NCLEX 150 QUESTIONS ANSWERS AND CLINICAL REASONING

EXAM PREP # 4

1. A young adult who was in a motorcycle accident is brought to the emergency room with a closed head injury with suspected subdural hematoma. Although the client complains of a severe headache, he is alert and answers questions appropriately. The nurse would question which of the following orders?

1. "Promethazine (Phenergan) 25 mg IM 3 h."
2. "Morphine sulfate 10 mg IM q3-4h."
3. "Docusate sodium (Colace) 50 mg PO bid."
4. "Ranitidine (Zantac) 50 mg IVPB q12h."

Strategy: All answers are implementations. Determine the outcome of each answer choice. Is it desired?
(1) H1 receptor blocker, used as an antiemetic
(2) correct–narcotic analgesic, causes CNS and respiratory depression, contraindicated in head
injury because it masks signs of increased intracranial pressure
(3) stool softener, used for an immobilized patient
(4) H2 histamine antagonist, reduces acid production in stomach, prevents stress ulcers

2. The nurse has just returned to the desk and has four phone messages to return. Which of the following messages should the nurse return FIRST?

1. A woman in her first trimester of pregnancy complaining of heartburn.
2. A man complaining of heartburn that radiates to his jaw.
3. A woman complaining of hot flashes and difficulty sleeping.
4. A boy complaining of knee pain after playing basketball.

Strategy: Determine the least stable client.
(1) caused by reflux of gastric contents into esophagus, treatment is small frequent meals, don't
consume fluids with food, don't wear tight clothing
(2) correct–indicates chest pain, needs to seek medical attention immediately
(3) caused by menopause, treat with hormone replacement therapy (HRT)
(4) should treat with rest and ice

3. A patient is admitted to the surgical unit with a diagnosis of rule out intestinal obstruction. The nurse is preparing to insert a Salem sump NG tube as ordered. In which of the following positions would it be BEST for the nurse to place this patient during the procedure?

1. Head of bed elevated 30°–45°.
2. Head of bed elevated 60°–90°.
3. Side-lying with head elevated 15°.
4. Lying flat with head turned to the left side.

Strategy: Remember the positioning strategy.
(1) not the best position
(2) correct–facilitates swallowing and movement of tube through GI tract
(3) not the best position
(4) not the best position

4. The nurse is monitoring the fluid status of a 63-year-old woman receiving IV fluids following surgery. Which of the following symptoms would suggest to the nurse that the patient has fluid volume overload?

1. Temperature 101°F (38.3°C), BP 96/60, pulse 96 and thready.
2. Cool skin, respiratory crackles, pulse 86 and bounding.
3. Complaints of a headache, abdominal pain, and lethargy.
4. Urinary output 700 cc/24 h, CVP of 5, and nystagmus.

Strategy: Determine how each answer choice relates to fluid volume overload.
(1) indicates dehydration
(2) correct–will see bounding pulse, elevated BP, distended neck veins, edema, headache, polyuria, diarrhea, liver enlargement
(3) symptoms could be from causes other than volume overload
(4) slightly reduced output, CVP would be elevated, normal CVP 4-10 mm/H2 O, involuntary eye movements not seen

5. A woman has been recently diagnosed with systemic lupus and shares with the nurse, "I am thinking about getting pregnant, but I don't know how I will be able to tolerate a pregnancy since I have lupus." Which of the following responses by the nurse is BEST?

1. "Most women find that they feel better when they are pregnant."
2. "How long have you been in remission?"
3. "Women with lupus frequently have slightly longer gestations."
4. "It is best to become pregnant within the first six months of diagnosis."

Strategy: Answers are a mix of assessments and implementations. Does this situation require assessment? Yes.
(1) maternal morbidity and mortality are increased with SLE
(2) correct–should be in remission for at least 5 months prior to conceiving
(3) gestation not affected by SLE
(4) recommended that a woman wait two years following diagnosis before conceiving

6. The multidisciplinary team decides to implement behavior modification with a client. Which of the following nursing actions is of primary importance during this time?

1. Confirm that all staff members understand and comply with the treatment plan.
2. Establish mutually agreed upon, realistic goals.
3. Ensure that the potent reinforcers (rewards) are important to the client.
4. Establish a fixed interval schedule for reinforcement.

Strategy: All answers are implementations. Determine the outcome of each answer choice. Is it desired?
(1) correct–to implement a behavior modification plan successfully, all staff members need to be included in program development, and time must be allowed for discussion of concerns from each nursing staff member; consistency and follow-through is important to prevent or diminish the level of manipulation by the staff or client during implementation of this program
(2) not of primary importance in designing an effective behavior modification program
(3) not of primary importance in designing an effective behavior modification program
(4) not of primary importance in designing an effective behavior modification program

7. A client received six units of regular insulin three hours ago. The nurse would be MOST concerned if which of the following was observed?

1. Kussmaul respirations and diaphoresis.
2. Anorexia and lethargy.
3. Diaphoresis and trembling.
4. Headache and polyuria.

Strategy: "MOST concerned" indicates a complication.
(1) Kussmaul respirations are signs of hyperglycemia
(2) not indicative of hypoglycemia
(3) correct–regular insulin peaks in two to four hours; indicates hypoglycemia; give skim milk
(4) not indicative of hypoglycemia

8. The nursing assistant reports to the nurse that a client who is one-day postoperative after an angioplasty is refusing to eat and states, "I just don't feel good." Which of the following actions, if taken by the nurse, is BEST?

1. The nurse talks with the client about how he is feeling.
2. The nurse instructs the nursing assistant to sit with the client while he eats.
3. The nurse contacts the physician to obtain an order for an antacid.
4. The nurse evaluates the most recent vital signs recorded in the chart.

Strategy: Answers are a mix of assessments and implementations. Does this situation require assessment? Yes. Is the assessment appropriate? Yes.
(1) correct–assessment required; monitor for closure of vessel, bleeding, hypotension, dysrhythmias
(2) assess cause of problem before implementing
(3) assess cause of problem before implementing
(4) more important to assess what is happening now

9. The nurse prepares a 25-year-old woman for a cesarean section. The patient says she had major surgery several years ago and asks if she will receive a similar "shot" before surgery. The nurse's response should be based on an understanding that the preoperative medication given before a cesarean section

1. contains a lower overall dosage of medication than is given before general surgery.
2. contains reduced amounts of sedatives and hypnotics than are given before general surgery.
3. contains reduced amounts of narcotics than are given before general surgery.
4. contains medications similar in type and dosages to those given before general surgery.

Strategy: Think about the action of the medications.
(1) decreased dosage of narcotics are used
(2) dosages of sedatives and hypnotics will be similar
(3) correct–decreased so less narcotic crosses the placental barrier causing respiratory depression
in the infant
(4) dosages of narcotics are reduced

10. The nurse is caring for an 11-year-old patient being treated for a fractured right femur with balanced suspension traction with a Thomas splint and Pearson attachment. The nurse notes that the patient's left leg is externally rotated. The nurse should

1. place a trochanter roll on the outer aspect of the thigh.
2. perform resistive range of motion of the left leg.
3. adduct and internally rotate the left leg.
4. instruct the patient to maintain the left leg in a neutral position.

Strategy: Answers are implementations. Determine the outcome of each answer choice. Is it desired?
(1) correct–holds hip in neutral position and leg in normal alignment, entire weight of leg cannot be held by props placed below knee
(2) exercise would not prevent future external rotation of the leg
(3) adduct (add to midline of body) does not change external rotation, internal rotation is not beneficial, normal alignment is required
(4) leg will externally rotate unless propped in proper alignment

11. The nurse is preparing a five-year-old child for surgery. The nurse notes that the child's parents are divorced and have joint legal custody. The informed consent for surgery has been signed by the mother. Which of the following actions by the nurse is BEST?

1. Notify the physician.
2. Inform surgery.
3. Contact the father to obtain consent.
4. Continue the child's preoperative preparation.

Strategy: All answers are implementations. Determine the outcome of each answer choice. Is it desired?
(1) no reason to notify the physician
(2) no reason to call the OR
(3) consent from either divorced parent is sufficient
(4) correct–parent or legal guardian required to give informed consent prior to surgical procedure

12. The nurse is caring for clients on the neurology unit. What would be the MOST appropriate action for the nurse to take after noting that a client suddenly developed a fixed and dilated pupil?

1. Reassess in five minutes.
2. Check the client's visual acuity.
3. Lower the head of the client's bed.
4. Contact the physician.

Strategy: Answers are a mix of assessments and implementations. Is this a situation that requires assessment or validation? No. Determine the outcome of the implementations.
(1) assessment, situation does not require validation
(2) assessment, has symptoms of increased ICP
(3) implementation, would increase the intracranial pressure
(4) correct–implementation, fixed and dilated pupil represents a neurological emergency

13. A mother brings her two-year-old boy to the pediatrician's office. Which of the following symptoms would suggest to the nurse that the child has strabismus?

1. When the child draws, he places his head close to the table.
2. The child rubs his eyes frequently.
3. The child closes one eye to see a poster on the wall.
4. The child is unable to see objects in the periphery of his visual field.

Strategy: Think about each answer choice.
(1) suggestive of refractive error, myopia (nearsightedness), able to see objects at close range
(2) suggestive of refractive error
(3) correct–visual axes are not parallel so the brain receives two images
(4) suggestive of cataracts or problem with peripheral vision

14. A client is given morphine 6 mg IV push for postoperative pain. Following administration of this drug, the nurse observes the following: pulse 68, respirations 8, BP 100/68, client sleeping quietly. Which of the following nursing actions is MOST appropriate?

1. Allow the client to sleep undisturbed.
2. Administer oxygen via facemask or nasal prongs.
3. Administer naloxone (Narcan).
4. Place epinephrine 1:1,000 at the bedside.

Strategy: All answers are implementations. Determine the outcome of each answer choice. Is it desired?
(1) should be given Narcan for low respiratory rate
(2) problem is low respirations, this may be administered after medication
(3) correct–IV naloxone (Narcan) should be given to reverse respiratory depression; respiratory rate
of 8 is too low and necessitates a nursing action
(4) unnecessary

15. The school nurse is teaching a group of preschool mothers about poison prevention in the home. Which of the following statements, if made by a mother to the nurse, indicates that further teaching is necessary?

1. "I should have a bottle of Ipecac for each of my children."
2. "I should induce vomiting if my child swallows lighter fluid."
3. "Giving my child water or milk may help dilute the poison."
4. "Proper storage is the key to poison prevention in the home."

Strategy: "Further teaching is necessary" indicates an incorrect statement.
(1) Ipecac is available in 30 cc vials, advise parents to have available full doses for each child, doses range from 10 to 30 cc
(2) correct–vomiting contraindicated when child ingests hydrocarbons due to danger of aspiration
(3) small amounts of water or milk may dilute toxins
(4) store in locked cabinets

16. The nurse is caring for a manic client in the seclusion room, and it is time for lunch. It is MOST appropriate for the nurse to take which of the following actions?

1. Take the client to the dining room with 1:1 supervision.
2. Inform the client he may go to the dining room when he controls his behavior.
3. Hold the meal until the client is able to come out of seclusion.
4. Serve the meal to the client in the seclusion room.

Strategy: All answers are implementations. Determine the outcome of each answer choice. Is it desired?
(1) should remain in the seclusion room
(2) should have meal at regular time
(3) should have meal at regular time
(4) correct–should eat at regular time; remain in the seclusion room for client's safety

17. Which of the following nursing actions has the HIGHEST priority for a teenager admitted with burns to 50% of his body?

1. Counseling regarding problems of body image.
2. Maintain airborne precautions.
3. Maintain aseptic technique during procedures.
4. Encourage peers to visit on a regular basis.

Strategy: Think "Maslow."
(1) psychosocial, not highest priority
(2) physical, use standard precautions
(3) correct–safety is a priority for the client who is at high risk for infection
(4) psychosocial, important for an adolescent, but is not highest priority

18. The home health care nurse is caring for a 30-year-old woman with type I diabetes mellitus. The client has been maintained on a regimen of NPH and regular insulin and a 1,800-calorie diabetic diet with normal blood sugar levels. Morning self-monitoring blood sugar (SMBG) readings the past two days were 205 mg/dL and 233 mg/dL. The nurse expects the physician to

1. reduce the client's diet to 1,500 calorie ADA.
2. order 3 additional units of NPH insulin at 10 PM.
3. order an additional 10 units of regular insulin at 8 PM.
4. eliminate the client's bedtime snack.

Strategy: All answers are implementations. Determine the outcome of each answer choice. Is it desired?
(1) diet should not be reduced
(2) correct–dawn phenomena, treatment is to adjust evening diet, bedtime snack, insulin dose,
and exercise to prevent early morning hyperglycemia
(3) peaks in 4–6 hours, would not prevent dawn phenomena
(4) would adjust snack, not eliminate it

19. After sustaining a closed head injury and numerous lacerations and abrasions to the face and neck, a five-year-old child is admitted to the emergency room. The client is unconscious and has minimal response to noxious stimuli. Which of the following assessments, if observed by the nurse three hours after admission, should be reported to the physician?

1. The client has slight edema of the eyelids.
2. There is clear fluid draining from the client's right ear.
3. There is some bleeding from the child's lacerations.
4. The client withdraws in response to painful stimuli.

Strategy: Think about how each answer choice relates to a head injury.
(1) not priority
(2) correct–indicates a rupture of meninges and presents a potential complication of meningitis
(3) not priority
(4) is not a change in assessment

20. A psychiatric nurse is assigned to conduct an admission nursing history on a new client. The admission should include which of the following?

1. The nurse's opinion regarding the mental and emotional status of the client.
2. Data addressing the client's emotional state.
3. Data that address a biopsychosocial approach, including a family system assessment.
4. Specific data detailing the client's mental status.

Strategy: Think about each answer choice.
(1) depends on opinions that are not based on a complete assessment
(2) limits the degree of information that is obtained from the client
(3) correct–complete nursing history includes biopsychosocial data; client's psychosocial and physical status are evaluated along with an assessment of the client's family system and social support network; evaluation of the client's cognitive ability is important during the physiological status assessment
(4) is necessary information about mental status, but is also an incomplete assessment

21. Prochlorperazine maleate (Compazine) 10 mg IM has been ordered for a client. The client is also to receive Stadol 2 mg IM. Before administering these medications, the nurse should

1. obtain respirations and temperature.
2. dilute with 9 ml of NS.
3. draw the medications in separate syringes.
4. verify the route of administration.

Strategy: All answers are implementations. Determine the outcome of each answer choice. Is it desired?
(1) should monitor blood pressure and heart rate for orthostatic hypotension; respiration and temperature are not as high a priority
(2) inappropriate
(3) correct–Compazine should be considered incompatible in a syringe with all other medications
(4) unnecessary

22. The nurse is caring for clients in the student health center. A client confides to the nurse that the client's boyfriend informed her that he tested positive for hepatitis B. Which of the following responses by the nurse is BEST?

1. "That must have been a real shock to you."
2. "You should be tested for hepatitis B."
3. "You'll receive the hepatitis B immune globulin (HBIG)."
4. "Have you had unprotected sex with your boyfriend?"

Strategy: Answers are a mix of assessments and implementations. Does this situation require assessment? Yes. Is there an appropriate assessment? Yes.
(1) nurse is interjecting own feelings
(2) will require testing, not best response initially
(3) implementation, receive HBIG for postexposure prophylaxis; may also receive HBV vaccine
(4) correct–assessment, transmitted through parenteral drug abuse and sexual contact; determine exposure before implementing

23. A young adult patient constantly seeks attention from the nurses, stomping away from the nurses' station and pouting when her requests are refused. Which of the following responses by the nurse is MOST appropriate?

1. Have the patient establish trust with one staff person with whom therapeutic interventions should occur.
2. Give the patient unsolicited attention when she is not exhibiting the unacceptable behaviors.
3. Ignore the patient when she exhibits attention-seeking behavior.
4. Rotate the staff so the patient will learn to relate to more than one nurse.

Strategy: All answers are implementations. Determine the outcome of each answer choice. Is it desired?
(1) staff should use a consistent undivided approach
(2) correct–reward nonseeking attention behaviors by giving the patient unsolicited attention
(3) remain nonjudgmental, carry out limit-setting
(4) staff should use a consistent undivided approach

24. After abdominal surgery, a client has a nasogastric tube attached to low suctioning. The client becomes nauseated, and the nurse observes a decrease in the flow of gastric secretions. Which of the following nursing interventions would be MOST appropriate?

1. Irrigate the nasogastric tube with distilled water.
2. Aspirate the gastric contents with a syringe.
3. Administer an antiemetic medicine.
4. Insert a new nasogastric tube.

Strategy: All answers are implementations. Determine the outcome of each answer choice. Is it desired?
(1) tube would be irrigated with normal saline after the position of the tube was evaluated
(2) correct–to confirm placement, nurse should aspirate and test the pH of the aspirate, results should be 0-4
(3) does not assess status of nasogastric tube
(4) does not assess status of nasogastric tube

25. A 38-year-old woman, mother of two, has a mastectomy for breast cancer. When she returns to the physician's office a month later for a routine check-up, the nurse asks the client how she has been. Which of the following responses, if made by the client to the nurse, indicates that the client is experiencing a normal reaction to the surgery?

1. "I have been helping my family deal with their feelings about the surgery."
2. "I have been having difficulty coping with the surgery and cry frequently."
3. "I have been unable to leave the house or talk to my friends about the surgery."
4. "I am doing just great since the surgery and have gone back to work at my job."

Strategy: Think about each answer choice. Does it describe an expected response to a crisis situation?
(1) will not be able to help others this soon after surgery
(2) correct–normal reaction one month later
(3) excessive, abnormal reaction
(4) indicates integration, too early for this stage

26. The nurse is caring for clients in outpatient surgery. The mother of a four-year-old asks the nurse how to prepare her daughter for eye surgery. Which of the following statements by the nurse is BEST?

1. "Draw a picture of the eye to explain what will happen."
2. "Tell your daughter that the procedure will take one hour."
3. "Use dolls or puppets to explain how to get ready for surgery."
4. "Read an age-appropriate illustrated book about eye surgery to your daughter."

Strategy: Think about growth and development.
(1) appropriate for school-aged child
(2) preschooler can't relate to the concept of one hour
(3) correct–use puppet or doll to show where procedure is performed; explain procedure in simple
terms and what the child will see, hear, taste, smell, and feel
(4) appropriate for school-aged child

27. A 23-year-old woman at 32-weeks gestation is seen in the outpatient clinic. Which of the following findings, if assessed by the nurse, would indicate a possible complication?

1. The client's urine test is positive for glucose and acetone.
2. The client has 1+ pedal edema in both feet at the end of the day.
3. The client complains of an increase in vaginal discharge.
4. The client says she feels pressure against her diaphragm when the baby moves.

Strategy: Determine how each answer choice relates to pregnancy.
(1) correct–abnormal finding, could indicate gestational diabetes (GDM), hazard of placental insufficiency
(2) not unusual, caused by pressure of enlarging uterus on veins returning blood from lower extremities
(3) common near term with increased vascularity of vagina and perineum, only abnormal if bloody, foul-smelling, or abnormally colored
(4) not unusual, due to pressure of enlarging uterus

28. A nurse is caring for a 37-year-old woman with metastatic ovarian cancer admitted for nausea and vomiting. The physician orders total parenteral nutrition (TPN), a nutritional consult, and diet recall. Which of the following is the BEST indication that the patient's nutritional status has improved after 4 days?

1. The patient eats most of the food served to her.
2. The patient has gained 1 pound since admission.
3. The patient's albumin level is 4.0mg/dL.
4. The patient's hemoglobin is 8.5g/dL.