



Vendor: NCLEX

Exam Code: NCLEX-RN

Exam Name: National Council Licensure Examination

Version: Demo

NCLEX-RN

QUESTION 1

A 25-year-old client believes she may be pregnant with her first child. She schedules an obstetric examination with the nurse practitioner to determine the status of her possible pregnancy. Her last menstrual period began May 20, and her estimated date of confinement using Nägele's rule is:

- A. March 27
- B. February 1
- C. February 27
- D. January 3

Correct Answer: C

Section: (none)

Explanation

Explanation/Reference:

Explanation:

(A) March 27 is a miscalculation. (B) February 1 is a miscalculation. (C) February 27 is the correct answer. To calculate the estimated date of confinement using Nägele's rule, subtract 3 months from the date that the last menstrual cycle began and then add 7 days to the result. (D) January 3 is a miscalculation.

QUESTION 2

The nurse practitioner determines that a client is approximately 9 weeks' gestation. During the visit, the practitioner informs the client about symptoms of physical changes that she will experience during her first trimester, such as:

- A. Nausea and vomiting
- B. Quickening
- C. A 68 lb weight gain
- D. Abdominal enlargement

Correct Answer: A

Section: (none)

Explanation

Explanation/Reference:

Explanation:

(A) Nausea and vomiting are experienced by almost half of all pregnant women during the first 3 months of pregnancy as a result of elevated human chorionic gonadotropin levels and changed carbohydrate metabolism. (B) Quickening is the mother's perception of fetal movement and generally does

not occur until 1820 weeks after the last menstrual period in primigravidas, but it may occur as early as 16 weeks in multigravidas. (C) During the first trimester there should be only a modest weight gain of 24 lb. It is not uncommon for women to lose weight during the first trimester owing to nausea and/or vomiting. (D) Physical changes are not apparent until the second trimester, when the uterus rises out of the pelvis.

QUESTION 3

A client is 6 weeks pregnant. During her first prenatal visit, she asks, "How much alcohol is safe to drink during pregnancy?" The nurse's response is:

- A. Up to 1 oz daily
- B. Up to 2 oz daily
- C. Up to 4 oz weekly
- D. No alcohol

Correct Answer: D

Section: (none)

Explanation

Explanation/Reference:

Explanation:

(A, B, C) No amount of alcohol has been determined safe for pregnant women. Alcohol should be avoided owing to the risk of fetal alcohol syndrome. (D) The recommended safe dosage of alcohol consumption during pregnancy is none.

QUESTION 4

A 38-year-old pregnant woman visits her nurse practitioner for her regular prenatal checkup. She is 30 weeks' gestation. The nurse should be alert to which condition related to her age?

- A. Iron-deficiency anemia
- B. Sexually transmitted disease (STD)
- C. Intrauterine growth retardation
- D. Pregnancy-induced hypertension (PIH)

Correct Answer: D

Section: (none)

Explanation

Explanation/Reference:

Explanation:

(A) Iron-deficiency anemia can occur throughout pregnancy and is not age related. (B) STDs can occur prior to or during pregnancy and are not age related. (C) Intrauterine growth retardation is an abnormal process where fetal development and maturation are delayed. It is not age related. (D) Physical risks for the pregnant client older than 35 include increased risk for PIH, cesarean delivery, fetal and neonatal mortality, and trisomy.

QUESTION 5

A client returns for her 6-month prenatal checkup and has gained 10 lb in 2 months. The results of her physical examination are normal. How does the nurse interpret the effectiveness of the instruction about diet and weight control?

- A. She is compliant with her diet as previously taught.
- B. She needs further instruction and reinforcement.
- C. She needs to increase her caloric intake.
- D. She needs to be placed on a restrictive diet immediately.

Correct Answer: B

Section: (none)

Explanation

Explanation/Reference:

Explanation:

(A) She is probably not compliant with her diet and exercise program. Recommended weight gain during second and third trimesters is approximately 12 lb. (B) Because of her excessive weight gain of 10 lb in 2 months, she needs re-evaluation of her eating habits and reinforcement of proper dietary habits for pregnancy. A 2200-calorie diet is recommended for most pregnant women with a weight gain of 2730 lb over the 9-month period. With rapid and excessive weight gain, PIH should also be suspected. (C) She does not need to increase her caloric intake, but she does need to re-evaluate dietary habits. Ten pounds in 2 months is excessive weight gain during pregnancy, and health teaching is warranted. (D) Restrictive dieting is not recommended during pregnancy.

QUESTION 6

Pregnant women with diabetes often have problems related to the effectiveness of insulin in controlling their glucose levels during their second half of pregnancy. The nurse teaches the client that this is due to:

- A. Decreased glomerular filtration and increased tubular absorption
- B. Decreased estrogen levels
- C. Decreased progesterone levels
- D. Increased human placental lactogen levels

Correct Answer: D

Section: (none)

Explanation

Explanation/Reference:

Explanation:

(A) There is a rise in glomerular filtration rate in the kidneys in conjunction with decreased tubular glucose reabsorption, resulting in glycosuria. (B)

Insulin is inhibited by increased levels of estrogen. (C) Insulin is inhibited by increased levels of progesterone. (D) Human placental lactogen levels increase later in pregnancy. This hormonal antagonist reduces insulin's effectiveness, stimulates lipolysis, and increases the circulation of free fatty acids.

QUESTION 7

Diabetes during pregnancy requires tight metabolic control of glucose levels to prevent perinatal mortality. When evaluating the pregnant client, the nurse knows the recommended serum glucose range during pregnancy is:

- A. 70 mg/dL and 120 mg/dL
- B. 100 mg/dL and 200 mg/dL
- C. 40 mg/dL and 130 mg/dL
- D. 90 mg/dL and 200 mg/dL

Correct Answer: A

Section: (none)

Explanation

Explanation/Reference:

Explanation:

(A) The recommended range is 70-120 mg/dL to reduce the risk of perinatal mortality. (B, C, D) These levels are not recommended. The higher the blood glucose, the worse the prognosis for the fetus. Hypoglycemia can also have detrimental effects on the fetus.

QUESTION 8

When assessing fetal heart rate status during labor, the monitor displays late decelerations with tachycardia and decreasing variability. What action should the nurse take?

- A. Continue monitoring because this is a normal occurrence.
- B. Turn client on right side.
- C. Decrease IV fluids.
- D. Report to physician or midwife.

Correct Answer: D

Section: (none)

Explanation

Explanation/Reference:

Explanation:

(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.

QUESTION 9

A client has been diagnosed as being preeclamptic. The physician orders magnesium sulfate. Magnesium sulfate (MgSO₄) is used in the management of preeclampsia for:

- A. Prevention of seizures
- B. Prevention of uterine contractions
- C. Sedation
- D. Fetal lung protection

Correct Answer: A

Section: (none)

Explanation

Explanation/Reference:

Explanation:

(A) MgSO₄ is classified as an anticonvulsant drug. In preeclampsia management, MgSO₄ is used for prevention of seizures. (B) MgSO₄ has been used to inhibit hyperactive labor, but results are questionable. (C) Negative side effects such as respiratory depression should not be confused with generalized sedation. (D) MgSO₄ does not affect lung maturity. The infant should be assessed for neuromuscular and respiratory depression.

QUESTION 10

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

Section: (none)

Explanation

Explanation/Reference:

Explanation:

(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 11

Provide the 1-minute Apgar score for an infant born with the following findings: Heart rate:

Above 100 Respiratory effort: Slow, irregular Muscle tone: Some flexion of extremities Reflex irritability: Vigorous cry Color: Body pink, blue extremities

- A. 7
- B. 10
- C. 8
- D. 9

Correct Answer: A

Section: (none)

Explanation

Explanation/Reference:

Explanation:

(A) Seven out of a possible perfect score of 10 is correct. Two points are given for heart rate above 100; 1 point is given for slow, irregular respiratory effort; 1 point is given for some flexion of extremities in assessing muscle tone; 2 points are given for vigorous cry in assessing reflex irritability; 1 point is assessed for color when the body is pink with blue extremities (acrocyanosis). (B) For a perfect Apgar score of 10, the infant would have a heart rate over 100 but would also have a good cry, active motion, and be completely pink. (C) For an Apgar score of 8 the respiratory rate, muscle tone, or color would need to fall into the 2-point rather than the 1-point category. (D) For this infant to receive an Apgar score of 9, four of the areas evaluated would need ratings of 2 points and one area, a rating of 1 point.

QUESTION 12

A pregnant woman at 36 weeks' gestation is followed for PIH and develops proteinuria. To increase protein in her diet, which of the following foods will provide the greatest amount of protein when added to her intake of 100 mL of milk?

- A. Fifty milliliters light cream and 2 tbsp corn syrup
- B. Thirty grams powdered skim milk and 1 egg
- C. One small scoop (90 g) vanilla ice cream and 1 tbsp chocolate syrup
- D. One package vitamin-fortified gelatin drink

Correct Answer: B

Section: (none)

Explanation

Explanation/Reference:

Explanation:

(A) This choice would provide more unwanted fat and sugar than protein. (B) Skim milk would add protein. Eggs are good sources of protein while low in fat and calories. (C) The benefit of protein from ice cream would be outweighed by the fat content. Chocolate syrup has caffeine, which is contraindicated or limited in pregnancy. (D) Although most animal proteins are higher in protein than plant proteins, gelatin is not. It loses protein during the processing for food consumption.

QUESTION 13

The physician recommends immediate hospital admission for a client with PIH. She says to the nurse, "It's not so easy for me to just go right to the hospital like that." After acknowledging her feelings, which of these approaches by the nurse would probably be best?

- A. Stress to the client that her husband would want her to do what is best for her health.
- B. Explore with the client her perceptions of why she is unable to go to the hospital.
- C. Repeat the physician's reasons for advising immediate hospitalization.
- D. Explain to the client that she is ultimately responsible for her own welfare and that of her baby.

Correct Answer: B

Section: (none)

Explanation

Explanation/Reference:

Explanation:

(A) This answer does not hold the client accountable for her own health. (B) The nurse should explore potential reasons for the client's anxiety: are there small children at home, is the husband out of town? The nurse should aid the client in seeking support or interventions to decrease the anxiety of hospitalization. (C) Repeating the physician's reason for recommending hospitalization may not aid the client in dealing with her reasons for anxiety. (D) The concern for self and welfare of baby may be secondary to a woman who is in a crisis situation. The nurse should explore the client's potential reasons for anxiety. For example, is there another child in the home who is ill, or is there a husband who is overseas and not able to return on short notice?

QUESTION 14

Which of the following findings would be abnormal in a postpartal woman?

- A. Chills shortly after delivery
- B. Pulse rate of 60 bpm in morning on first postdelivery day
- C. Urinary output of 3000 mL on the second day after delivery
- D. An oral temperature of 101F (38.3C) on the third day after delivery

Correct Answer: D

Section: (none)

Explanation

Explanation/Reference:

Explanation:

(A) Frequently the mother experiences a shaking chill immediately after delivery, which is related to a nervous response or to vasomotor changes. If not followed by a fever, it is clinically innocuous. (B) The pulse rate during the immediate postpartal period may be low but presents no cause for alarm. The body attempts to adapt to the decreased pressures intra-abdominally as well as from the reduction of blood flow to the vascular bed. (C) Urinary output increases during the early postpartal period (12-24 hours) owing to diuresis. The kidneys must eliminate an estimated 2000-3000 mL of extracellular fluid associated with a normal pregnancy. (D) A temperature of 100.4°F (38°C) may occur after delivery as a result of exertion and dehydration of labor. However, any temperature greater than 100.4°F needs further investigation to identify any infectious process.

QUESTION 15

What is the most effective method to identify early breast cancer lumps?

- A. Mammograms every 3 years
- B. Yearly checkups performed by physician
- C. Ultrasounds every 3 years
- D. Monthly breast self-examination

Correct Answer: D

Section: (none)

Explanation

Explanation/Reference:

Explanation:

(A) Mammograms are less effective than breast self-examination for the diagnosis of abnormalities in younger women, who have denser breast tissue. They are more effective for women older than 40. (B) Up to 15% of early-stage breast cancers are detected by physical examination; however, 95% are detected by women doing breast self-examination. (C) Ultrasound is used primarily to determine the location of cysts and to distinguish cysts from solid masses. (D) Monthly breast self-examination has been shown to be the most effective method for early detection of breast cancer. Approximately 95% of lumps are detected by women themselves.

QUESTION 16

Which of the following risk factors associated with breast cancer would a nurse consider most significant in a client's history?

- A. Menarche after age 13
- B. Nulliparity
- C. Maternal family history of breast cancer
- D. Early menopause

Correct Answer: C

Section: (none)

Explanation

Explanation/Reference:

Explanation:

(A) Women who begin menarche late (after 13 years old) have a lower risk of developing breast cancer than women who have begun earlier. Average age for menarche is 12.5 years. (B) Women who have never been pregnant have an increased risk for breast cancer, but a positive family history poses an even greater risk. (C) A positive family history puts a woman at an increased risk of developing breast cancer. It is recommended that mammography screening begin 5 years before the age at which an immediate female relative was diagnosed with breast cancer. (D) Early menopause decreases the risk of developing breast cancer.

QUESTION 17

Which of the following procedures is necessary to establish a definitive diagnosis of breast cancer?

- A. Diaphanography
- B. Mammography
- C. Thermography
- D. Breast tissue biopsy

Correct Answer: D

Section: (none)

Explanation

Explanation/Reference:

Explanation:

(A) Diaphanography, also known as transillumination, is a painless, noninvasive imaging technique that involves shining a light source through the breast tissue to visualize the interior. It must be used in conjunction with a mammogram and physical examination. (B) Mammography is a useful tool for screening but is not considered a means of diagnosing breast cancers. (C) Thermography is a pictorial representation of heat patterns on the surface of the breast. Breast cancers appear as a "hot spot" owing to their higher metabolic rate. (D) Biopsy either by needle aspiration or by surgical incision is the primary diagnostic technique for confirming the presence of cancer cells.

QUESTION 18

The nurse should know that according to current thinking, the most important prognostic factor for a client with breast cancer is:

- A. Tumor size
- B. Axillary node status
- C. Client's previous history of disease
- D. Client's level of estrogen-progesterone receptor assays

Correct Answer: B

Section: (none)

Explanation

Explanation/Reference:

Explanation:

(A) Although tumor size is a factor in classification of cancer growth, it is not an indicator of lymph node spread. (B) Axillary node status is the most important indicator for predicting how far the cancer has spread. If the lymph nodes are positive for cancer cells, the prognosis is poorer. (C) The client's previous history of cancer puts her at an increased risk for breast cancer recurrence, especially if the cancer occurred in the other breast. It does not predict prognosis, however. (D) The estrogen-progesterone assay test is used to identify present tumors being fed from an estrogen site within the body. Some breast cancers grow rapidly as long as there is an estrogen supply such as from the ovaries. The estrogen-progesterone assay test does not indicate the prognosis.

QUESTION 19

When teaching a sex education class, the nurse identifies the most common STDs in the United States as:

- A. Chlamydia
- B. Herpes genitalis
- C. Syphilis
- D. Gonorrhea

Correct Answer: A

Section: (none)

Explanation

Explanation/Reference:

Explanation:

(A) Chlamydia trachomatis infection is the most common STD in the United States. The Centers for Disease Control and Prevention recommend screening of all high-risk women, such as adolescents and women with multiple sex partners. (B) Herpes simplex genitalia is estimated to be found in 5-20 million people in the United States and is rising in occurrence yearly. (C) Syphilis is a chronic infection caused by Treponema pallidum. Over the last several years the number of people infected has begun to increase. (D) Gonorrhea is a bacterial infection caused by the organism Neisseria gonorrhoeae. Although gonorrhea is common, chlamydia is still the most common STD.

QUESTION 20

A 30-year-old male client is admitted to the psychiatric unit with a diagnosis of bipolar disorder. For the last 2 months, his family describes him as being "on the move," sleeping 34 hours nightly, spending lots of money, and losing approximately 10 lb. During the initial assessment with the client, the nurse would expect him to exhibit which of the following?

- A. Short, polite responses to interview questions
- B. Introspection related to his present situation
- C. Exaggerated self-importance
- D. Feelings of helplessness and hopelessness

Correct Answer: C

Section: (none)

Explanation

Explanation/Reference:

Explanation:

(A) During the manic phase of bipolar disorder, clients have short attention spans and may be abusive toward authority figures. (B) Introspection requires focusing and concentration; clients with mania experience flight of ideas, which prevents concentration. (C) Grandiosity and an inflated sense of self-worth are characteristic of this disorder. (D) Feelings of helplessness and hopelessness are symptoms of the depressive stage of bipolar disorder.

QUESTION 21

The therapeutic blood-level range for lithium is:

- A. 0.251.0 mEq/L
- B. 0.51.5 mEq/L
- C. 1.02.0 mEq/L
- D. 2.02.5 mEq/L

Correct Answer: B

Section: (none)

Explanation

Explanation/Reference:

Explanation:

(A) This range is too low to be therapeutic. (B) This is the therapeutic range for lithium. (C) This range is above the therapeutic level. (D) This range is toxic and may cause severe side effects.

QUESTION 22

A client with bipolar disorder taking lithium tells the nurse that he has ringing in his ears, blurred vision, and diarrhea. The nurse notices a slight tremor in his left hand and a slurring pattern to his speech. Which of the following actions by the nurse is appropriate?

- A. Administer a stat dose of lithium as necessary.
- B. Recognize this as an expected response to lithium.
- C. Request an order for a stat blood lithium level.
- D. Give an oral dose of lithium antidote.

Correct Answer: C

Section: (none)

Explanation

Explanation/Reference:

Explanation:

(A) These symptoms are indicative of lithium toxicity. A stat dose of lithium could be fatal. (B) These are toxic effects of lithium therapy. (C) The client is exhibiting symptoms of lithium toxicity, which may be validated by lab studies. (D) There is no known lithium antidote.

QUESTION 23

Which of the following activities would be most appropriate during occupational therapy for a client with bipolar disorder?

- A. Playing cards with other clients
- B. Working crossword puzzles
- C. Playing tennis with a staff member
- D. Sewing beads on a leather belt

Correct Answer: C

Section: (none)

Explanation

Explanation/Reference:

Explanation:

(A) This activity is too competitive, and the manic client might become abusive toward the other clients. (B) During mania, the client's attention span is too short to accomplish this task. (C) This activity uses gross motor skills, eases tension, and expands excess energy. A staff member is better equipped to interact therapeutically with clients. (D) This activity requires the use of fine motor skills and is very tedious.

QUESTION 24

A client diagnosed with bipolar disorder continues to be hyperactive and to lose weight. Which of the following nutritional interventions would be most therapeutic for him at this time?

- A. Small, frequent feedings of foods that can be carried
- B. Tube feedings with nutritional supplements
- C. Allowing him to eat when and what he wants
- D. Giving him a quiet place where he can sit down to eat meals

Correct Answer: A

Section: (none)

Explanation

Explanation/Reference:

Explanation:

(A) The manic client is unable to sit still long enough to eat an adequate meal. Small, frequent feedings with finger foods allow him to eat during periods of activity. (B) This type of therapy should be implemented when other methods have been exhausted. (C) The manic client should not be in control of his treatment plan. This type of client may forget to eat. (D) The manic client is unable to sit down to eat full meals.

QUESTION 25

Three weeks following discharge, a male client is readmitted to the psychiatric unit for depression. His wife stated that he had threatened to kill himself with a handgun. As the nurse admits him to the unit, he says, "I wish I were dead because I am worthless to everyone; I guess I am just no good." Which response by the nurse is most appropriate at this time?

- A. "I don't think you are worthless. I'm glad to see you, and we will help you."
- B. "Don't you think this is a sign of your illness?"
- C. "I know with your wife and new baby that you do have a lot to live for."
- D. "You've been feeling sad and alone for some time now?"

Correct Answer: D

Section: (none)

Explanation

Explanation/Reference:

Explanation:

(A) This response does not acknowledge the client's feelings. (B) This is a closed question and does not encourage communication. (C) This response negates the client's feelings and does not require a response from the client. (D) This acknowledges the client's implied thoughts and feelings and encourages a response.

QUESTION 26

Which of the following statements relevant to a suicidal client is correct?

- A. The more specific a client's plan, the more likely he or she is to attempt suicide.
- B. A client who is unsuccessful at a first suicide attempt is not likely to make future attempts.
- C. A client who threatens suicide is just seeking attention and is not likely to attempt suicide.
- D. Nurses who care for a client who has attempted suicide should not make any reference to the word "suicide" in order to protect the client's ego.

Correct Answer: A

Section: (none)

Explanation

Explanation/Reference:

Explanation:

(A) This is a high-risk factor for potential suicide. (B) A previous suicide attempt is a definite risk factor for subsequent attempts. (C) Every threat of

suicide should be taken seriously. (D) The client should be asked directly about his or her intent to do bodily harm. The client is never hurt by direct, respectful questions.

QUESTION 27

The physician orders fluoxetine (Prozac) for a depressed client. Which of the following should the nurse remember about fluoxetine?

- A. Because fluoxetine is a tricyclic antidepressant, it may precipitate a hypertensive crisis.
- B. The therapeutic effect of the drug occurs 24 weeks after treatment is begun.
- C. Foods such as aged cheese, yogurt, soy sauce, and bananas should not be eaten with this drug.
- D. Fluoxetine may be administered safely in combination with monoamine oxidase (MAO) inhibitors.

Correct Answer: B

Section: (none)

Explanation

Explanation/Reference:

Explanation:

(A) Fluoxetine is not a tricyclic antidepressant. It is an atypical antidepressant. (B) This statement is true. (C) These foods are high in tyramine and should be avoided when the client is taking MAO inhibitors. Fluoxetine is not an MAO inhibitor. (D) Fatal reactions have been reported in clients receiving fluoxetine in combination with MAO inhibitors.

QUESTION 28

The day following his admission, the nurse sits down by a male client on the sofa in the dayroom. He was admitted for depression and thoughts of suicide. He looks at the nurse and says, "My life is so bad no one can do anything to help me." The most helpful initial response by the nurse would be:

- A. "It concerns me that you feel so badly when you have so many positive things in your life."
- B. "It will take a few weeks for you to feel better, so you need to be patient."
- C. "You are telling me that you are feeling hopeless at this point?"
- D. "Let's play cards with some of the other clients to get your mind off your problems for now."

Correct Answer: C

Section: (none)

Explanation

Explanation/Reference:

Explanation:

(A) This response does not acknowledge the client's feelings and may increase his feelings of guilt. (B) This response denotes false reassurance. (C) This response acknowledges the client's feelings and invites a response. (D) This response changes the subject and does not allow the client to talk about his feelings.

QUESTION 29

A long-term goal for the nurse in planning care for a depressed, suicidal client would be to:

- A. Provide him with a safe and structured environment.
- B. Assist him to develop more effective coping mechanisms.
- C. Have him sign a "no-suicide" contract.
- D. Isolate him from stressful situations that may precipitate a depressive episode.

Correct Answer: B

Section: (none)

Explanation

Explanation/Reference:

Explanation:

(A) This statement represents a short-term goal. (B) Long-term therapy should be directed toward assisting the client to cope effectively with stress. (C) Suicide contracts represent short-term interventions. (D) This statement represents an unrealistic goal. Stressful situations cannot be avoided in reality.

QUESTION 30

After 3 weeks of treatment, a severely depressed client suddenly begins to feel better and starts interacting appropriately with other clients and staff. The nurse knows that this client has an increased risk for:

- A. Suicide
- B. Exacerbation of depressive symptoms
- C. Violence toward others
- D. Psychotic behavior

Correct Answer: A

Section: (none)

Explanation

Explanation/Reference:

Explanation:

(A) When the severely depressed client suddenly begins to feel better, it often indicates that the client has made the decision to kill himself or herself and has developed a plan to do so. (B) Improvement in behavior is not indicative of an exacerbation of depressive symptoms. (C) The depressed client has a tendency for self-violence, not violence toward others. (D) Depressive behavior is not always accompanied by psychotic behavior.

QUESTION 31

Nursing care for the substance abuse client experiencing alcohol withdrawal delirium includes:

- A. Maintaining seizure precautions
- B. Restricting fluid intake
- C. Increasing sensory stimuli
- D. Applying ankle and wrist restraints

Correct Answer: A

Section: (none)

Explanation

Explanation/Reference:

Explanation:

(A) These clients are at high risk for seizures during the 1st week after cessation of alcohol intake. (B) Fluid intake should be increased to prevent dehydration. (C) Environmental stimuli should be decreased to prevent precipitation of seizures. (D) Application of restraints may cause the client to increase his or her physical activity and may eventually lead to exhaustion.

QUESTION 32

A psychotic client who believes that he is God and rules all the universe is experiencing which type of delusion?

- A. Somatic
- B. Grandiose
- C. Persecutory
- D. Nihilistic

Correct Answer: B

Section: (none)

Explanation

Explanation/Reference:

Explanation:

(A) These delusions are related to the belief that an individual has an incurable illness. (B) These delusions are related to feelings of self-importance and uniqueness. (C) These delusions are related to feelings of being conspired against. (D) These delusions are related to denial of self- existence.

QUESTION 33

A client confides to the nurse that he tasted poison in his evening meal. This would be an example of what type of hallucination?

- A. Auditory
- B. Gustatory
- C. Olfactory
- D. Visceral

Correct Answer: B

Section: (none)

Explanation

Explanation/Reference:

Explanation:

(A) Auditory hallucinations involve sensory perceptions of hearing. (B) Gustatory hallucinations involve sensory perceptions of taste. (C) Olfactory hallucinations involve sensory perceptions of smell. (D) Visceral hallucinations involve sensory perceptions of sensation.

QUESTION 34

A schizophrenic client has made sexual overtures toward her physician on numerous occasions. During lunch, the client tells the nurse, "My doctor is in love with me and wants to marry me." This client is using which of the following defense mechanisms?

- A. Displacement
- B. Projection
- C. Reaction formation
- D. Suppression

Correct Answer: B

Section: (none)

Explanation

Explanation/Reference:

Explanation:

(A) Displacement involves transferring feelings to a more acceptable object. (B) Projection involves attributing one's thoughts or feelings to another person. (C) Reaction formation involves transforming an unacceptable impulse into the opposite behavior. (D) Suppression involves the intentional exclusion of unpleasant thoughts or experiences.

QUESTION 35

Hypoxia is the primary problem related to near-drowning victims. The first organ that sustains irreversible damage after submersion in water is the:

- A. Kidney (urinary system)
- B. Brain (nervous system)
- C. Heart (circulatory system)
- D. Lungs (respiratory system)

Correct Answer: B

Section: (none)

Explanation

Explanation/Reference:

Explanation:

(A) The kidney can survive after 30 minutes of water submersion. (B) The cerebral neurons sustain irreversible damage after 46 minutes of water submersion. (C) The heart can survive up to 30 minutes of water submersion. (D) The lungs can survive up to 30 minutes of water submersion.

QUESTION 36

One of the most dramatic and serious complications associated with bacterial meningitis is Waterhouse- Friderichsen syndrome, which is:

- A. Peripheral circulatory collapse
- B. Syndrome of inappropriate antidiuretic hormone
- C. Cerebral edema resulting in hydrocephalus
- D. Auditory nerve damage resulting in permanent hearing loss

Correct Answer: A

Section: (none)

Explanation

Explanation/Reference:

Explanation:

(A) Waterhouse-Friderichsen syndrome is peripheral circulatory collapse, which may result in extensive and diffuse intravascular coagulation and thrombocytopenia resulting in death. (B) Syndrome of inappropriate antidiuretic hormone is a complication of meningitis, but it is not Waterhouse-Friderichsen syndrome. (C) Cerebral edema resulting in hydrocephalus is a complication of meningitis, but it is not Waterhouse-Friderichsen syndrome. (D) Auditory nerve damage resulting in permanent hearing loss is a complication of meningitis, but it is not Waterhouse- Friderichsen syndrome.

QUESTION 37

An 8-year-old child comes to the physician's office complaining of swelling and pain in the knees. His mother says, "The swelling occurred for no reason, and it keeps getting worse." The initial diagnosis is Lyme disease. When talking to the mother and child, questions related to which of the following would be important to include in the initial history?

- A. A decreased urinary output and flank pain
- B. A fever of over 103F occurring over the last 23 weeks
- C. Rashes covering the palms of the hands and the soles of the feet
- D. Headaches, malaise, or sore throat

Correct Answer: D

Section: (none)

Explanation

Explanation/Reference:

Explanation:

(A) Urinary tract symptoms are not commonly associated with Lyme disease. (B) A fever of 103F is not characteristic of Lyme disease. (C) The rash that is associated with Lyme disease does not appear on the palms of the hands and the soles of the feet. (D) Classic symptoms of Lyme disease include headache, malaise, fatigue, anorexia, stiff neck, generalized lymphadenopathy, splenomegaly, conjunctivitis, sore throat, abdominal pain, and cough.

QUESTION 38

The most commonly known vectors of Lyme disease are:

- A. Mites
- B. Fleas
- C. Ticks
- D. Mosquitoes

Correct Answer: C

Section: (none)

Explanation

Explanation/Reference:

Explanation:

(A) Mites are not the common vector of Lyme disease. (B) Fleas are not the common vector of Lyme disease. (C) Ticks are the common vector of Lyme disease. (D) Mosquitoes are not the common vector of Lyme disease.

QUESTION 39

A laboratory technique specific for diagnosing Lyme disease is:

- A. Polymerase chain reaction
- B. Heterophil antibody test
- C. Decreased serum calcium level
- D. Increased serum potassium level

Correct Answer: A

Section: (none)

Explanation

Explanation/Reference:

Explanation:

(A) Polymerase chain reaction is the laboratory technique specific for Lyme disease. (B) Heterophil antibody test is used to diagnose mononucleosis. (C) Lyme disease does not decrease the serum calcium level. (D) Lyme disease does not increase the serum potassium level.

QUESTION 40

The nurse would expect to include which of the following when planning the management of the client with Lyme disease?

- A. Complete bed rest for 68 weeks
- B. Tetracycline treatment
- C. IV amphotericin B
- D. High-protein diet with limited fluids

Correct Answer: B

Section: (none)

Explanation

Explanation/Reference:

Explanation:

(A) The client is not placed on complete bed rest for 6 weeks. (B) Tetracycline is the treatment of choice for children with Lyme disease who are over the age of 9. (C) IV amphotericin B is the treatment for histoplasmosis. (D) The client is not restricted to a high-protein diet with limited fluids.

QUESTION 41

A 3-year-old child is hospitalized with burns covering her trunk and lower extremities. Which of the following would the nurse use to assess adequacy of fluid resuscitation in the burned child?

- A. Blood pressure
- B. Serum potassium level
- C. Urine output
- D. Pulse rate

Correct Answer: C

Section: (none)

Explanation

Explanation/Reference:

Explanation:

(A) Blood pressure can remain normotensive even in a state of hypovolemia. (B) Serum potassium is not reliable for determining adequacy of fluid resuscitation. (C) Urine output, alteration in sensorium, and capillary refill are the most reliable indicators for assessing adequacy of fluid resuscitation. (D) Pulse rate may vary for many reasons and is not a reliable indicator for assessing adequacy of fluid resuscitation.

QUESTION 42

Proper positioning for the child who is in Bryant's traction is:

- A. Both hips flexed at a 90-degree angle with the knees extended and the buttocks elevated off the bed
- B. Both legs extended, and the hips are not flexed
- C. The affected leg extended with slight hip flexion
- D. Both hips and knees maintained at a 90-degree flexion angle, and the back flat on the bed

Correct Answer: A

Section: (none)

Explanation

Explanation/Reference:

Explanation:

(A) The child's weight supplies the countertraction for Bryant's traction; the buttocks are slightly elevated off the bed, and the hips are flexed at a 90-degree angle. Both legs are suspended by skin traction. (B) The child in Buck's extension traction maintains the legs extended and parallel to the bed. (C) The child in Russell traction maintains hip flexion of the affected leg at the prescribed angle with the leg extended. (D) The child in "9090" traction maintains both hips and knees at a 90-degree flexion angle and the back is flat on the bed.

QUESTION 43

A child sustains a supracondylar fracture of the femur. When assessing for vascular injury, the nurse should be alert for the signs of ischemia, which include:

- A. Bleeding, bruising, and hemorrhage
- B. Increase in serum levels of creatinine, alkaline phosphatase, and aspartate transaminase
- C. Pain, pallor, pulselessness, paresthesia, and paralysis
- D. Generalized swelling, pain, and diminished functional use with muscle rigidity and crepitus

Correct Answer: C

Section: (none)

Explanation

Explanation/Reference:

Explanation:

(A) Bleeding, bruising, and hemorrhage may occur due to injury but are not classic signs of ischemia. (B) An increase in serum levels of creatinine, alkaline phosphatase, and aspartate transaminase is related to the disruption of muscle integrity. (C) Classic signs of ischemia related to vascular injury secondary to long bone fractures include the five "P's": pain, pallor, pulselessness, paresthesia, and paralysis. (D) Generalized swelling, pain, and diminished functional use with muscle rigidity and crepitus are common clinical manifestations of a fracture but not ischemia.

QUESTION 44

When administering phenytoin (Dilantin) to a child, the nurse should be aware that a toxic effect of phenytoin therapy is:

- A. Stevens-Johnson syndrome
- B. Folate deficiency
- C. Leukopenic aplastic anemia
- D. Granulocytosis and nephrosis

Correct Answer: A

Section: (none)

Explanation

Explanation/Reference:

Explanation:

(A) Stevens-Johnson syndrome is a toxic effect of phenytoin. (B) Folate deficiency is a side effect of phenytoin, but not a toxic effect. (C) Leukopenic aplastic anemia is a toxic effect of carbamazepine (Tegretol). (D) Granulocytosis and nephrosis are toxic effects of trimethadione (Tridione).

QUESTION 45

A six-month-old infant has been admitted to the emergency room with febrile seizures. In the teaching of the parents, the nurse states that:

- A. Sustained temperature elevation over 103F is generally related to febrile seizures
- B. Febrile seizures do not usually recur
- C. There is little risk of neurological deficit and mental retardation as sequelae to febrile seizures
- D. Febrile seizures are associated with diseases of the central nervous system

Correct Answer: C

Section: (none)

Explanation

Explanation/Reference:

Explanation:

(A) The temperature elevation related to febrile seizures generally exceeds 101F, and seizures occur during the temperature rise rather than after a prolonged elevation. (B) Febrile seizures may recur and are more likely to do so when the first seizure occurs in the 1st year of life. (C) There is little risk of neurological deficit, mental retardation, or altered behavior secondary to febrile seizures. (D) Febrile seizures are associated with disease of the central nervous system.

QUESTION 46

When assessing a child with diabetes insipidus, the nurse should be aware of the cardinal signs of:

- A. Anemia and vomiting
- B. Polyuria and polydipsia

- C. Irritability relieved by feeding formula
- D. Hypothermia and azotemia

Correct Answer: B

Section: (none)

Explanation

Explanation/Reference:

Explanation:

(A) Anemia and vomiting are not cardinal signs of diabetes insipidus. (B) Polyuria and polydipsia are the cardinal signs of diabetes insipidus. (C) Irritability relieved by feeding water, not formula, is a common sign, but not the cardinal sign, of diabetes insipidus. (D) Hypothermia and azotemia are signs, but not cardinal signs, of diabetes insipidus.

QUESTION 47

The usual treatment for diabetes insipidus is with IM or SC injection of vasopressin tannate in oil. Nursing care related to the client receiving IM vasopressin tannate would include:

- A. Weigh once a week and report to the physician any weight gain of 10 lb.
- B. Limit fluid intake to 500 mL/day.
- C. Store the medication in a refrigerator and allow to stand at room temperature for 30 minutes prior to administration.
- D. Hold the vial under warm water for 10-15 minutes and shake vigorously before drawing medication into the syringe.

Correct Answer: D

Section: (none)

Explanation

Explanation/Reference:

Explanation:

(A) Weight should be obtained daily. (B) Fluid is not restricted but is given according to urine output. (C) The medication does not have to be stored in a refrigerator. (D) Holding the vial under warm water for 10-15 minutes or rolling between your hands and shaking vigorously before drawing medication into the syringe activates the medication in the oil solution.

QUESTION 48

A child is admitted to the emergency room with her mother. Her mother states that she has been exposed to chickenpox. During the assessment, the nurse would note a characteristic rash:

- A. That is covered with vesicular scabs all in the macular stage
- B. That appears profusely on the trunk and sparsely on the extremities
- C. That first appears on the neck and spreads downward
- D. That appears especially on the cheeks, which gives a "slapped-cheek" appearance

Correct Answer: B

Section: (none)

Explanation

Explanation/Reference:

Explanation:

(A) A rash with vesicular scabs in all stages (macule, papule, vesicle, and crusts). (B) A rash that appears profusely on the trunk and sparsely on the extremities. (C) A rash that first appears on the neck and spreads downward is characteristic of rubeola and rubella. (D) A rash, especially on the cheeks, that gives a "slapped-cheek" appearance is characteristic of roseola.

QUESTION 49

Discharge teaching was effective if the parents of a child with atopic dermatitis could state the importance of:

- A. Maintaining a high-humidified environment
- B. Furry, soft stuffed animals for play
- C. Showering 34 times a day
- D. Wrapping hands in soft cotton gloves

Correct Answer: D

Section: (none)

Explanation

Explanation/Reference:

Explanation:

(A) Maintaining a low-humidified environment. (B) Avoiding furry, soft stuffed animals for play, which may increase symptoms of allergy. (C) Avoiding showering, which irritates the dermatitis, and encouraging bathing 4 times a day in colloid bath for temporary relief. (D) Wrapping hands in soft cotton gloves to prevent skin damage during scratching.

QUESTION 50

The priority nursing goal when working with an autistic child is:

- A. To establish trust with the child
- B. To maintain communication with the family
- C. To promote involvement in school activities
- D. To maintain nutritional requirements

Correct Answer: A

Section: (none)

Explanation

Explanation/Reference:

Explanation:

(A) The priority nursing goal when working with an autistic child is establishing a trusting relationship. (B) Maintaining a relationship with the family is important but having the trust of the child is a priority. (C) To promote involvement in school activities is inappropriate for a child who is autistic. (D) Maintaining nutritional requirements is not the primary problem of the autistic child.

QUESTION 51

The child with iron poisoning is given IV deferoxamine mesylate (Desferal). Following administration, the child suffers hypotension, facial flushing, and urticaria. The initial nursing intervention would be to:

- A. Discontinue the IV
- B. Stop the medication, and begin a normal saline infusion
- C. Take all vital signs, and report to the physician
- D. Assess urinary output, and if it is 30 mL an hour, maintain current treatment

Correct Answer: B

Section: (none)

Explanation

Explanation/Reference:

Explanation:

(A) The IV line should not be discontinued because other IV medications will be needed. (B) Stop the medication and begin a normal saline infusion. The child is exhibiting signs of an allergic reaction and could go into shock if the medication is not stopped. The line should be kept opened for other medication. (C) Taking vital signs and reporting to the physician is not an adequate intervention because the IV medication continues to flow. (D) Assessing urinary output and, if it is 30 mL an hour, maintaining current treatment is an inappropriate intervention owing to the child's obvious allergic reaction.

QUESTION 52

As the nurse assesses a male adolescent with chlamydia, the nurse determines that a sign of chlamydia is:

- A. Enlarged penis
- B. Secondary lymphadenitis
- C. Epididymitis
- D. Hepatomegaly

Correct Answer: C

Section: (none)

Explanation

Explanation/Reference:

Explanation:

(A) An enlarged penis is not a sign of chlamydia. (B) Secondary lymphadenitis is a complication of lymphogranuloma venereum. (C) Untreated chlamydial infection can spread from the urethra, causing epididymitis, which presents as a tender, scrotal swelling. (D) Hepatomegaly is not a complication.

QUESTION 53

When teaching a mother of a 4-month-old with diarrhea about the importance of preventing dehydration, the nurse would inform the mother about the importance of feeding her child:

- A. Fruit juices
- B. Diluted carbonated drinks
- C. Soy-based, lactose-free formula
- D. Regular formulas mixed with electrolyte solutions

Correct Answer: C

Section: (none)

Explanation

Explanation/Reference:

Explanation:

(A) Diluted fruit juices are not recommended for rehydration because they tend to aggravate the diarrhea. (B) Diluted soft drinks have a high-carbohydrate content, which aggravates the diarrhea. (C) Soy-based, lactose-free formula reduces stool output and duration of diarrhea in most infants. (D) Regular formulas contain lactose, which can increase diarrhea.

QUESTION 54

The primary reason that an increase in heart rate (100 bpm) detrimental to the client with a myocardial infarction (MI) is that:

- A. Stroke volume and blood pressure will drop proportionately
- B. Systolic ejection time will decrease, thereby decreasing cardiac output
- C. Decreased contractile strength will occur due to decreased filling time
- D. Decreased coronary artery perfusion due to decreased diastolic filling time will occur, which will increase ischemic damage to the myocardium

Correct Answer: D

Section: (none)

Explanation

Explanation/Reference:

Explanation:

(A) Decreased stroke volume and blood pressure will occur secondary to decreased diastolic filling. (B) Tachycardia primarily decreases diastole; systolic time changes very little. (C) Contractility decreases owing to the decreased filling time and decreased time for fiber lengthening. (D) Decreased O₂ supply due to decreased time for filling of the coronary arteries increases ischemia and infarct size. Tachycardia primarily robs the heart of diastolic time, which is the primary time for coronary artery filling.

QUESTION 55

To appropriately monitor therapy and client progress, the nurse should be aware that increased myocardial work and O₂ demand will occur with which of the following?

- A. Positive inotropic therapy
- B. Negative chronotropic therapy
- C. Increase in balance of myocardial O₂ supply and demand
- D. Afterload reduction therapy

Correct Answer: A

Section: (none)

Explanation

Explanation/Reference:

Explanation:

(A) Inotropic therapy will increase contractility, which will increase myocardial O₂ demand. (B) Decreased heart rate to the point of bradycardia will increase coronary artery filling time. This should be used cautiously because tachycardia may be a compensatory mechanism to increase cardiac output. (C) The goal in the care of the MI client with angina is to maintain a balance between myocardial O₂ supply and demand. (D) Decrease in systemic vascular resistance by drug therapy, such as IV nitroglycerin or nitroprusside, or intra-aortic balloon pump therapy, would decrease myocardial work and O₂ demand.

QUESTION 56

The nurse would need to monitor the serum glucose levels of a client receiving which of the following medications, owing to its effects on glycogenolysis and insulin release?

- A. Norepinephrine (Levophed)
- B. Dobutamine (Dobutrex)
- C. Propranolol (Inderal)
- D. Epinephrine (Adrenalin)

Correct Answer: D

Section: (none)

Explanation

Explanation/Reference:

Explanation:

(A) Norepinephrine's side effects are primarily related to safe, effective care environment and include decreased peripheral perfusion and bradycardia. (B) Dobutamine's side effects include increased heart rate and blood pressure, ventricular ectopy, nausea, and headache. (C) Propranolol's side effects include elevated blood urea nitrogen, serum transaminase, alkaline phosphatase, and lactic dehydrogenase. (D) Epinephrine increases serum glucose levels by increasing glycogenolysis and inhibiting insulin release. Prolonged use can elevate serum lactate levels, leading to metabolic acidosis, increased urinary catecholamines, false elevation of blood urea nitrogen, and decreased coagulation time.

QUESTION 57

Which of the following medications requires close observation for bronchospasm in the client with chronic obstructive pulmonary disease or asthma?

- A. Verapamil (Isoptin)
- B. Amrinone (Inocor)
- C. Epinephrine (Adrenalin)
- D. Propranolol (Inderal)

Correct Answer: D

Section: (none)

Explanation

Explanation/Reference:

Explanation:

(A) Verapamil has the respiratory side effect of nasal or chest congestion, dyspnea, shortness of breath (SOB), and wheezing. (B) Amrinone has the effect of increased contractility and dilation of the vascular smooth muscle. It has no noted respiratory side effects. (C) Epinephrine has the effect of bronchodilation through stimulation. (D) Propranolol, esmolol, and labetalol are all - blocking agents, which can increase airway resistance and cause bronchospasms.

QUESTION 58

The following medications were noted on review of the client's home medication profile. Which of the medications would most likely potentiate or elevate serum digoxin levels?

- A. KCl
- B. Thyroid agents
- C. Quinidine
- D. Theophylline

Correct Answer: C

Section: (none)

Explanation

Explanation/Reference:

Explanation:

(A) Hypokalemia can cause digoxin toxicity. Administration of KCl would prevent this. (B) Thyroid agents decrease digoxin levels. (C) Quinidine increases digoxin levels dramatically. (D) Theophylline is not noted to have an effect on digoxin levels.

QUESTION 59

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

Section: (none)

Explanation

Explanation/Reference:

Explanation:

(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 most individuals. (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 60

When inspecting a cardiovascular client, the nurse notes that he needs to sit upright to breathe. This behavior is most indicative of:

- A. Pericarditis
- B. Anxiety
- C. Congestive heart failure
- D. Angina

Correct Answer: C

Section: (none)

Explanation

Explanation/Reference:

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