NEXT GENERATION NCLEX EXPERIENCE RN 3.0 CLINICAL JUDGEMENT PRACTICE 3

RN 3.0 Clinical Judgment Practice 3

CLOSE

 INCORRECT

Time Remaining: 08:18:50
Pause Remaining: 08:20:00

PAUSE

FLAG

A nurse is caring for a client on a medical surgical unit.

Exhibit 1 Exhibit 2 Exhibit 3 Exhibit 4

History and Physical

Day 1:

1400:

Client is postoperative following a gastric bypass.

Weight 148.8 kg (328 lb)

BMI 54.6

Click to highlight below the interventions the nurse should take for each body system. To deselect an intervention, click on the intervention again.

Body System	Interventions
Gastrointestinal	Offer sips of clear liquids to the client. Remove the nasogastric tube.Administer a bolus of morphine.Encourage the client to lie on their right side.
Respiratory	Monitor oxygen saturation continuously. Administer oxygen via nasal canula.
Genitourinary	Remove the urinary catheter.
Integumentary	Change the abdominal dressing. Evaluate the skin around the drainage tube.

INCORRECT My Answer

Correct Answer

When taking action, the nurse should apply oxygen and monitor the client's saturation continuously to ensure appropriate oxygenation because the client's saturation level has dropped. The nurse should administer the prescribed morphine because the client is experiencing an increased pain level. The nurse should change the client's dressing and assess the skin around the tubes to prevent any skin breakdown due to damp skin or pressure from the tube.

CONTINUE

Copyright © 2023 Assessment Technologies Institute, L.L.C. All rights reserved.

Question: 2 of 8

PARTIALLY CORRECT

Time Remaining: 08:17:07
Pause Remaining: 08:20:00

PAUSE

FLAG

A nurse in an acute care setting is caring for a client who is experiencing an ischemic stroke.

Exhibit 1 Exhibit 2

Nurses' Notes

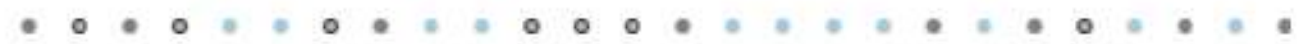
0800:

Client reports mild headache and a tingling sensation in the back of the neck.
Alteplase 90 mg IV started.

0815:

Client reports headache and nausea.
Alteplase infusing.

For each body system below, click to specify the potential nursing intervention that would be appropriate for the care of the client. Each body system may support more than 1 potential nursing intervention.



Body System	Potential Nursing Interventions
Cognition	☐ Open the curtains and turn on lights to brighten the room. ☑ Initiate oxygen via nasal cannula. ☐ Perform neurologic evaluations every 1 hr. ☐ Cluster nursing interventions.
Cardiac	☐ Stop the alteplase. ☑ Initiate an antihypertensive medication. ☑ Take the client's BP using a manual device. ☐ Place the client in supine position.

(Each category must have at least 1 response option selected.)

PARTIALLY CORRECT My Answer

When taking action, the nurse should recognize increased BP, nausea, vomiting, and bleeding are contraindications for administering thrombolytic therapy, and the medication should be discontinued. An increased BP needs to be controlled before and during thrombolytic therapy. Administering an antihypertensive is indicated for clients who are hypertensive. The nurse should recognize that confusion and headache can be indications of increased intracranial pressure. Therefore, the nurse should take actions to ensure adequate perfusion to the client's brain such as administering oxygen, elevating the client's head of bed, decreasing stimulation in the environment, and not overexerting the client who has multiple care needs.

Correct Answer

PREVIOUS

CONTINUE

Question: 3 of 8

CORRECT

Time Remaining: 08:14:57
Pause Remaining: 08:20:00

PAUSE

FLAG

Exhibit 1 | Exhibit 2 | Exhibit 3 | Exhibit 4 | Exhibit 5

Medical History

Day 1:

24-year-old client who has a history of major depressive disorder is admitted to an inpatient eating disorder clinic. Client reports frequent episodes of binge eating, self-induced vomiting, and laxative use. Client states, "I am huge. My stomach and legs have gotten so big. I look horrible. I need to exercise more." Client reports eating large amounts of food and vomiting about 10 times per week for about 6 months.

Select the 5 findings that require immediate follow-up.

- [x] Chloride level
- [x] Blood pressure
- [x] Heart rate
- [x] Potassium level
- [ ] WBC count
- [ ] Sodium level
- [ ] Hemoglobin
- [ ] Body temperature
- [x] Skin turgor

CORRECT My Answer

When recognizing cues, the nurse should identify that tachycardia, hypotension, hypokalemia, hypochloremia, and decreased skin turgor are all indicators of dehydration. If left untreated dehydration can lead to shock. The nurse should report these assessment findings to the provider immediately for follow-up.

PREVIOUS

CONTINUE