

Nursing NCSBN-NCLEX-RN

National Council Licensure Examination Exam

Questions And Answers PDF Format:

For More Information – Visit link below:
<https://www.certsgrade.com/>

Version = Product



Latest Version: 6.0

Question: 1

A 47-year-old client has been admitted to the general surgery unit for bowel obstruction. The doctor has ordered that an NG tube be inserted to aid in bowel de-compression. When preparing to insert a NG tube, the nurse measures from the:

- A. Lower lip to the shoulder to the upper sternum
- B. Tip of the nose to the lower lip to the umbilicus
- C. End of the tube to the first measurement line on the tube
- D. Tip of the nose to the ear lobe to the xiphoid process or midepigastic area

Answer: D

Explanation:

(A) This measurement is _50 cm (48–49 cm). Fifty centimeters is considered the length necessary for the distal end of the tube to be in place in the stomach. This measurement is too short. (B) This measurement is _50 cm (47–48 cm). Fifty centimeters is considered the length necessary for the distal end of the tube to be in place in the stomach. This measurement is too short. (C) This measurement gives an approximate indication of the length necessary for the distal end of the tube to be in place in the stomach, but it is not as accurate as actually measuring the client (nose-ear-xiphoid). (D) This is the correct measurement of 50 cm from the tip of the client's nose to the tip of the earlobe to the xiphoid process (called the NEX [nose-ear-xiphoid] measurement). It is approximately equal to the distance necessary for the distal end of the tube to be located in the correct position in the stomach.

Question: 2

A 65-year-old client who has a new colostomy is preparing for discharge from the hospital. As part of the instructions on colostomy care, the nurse explains to the client that to regulate the bowel, colostomy irrigation should be performed at the same time each day. The best time is:

- A. After meals
- B. Before meals
- C. Every 2 hours
- D. At bedtime

Answer: A

Explanation:

(A) Bowel movements should be regulated at a specific time each day to prevent "accidents." Irrigating after meals takes advantage of the gastrocolic reflex and time of increased peristalsis, so better results may be produced. After meals is the normal time that peristalsis begins in most persons and evacuation

of feces occurs. (B) Irrigating before meals may cause poor results because of decreased gastrocolic reflex and decreased peristalsis. (C) Irrigating a colostomy every 2 hours may produce hyperactivity of the bowel, leading to irritation and diarrhea. This would not aid in regulation of the bowel. (D) If irrigation of a colostomy were done at bedtime, there is greater chance of having an “accident” during sleep. This would not be an advantageous practice of bowel regulation.

Question: 3

A 72-year-old client with a new colostomy is being evaluated at the clinic today for constipation. When discussing diet with the client, the nurse recognizes that which one of the following foods most likely caused this problem?

- A. Fried chicken
- B. Eggs
- C. Tapioca
- D. Cabbage

Answer: C

Explanation:

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

Question: 4

When giving discharge instructions to a 24-year-old client who had a short-arm cast applied for a fractured right ulna, the nurse recognizes the importance of telling him that the drying time for a plaster of Paris cast is approximately:

- A. 30 minutes
- B. 1–4 hours
- C. 12–24 hours
- D. 24–72 hours

Answer: D

Explanation:

(A) Synthetic cast materials harden in 3–15 minutes. Weight bearing is permitted in 15–30 minutes. Drying time for plaster of Paris is about 24–72 hours. (B, C) Plaster of Paris cast materials are heavier than synthetic materials and require a drying time of 24–72 hours. Synthetic materials dry within 30 minutes. (D) Plaster of Paris cast materials are heavier than synthetic materials and require a longer

period to set and dry. Even though setting time (hardening) is only 3–15 minutes, the drying time for plaster of Paris is 24–72 hours. This depends on the size and thickness of the cast, exposure to air, and humidity in the air.

Question: 5

A 58-year-old client on a general surgery unit is scheduled for transurethral resection of the prostate (TURP) in 2 hours. The nurse explains to the client that this procedure means:

- A. Removal of the prostate tissue by way of a lower abdominal midline incision through the bladder and into the prostate gland
- B. Removal of prostate tissue by a resectoscope that is inserted through the penile urethra
- C. Removal of the prostate tissue by an open surgical approach through an incision between the ischial tuberosities, the scrotum, and the rectum
- D. Removal of prostate tissue by an open surgical approach through a low horizontal incision, bypassing the bladder, to the prostate gland

Answer: B

Explanation:

(A) This describes a suprapubic (transvesical) prostatectomy procedure. (B) This is the correct description of a TURP procedure. (C) This describes a perineal prostatectomy procedure. (D) This describes a retropubic (extravesical) prostatectomy procedure.

Question: 6

A postoperative TURP client returns from the recovery room to the general surgery unit and is in stable condition. One hour later the nurse assesses him and finds him to be confused and disoriented. She recognizes that this is most likely caused by:

- A. Hypovolemic shock
- B. Hypokalemia
- C. Hypernatremia
- D. Hyponatremia

Answer: D

Explanation:

(A) Early signs of hypovolemic shock include hypotension, tachycardia, tachypnea, pallor, and diaphoresis. (B) Early signs of potassium depletion include muscular weakness or paralysis, tetany, postural hypotension, weak pulse, shallow respirations, apathy, weak voice, and electrocardiographic changes. (C) Early signs of an elevated sodium level include dry oral mucous membranes, marked thirst, hypertension, tachycardia, oliguria or anuria, anxiety, and agitation. (D) This answer is correct. Important early clinical findings of a decreased sodium concentration include confusion and

disorientation. Hyponatremia can occur after a TURP because absorption during surgery through the prostate veins can increase circulating blood volume and decrease sodium concentration.

Question: 7

A postoperative TURP client is ordered continuous bladder irrigations. Later in the evening on the first postoperative day, he complains of increasing suprapubic pain. When assessing the client, the nurse notes diminished flow of bloody urine and several large blood clots in the drainage tubing. Which one of the following should be the initial nursing intervention?

- A. Call the physician about the problem.
- B. Irrigate the Foley catheter.
- C. Change the Foley catheter.
- D. Administer a prescribed narcotic analgesic.

Answer: B

Explanation:

(A) The physician should be notified as problems arise, but in this case, the nurse can attempt to irrigate the Foley catheter first and call the physician if irrigation is unsuccessful. Notifying the physician of problems is a subsequent nursing intervention. (B) This answer is correct. Assessing catheter patency and irrigating as prescribed are the initial priorities to maintain continuous bladder irrigation. Manual irrigation will dislodge blood clots that have blocked the catheter and prevent problems of bladder distention, pain, and possibly fresh bleeding. (C) The Foley catheter would not be changed as an initial nursing intervention, but irrigation of the catheter should be done as ordered to dislodge clots that interfere with patency. (D) Even though the client complains of increasing suprapubic pain, administration of a prescribed narcotic analgesic is not the initial priority. The effect of the medication may mask the symptoms of a distended bladder and lead to more serious complications.

Question: 8

A postoperative prostatectomy client is preparing for discharge from the hospital the next morning. The nurse realizes that additional instructions are necessary when he states:

- A. "If I drink 10 to 12 glasses of fluids each day, that will help to prevent any clot formation in my urine."
- B. "The isometric exercises will help to strengthen my perineal muscles and help me control my urine."
- C. "If I feel as though I have developed a fever, I will take a rectal temperature, which is the most accurate."
- D. "I do not plan to do any heavy lifting until I visit my doctor again."

Answer: C

Explanation:

(A) This is correct health teaching. Drinking 10–12 glasses of clear liquid will help increase urine volumes

and prevent clot formation. (B) This is correct health teaching. These types of exercises are prescribed by physicians to assist postprostatectomy clients to strengthen their perineal muscles. (C) This action is not recommended post-TURP because of the close proximity of the prostate and rectum. (D) This is correct healthcare teaching. The client should limit walking long distances, lifting heavy objects, or driving a car until these activities are cleared by the physician at the first office visit.

Question: 9

A 67-year-old postoperative TURP client has hematuria. The nurse caring for him reviews his postoperative orders and recognizes that which one of the following prescribed medications would best relieve this problem?

- A. Acetaminophen suppository 650 mg
- B. Meperidine 50 mg IM
- C. Promethazine 25 mg IM
- D. Aminocaproic acid (Amicar) 6 g/24 hr

Answer: D

Explanation:

(A) Acetaminophen (Tylenol) has analgesic and antipyretic actions approximately equivalent to those of aspirin. It produces analgesia possibly by action on the peripheral nervous system. It reduces fever by direct action on the hypothalamus heat-regulating center with consequent peripheral vasodilation. It is generally used for temporary relief of mild to moderate pain, such as a simple headache, minor joint and muscle pains, and control of fever. (B) Meperidine is a narcotic agonist analgesic with properties similar to morphine except that it has a shorter duration of action and produces less depression of urinary retention and smooth muscle spasm. It is used for moderate to severe pain, for a preoperative medication, for support of anesthesia, and for obstetrical analgesia. In a postoperative TURP client, it would be used in conjunction with other medications for relief of moderate to severe pain, but not specifically for bladder spasms associated with TURP surgery. (C) Promethazine hydrochloride is an antihistamine, antiemetic preparation. It exerts antiserotonin, anticholinergic, and local anesthetic actions. It is used for symptomatic relief of various allergic conditions, motion sickness, nausea, and vomiting. It is used for preoperative, postoperative, and obstetrical sedation and as an adjunct to analgesics for control of pain. (D) This answer is correct because aminocaproic acid is prescribed specifically for hematuria. Aminocaproic acid is excreted in the urine. The nurse should be alert for possible signs of thrombosis, particularly in the extremities.

Question: 10

A 52-year-old client is scheduled for a small-bowel resection in the morning. In conjunction with other preoperative preparation, the nurse is teaching her diaphragmatic breathing exercises. She will teach the client to:

- A. Inhale slowly and deeply through the nose until the lungs are fully expanded, hold the breath a couple

of seconds, and then exhale slowly through the mouth. Repeat 2–3 more times to complete the series every 1–2 hours while awake

B. Purse the lips and take quick, short breaths approximately 18–20 times/min

C. Take a large gulp of air into the mouth, hold it for 10–15 seconds, and then expel it through the nose. Repeat 4–5 times to complete the series

D. Inhale as deeply as possible and then immediately exhale as deeply as possible at a rate of approximately 20–24 times/min

Answer: A

Explanation:

(A) This is the correct method of teaching diaphragmatic breathing, which allows full lung expansion to increase oxygenation, prevent atelectasis, and move secretions up and out of the lungs to decrease risk of pneumonia. (B) Quick, short breaths do not allow for full lung expansion and movement of secretions up and out of the lungs. Quick, short breaths may lead to O₂ depletion, hyperventilation, and hypoxia. (C) Expelling breaths through the nose does not allow for full lung expansion and the use of diaphragmatic muscles to assist in moving secretions up and out of the lungs. (D) Inhaling and exhaling at a rate of 20–24 times/min does not allow time for full lung expansion to increase oxygenation. This would most likely lead to O₂ depletion and hypoxia.

Question: 11

A 27-year-old healthy primigravida is brought to the labor and birthing room by her husband at 32 weeks' gestation. She experienced a sudden onset of painless vaginal bleeding. Following an ultrasound examination, the diagnosis of bleeding secondary to complete placenta previa is made. Expected assessment findings concerning the abdomen would include:

A. A rigid, boardlike abdomen

B. Uterine atony

C. A soft relaxed abdomen

D. Hypertonicity of the uterus

Answer: C

Explanation:

(A) A rigid, boardlike abdomen is an assessment finding indicative of placenta abruptio. (B) A cause of postbirth hemorrhage is uterine atony. With placenta previa, uterine tone is within normal range. (C) The placenta is located directly over the cervical os in complete previa. Blood will escape through the os, resulting in the uterus and abdomen remaining soft and relaxed. (D) In placenta abruptio, hypertonicity of the uterus is caused by the entrapment of blood between the placenta and uterine wall, a retroplacental bleed. This does not exist in placenta previa.

Question: 12

A 27-year-old primigravida stated that she got up from the chair to fix dinner and bright red blood was running down her legs. She denies any pain previously or currently. The client is very concerned about whether her baby will be all right. Her vital signs include P 120 bpm, respirations 26 breaths/min, BP 104/58 mm Hg, temperature 98.2°F, and fetal heart rate 146 bpm. Laboratory findings revealed hemoglobin 9.0 g/dL, hematocrit 26%, and coagulation studies within normal range. On admission, the peripad she wore was noted to be half saturated with bright red blood. A medical diagnosis of placenta previa is made. The priority nursing diagnosis for this client would be:

- A. Decreased cardiac output related to excessive bleeding
- B. Potential for fluid volume excess related to fluid resuscitation
- C. Anxiety related to threat to self
- D. Alteration in parenting related to potential fetal injury

Answer: A

Explanation:

(A) Based on the client's history, presence of bright red vaginal bleeding, and hemoglobin value on admission, the priority nursing diagnosis would be decreased cardiac output related to excessive bleeding. (B) This nursing diagnosis is a potential problem that does not exist at the present time, and therefore is not the priority problem. (C) The client's expressed anxiety is for her child. The fetus will remain physiologically safe if the decreased cardiac output is resolved. (D) Initial spontaneous bleeding with placenta previa is rarely life threatening to the mother or the fetus. Delivery of the fetus will be postponed until fetal maturity is achieved and survival is likely.

Question: 13

A 27-year-old primigravida at 32 weeks' gestation has been diagnosed with complete placenta previa. Conservative management including bed rest is the proper medical management. The goal for fetal survival is based on fetal lung maturity. The test used to determine fetal lung maturity is:

- A. Dinitrophenylhydrazine
- B. Metachromatic stain
- C. Blood serum phenylalanine test
- D. Lecithin-sphingomyelin ratio

Answer: D

Explanation:

(A) Dinitrophenylhydrazine is a laboratory test used to detect phenylketonuria, maple syrup urine disease, and Lowe's syndrome. (B) Metachromatic stain is a laboratory test that may be used to diagnose Tay-Sachs and other lipid diseases of the central nervous system. (C) The blood serum phenylalanine test is diagnostic of phenylketonuria and can be used for wide-scale screening. (D) A lecithin-sphingomyelin ratio of at least 2:1 is indicative of fetal lung maturity, and survival of the fetus is likely.

Question: 14

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:

- A. Shave the client's abdomen and arrange her lab work
- B. Determine the status of the fetus by fetal heart tones
- C. Start an IV infusion in the client's arm
- D. Insert an indwelling catheter into her bladder

Answer: B

Explanation:

(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.

Question: 15

A 29-year-old client delivered her fifth child by the Lamaze method and developed a postpartal hemorrhage in the recovery room. What are the initial symptoms of shock that she may experience?

- A. Marked elevation in blood pressure, respirations, and pulse
- B. Decreased systolic pressure, cold skin, and anuria
- C. Rapid pulse; narrowed pulse pressure; cool, moist skin
- D. No urinary output, tachycardia, and restlessness

Answer: C

Explanation:

(A) Early shock does not exhibit the symptom of marked elevation in blood pressure. A narrowing of the pulse pressure is indicative of early shock. (B) Anuria is a clinical finding in late shock. (C) All of these clinical findings are congruent with early shock. (D) Absence of urinary output is a clinical finding in the late phase of shock.

For More Information – **Visit link below:**
<https://www.certsgrade.com/>

PRODUCT FEATURES

-  **100% Money Back Guarantee**
-  **90 Days Free updates**
-  **Special Discounts on Bulk Orders**
-  **Guaranteed Success**
-  **50,000 Satisfied Customers**
-  **100% Secure Shopping**
-  **Privacy Policy**
-  **Refund Policy**

16 USD Discount Coupon Code: NB4XKTMZ



Visit us at: <https://www.certsgrade.com/pdf/ncsbn-nclex-rn>