NCLEX-RN$^{Q\&As}$

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QUESTION 1

A 48-year-old client is in the surgical intensive care unit after having had three-vessel coronary artery bypass surgery yesterday. She is extubated, awake, alert and talking. She is receiving digitalis for atrial arrhythmias. This morning serum electrolytes were drawn. Which abnormality would require immediate intervention by the nurse after contacting the physician?

A. Serum osmolality is elevated indicating hemoconcentration. The nurse should increase IV fluid rate.

B. Serum sodium is low. The nurse should change IV fluids to normal saline.

C. Blood urea nitrogen is subnormal. The nurse should increase the protein in the client\\'s diet as soon as possible.

D. Serum potassium is low. The nurse should administer KCl as ordered.

Correct Answer: D

(A) An elevated serum osmolality poses no immediate danger and is not corrected rapidly. (B) A low serum sodium alone does not warrant changing IV fluids to normal saline. Other assessment parameters, such as hydration status, must be considered. (C) A low serum blood urea nitrogen is not necessarily indicative of protein deprivation. It may also be the result of overhydration. (D)A low serum potassium potentiates the effects of digitalis, predisposing the client to dangerous arrhythmias. It must be corrected immediately.

QUESTION 2

A type I diabetic client delivers a male newborn. The newborn is 45 minutes old. What is the primary nursing goal in the nursery during the first hours for this newborn?

A. Bonding

B. Maintain normal blood sugar

C. Maintain normal nutrition

D. Monitor intake and output

Correct Answer: B

(A) Bonding is necessary but would not be the priority with this newborn in the nursery. (B) The infant will be at risk for hypoglycemia because of excess insulin production. (C) Normal nutrition is a goal for all newborns. (D) Monitoring intake and output is necessary but is not the most critical nursing goal.

QUESTION 3

A chronic alcoholic client\\'s condition deteriorates, and he begins to exhibit signs of hepatic coma. Which of the following is an early sign of impending hepatic coma?

A. Hiccups

B. Anorexia

C. Mental confusion

D. Fetor hepaticus

Correct Answer: C

(A)

Hiccups are not a sign of impending hepatic coma. (B) Anorexia is not a sign of impending hepatic coma. (C) One of the earliest symptoms of hepatic coma is mental confusion. Asterixis, a flapping tremor of the hand, may also be seen.

(D)

This sign is associated with the later stages of hepatic coma. Fetor hepaticus, a characteristic odor on the breath that smells like acetone, may sometimes be noted when the liver fails.

QUESTION 4

A new mother experiences strong uterine contractions while breast-feeding her baby. She excitedly rings for the nurse. When the nurse arrives the mother tells her, "Something is wrong. This is like my labor." Which reply by the nurse identifies the physiological response of the client?

A. "Your breasts are secreting a hormone that enters your bloodstream and causes your abdominal muscles to contract."

B. "Prolactin increases the blood supply to your uterus, and you are feeling the effects of this blood vessel engorgement."

C. "The same hormone that is released in response to the baby\\'s sucking, causing milk to flow, also causes the uterus to contract."

D. "There is probably a small blood clot or placental fragment in your uterus, and your uterus is contracting to expel it."

Correct Answer: C

(A) Mammary growth as well as milk production and maintenance in the breast occur in response to hormones produced primarily by the hypothalamus and the pituitary gland. (B) Prolactin stimulates the alveolar cells of the breast to produce milk. It is important in the initiation of breast-feeding. (C) Oxytocin, which is released by the posterior pituitary, stimulates the let-down reflex by contraction of the myoepithelial cells surrounding the alveoli. In addition, it causes contractions of the uterus and uterine involution. (D) Afterpains may occur with retained placental fragments. A boggy uterus and continued bleeding are other symptoms that occur in response to retained placental fragments.

QUESTION 5

The nurse begins morning assessment on a male client and notices that she is unable to palpate either of his dorsalis pedis pulses in his feet. What is the first nursing action after assessing this finding?

A. Palpate these pulses again in 15 minutes.

B. Use a Doppler to determine presence and strength of these pulses.

C. Document the finding that the pulses are not palpable.

D. Call the physician and notify the physician of this finding.

Correct Answer: B

(A)

Palpating these pulses again in 15 minutes may only result in the same findings. (B) Any time during an assessment that the nurse is unable to palpate pulses, the nurse should then obtain a Doppler and assess for presence or absence of the pulse and pulse strength, if a pulse is present. (C) Pulses may be present and assessed through use of a Doppler. Absence of palpable pulses does not indicate absence of blood flow unless pulses cannot be located with a Doppler.

(D)

The nurse would only call the physician after determining that the pulses are absent by both palpation and Doppler.