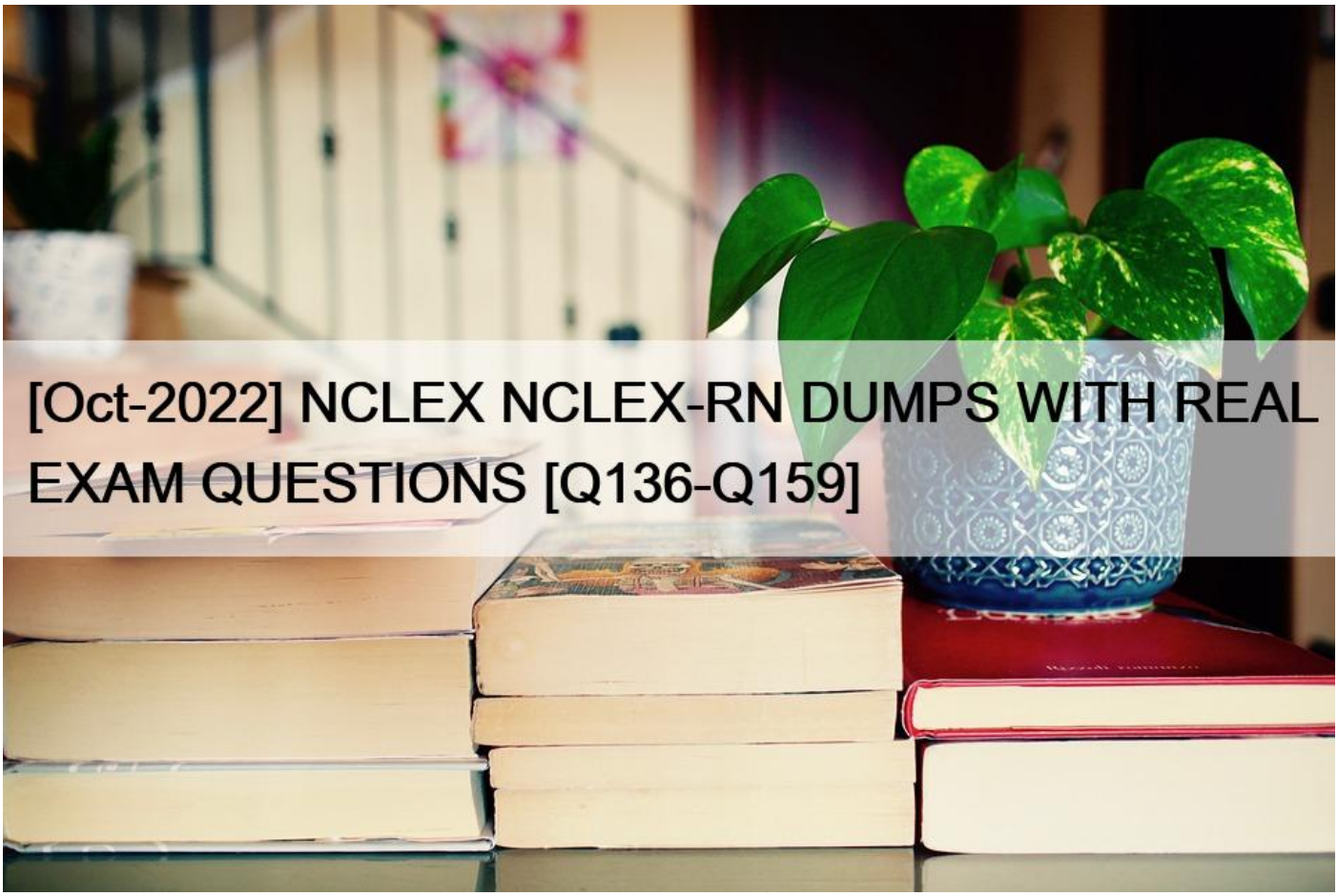
[Oct-2022 NCLEX NCLEX-RN DUMPS WITH REAL EXAM QUESTIONS [Q136-Q159



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NO.136 In acute episodes of mania, lithium is effective in 1-2 weeks, but it may take up to 4 weeks, or even a few months, to treat symptoms fully. Sometimes an antipsychotic agent is prescribed during the first few days or weeks of an acute episode to manage severe behavioral excitement and acute psychotic symptoms. In addition to the lithium, which one of the following medications might the physician prescribe?
* Diazepam (Valium)
* Haloperidol (Haldol)
* Sertraline (Zoloft)
* Alprazolam (Xanax)

(A) Diazepam is an antianxiety medication and is not designed to reduce psychotic symptoms. (B) Haloperidol is an antipsychotic medication and may be used until the lithium takes effect. (C) Sertraline is an antidepressant and is used primarily to reduce symptoms of depression. (D) Alprazolam is an antianxiety medication and is not designed to reduce psychotic symptoms.

NO.137 Pregnant women with diabetes often have problems related to the effectiveness of insulin in controlling their glucose levels during their second half of pregnancy. The nurse teaches the client that this is due to:

* Decreased glomerular filtration and increased tubular absorption
* Decreased estrogen levels
* Decreased progesterone levels
* Increased human placental lactogen levels

(A) There is a rise in glomerular filtration rate in the kidneys in conjunction with decreased tubular glucose reabsorption, resulting in glycosuria. (B) Insulin is inhibited by increased levels of estrogen. (C) Insulin is inhibited by increased levels of progesterone. (D) Human placental lactogen levels increase later in pregnancy. This hormonal antagonist reduces

insulin’s effectiveness, stimulates lipolysis, and increases the circulation of free fatty acids.

NO.138 Two weeks after a client’s admission for depression, the physician orders a consult for electroconvulsive therapy (ECT). Which of the following conditions, if present, would be a contraindication for ECT?

* Brain tumor or other space-occupying lesion
* History of mitral valve prolapse
* Surgically repaired herniated lumbar disk
* History of frequent urinary tract infections

Explanation

(A) A contraindication for ECT is a space-occupying lesion such as a brain tumor. During ECT, intracranial pressure increases. Therefore, ECT would not be prescribed for a client whose intracranial pressure is already elevated. (B) Any cardiac dysrhythmias or complications that arise during ECT are usually attributed to the IV anesthetics used, not to preexisting cardiac structural conditions. (C) Musculoskeletal injuries during ECT are extremely rare because of the IV use of centrally acting muscle relaxers. (D) A history of any kind of infection would not contraindicate the use of ECT. In fact, concurrent treatment of infections with ECT is not uncommon.

NO.139 Medication is administered to a client who has been placed in restraints after a sudden violent episode, and his EPSs subside. Restraints can be removed when:

* The physician orders it
* A therapeutic alliance has been established, and violent behavior subsides
* The violent behavior subsides, and the client agrees to behave
* The nurse deems that removal of restraints is necessary

Explanation

(A) The physicianmayorder release of restraints, but prior to that, the client must meet criteria for release. (B) While the client is still restrained, but after violent behavior has subsided, a therapeutic bridge is built. This alliance encourages dialogue between nurse and client, allowing the client to determine causative factors, feelings prior to loss of control, and adaptive alternatives to violence. (C) If the client only “agrees to behave” after violent behavior subsides, he has developed no insight into cause and effect of violence or his response to stress. (D)Removal of restraints occurs only when the client meets the criteria for release, not just because the nurse says it is necessary.

NO.140 A 14-year-old boy fell off his bike while “popping a wheelie” on the dirt trails. He has sustained a head injury with laceration of his scalp over his temporal lobe. If he were to complain of headache during the first

24 hours of his hospitalization, the nurse would:

* Ask the physician to order a sedative
* Have the client describe his headache every 15 minutes
* Increase his fluid intake to 3000 mL/24 hr
* Offer diversionary activities

Explanation/Reference:

Explanation:

(A) CNS depressants are not given for headache due to head injury because they would mask changes in neurological status and because they could further depress the CNS. (B) The client should not be asked to think about his headache every 15 minutes. (C) Fluid intake should be normal or restricted for a client with a head injury. Normal fluid intake for a 14 year old is about 2000-2400 mL daily. (D) Diversion may help the child to focus on a pleasant activity instead of on his headache.

NO.141 A 16-year-old client comes to the prenatal clinic for her monthly appointment. She has gained 14 lb from her

7th to 8th month; her face and hands indicate edema. She is diagnosed as having PIH and referred to the high-risk prenatal clinic. The client’s weight increase is most likely due to:
* Overeating and subsequent obesity
* Obesity prior to conception
* Hypertension due to kidney lesions
* Fluid retention

Explanation

(A) Overeating can lead to obesity, but not to edema. (B) There is no indication of obesity prior to pregnancy.

PIH is more prevalent in the underweight than in the obese in this age group. (C) Hypertension can be due to kidney lesions, but it would have been apparent earlier in the pregnancy. (D) The weight gain in PIH is due to the retention of sodium ions and fluid and is one of the three cardinal symptoms of PIH.

NO.142 To prevent transmission of bacterial meningitis, the nurse would instruct an infected baby’s mother to:
* Avoid touching the baby while in the room.
* Stay outside of the baby’s room.
* Wear a gown and gloves and wash her hands before and after leaving the room.
* Wear a mask while in the room.

Section: Questions Set G

Explanation:

(A) The mother should be allowed and encouraged to touch her baby. (B) With care, transmission can be prevented. There is no need for the mother to stay outside the room. (C) Everyone entering the baby’s room should take appropriate measures to prevent transmission of pathogens. (D) Wearing a mask will not protect against transmission of pathogens.

NO.143 Signs and symptoms of an allergy attack include which of the following?
* Wheezing on inspiration
* Increased respiratory rate
* Circumoral cyanosis
* Prolonged expiration

Explanation/Reference:

Explanation:

(A) Wheezing occurs during expiration when air movement is impaired because of constricted edematous bronchial lumina. (B) Respirations are difficult, but the rate is frequently normal. (C) The circumoral area is usually pale. Cyanosis is not an early sign of hypoxia. (D) Expiration is prolonged because the alveoli are greatly distended and air trapping occurs.

NO.144 The nurse knows that children are more susceptible to respiratory tract infections owing to physiological differences. These

childhood differences, when compared to an adult, include:
* Fewer alveoli, slower respiratory rate
* Diaphragmatic breathing, larger volume of air
* Larger number of alveoli, diaphragmatic breathing
* Rounded shape of chest, smaller volume of air
(A) Although a child has fewer alveoli than an adult, the child’s respiratory rate is faster. (B) Although a child may use diaphragmatic breathing, the adult exchanges a larger volume of air. (C) The adult has a larger number of alveoli than a child. (D) The child’s chest is rounded whereas the adult chest is more of an oval shape, and the child does exchange a smaller volume of air than an adult.

NO.145 The day following his admission, the nurse sits down by a male client on the sofa in the dayroom. He was admitted for depression and thoughts of suicide. He looks at the nurse and says, “My life is so bad no one can do anything to help me.” The most helpful initial response by the nurse would be:
* “It concerns me that you feel so badly when you have so many positive things in your life.”
* “It will take a few weeks for you to feel better, so you need to be patient.”
* “You are telling me that you are feeling hopeless at this point?”
* “Let’s play cards with some of the other clients to get your mind off your problems for now.”
(A) This response does not acknowledge the client’s feelings and may increase his feelings of guilt. (B) This response denotes false reassurance. (C) This response acknowledges the client’s feelings and invites a response. (D) This response changes the subject and does not allow the client to talk about his feelings.

NO.146 A female client comes for her second prenatal visit. The nurse-midwife tells her, “Your blood tests reveal that you do not show immunity to the German measles.” Which notation will the nurse include in her plan of care for the client? “Will need . . .
* Rh-immune globulin at the next visit”
* Rh-immune globulin within 3 days of delivery”
* Rubella vaccine at the next visit”
* Rubella vaccine after delivery on the day of discharge”
Section: Questions Set E

Explanation:

(A) Rh immune globulin is given to Rh-negative mothers to prevent the maternal Rh immune response. (B) Rh immune globulin is given to Rh-negative mothers to prevent the maternal Rh immune response. (C) The rubella vaccine is not given during pregnancy because of its teratogenicity. (D) Nonimmune mothers are vaccinated early in the postpartum period to prevent future infection with the rubella virus.

NO.147 A client is a depressed, 48-year-old salesman. A serious concern for the nurse working with depressed clients is the potential of suicide. The time that suicide is most likely to occur is:
* In the acutely depressed state
* When the depression starts to lift
* In the denial phase
* During a manic episode
Explanation/Reference:

Explanation:

(A) The client may be too disorganized in the acute phase to make a workable plan. (B) When the depression starts to lift, the client is able to make a workable plan. (C) There usually is not a significant denial phase related to depression. Suicide occurs in a state of despair and hopelessness. (D) Suicide is uncommon in the manic state. In this state, clients do not feel hopeless, but euphoric and

overly confident.

NO.148 The nurse would expect to include which of the following when planning the management of the client with Lyme disease?
* Complete bed rest for 6-8 weeks
* Tetracycline treatment
* IV amphotericin B
* High-protein diet with limited fluids

Section: Questions Set A

Explanation

Explanation:

(A) The client is not placed on complete bed rest for 6 weeks. (B) Tetracycline is the treatment of choice for children with Lyme disease who are over the age of 9. (C) IV amphotericin B is the treatment for histoplasmosis. (D) The client is not restricted to a high-protein diet with limited fluids.

NO.149 After 7 hours in restraints and a total of 30-mg haloperidol in divided doses, a client complains of stiffness in his neck and his tongue “pulling to one side.” These extrapyramidal symptoms (EPS) will most likely be relieved by the administration of:
* Lorazepam (Ativan)
* Benztropine (Cogentin)
* Thiothixene (Navane)
* Flurazepan (Dalmane)

(A) Lorazepam is an antianxiety agent that produces muscle relaxation and inhibits cortical and limbic arousal. It has no action in the basal ganglia of the brain. (B) Benztropine acts to reduce EPS by blocking excess CNS cholinergic activity associated with dopamine deficiency in the basal ganglia by displacing acetylcholine at the receptor site. (C) Thiothixene is an antipsychotic known to block dopamine in the limbic system, thereby causing EPS. (D) Flurazepan is a hypnotic that acts in the limbic system, thalamus, and hypothalamus of the CNS to produce sleep. It has no known action in the vasal ganglia.

NO.150 A client is having episodes of hyperventilation related to her surgery that is scheduled tomorrow.

Appropriate nursing actions to help control hyperventilating include:
* Administering diazepam (Valium) 10-15 mg po q4h and q1h prn for hyperventilating episode
* Keeping the temperature in the client’s room at a high level to reduce respiratory stimulation
* Having the client hold her breath or breathe into a paper bag when hyperventilation episodes occur
* Using distraction to help control the client’s hyperventilation episodes

Explanation/Reference:

Explanation:

(A) An adult diazepam dosage for treatment of anxiety is 2-10 mg PO 2-4 times daily. The order as written would place a client at risk for overdose. (B) A high room temperature could increase hyperventilating episodes by stimulating the respiratory system. (C) Breath holding and breathing into a paper bag may be useful in controlling hyperventilation. Both measures increase CO2 retention. (D) Distraction will not prevent or control hyperventilation caused by anxiety or fear.

NO.151 A 2-year-old child is recovering from surgery. Considering growth and development according to Erikson, the nurse identifies which of the following play activities as most appropriate?
* Assembling a puzzle with large pieces
* Being taken for a wheelchair ride

* Listening to a story about the Muppets
* Watching Sesame Street on television

Explanation/Reference:

Explanation:

(A) A 2-year-old child is in the stage of autonomy, according to Erikson. Assembling a puzzle with large pieces enables her to “do it herself.” (B) A wheelchair ride would probably be fun, but it is not directed toward helping the child to achieve autonomy. (C) Listening to a story may be fun and educational, but it is not directed toward helping the child to achieve autonomy. (D) Watching television may be a favorite activity, but it does not foster autonomy.

NO.152 A 7-year-old child is brought to the ER at midnight by his mother after symptoms appeared abruptly. The nurse’s initial assessment reveals a temperature of 104.5?F (40.3?C), difficulty swallowing, drooling, absence of a spontaneous cough, and agitation. These symptoms are indicative of which one of the following?

* Acute tracheitis
* Acute spasmodic croup
* Acute epiglottis
* Acute laryngotracheobronchitis

Explanation/Reference:

Explanation:

(A) Clinical manifestations of acute tracheitis include a 2-3 day history of URI, croupy cough, stridor, purulent secretions, high fever. (B) Clinical manifestations of spasmodic croup include a history of URI, croupy cough, stridor, dyspnea, low-grade fever, and a slow progression. The age group most affected is 3 months to 3 years. (C) Three clinical observations have been found to be predictive of epiglottitis: the presence of drooling, absence of spontaneous cough, and agitation.Epiglottitis has a rapid onset that is accompanied by high fever and dysphagia. (D) Clinical manifestations of acute laryngotracheobronchitis (LTB) include slow onset with a history of URI, low-grade fever, stridor, brassy cough, and irritability.

NO.153 After 7 hours in restraints and a total of 30-mg haloperidol in divided doses, a client complains of stiffness in his neck and his tongue “pulling to one side.” These extrapyramidal symptoms (EPS) will most likely be relieved by the administration of:

* Lorazepam (Ativan)
* Benztropine (Cogentin)
* Thiothixene (Navane)
* Flurazepan (Dalmane)

Explanation/Reference:

Explanation:

(A) Lorazepam is an antianxiety agent that produces muscle relaxation and inhibits cortical and limbic arousal. It has no action in the basal ganglia of the brain. (B) Benztropine acts to reduce EPS by blocking excess CNS cholinergic activity associated with dopamine deficiency in the basal ganglia by displacing acetylcholine at the receptor site. (C) Thiothixene is an antipsychotic known to block dopamine in the limbic system, thereby causing EPS. (D) Flurazepan is a hypnotic that acts in the limbic system, thalamus, and hypothalamus of the CNS to produce sleep. It has no known action in the vasal ganglia.

NO.154 The client has been in active labor for the last 12 hours. During the last 3 hours, labor has been augmented with oxytocin because of hypoactive uterine contractions. Her physician assesses her cervix as 95% effaced, 8 cm dilated, and the fetus is at 0 station. Her oral temperature is 100.2F at this time. The physician orders that she be prepared for a cesarean delivery. In preparing the client for the cesarean delivery, which one of the following physician’s orders should the RN question?

* Administer meperidine (Demerol) 100 mg IM 1 hour prior to the delivery.
* Discontinue the oxytocin infusion.
* Insert an indwelling Foley catheter prior to delivery.
* Prepare abdominal area from below the nipples to below the symphysis pubis area.

(A) Meperidine is a narcotic analgesic medication that crosses the placental barrier and reaches the fetus, causing respiratory depression in the fetus. A narcotic medication should never be included in the preoperative order for a cesarean delivery. (B) Oxytocin infusion would be discontinued if client is being prepared for a cesarean delivery because the medication would not be needed. (C) The bladder is always emptied prior to and during the surgical intervention to prevent the urinary bladder from accidentally being incised while the uterine incision is made. (D) The abdominal area is always prepared to rid the area of hair before the abdominal incision is made. Abdominal hair cannot be sterilized and could become a source for postoperative incisional infection.

NO.155 An 11-month-old infant is admitted with a possible diagnosis of pyloric stenosis. Which of the following best describes the characteristic clinical manifestations of pyloric stenosis?

* Pain, especially when eating
* Poor appetite and sucking reflex
* Increased frequency and quantity of stools
* Palpable olive-shaped mass in the epigastrium just right of the umbilical cord

Explanation

(A) There is no evidence of pain in infants with pyloric stenosis whether eating or not. (B) There are both good appetite and feeding habits in these children. (C) Because of regurgitation, there is usually decreased frequency and quantity of stools and also signs of dehydration and weight loss. (D) Along with upper abdominal distention, there is a characteristic palpable olive-shaped mass located to the right of the umbilicus.

NO.156 A client is being treated for congestive heart failure. His medical regimen consists of digoxin (Lanoxin) 0.25 mg po daily and furosemide 20 mg po bid. Which laboratory test should the nurse monitor?

* Intake and output
* Calcium
* Potassium
* Magnesium

Explanation/Reference:

Explanation:

(A) Intake and output are not laboratory tests. (B) Serum calcium levels are not affected by digoxin or furosemide. (C) Furosemide is a non-potassium-sparing loop diuretic. Hypokalemia is a common side effect of furosemide and may enhance digoxin toxicity. (D) Serum magnesium levels are not affected by digoxin or furosemide.

NO.157 A child sustains a supracondylar fracture of the femur. When assessing for vascular injury, the nurse should be alert for the signs of ischemia, which include:

* Bleeding, bruising, and hemorrhage
* Increase in serum levels of creatinine, alkaline phosphatase, and aspartate transaminase
* Pain, pallor, pulselessness, paresthesia, and paralysis
* Generalized swelling, pain, and diminished functional use with muscle rigidity and crepitus

Explanation

(A) Bleeding, bruising, and hemorrhage may occur due to injury but are not classic signs of ischemia. (B) An increase in serum levels of creatinine, alkaline phosphatase, and aspartate transaminase is related to the disruption of muscle integrity. (C) Classic signs of ischemia related to vascular injury secondary to long bone fractures include the five “P’s”: pain,

pallor, pulselessness, paresthesia, and paralysis. (D) Generalized swelling, pain, and diminished functional use with muscle rigidity and crepitus are common clinical manifestations of a fracture but not ischemia.

NO.158 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?
* Hiccups
* Anorexia
* Mental confusion
* Fetor hepaticus

(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.

NO.159 The nurse should facilitate bonding during the postpartum period. What should the nurse expect to observe in the taking-hold phase?
* Mother is concerned about her recovery.
* Mother calls infant by name.
* Mother lightly touches infant.
* Mother is concerned about her weight gain.

(A) This observation can be made during the taking-in phase when the mother’s needs are more important. (B) This observation can be made during the taking-hold phase when the mother is actively involved with herself and the infant. (C, D) This observation can be made during the taking-in phase.