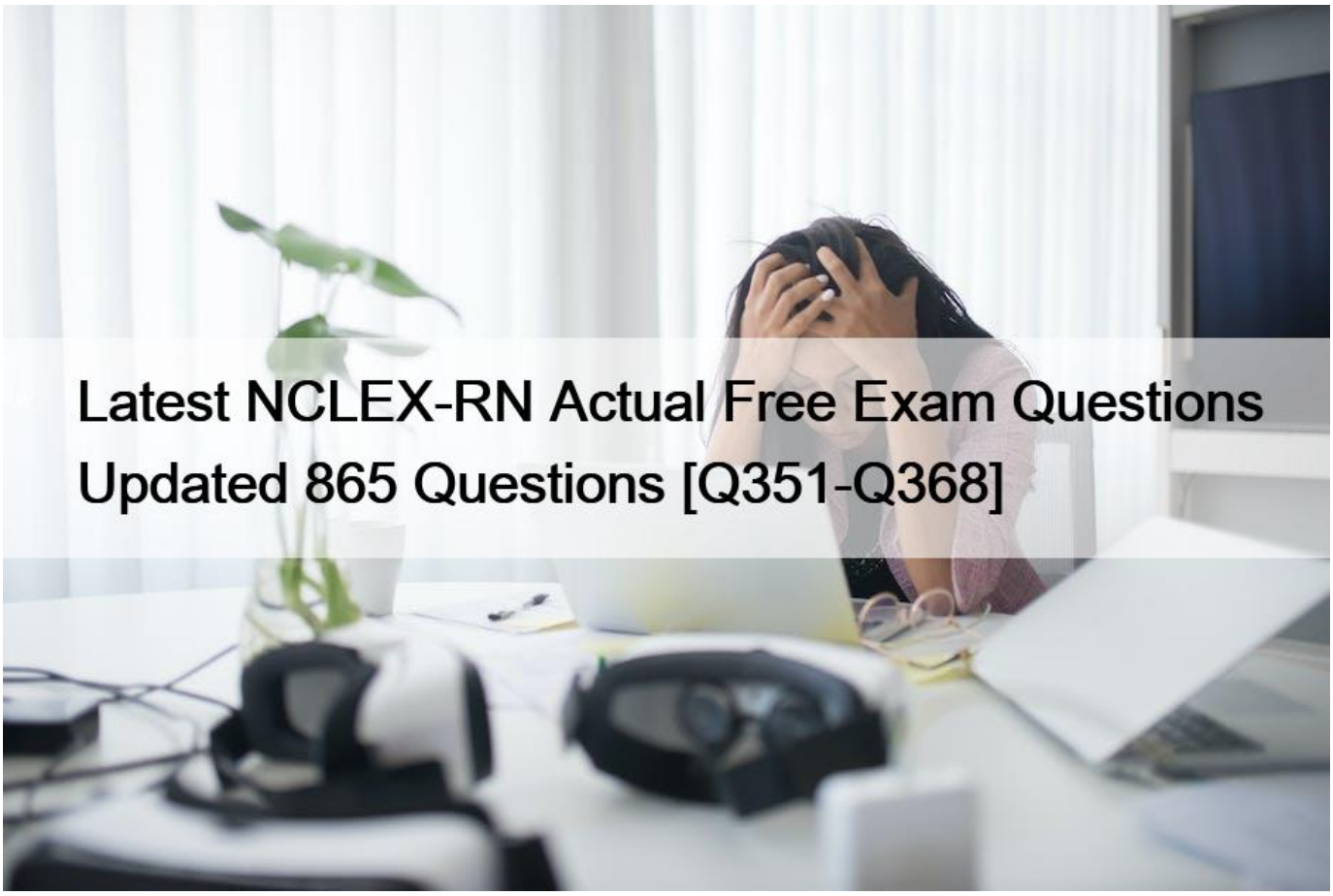
Latest NCLEX-RN Actual Free Exam Questions Updated 865 Questions [Q351-Q368



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Free NCLEX-RN Exam Braindumps certification guide Q&A

NCLEX-RN exam is a computer-adaptive test (CAT) that adapts to the test taker's abilities. This means that the difficulty level of the questions will adjust based on the test taker's responses. NCLEX-RN exam consists of a minimum of 75 questions and a maximum of 265 questions. Test takers have up to six hours to complete the exam, which includes two optional breaks.

NEW QUESTION 351

After an infant is delivered by cesarean delivery and placed on the warmer, the RN dries and assesses the infant. At 1 and 5 minutes after birth, the RN does the Apgar scoring of the infant. The RN knows that because this infant was delivered by cesarean section, he is at increased risk for having which one of the following:

* Cold stress
* Cyanosis
* Respiratory distress syndrome

* Seizures

(A) The infant is placed on the warmer and dried after birth. Cold stress occurs when the infant is not dried and kept warm. (B) The fact that this infant was born by cesarean delivery does not place him at a greater risk for cyanosis than an infant delivered vaginally. Cyanosis occurs when infants cannot oxygenate their blood after the umbilical cord is severed. (C) Infants born by cesarean delivery are at a higher risk for developing respiratory distress syndrome because these infants do not pass through the pelvis, where the chest is compressed and fluid is able to escape from the lungs. (D) Cesarean-delivered infants are not at greater risk for seizures than infants delivered vaginally.

NEW QUESTION 352

Which of the following nursing orders has the highest priority for a child with epiglottitis?

* Vital signs every shift
* Tracheostomy set at bedside
* Intake and output
* Specific gravity every shift

Section: Questions Set G

Explanation:

(A) Because of the possibility of fever or respiratory failure, vital signs should be done more often than every eight hours. (B) If the epiglottitis worsens, the edema and laryngospasm may close the airway and an emergency tracheostomy may be necessary. (C) Although intake and output are a part of the nursing care of a child with epiglottitis, it is not as important as the safety measure of keeping the tracheostomy set at the bedside. (D) Specific gravity will indicate hydration status, but it is not as important as keeping the tracheostomy set at the bedside.

NEW QUESTION 353

A 30-year-old client has been admitted to the psychiatric service with the diagnosis of schizophrenia. He tells the nurse that when the woman he had been dating broke up with him, the CIA had replaced her with an identical twin. The client is experiencing:

* Grandiose delusions
* Paranoid delusions
* Auditory hallucinations
* Visual hallucinations

(A) There are no indications that the client’s thoughts reflect special powers or talents characteristic of grandiosity. (B) The client’s thought content is fixed, false, persecutory,

and suspicious in nature, which is characteristic of paranoid delusions. (C, D) The client is

not demonstrating a sensory experience.

NEW QUESTION 354

A family is experiencing changes in their lifestyle in many ways. The invalid grandmother has moved in with them. The couple have a 2-year-old son by their marriage, and the wife has two children by her previous marriage. The older children are in high school. In applying systems theory to this family, it is important for the nurse to remember which of the following principles?

* The parts of a system are only minimally related.
* Dysfunction in one part affects every other part.
* A family system has no boundaries.
* Healthy families are enmeshed.

(A) The parts of a system are interrelated. (B) Any change in any part of the system affects all other parts. (C) A family system, like

any other system, has boundaries. (D) Healthy families are neither enmeshed nor disengaged.

NEW QUESTION 355

A 72-year-old client with a new colostomy is being evaluated at the clinic today for constipation. When discussing diet with the client, the nurse recognizes that which one of the following foods most likely caused this problem?
* Fried chicken
* Eggs
* Tapioca
* Cabbage
Section: Questions Set D

Explanation:

(A) Fried, greasy food, such as fried chicken, will produce diarrhealike stools in individuals with all types of GI ostomies. (B) Eggs will cause odor-producing stools in individuals with all types of GI ostomies. (C) Tapioca and rice products will cause constipation in individuals with all types of GI ostomies. (D) Cabbage will cause odor-producing and flatus-producing stools in individuals with all types of GI ostomies.

NEW QUESTION 356

Seven days ago, a 45-year-old female client had an ileostomy. She is self-sufficient and well otherwise. Which of the following long-term objectives would be unrealistic?
* She should be able to control evacuation of her bowels.
* She should be able to return to a regular diet.
* She should be able to resume sexual activity.
* She should be able to manage her own care.
Section: Questions Set E

Explanation:

(A) Because of the location of an ileostomy, the client will not be able to control the evacuation of her bowels.

The ileostomy will drain liquid stool continuously. (B) The client should be able to return to a normal, well- balanced diet. She should avoid foods that cause diarrhea or excessive gas production, and she should eat small meals. (C) The client should be able to resume sexual activity. She will be able to wear a pouch. (D) The client has no other health or mental problems and should be able to manage her own ileostomy.

NEW QUESTION 357

A 35-year-old client is admitted to the hospital with diabetic ketoacidosis. Results of arterial blood gases are pH 7.2, PaO2 90, PaCO2 45, and HCO3 16. The nursing assessment of arterial blood gases indicate the presence of:
* Respiratory alkalosis
* Respiratory acidosis
* Metabolic alkalosis
* Metabolic acidosis
Explanation/Reference:

Explanation:

(A) Respiratory alkalosis is determined by elevated pH and low PaCO2. (B) Respiratory acidosis is determined by low pH and elevated PaCO2. (C) Metabolic alkalosis is determined by elevated pH and HCO3.(D) Metabolic acidosis is determined by low pH and HCO3.

NEW QUESTION 358

A 4-year-old boy is brought to the emergency room with bruises on his head, face, arms, and legs. His mother states that he fell down some steps. The nurse suspects that he may have been physically abused. In accordance with the law, the nurse must:
* Tell the physician her concerns
* Report her suspicions to the authorities
* Talk to the child’s father
* Confront the child’s mother
(A) Although the nurse probably would talk to the physician about these concerns, the nurse is not required by law to do so. (B) All healthcare workers are required by the Federal Child Abuse Prevention and Treatment Act of 1974 to report suspected and actual cases of child abuse and/or neglect. (C) Talking to the child’s father may or may not help the child, and the nurse is not required by law to do so. (D) Confrontation may not be indicated; the nurse is not required by law to confront the child’s mother with these suspicions.

NEW QUESTION 359

The nurse begins morning assessment on a male client and notices that she is unable to palpate either of his dorsalis pedis pulses in his feet. What is the first nursing action after assessing this finding?
* Palpate these pulses again in 15 minutes.
* Use a Doppler to determine presence and strength of these pulses.
* Document the finding that the pulses are not palpable.
* Call the physician and notify the physician of this finding.
Explanation/Reference:

Explanation:

(A) Palpating these pulses again in 15 minutes may only result in the same findings. (B) Any time during an assessment that the nurse is unable to palpate pulses, the nurse should then obtain a Doppler and assess for presence or absence of the pulse and pulse strength, if a pulse is present. (C) Pulses may be present and assessed through use of a Doppler. Absence of palpable pulses does not indicate absence of blood flow unless pulses cannot be located with a Doppler. (D) The nurse would only call the physician after determining that the pulses are absent by both palpation and Doppler.

NEW QUESTION 360

When assessing fetal heart rate status during labor, the monitor displays late decelerations with tachycardia and decreasing variability. What action should the nurse take?
* Continue monitoring because this is a normal occurrence.
* Turn client on right side.
* Decrease IV fluids.
* Report to physician or midwife.
(A) This is not a normal occurrence. Late decelerations need prompt intervention for immediate infant recovery. (B) To increase O2 perfusion to the unborn infant, the mother should be placed on her left side. (C) IV fluids should be increased, not decreased. (D) Immediate action is warranted, such as reporting findings, turning mother on left side, administering O2, discontinuing oxytocin (Pitocin), assessing maternal blood pressure and the labor process, preparing for immediate cesarean delivery, and explaining plan of action to client.

NEW QUESTION 361

A 24-hours’ postpartum client complains of discomfort at the episiotomy site. On assessment, the nurse notes the episiotomy is without signs of infection. To relieve the discomfort, the nurse should first:
* Assist her with a sitz bath
* Administer the prescribed medication for pain
* Teach her Kegel exercises
* Apply an ice pack

Explanation

(A) Warm, moist heat will promote circulation and provide comfort. A sitz bath should be tried before medication is given. (B) Pain medication can be given when other comfort measures such as a sitz bath and topical applications are ineffective. (C) Kegel exercises facilitate sitting by decreasing tension on the episiotomy. They will not be effective for pain control or sustained comfort level. (D) Ice packs are appropriate to apply in the first 12 hours postdelivery to produce vasoconstriction and to reduce edema to the area.

NEW QUESTION 362

Iron dextran (Imferon) is a parenteral iron preparation.

The nurse should know that it:
* Is also called intrinsic factor
* Must be given in the abdomen
* Requires use of the Z-track method
* Should be given SC

(A) Intrinsic factor is needed to absorb vitamin B12.(B) Iron dextran is given parenterally, but Z-track in a large muscle. (C) A Ztrack method of injection is required to prevent staining and irritation of the tissue. (D) An SC injection is not deep enough and may cause subcutaneous fat abscess formation.

NEW QUESTION 363

In assessing the nature of the stool of a client who has cystic fibrosis, what would the nurse expect to see?
* Clay-colored stools
* Steatorrhea stools
* Dark brown stools
* Blood-tinged stools

Section: Questions Set B

Explanation:

(A) Clay-colored stools indicate dysfunction of the liver or biliary tract. (B) In the early stages of cystic fibrosis, fat absorption is primarily affected resulting in fat, foul, frothy, bulky stools. (C) Dark brown stools indicate normal passage through the colon. (D) Blood-tinged stools indicate dysfunction of the gastrointestinal (GI) tract.

NEW QUESTION 364

The nurse is interviewing a client with a diagnosis of possible abdominal aortic aneurysm. Which of the following statements will be reflected in the client’s chief complaint?
* “I’ve been having a dull pain at the upper left shoulder.”
* “My legs have been numb for three months.”

* “I’ve only been urinating three times a day lately.”
* “I don’t remember anything in particular, I just haven’t felt well.”

Explanation/Reference:

Explanation:

(A, B, C) These complaints are not specific signs and symptoms associated with abdominal aortic aneurysm. If symptoms are present, the aneurysm is expanding or rupture is imminent. (D) Many clients may experience no symptoms. The only symptom may be a pulsation noted in the abdomen in the reclining position.

NEW QUESTION 365

A 70-year-old homeless woman is admitted with pneumonia. She is weak, emaciated, and febrile. The physician orders enteral feedings intermittently by nasogastric tube. When inserting the nasogastric tube, once the tube passes through the oropharynx, the nurse will instruct the client to:

* Tilt her head backwards
* Swallow as tube passes
* Hold breath as tube passes
* Cough as tube passes

Explanation/Reference:

Explanation:

(A) Head should be tilted slightly forward to facilitate insertion. (B) Swallowing assists with insertion of tube and closes off airway. (C) Client should be swallowing as tube passes; holding the breath facilitates nothing. (D) Coughing may expel tube.

NEW QUESTION 366

The nurse would teach a male client ways to minimize the risk of infection after eye surgery. Which of the following indicates the client needs further teaching?

* “I will wash my hands before instilling eye medications.”
* “I will wear sunglasses when going outside.”
* “I will wear an eye patch for the first 3 postoperative days.”
* “I will maintain the sterility of the eye medications.”

Section: Questions Set B

Explanation:

(A) Hand washing would be an important action designed to prevent transmission of pathogens from the hands to the eye. (B) Wearing sunglasses when going outside will prevent airborne pathogens from entering the eye.

(C) Eye patches are most frequently ordered to be worn while the client sleeps or naps, not constantly for this length of time. (D) Eye medications are sterile; clients need to be taught how to maintain this sterility.

NEW QUESTION 367

The health team needs to realize that the compulsive concern with cleanliness that a client with severe anxiety exhibits is most likely an attempt to:

* Reduce his anxiety
* Avoid going to psychotherapy

* Manipulate the health team members
* Increase his self-image by showing higher standards than the fellow clients

(A) These behaviors are attempts to relieve anxiety. (B) Avoidance is not a pattern in the obsessive client. (C) Although these behaviors may seem to manipulate others, that is not the purpose behind the activity. (D) Inflated self-esteem is not a characteristic of the severely anxious client.

NEW QUESTION 368

A client with emphysema is placed on diuretics. In order to avoid potassium depletion as a side effect of the drug therapy, which of the following foods should be included in his diet?

* Celery
* Potatoes
* Tomatoes
* Liver

Section: Questions Set A

Explanation:

(A) Celery is high in sodium. (B) Potatoes are high in potassium. (C) Tomatoes are high in sodium. (D) Liver is high in iron.

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