the flanks.

QUESTION 15

An expected response to sodium polystyrene sulfonate (Kayexalate) is:

A. Increase in serum magnesium

B. Increase in serum HCO3

C. Decrease in serum potassium

D. Decrease in serum calcium

Correct Answer: C

(A) Sodium polystyrene sulfonate administration will not increase serum magnesium. Hypermagnesemia is virtually unknown except for clients in renal failure. (B) Sodium polystyrene sulfonate administration is not known to increase serum bicarbonate. (C) Decrease in serum potassium, the expected response of sodium polystyrene sulfonate, is secondary to the binding of this drug and potassium in the colon, and potassium is removed through the feces. (D) Serum calcium may actually increase with sodium polystyrene sulfonate administration, especially if calcium chloride is administered concurrently with this drug.