# National Council Licensure Examination(NCLEX-RN)

## NCLEX NCLEX-RN

## Version Demo

**Total Demo Questions: 20**

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# Topic Break Down

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## QUESTION NO: 1

A 26-year-old client has no children. She has had an abdominal hysterectomy. In the first 24 hours postoperatively, the nurse would be concerned if the client:

**A.** Cries easily and says she is having abdominal pain

**B.** Develops a temperature of 102_F

**C.** Has no bowel sounds

**D.** Has a urine output of 200 mL for 4 hours

## ANSWER: B

**Explanation:**

(A) The client may be more tearful than normal due to the stress of the surgery and its implications for her future life. She would be expected to have pain following surgery. (B) A temperature of 102_F indicates an infectious process. This is not a normal sequence to surgery and indicates a need for further assessment. (C) The client is expected to have no bowel soundsfor 24–48 hours after surgery because of the trauma to the bowel. (D) Normal urine output is 30 mL/hr. This represents an output of 50 mL/hr, which is greater than normal.

## QUESTION NO: 2

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 2–3 weeks

**C.** Rashes covering the palms of the hands and the soles of the feet

**D.** Headaches, malaise, or sore throat

## ANSWER: D

**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 diseasedoes 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 NO: 3

A 68-year-old client developed acute respiratory distress syndrome while hospitalized for pneumonia. After a

respiratory arrest, an endotracheal tube was inserted. Several days later, numerous attempts to wean him from mechanical ventilation were ineffective, and a tracheostomy was created. For the first 24 hours following tracheostomy, it is important to minimize bleeding around the insertion site. The nurse can accomplish this by:

**A.** Deflating the cuff for 10 minutes every other hour instead of 5 minutes every hour

**B.** Avoiding manipulation of the tracheostomy including cuff deflation

**C.** Reporting any signs of crepitus immediately to the physician

**D.** Changing tracheostomy dressing only as necessary using one-half strength hydrogen peroxide to cleanse the site

## ANSWER: B

**Explanation:**

(A) The tracheal cuff should not be deflated within the first 24 hours following surgery. (B) To minimize bleeding, any manipulation, including cuff deflation, should be avoided. (C) Small amounts of crepitus are expected to occur; however, large amounts or expansion of the area of crepitus should be reported to the physician. (D) The tracheostomy site may be changed as often as necessary, but site care should be done with normal saline.

## QUESTION NO: 4

A 43-year-old client is admitted to the hospital with a diagnosis of peripheral vascular disorder. She arrives in her

room via stretcher and requires assistance to move to her bed. The nurse notes that her left leg is cold to touch. She complains of having recently experienced muscle spasms in that leg. To determine if these muscle spasms are indicative of intermittent claudication, the nurse would begin her assessment with the following question:

**A.** “Would you describe the intensity, duration, and symptoms associated with your pain?”

**B.** “Do you experience swelling at the end of the day in the affected and unaffected leg?”

**C.** “Have you had any lesions of the affected leg that have been difficult to heal?”

**D.** “Do your muscle spasms occur following rest, walking, or exercising?”

## ANSWER: D

**Explanation:**

(A) Describing pain is an important aspect of the assessment; however, assessing activity preceding muscle spasms is equally important. (B) Edema may occur with peripheral vascular disease, but it is not of particular importance in assessing intermittent claudication. (C) Lesions may be present with peripheral vascular disease, but they are not an indication of intermittent claudication. (D) With intermittent claudication, muscle spasms occur intermittently, mainly with walking and after exercising. Rest may relieve muscle spasms.

## QUESTION NO: 5

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

## ANSWER: B

**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 NO: 6

A client who has gout is most likely to form which type of renal calculi?

**A.** Struvite stones

**B.** Staghorn calculi

**C.** Uric acid stones

**D.** Calcium stones

## ANSWER: C

**Explanation:**

(A) The presence of urinary tract infection is a factor in the formation of struvite stones. (B) Staghorn calculi is the other name for struvite stones associated with urinary tract infection. (C) Clients who have gout form uric acid stones. (D) Clients who have increased urinary excretion of calcium form calcium stones.

## QUESTION NO: 7

When a client arrives on the labor and delivery unit, she informs the nurse that she has been having contractions for the last 5 hours. Now the pain is constant and not cyclical as it was earlier. The nurse considers the possibility of uterine rupture. Which of the following symptoms would be consistent with a uterine rupture?

**A.** A large gush of clear fluid from the vagina

**B.** Systolic hypertension

**C.** Abdominal rigidity

**D.** Increased fetal movements

**ANSWER: C**

**Explanation:**

(A) This symptom would indicate a rupture of the membranes, which would be expected during labor. There would be no cause for alarm if the fluid were clear. (B) With uterine rupture and the risk of maternal shock secondary to blood loss, the most likely sign would be hypotension indicating hypovolemic shock. (C) In the event of a uterine rupture, an abdominal examination would likely reveal rigidity or tenderness. (D) The most likely finding would be a decrease in fetal movement related to fetal distress due to impaired uteroplacental blood flow. Maintaining the client on her left side would help to maximize uterine blood flow.

## QUESTION NO: 8

A pregnant client is at the clinic for a third trimester prenatal visit. During this examination, it has been determined that her fetus is in a vertex presentation with the occiput located in her right anterior quadrant. On her chart this would be noted as:

**A.** Right occipitoposterior

**B.** Right occipitoanterior

**C.** Right sacroanterior

**D.** LOA

**ANSWER: B**

**Explanation:**

(A) The fetus in the right occipitoposterior position would be presenting with the occiput in the maternal right posterior quadrant. (B) Fetal position is defined by the location of the fetal presenting part in the four quadrants of the maternal pelvis. The right occipitoanterior is a fetus presenting with the occiput in mother's right anterior quadrant. (C) The fetus in right sacroanterior position would be presenting a sacrum, not an occiput. (D) The fetus in left occipitoanterior position would be presenting with the occiput in the mother's left anterior quadrant.

## QUESTION NO: 9

A client diagnosed with severe anemia is to receive 2 U of packed red blood cells. Prior to starting the blood transfusion, the nurse must:

**A.** Take a baseline set of vital signs

**B.** Hang Ringer's lactate as the companion fluid

**C.** Use microdrip tubing for the blood administration

**D.** Have the registered nurse in charge assume responsibility for verifying the client and blood product information

**ANSWER: A**

**Explanation:**

(A) A baseline set of vital signs is necessary to determine if any transfusion reactions occur as the blood product is being administered. (B) The only companion fluid to be used during a blood transfusion is normal saline. The calcium in Ringer's lactate can cause clotting. (C) Only a blood administration set should be used. A microdrip tube would cause lysis of the red blood cells. (D) Proper identification of the recipient and the blood product must be validated by at least two people.

## QUESTION NO: 10

A male client is undergoing cardiac tests. He has been instructed to wear a Holter monitor. The nurse knows she has included the appropriate information in her teaching when the client tells her:

**A.** "He should remove the electrodes for bathing."

**B.** "Damage to his heart muscle will be recorded by the monitor."

**C.** "He is to keep a record of everything he does during the day."

**D.** "He is to refrain from activities that cause chest pain."

**ANSWER: C**

**Explanation:**

(A) The client should leave the electrodes in place during the entire time the test is ordered. He should not even remove the electrodes for bathing. (B) The Holter monitor will record cardiac electrical activity but will not record damage to his myocardium. (C) The client should keep a record of all of his activities so the physician can correlate the ECG findings with his activities. (D) The client should continue doing his regular activities. The purpose of the Holter monitor is to record heart activity during routine activities.

## QUESTION NO: 11

A 9-month-old infant is being examined in the general pediatric clinic for a routine well-child checkup. His immunizations are up to date, and his mother reports that he has had no significant illnesses or injuries. Which of the following signs would lead the nurse to believe that he has had a cerebral injury?

**A.** Hyperextension of the neck with evidence of pain on flexion

**B.** Holding the head to one side and pointing the chin toward the other side

**C.** Holding the head erect and in the midline when in a vertical position

**D.** Significant head lag when raised to a sitting position

**ANSWER: D**

**Explanation:**

(A) This position is indicative of a possible meningeal irritation or infection such as meningitis. (B) This position is seen most frequently in infants who have had an injury to the sternocleidomastoid muscle. (C) Most infants aged 4 months and older are able to maintain this position. (D) Infants older than 6 months of age should not have significant head lag. This is a sign of cerebral injury and should be referred for further evaluation.

## QUESTION NO: 12

A client is pleased about being pregnant, yet states, “It is really not the best time, but I guess it will be OK.” The nurse’s assessment of this response is:

**A.** Initial maternal-infant bonding may be poor.

**B.** Client may have a poor relationship with her husband.

**C.** This response is normal in the first trimester.

**D.** This response is abnormal, to be re-evaluated at the next visit.

**ANSWER: C**

**Explanation:**

(A) Ambivalence is normal during the first trimester. Reva Rubin addresses the issue of “not now” in the first trimester. The statement still leaves room for exploration. (B) There are no data to support this. This statement by the mother still leaves room for exploration. (C) Ambivalenceis normal during the first trimester. Reva Rubin addresses the issue of “not now.” This fact should be shared with the mother during further exploration of the comment. (D) It is not abnormal. If it were, another month would also be too long to wait.

## QUESTION NO: 13

Chorioamnionitis is a maternal infection that is usually associated with:

**A.** Prolonged rupture of membranes

**B.** Postterm deliveries

**C.** Maternal pyelonephritis

**D.** Maternal dehydration

**ANSWER: A**

**Explanation:**

(A) Chorioamnionitis is an inflammation of the chorion and amnion that is generally associated with premature or prolonged rupture of membranes. (B)

Postterm deliveries have not been shown to increase the risk of chorioamnionitis unless there has been prolonged rupture of membranes. (C) Pyelonephritis is a kidney infection that develops in 20%–40% of untreated maternal UTIs. (D) Maternal dehydration, though of great concern, is not related to chorioamnionitis.

## QUESTION NO: 14

A client has been in labor 10 hours and is becoming very tired. She has dilated to 7 cm and is at 0 station with the fetus in a right occipitoposterior position. She is complaining of severe backache with each contraction. One comfort measure the nurse can employ is to:

**A.** Place her in knee-chest position during the contraction

**B.** Use effleurage during the contraction

**C.** Apply strong sacral pressure during the contraction

**D.** Have her push with each contraction

## ANSWER: C

**Explanation:**

(A) This measure is inappropriate. The knee-chest position is employed to take pressure off the cord. (B) Effleurage is a comfort measure but not the one that will contribute most to the relief of backache caused by a posterior position. (C) Sacral pressure will counteract the pressure created by the position of the fetal head. (D) The client is not completely dilated. Pushing is contraindicated until the second stage of labor.

## QUESTION NO: 15

A 4-year-old child is being discharged from the hospital after being treated for severe croup. Which one of the following instructions should the nurse give to the child's mother for the home treatment of croup?

**A.** Take him in the bathroom, turn on the hot water, and close the door.

**B.** Give him a dose of antihistamine.

**C.** Give large amounts of clear liquids if drooling occurs.

**D.** Place him near a cool mist vaporizer and encourage crying.

## ANSWER: A

**Explanation:**

(A) Initial home treatment of croup includes placing the child in an environment of high humidity to liquefy and mobilize secretions. (B) Antihistamines should be avoided because they can cause thickening of secretions. (C) Drooling is a characteristic sign of airway obstruction and the child should be taken directly to the emergency room. (D) Crying increases respiratory distress and hypoxia in the child with croup. The nurse should promote methods that will calm the child.

## QUESTION NO: 16

A client has been taking lithium 300 mg po bid for the past two weeks. This morning her lithium level was 1 mEq/L. The nurse should:

**A.** Notify the physician immediately

**B.** Hold the morning lithium dose and continue to observe the client

**C.** Administer the morning lithium dose as scheduled

**D.** Obtain an order for benztropine (Cogentin)

## ANSWER: C

**Explanation:**

(A) There is no need to phone the physician because the lithium level is within therapeutic range and because there are no indications of toxicity present. (B) There is no reason to withhold the lithium because the blood level is within therapeutic range. Also, it is necessary to give the medication as scheduled to maintain adequate blood levels. (C) The lab results indicate that the client's lithium level is within therapeutic range (0.2–1.4 mEq/L), so the medication should be given as ordered. (D) Benztropine is an antiparkinsonism drug frequently given to counteractextrapyramidal symptoms associated with the administration of antipsychotic drugs (not lithium).

## QUESTION NO: 17

MgSO4 is ordered IV following the established protocol for a client with severe PIH. The anticipated effects of this therapy are anticonvulsant and:

**A.** Vasoconstrictive

**B.** Vasodilative

**C.** Hypertensive

**D.** Antiemetic

## ANSWER: B

**Explanation:**

(A) An anticonvulsant effect is the goal of drug therapy for PIH. However, we would not want to increase the vasoconstriction that is already present.

This would make the symptoms more severe. (B) An anticon-vulsant effect and vasodilation are the desired outcomes when administering this drug. (C)

An anticonvulsant effect is the goal of drug therapy for PIH; however, hypertensive drugs would increase the blood pressure even more. (D) An anticonvulsant effect is the goal of drug therapy for PIH. MgSO4is not classified as an antiemetic. Antiemetics are not indicated for PIH treatment.

## QUESTION NO: 18

The nurse is caring for a client who has diabetes insipidus. The nurse would describe this client's urine output pattern as:

**A.** Anuria

**B.** Oliguria

**C.** Dysuria

**D.** Polyuria

## ANSWER: D

**Explanation:**

(A)Anuriais defined as absence of urine output, which is not indicative of the urinary pattern of diabetes insipidus.
(B)Oliguriais defined as <500 mL of urine per day, which is not a urinary output pattern associated with diabetes insipidus.
(C)Dysuriais defined as difficult urination. Clients with diabetes insipidus do not have dysuria as a symptom of their disease.
(D) Polyuria is a primary symptom of diabetes insipidus. These clients have decreased or absent vasopressin secretion, which causes water loss in the urine and sodium increases.

## QUESTION NO: 19

A 45-year-old client diagnosed with major depression is scheduled for electroconvulsive therapy (ECT) in the morning. Which of the following medications are routinely administered either before or during ECT?

**A.** Thioridazine (Mellaril), lithium, and benztropine

**B.** Atropine, sodium brevitol, and succinylcholine chloride (Anectine)

**C.** Sodium, potassium, and magnesium

**D.** Carbamazepine (Tegretol), haloperidol, and trihexyphenidyl (Artane)

## ANSWER: B

**Explanation:**

(A) Thioridazine (an antipsychotic drug), lithium (an antimanic drug), and benztropine (an antiparkinsonism agent) are generally administered to treat schizophrenic and bipolar disorders. (B) Atropine (a cholinergic blocker), sodium brevitol (a shortacting anesthetic), and succinylcholine (a neuromuscular blocker) are administered either before or during ECT to coun teract bradycardia and to provide anesthesia and total muscle relaxation. (C) These are electrolyte substances administered to correct fluid and electrolyte imbalances in the body. (D) Carbamazepine (an anticonvulsant), haldoperidol (an antipsychotic), and trihexyphenydyl (an antiparkinsonism agent) are usually administered in psychiatric settings to control problems associated with psychotic behavior.

## QUESTION NO: 20

A client is being discharged with albuterol (Proventil) and beclomethasone dipropionate (Vanceril) to be administered via inhalation three times a day and at bedtime. Client teaching regarding the sequential order in which the drugs should be administered includes:

**A.** Glucocorticoid followed by the bronchodilator

**B.** Bronchodilator followed by the glucocorticoid

**C.** Alternate successive administrations

**D.** According to the client's preference

**ANSWER: B**

**Explanation:**

(A) The client would not receive therapeutic effects of the glucocorticoid when it is inhaled through constricted airways. (B) Bronchodilating the airways first allows for the glucocorticoid to be inhaled through open airways and increases the penetration of the steroid for maximum effectiveness of the drug. (C) Inac- Inaccurate use of the inhalers will lead to decreased effectiveness of the treatment. (D) Client teaching regarding the use and effects of inhalers will promote client understanding and compliance.