

# NCLEX RN COMPREHENSIVE EXAM WITH NGN, 2023 VERSION WITH A+ QUALITY

## 1. 1. Question

**1 point(s)**

**Category: Physiological Integrity**

A client with bacterial pneumonia is admitted to the pediatric unit. What would the nurse expect the admitting assessment to reveal?

- **A. High fever**
- B. Nonproductive cough
- C. Rhinitis
- **D. Vomiting and diarrhea**

**Incorrect**

**Correct Answer: A. High fever**

If the child has bacterial pneumonia, a high fever is usually present. Increased temperature (usually more than 38 C or 100.4 F) or fever with tachycardia and/or chills and sweats is a major clinical finding. Physical findings also vary from patient to patient and mainly depend on the severity of lung consolidation, the type of organism, the extent of the infection, host factors, and existence or nonexistence of pleural effusion.

- **Option B:** Bacterial pneumonia usually presents with a productive cough, not a nonproductive cough. The presence of a productive cough is the most common and significant presenting symptom. The lower respiratory tract is not sterile, and it always is exposed to environmental pathogens. Invasion and propagation of the above-mentioned bacteria into lung parenchyma at alveolar level causes bacterial pneumonia, and the body's inflammatory response against it causes the clinical syndrome of pneumonia.
- **Option C:** Rhinitis is often seen with viral pneumonia. Features in the history of bacterial pneumonia may

vary from indolent to fulminant. Clinical manifestation includes both constitutional findings and findings due to damage to the lung and related tissue.

- **Option D:** Vomiting and diarrhea are usually not seen with pneumonia. Atypical pneumonia presents with pulmonary and extrapulmonary manifestations, such as Legionella pneumonia, often presents with altered mentation and gastrointestinal symptoms.

2. 2. Question

**1 point(s)**

**Category: Safe and Effective Care Environment**

The nurse is caring for a client admitted with epiglottitis. Because of the possibility of complete obstruction of the airway, which of the following should the nurse have available?

- A. Intravenous access supplies
- **B. A tracheostomy set**
- C. Intravenous fluid administration pump
- **D. Supplemental oxygen**

**Incorrect**

**Correct Answer: B. A tracheostomy set**

For a child with epiglottitis and the possibility of complete obstruction of the airway, emergency tracheostomy equipment should always be kept at the bedside. Prepare for intubation or tracheostomy; Anticipate the need of an artificial airway. An artificial airway is required to promote oxygenation and ventilation and prevent aspiration.

- **Option A:** Administer IV antibiotics as ordered. After obtaining blood and epiglottic cultures, second-or-third generation cephalosporins and beta-lactamase-resistant antibiotics should be started as soon as possible.
- **Option C:** Discourage examining throat with a tongue blade or taking throat culture unless immediate emergency equipment and personnel at hand. Position the child in a sitting up and leaning forward position with mouth open and tongue out ("tripod" position).

Allows maximum entry of air into the lungs for improved oxygenation.

- **Option D:** Oxygen will not treat an obstruction. Endotracheal intubation must be readily available; assist with tracheostomy if needed or prepare for the procedure in surgery. Establishes airway if obstruction present and respiratory failure and asphyxia are imminent.

3. 3. Question

**1 point(s)**

**Category: Physiological Integrity**

A 25-year-old client with Grave's disease is admitted to the unit. What would the nurse expect the admitting assessment to reveal?

- A. Bradycardia
- B. Decreased appetite
- **C. Exophthalmos**
- **D. Weight gain**

**Incorrect**

**Correct Answer: C. Exophthalmos**

Exophthalmos (protrusion of eyeballs) often occurs with hyperthyroidism. Graves' orbitopathy (ophthalmopathy) is caused by inflammation, cellular proliferation and increased growth of extraocular muscles and retro-orbital connective and adipose tissues due to the actions of thyroid stimulating antibodies and cytokines released by cytotoxic T lymphocytes (killer cells). These cytokines and thyroid stimulating antibodies activate periorbital fibroblasts and preadipocytes, causing synthesis of excess hydrophilic glycosaminoglycans (GAG) and retro-orbital fat growth.

- **Option A:** Physical signs of hyperthyroidism include tachycardia, systolic hypertension with increased pulse pressure, signs of heart failure (like edema, rales, jugular venous distension, tachypnea), atrial fibrillation, fine tremors, hyperkinesia, hyperreflexia, warm and moist skin, palmar erythema and

onycholysis, hair loss, diffuse palpable goiter with thyroid bruit and altered mental status.

- **Option B:** Hyperthyroidism usually increases the appetite. If the client is taking in a lot more calories, they can gain weight even if their body is burning more energy. Make sure to eat healthy foods, get regular exercise, and work with a doctor on a nutrition plan. These steps can all help combat weight gain from an increased appetite.
- **Option D:** In younger patients, common presentations include heat intolerance, sweating, fatigue, weight loss, palpitation, hyper defecation, and tremors. Other features include insomnia, anxiety, nervousness, hyperkinesia, dyspnea, muscle weakness, pruritus, polyuria, oligomenorrhea or amenorrhea in the female, loss of libido, and neck fullness.

4. 4. Question

**1 point(s)**

**Category: Health Promotion and Maintenance**

The nurse is providing dietary instructions to the mother of an 8-year-old child diagnosed with celiac disease. Which of the following foods, if selected by the mother, would indicate her understanding of the dietary instructions?

- A. Ham sandwich on whole-wheat toast
- B. Spaghetti and meatballs
- C. Hamburger with ketchup
- **D. Cheese omelet**

**Correct**

**Correct Answer: D. Cheese omelet**

The child with celiac disease should be on a gluten-free diet. When a child has celiac disease, gluten causes the immune system to damage or destroy villi. Villi are the tiny, fingerlike tubules that line the small intestine. The villi's job is to get food nutrients to the blood through the walls of the small intestine. If villi are destroyed, the child may become malnourished, no matter how much he eats. This is because they aren't able to

absorb nutrients. Complications of the disorder include anemia, seizures, joint pain, thinning bones, and cancer.

- **Option A:** Be careful of corn and rice products. These don't contain gluten, but they can sometimes be contaminated with wheat gluten if they're produced in factories that also manufacture wheat products. Look for such a warning on the package label.
- **Option B:** Avoid all products with barley, rye, triticale (a cross between wheat and rye), farina, graham flour, semolina, and any other kind of flour, including self-rising and durum, not labeled gluten-free.
- **Option C:** Substitute potato, rice, soy, amaranth, quinoa, buckwheat, or bean flour for wheat flour. You can also use sorghum, chickpea or Bengal gram, arrowroot, and corn flour, as well as tapioca starch extract. These act as thickeners and leavening agents.

5. 5. Question

**1 point(s)**

**Category: Physiological Integrity**

The nurse is caring for an 80-year-old with chronic bronchitis. Upon the morning rounds, the nurse finds an O<sub>2</sub> sat of 76%. Which of the following actions should the nurse take **first**?

- A. Notify the physician
- B. Recheck the O<sub>2</sub> saturation level in 15 minutes
- **C. Apply oxygen by mask**
- **D. Assess the pulse**

**Incorrect**

**Correct Answer: C. Apply oxygen by mask**

Remember the ABCs (airway, breathing, circulation) when answering this question. Administer oxygen first to increase the O<sub>2</sub> saturation level. Provide humidified oxygen as ordered. Administering humidified oxygen prevents drying out the airways, decreases convective moisture losses, and improves compliance.

- **Option A:** Monitor vital signs and cardiac rhythm. Tachycardia, dysrhythmias, and changes in BP can reflect the effect of systemic hypoxemia on cardiac

function. Auscultate breath sounds, noting areas of decreased airflow and adventitious sounds. Breath sounds may be faint because of decreased airflow or areas of consolidation. Presence of wheezes may indicate bronchospasm or retained secretions. Scattered moist crackles may indicate interstitial fluid or cardiac decompensation.

- **Option B:** The normal oxygen saturation for a child is 92%–100%. Monitor O<sub>2</sub> saturation and titrate oxygen to maintain SpO<sub>2</sub> between 88% to 92%. Pulse oximetry reading of 87% below may indicate the need for oxygen administration while a pulse oximetry reading of 92% or higher may require oxygen titration.
- **Option D:** Before assessing the pulse, oxygen should be applied to increase the oxygen saturation. Monitor vital signs and cardiac rhythm. Tachycardia, dysrhythmias, and changes in BP can reflect the effect of systemic hypoxemia on cardiac function.

6. 6. Question

**1 point(s)**

**Category: Physiological Integrity**

A gravida 3 para 0 is admitted to the labor and delivery unit. The doctor performs an amniotomy. Which observation would the nurse be expected to make after the amniotomy?

- A. Fetal heart tones 160bpm
- **B. A moderate amount of straw-colored fluid**
- C. A small amount of greenish fluid
- **D. A small segment of the umbilical cord**

**Incorrect**

**Correct Answer: B. A moderate amount of straw-colored fluid**

An amniotomy is an artificial rupture of membranes and normal amniotic fluid is straw-colored and odorless. Successful rupture of membranes most commonly is determined by the immediate return of amniotic fluid from the vagina. This fluid usually is clear and odorless.

- **Option A:** Fetal heart tones of 160 indicate tachycardia. Monitoring of the fetal heart rate as well as uterine activity can be easily obtained via external monitoring systems. However, in certain circumstances, more direct evaluation of the fetal heart rate or uterine activity is required during labor.
- **Option C:** Greenish fluid is indicative of meconium. In certain circumstances, the fluid may either contain meconium or may be blood-tinged. It is important to note the color of the fluid at the time of rupture.
- **Option D:** If the nurse notes the umbilical cord, the client is experiencing a prolapsed cord and would need to be reported immediately. Typically, following artificial rupture of membranes, the practitioner should not immediately remove their hand from the vagina because it is at this point that the highest risk of potential cord prolapse can occur and will be noted as the amniotic fluid continues to drain. After the immediate flow of amniotic fluid ceases, and there is no palpable cord in the vagina, the vaginal hand then can be removed.

7. 7. Question

**1 point(s)**

**Category: Physiological Integrity**

The client is admitted to the unit. A vaginal exam reveals that she is 2cm dilated. Which of the following statements would the nurse expect her to make?

- A. "We have a name picked out for the baby."
- B. "I need to push when I have a contraction."
- C. "I can't concentrate if anyone is touching me."
- **D. "When can I get my epidural?"**

**Correct**

**Correct Answer: D. "When can I get my epidural?"**

Dilation of 2 cm marks the end of the latent phase of labor. During the latent phase, the cervix dilates slowly to approximately 6 centimeters. The latent phase is generally considerably longer and less predictable with regard to the rate

of cervical change than is observed in the active phase. A normal latent phase can last up to 20 hours and 14 hours in nulliparous and multiparous women respectively, without being considered prolonged.

- **Option A:** This is a vague answer. The latent phase is commonly defined as the 0 to 6 cm, while the active phase commences from 6 cm to full cervical dilation. The presenting fetal part also begins the process of engagement into the pelvis during the first stage. Throughout the first stage of labor, serial cervical exams are done to determine the position of the fetus, cervical dilation, and cervical effacement. Cervical effacement refers to the cervical length in the anterior-posterior plane. When the cervix is completely thinned out and no length is left, this is referred to as 100 percent effacement.
- **Option B:** This indicates the end of the first stage of labor. The first stage of labor begins when labor starts and ends with full cervical dilation to 10 centimeters. Labor often begins spontaneously or may be induced medically for a variety of maternal or fetal indications.
- **Option C:** This indicates the transition phase. The second stage of labor commences with complete cervical dilation to 10 centimeters and ends with the delivery of the neonate. This was also defined as the pelvic division phase by Friedman. After cervical dilation is complete, the fetus descends into the vaginal canal with or without maternal pushing efforts.

8. 8. Question

**1 point(s)**

**Category: Physiological Integrity**

The client is having fetal heart rates of 90–110 bpm during the contractions. The first action the nurse should take is:

- A. Reposition the monitor
- **B. Turn the client to her left side**
- C. Ask the client to ambulate
- **D. Prepare the client for delivery**



## Incorrect

### Correct Answer: B. Turn the client to her left side

The normal fetal heart rate is 120–160 bpm; 100–110bpm is bradycardia. The first action would be to turn the client to the left side and apply oxygen. A slow heart rate, or bradycardia, may indicate the baby is not getting enough oxygen delivery to the brain. A fast heart rate, or tachycardia, may indicate oxygen deprivation. There is an acceptable range of acceleration and deceleration – or speeding up and slowing down – of fetal heart rates during contractions and labor.

- **Option A:** Repositioning the monitor is not indicated at this time. Obstetricians and nurses must carefully review fetal monitor strips throughout labor and delivery to ensure fetal heart tones are reassuring and the baby is getting enough oxygen. If non-reassuring conditions occur, appropriate and timely actions must be taken.
- **Option C:** Asking the client to ambulate is not the best action for clients experiencing bradycardia. Generally, nursing interventions are attempted first to restore normal oxygenation to the baby. These include the administration of supplemental oxygen, changes in maternal position, increasing intravenous fluids, and the administration of medications that subdue contractions and maximize placental blood flow.
- **Option D:** There is no data to indicate the need to move the client to the delivery room at this time. If fetal heart tones remain non-reassuring despite nursing interventions, the fetus should be delivered by emergency cesarean section. Emergency cesarean section should be performed within 5 to 30 minutes depending on the circumstances.

#### 9. 9. Question

### 1 point(s)

#### Category: Physiological Integrity

In evaluating the effectiveness of IV Pitocin for a client with secondary dystocia, the nurse should expect:

- A. A painless delivery

- B. Cervical effacement
- C. Infrequent contractions
- **D. Progressive cervical dilation**

### Correct

#### **Correct Answer: D. Progressive cervical dilation**

The expected effect of Pitocin is cervical dilation. Oxytocin is indicated and approved by the FDA for two specific time frames in the obstetric world: antepartum and postpartum. In the antepartum period, exogenous oxytocin is FDA-approved for strengthening uterine contractions with the aim of successful vaginal delivery of the fetus.

- **Option A:** Pitocin causes more intense contractions, which can increase the pain. When oxytocin is released, it stimulates uterine contractions, and these uterine contractions, in turn, cause more oxytocin to be released; this is what causes the increase in both the intensity and frequency of contractions and enables a mother to carry out vaginal delivery completely.
- **Option B:** Cervical effacement is caused by pressure on the presenting part. During the later stages of pregnancy, the fetus's head drops into the pelvis, pushing it against the cervix. This process stretches the cervix, causing it to thin and shorten. Measurement of effacement is usually in percentages. For example, when the cervix is 100% effaced, it means that it is completely thinned and shortened.
- **Option C:** Infrequent contractions is opposite the action of Pitocin. Exogenous oxytocin causes the same response in the female reproductive system as that of endogenous oxytocin. Both types of oxytocin stimulate uterine contractions in the myometrium by causing G-protein coupled receptors to stimulate a rise in intracellular calcium in uterine myofibrils.

10. 10. Question

**1 point(s)**

**Category: Physiological Integrity**