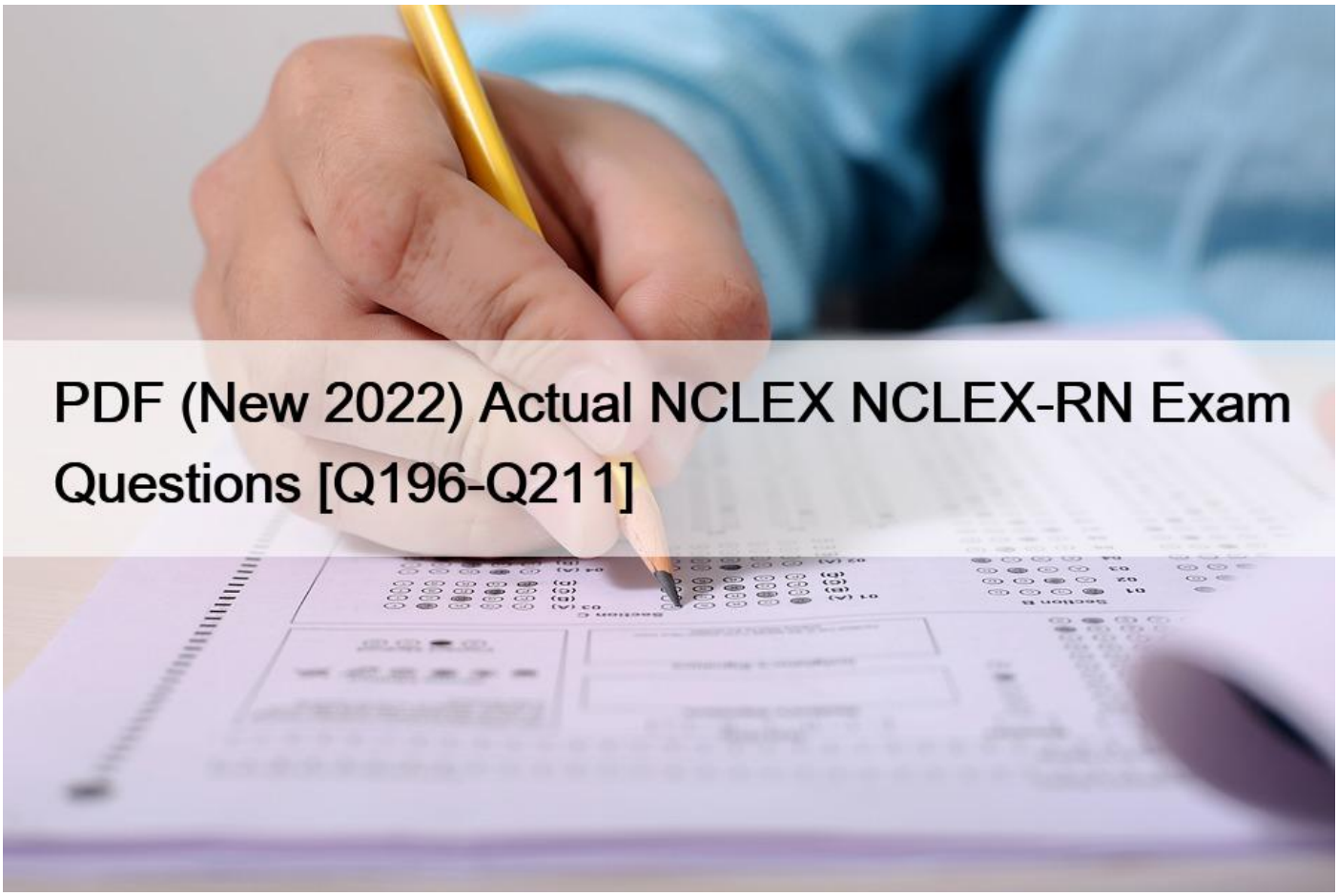
PDF (New 2022) Actual NCLEX NCLEX-RN Exam Questions [Q196-Q211



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A female client presents to the obstetric-gynecology clinic for a pregnancy test, the result which turns out to be positive. Her last menstrual period began December 10, 1993. Using Nägele’s rule, the nurse estimates her date of delivery to be:
* September 17, 1994
* September 10, 1994
* September 3, 1994
* August 17, 1994

Explanation/Reference:

Explanation:

(A) According to Nägele’s rule, the estimated date of delivery is calculated by adding 7 days to the date of the first day of the normal menstrual period (December 10 + 7 days = December 17), and then by counting back 3 months (December 17 -3 mo = September 17). (B, C, D) These answers are incorrect.

NEW QUESTION 197

A client has just been transferred to the floor from the labor and delivery unit following delivery of a stillborn term infant. She is very despondent. When the nurse attempts to take her vital signs, she responds in anger, stating, “You leave me alone. You don’t care anything about me. It’s people like you who let my baby die.” The nurse’s best course of action is to:
* Quietly leave her room, allowing her more private time to deal with her loss.
* Tell her that what happened was for the best and that she is still young and can have other children.
* Tell her how sorry you are, and let her know that her child is now a little angel in heaven.
* Tell her how sorry you are about the loss of her baby, and acknowledge her anger as being a normal stage of grief. Assure her that you are there to help her in any way you can.

Explanation/Reference:

Explanation:

(A) Parents do need their privacy following a loss, but the nurse still has a responsibility to provide postpartum physical care. (B) This is a negative statement, which is not therapeutic. The client is not concerned about future children but is in the first stages of grief, denial, and anger. (C) This is a negative statement, which is not therapeutic. The client does not want to hear about her baby in heaven. She cannot believe that God could love or want her child more than she could. (D) Acknowledging that anger is normal and beneficial will help the client to understand the normal stages of grief. Expressing sorrow over her loss and assuring her that the support is there to take care of her physical and emotional needs will help to promote a trusting relationship.

NEW QUESTION 198

At her first prenatal visit, a 21-year-old woman who is gravida 2, para 0, ab 1, is currently at 32 weeks’ gestation and has a history of drug abuse, smoking, and occasional ethyl alcohol use. Fetal ultrasound tests indicate poor fetal growth. The most likely reason for the infant’s intrauterine growth retardation is:
* The client’s young age
* The client’s previous abortion
* The client’s history of drug, ethyl alcohol, and tobacco use
* The client’s late prenatal care
(A) Although adolescents frequently have a higher incidence of low-birth-weight infants, this client is 21 years old. (B) Uncomplicated induced abortions have not been proved to influence the growth of infants of subsequent pregnancies. (C) Compounds in cigarettes and some illicit drugs cause maternal vasoconstriction and a subsequent reduction in O2 availability for the fetus owing to the resulting reduction in uteroplacental blood flow. As few as one or two drinks of alcohol per day will decrease birth weight. (D) Although early prenatal care has been shown to improve pregnancy outcomes, not seeking care until the second week of gestation does not, in and of itself, cause intrauterine growth retardation.

NEW QUESTION 199

During discharge planning, parents of a child with rheumatic fever should be able to identify which of the following as toxic symptoms of sodium salicylate?
* Tinnitus and nausea
* Dermatitis and blurred vision
* Unconsciousness and acetone odor of the breath
* Chills and an elevation of temperature
Explanation/Reference:

Explanation:

(A) These are toxic symptoms of sodium salicylate. (B, C, D) These are not symptoms associated with sodium salicylate.

NEW QUESTION 200

A client who is gravida 1 para 1 vaginally delivered a 7- lb girl. She received a midline episiotomy at delivery. When assessing the level of her uterus immediately following delivery, the nurse would expect the fundus to be located:
* At the umbilicus
* At the symphysis pubis
* Midway between the umbilicus and the xiphoid process
* Midway between the umbilicus and the symphysis pubis
Explanation/Reference:

Explanation:

(A) Within 12 hours of delivery, the fundus of the uterus rises to, or slightly above or below, the umbilicus.

Fundal height generally decreases 1 fingerbreadth, or 1 cm/day. (B) The uterus descends into the pelvic cavity at approximately 10-12 postpartal days and can no longer be palpated abdominally. (C) Within 12 hours of delivery, the fundus of the uterus rises to, or slightly above or below, the umbilicus. Fundal height generally decreases 1 fingerbreadth, or 1 cm/day. An enlarged uterus may indicate subinvolution or postpartal hemorrhage. (D) Immediately following delivery, the uterus lies midline, about midway between the umbilicus and the symphysis pubis.

NEW QUESTION 201

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?
* Hyperextension of the neck with evidence of pain on flexion
* Holding the head to one side and pointing the chin toward the other side
* Holding the head erect and in the midline when in a vertical position
* Significant head lag when raised to a sitting position
(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.

NEW QUESTION 202

When teaching a sex education class, the nurse identifies the most common STDs in the United States as:
* Chlamydia
* Herpes genitalis
* Syphilis
* Gonorrhea
(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.

NEW QUESTION 203

On the first postpartal day, a client tells the nurse that she has been changing her perineal pads every 1/2 hour because they are saturated with bright red vaginal drainage. When palpating the uterus, the nurse assesses that it is somewhat soft, 1 fingerbreadth above the umbilicus, and midline. The nursing action to be taken is to:
* Gently massage the uterus until firm, express any clots, and note the amount and character of lochia
* Catheterize the client and reassess the uterus
* Begin IV fluids and administer oxytocic medication
* Administer analgesics as ordered to relieve discomfort
Section: Questions Set D

Explanation:

(A) Gentle massage and expression of clots will let the fundus return to a state of firmness, allowing the uterus to function as the “living ligature.” (B) A distended bladder may promote uterine atony; however, after determining the bladder is distended, the nurse would have the client void. Catheterization is only done if normal bladder function has not returned. (C) Oxytocic medications are ordered and administered if the uterus does not remain contracted after gentle massage and determining if the bladder is empty. (D) The client is not complaining of discomfort or pain; therefore, analgesics are not necessary.

NEW QUESTION 204

A client had abdominal surgery this morning. The nurse notices that there is a small amount of bloody drainage on his surgical dressing. The nurse would document this as what type of drainage?

* Serosanguinous
* Purulent
* Sanguinous
* Catarrhal

Explanation

(A) Drainage from a surgical incision usually proceeds from sanguinous to serosanguinous. (B) Purulent drainage usually indicates infection and should not be seen initially from a surgical incision. (C) Drainage from a surgical incision is initially sanguinous, proceeding to serosanguinous, and then to serous. (D) Catarrhal is a type of exudate seen in upper respiratory infections, not in surgical incisions.

NEW QUESTION 205

A client is having a vertical partial laryngectomy, and the nurse is planning his postoperative care. A priority postoperative nursing diagnosis for a client having a vertical partial laryngectomy would be:

* Activity intolerance
* Ineffective airway clearance
* High risk for infection
* Altered oral mucous membrane

(A)

The laryngectomy client should be able to gradually increase activities without difficulty.

(B)

The laryngectomy client may have copious amounts of secretions and require suctioning for the first 24-48 hours. The cannula will require cleaning even after the first 24 hours because mucus collects in it. (C) The client does have a potential for infection, but it is not a more importantnursing priority than the ineffective airway clearance. (D) This problem is not a more important nursing priority than ineffective airway clearance. The client’s mouth may become dry, but good oral care should take care of the dryness.

NEW QUESTION 206

The nurse discovers that a 78-year-old client who received hydralazine (Apresoline) 20 mg 45 minutes ago has a blood pressure of 70/40 mm Hg. The client has been on this dose of the medication for 3 years.

Which of the following data is most likely significant in relation to the cause of the low blood pressure?

* Pedal pulses 11 (weak)
* Twenty-four-hour intake 1000 mL/day for past 2 days
* Serum potassium 3.3
* Pulse rate 150 bpm

Explanation/Reference:

Explanation:

(A, D) Decreased pulse volume and increased pulse rate are signs of an acute hypotensive episode. (B) Inadequate fluid volume when taking vasodilators can result in a drop in blood pressure when vasodilation starts to physiologically occur as an action of the drug. (C) A potassium level of 3.3 would not be associated with a significant drop in blood pressure.

NEW QUESTION 207

The nurse is caring for a 6-week-old girl with meningitis. To help her develop a sense of trust, the nurse should:
* Give her a small soft blanket to hold
* Give her good perineal care after each diaper change
* Leave the door open to her room
* Pick her up when she cries
Explanation

(A) A soft blanket may be comforting, but it is not directed toward developing a sense of trust. (B) Good perineal care is important, but it is not directed toward developing a sense of trust. (C) An infant with meningitis needs frequent attention, but leaving the door open does not foster trust. (D) Consistently picking her up when she cries will help the child feel trust in her caregivers.

NEW QUESTION 208

A mother who is breast-feeding her newborn asks the RN, “How can I express milk from my breasts manually?” The RN tells her that the correct method for manual milk expression includes using the thumb and the index finger to:
* Alternately compress and release each nipple
* Roll the nipple and gently pull the nipple forward
* Slide the thumb and index finger forward from the outer border of the areola toward the end of the nipple
* Compress and release each breast at the outer border of the areola
(A) Manipulation of nipples will cause soreness and trauma. (B) Pulling the nipples will cause discomfort and soreness. (C) Sliding the thumb and index finger forward over the nipple will cause soreness. (D) The best method to express milk from the breast is to position the thumb and index finger at the outer border of the areola and compress. This is the location of the milk sinuses.

NEW QUESTION 209

One of the most dramatic and serious complications associated with bacterial meningitis is Waterhouse- Friderichsen syndrome, which is:
* Peripheral circulatory collapse
* Syndrome of inappropriate antiduretic hormone
* Cerebral edema resulting in hydrocephalus
* Auditory nerve damage resulting in permanent hearing loss
Section: Questions Set A

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.

NEW QUESTION 210

A 35-weeks-pregnant client is undergoing a nonstress test (NST). During the 20-minute examination, the nurse notes three fetal movements accompanied by accelerations of the fetal heart rate, each 15 bpm, lasting

15 seconds. The nurse interprets this test to be:
* Nonreactive

* Reactive
* Positive
* Negative

Explanation

(A) In a nonreactive NST, the criteria for reactivity are not met. (B) A reactive NST shows at least two accelerations of FHR with fetal movements, each 15 bpm, lasting 15 seconds or more, over 20 minutes. (C, D) This term is used to interpret a contraction stress test (CST), or oxytocin challenge test, not an NST.

NEW QUESTION 211

The nurse is notified that a 27-year-old primigravida diagnosed with complete placenta previa is to be admitted to the hospital for a cesarean section. The client is now at 36 weeks’ gestation and is presently having bright red bleeding of moderate amount. On admission, the nursing intervention that the nurse should give the highest priority to is:

* Shave the client’s abdomen and arrange her lab work
* Determine the status of the fetus by fetal heart tones
* Start an IV infusion in the client’s arm
* Insert an indwelling catheter into her bladder

(A) These nursing actions are necessary prior to the cesarean section, but not immediately necessary to maintain physiological equilibrium. (B) Determining the physiological status of the fetus would constitute the highest priority in evaluating and maintaining fetal life. (C) These nursing actions are necessary prior to the cesarean section, but not immediately necessary to maintain physiological equilibrium. (D) These nursing actions are necessary prior to the cesarean section, but not immediately necessary to maintain physiological equilibrium.