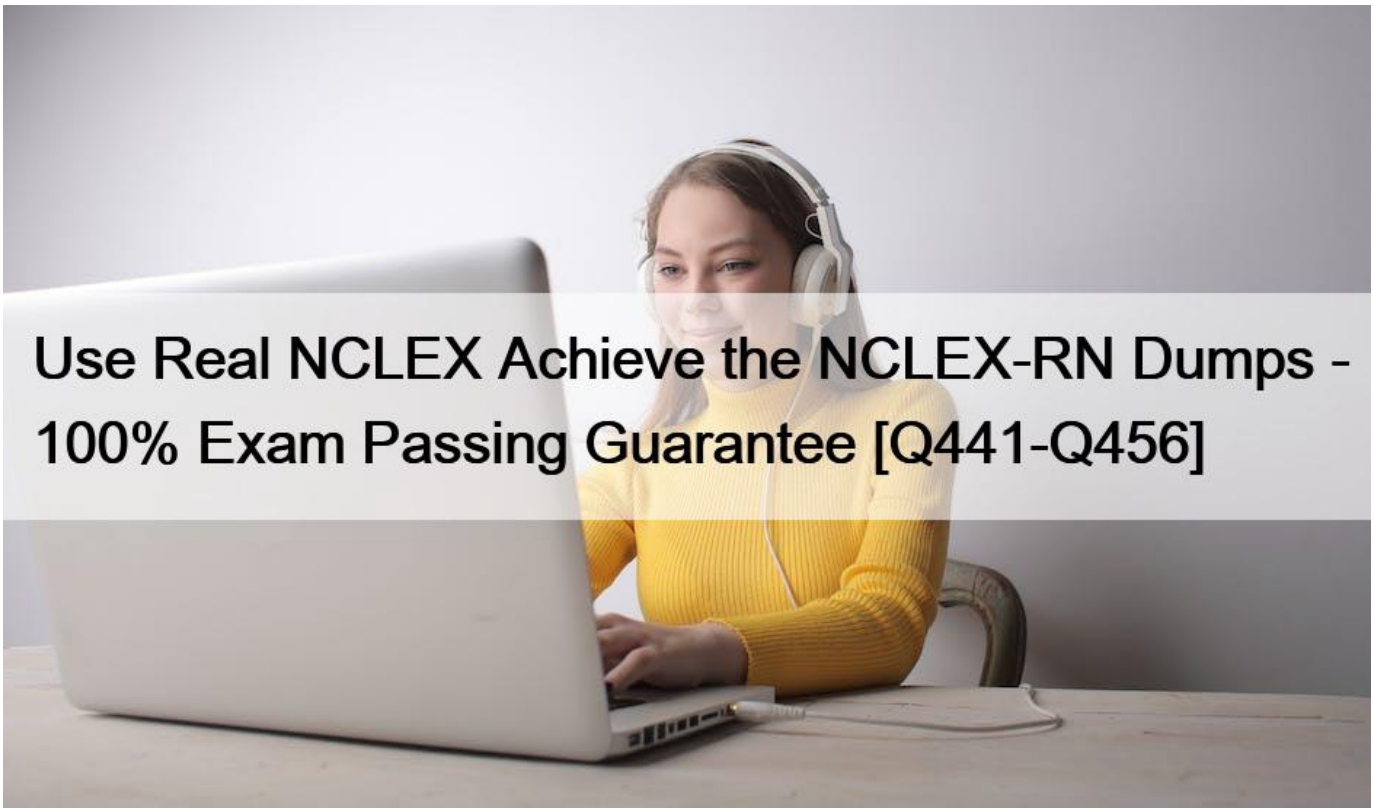
Use Real NCLEX Achieve the NCLEX-RN Dumps - 100% Exam Passing Guarantee [Q441-Q456



Use Real NCLEX Achieve the NCLEX-RN Dumps - 100% Exam Passing Guarantee Verified NCLEX-RN Q&As - Pass Guarantee NCLEX-RN Exam Dumps

To be eligible to take the NCLEX-RN exam, nurses must first complete an accredited nursing program, either a diploma program, an associate degree program, or a bachelor's degree program. Once they have completed their program, they must apply for licensure with their state board of nursing and register with Pearson VUE, the organization that administers the exam. After registering, they will receive an Authorization to Test (ATT) and can schedule their exam date and location.

NO.441 Nursing assessment of early evidence of septic shock in children at risk includes:
* Fever, tachycardia, and tachypnea
* Respiratory distress, cold skin, and pale extremities
* Elevated blood pressure, hyperventilation, and thready pulses
* Normal pulses, hypotension, and oliguria

(A) Fever, tachycardia, and tachypnea are the classic early signs of septic shock in children. (B) Respiratory distress, cold skin, and pale extremities are later signs of septic shock. (C) Elevated blood pressure, hyperventilation, and thready pulses are later signs of septic shock. (D) Normal pulses, hypotension, and oliguria are not early signs of septic shock.

NO.442 The nurse has been caring for a 16-year-old female who recently experienced date rape. After having had crisis intervention

and been hospitalized for 2 weeks, the nurse knows that the client is effectively coping with the rape when she tells the nurse:
* “I know it was my fault that it happened, because I shouldn’t have been out so late.”
* “If I had not worn that sexy dress that night, he wouldn’t have raped me.”
* “I know my date just had so much passion he couldn’t handle me saying ‘no.’ “
* “I know now that it was not my fault, but I want to continue counseling after my discharge.”
Explanation/Reference:

Explanation:

(A) This response does not show any insight; the client falsely assumes that she is responsible for the rape. (B) The client continues to falsely assume responsibility for the rapist’s behavior. (C) The client believes falsely that rape is an act of passion, rather than one of violence, control, and domination. (D) The client has insight into the rape; she does not believe it was her fault and shows good judgment in deciding to continue with counseling after discharge.

NO.443 The client has been in active labor for the last 12 hours. During the last 3 hours, labor has been augmented with oxytocin because of hypoactive uterine contractions. Her physician assesses her cervix as 95% effaced, 8 cm dilated, and the fetus is at 0 station. Her oral temperature is 100.2°F at this time. The physician orders that she be prepared for a cesarean delivery. In preparing the client for the cesarean delivery, which one of the following physician’s orders should the RN question?
* Administer meperidine (Demerol) 100 mg IM 1 hour prior to the delivery.
* Discontinue the oxytocin infusion.
* Insert an indwelling Foley catheter prior to delivery.
* Prepare abdominal area from below the nipples to below the symphysis pubis area.
Section: Questions Set C

Explanation:

(A) Meperidine is a narcotic analgesic medication that crosses the placental barrier and reaches the fetus, causing respiratory depression in the fetus. A narcotic medication should never be included in the preoperative order for a cesarean delivery. (B) Oxytocin infusion would be discontinued if client is being prepared for a cesarean delivery because the medication would not be needed. (C) The bladder is always emptied prior to and during the surgical intervention to prevent the urinary bladder from accidentally being incised while the uterine incision is made. (D) The abdominal area is always prepared to rid the area of hair before the abdominal incision is made. Abdominal hair cannot be sterilized and could become a source for postoperative incisional infection.

NO.444 A male client seeks counseling after his wife of 19 years threatened to divorce him. For most of their marriage, he has physically and verbally abused her. When asked about his behavior in the process of the nursing assessment, the client states, “I was mean to my wife because she insists on cooking meals and wearing clothes that I do not like.” This defense mechanism is an example of:
* Repression
* Regression
* Reaction formation
* Rationalization
Explanation

(A) Repression is blocking a desire from conscious expression. The client is conscious of his desires. (B) Regression is returning to an earlier form of expression, which is not demonstrated here. (C) Reaction formation is acting out the opposite of true feelings. The client felt anger concerning his wife’s cooking and acted out his feelings. (D) Rationalization is unconsciously falsifying an experience by giving a “rational” explanation. The client is attempting to justify his behavior by giving an explanation.

NO.445 A 74-year-old client seen in the emergency room is exhibiting signs of delirium. His family states that he has not slept, eaten, or taken fluids for the past 24 hours. The planning of nursing care for a delirious client is based on which of the following premises?
* The delirious client is capable of returning to his previous level of functioning.
* The delirious client is incapable of returning to his previous level of functioning.
* Delirium entails progressive intellectual and behavioral deterioration.
* Delirium is an insidious process.

(A) This answer is correct. If the cause is removed, the delirious client will recover completely. (B) This answer is incorrect. The demented client is incapable of returning to previous level of functioning. The delirious client is capable of returning to previous functioning. (C) This answer is incorrect. The demented client, not the delirious client, has progressive intellectual and behavioral deterioration. (D) This answer is incorrect. Delirium develops rapidly, whereas dementia is insidious.

NO.446 A hyperactive client is experiencing flight of ideas. The most therapeutic activity for him would be:
* Doing crafts in occupational therapy
* Working a 1000-piece puzzle
* Playing bridge with three other clients
* Playing basketball in the gym

Explanation/Reference:

Explanation:

(A) This activity requires motor skills and therefore would be difficult for a hyperactive client. (B) This activity would take too long, and the client would have difficulty concentrating owing to a limited attention span. (C) This client would not be able to concentrate enough to play card games. He would respond to all the stimuli in the area, become distracted, and leave the table. (D) This activity would allow the client to channel his energy in a positive way.

NO.447 A female client decides on hemodialysis. She has an internal vascular access device placed. To ensure patency of the device, the nurse must:
* Assess the site for leakage of blood or fluids
* Auscultate the site for a bruit
* Assess the site for bruising or hematoma
* Inspect the site for color, warmth, and sensation

Explanation/Reference:

Explanation:

(A) This is an internal device. Assessment of the site should include assessing for swelling, pain, warmth, and discoloration. This measure does not assess patency. (B) The presence of a bruit indicates good blood flow through the device. (C) The nurse should inspect the site for bruising or hematoma; however, this measure does not assure patency of the device. (D) The nurse should inspect the vascular access site frequently for signs of infection. However, this does not assure patency.

NO.448 Prior to administering digoxin to a client with congestive heart failure, the nurse needs to assess:
* Respiratory rate for 1 minute
* Radial pulse for 1 minute
* Radial pulse for 2 minutes
* Apical pulse for 1 minute

(A) Respiratory rate is not directly affected by digoxin therapy. (B) A radial pulse is not as accurate as an apical pulse. Dysrhythmias may not be detected. (C) A radial pulse is not as accurate as an apical pulse, regardless of assessment time. (D) Apical pulse should be measured for 1-minute prior to digoxin administration. Digoxin decreases the heart rate. Digoxin should be withheld if apical rates are <60 bpm or >120 bpm.

NO.449 A client with a head injury asks why he cannot have something for his headache. The nurse’s response is based on the understanding that analgesics could:
* Counteract the effects of antibiotics
* Elevate the blood pressure
* Mask symptoms of increasing intracranial pressure
* Stimulate the central nervous system
Section: Questions Set G

Explanation:

(A) Analgesic medication does not counteract the effects of antibiotics. (B) Analgesic medication may lower blood pressure elevated due to anxiety. (C) Analgesic medication, especially CNS depressants, is not given if there is danger of increasing ICP, because neurological changes may not be apparent. Also, further depression of the CNS is contraindicated. (D) Analgesics do not stimulate the CNS.

NO.450 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:
* Right occipitoposterior
* Right occipitoanterior
* Right sacroanterior
* LOA
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.

NO.451 A client is a depressed, 48-year-old salesman. A serious concern for the nurse working

with depressed clients is the potential of suicide. The time that suicide is most likely to occur is:
* In the acutely depressed state
* When the depression starts to lift
* In the denial phase
* During a manic episode
(A) The client may be too disorganized in the acute phase to make a workable plan. (B) When the depression starts to lift, the client is able to make a workable plan. (C) There usually is not a significant denial phase related to depression. Suicide occurs in a state of despair and hopelessness. (D) Suicide is uncommon in the manic state. In this state, clients do not feel hopeless, but euphoric and overly confident.

NO.452 A client is in active labor and has been admitted to the labor and delivery unit. The RN has just done a sterile vaginal exam and determines that the client is dilated 5 cm, effaced 85%, and the fetus’s head is at 0 station.

She asks if she could have a lumbar epidural now. The epidural is started, and the anesthetic agent used is bupivacaine (Marcaine). After the client has received her lumbar epidural, it is important for the RN to monitor her for which of the following side effects:
* Hypertension
* Hypotension
* Hypoglycemia

* Hyperglycemia

Explanation

(A) The medication bupivacaine will cause vasodilation in the vascular system, and this does not result in elevation of the ma-ternal blood pressure. (B) The medication bupivacaine will cause vasodilation in the vascular system, and this will result in lowering the maternal blood pressure. (C) Bupivacaine does not interfere with the functioning of the endocrine system. (D) Bupivacaine does not interfere with the functioning of the endocrine system.

NO.453 A 30-year-old client is exhibiting auditory hallucinations. In working with this client, the nurse would be most effective if the nurse:

* Encourages the client to discuss the voices
* Attempts to direct the client’s attention to the here and now
* Exhibits sincere interest in the delusional voices
* Gives the medication as necessary for the acting-out behavior

(A) This answer is incorrect. Encouraging discussion of the voices will reinforce the delusion. (B) This answer is correct. The nurse should appropriately present reality. (C) This answer is incorrect. Showing interest would reinforce the delusional system. (D) This answer is incorrect. The statement only indicates that the client is hearing voices. It does not state that the client is acting out.

NO.454 A client decided early in her pregnancy to breast-feed her first baby. She gave birth to a normal, full-term girl and is now progressing toward the establishment of successful lactation. To remove the baby from her breast, she should be instructed to:

* Gently pull the infant away
* Withdraw the breast from the infant’s mouth
* Compress the areolar tissue until the infant drops the nipple from her mouth
* Insert a clean finger into the baby’s mouth beside the nipple

Section: Questions Set B

Explanation:

(A) In pulling the infant away from the breast without breaking suction, nipple trauma is likely to occur. (B) In pulling the breast away from the infant without breaking suction, nipple trauma is likely to occur. (C) Compressing the maternal tissue does not break the suction of the infant on the breast and can cause nipple trauma. (D) By inserting a finger into the infant’s mouth beside the nipple, the lactating mother can break the suction and the nipple can be removed without trauma.

NO.455 A 9-week-old female infant has a diagnosis of bilateral cleft lip and cleft palate. She has been admitted to the pediatric unit after surgical repair of the cleft lip. Which of the following nursing interventions would be appropriate during the first 24 hours?

* Position on side or abdomen.
* Maintain elbow restraints in place unless she is being directly supervised.
* Clean suture line every shift.
* Offer pacifier when she cries.

Explanation

(A) Placing the infant on her abdomen may allow for injury to the suture line. (B) Elbow restraints prevent the infant from touching the suture line and yet leaves hands free. (C) The suture line is cleaned as often as every hour to prevent crusting and scarring. (D) Sucking of a bottle or pacifier places pressure on the suture line and may delay healing and cause scarring.

NO.456 A schizophrenic is admitted to the psychiatric unit. What affect would the nurse expect to observe?

* Anger
* Apathy and flatness
* Smiling
* Hostility

Section: Questions Set C

Explanation:

(A) Anger is an emotion that is not necessarily present in schizophrenia. (B) Lack of response to or involvement with environment and distancing are characteristic of schizophrenia. (C) Euphoria is more characteristic of manic-depressive disorder (bipolar disorder). (D) Hostility is an emotion that is not necessarily present in schizophrenia.