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FREE NCLEX RN Study Guide

DO NOT delegate what you can EAT!

- E – evaluate
- A – assess
- T – teach

addisons = down, down down up down

cushings = up up up down up

addisons = hyponatremia, hypotension, decreased blood vol, hyperkalemia, hypoglycemia

cushings = hypernatremia, hypertension, increased blood vol, hypokalemia, hyperglycemia

No Pee, no K (do not give potassium without adequate urine output)

Elevate Veins; dAngle Arteries for better perfusion

- A = appearance (color all pink, pink and blue, blue [pale])
- P = pulse (>100, < 100, absent)
- G = grimace (cough, grimace, no response)
- A = activity (flexed, flaccid, limp)
- R = respirations (strong cry, weak cry, absent)

TRANSMISSION-BASED PRECAUTIONS:

AIRBORNE

My – Measles

Chicken – Chicken Pox/Varicella

Haz – Herpes Zoster/Shingles

TB

or remember...

MTV = Airborne

Measles

TB

Varicella-Chicken Pox/Herpes Zoster-Shingles: Private Room – negative pressure with 6-12 air exchanges/hr Mask, N95 for TB

DROPLET

think of SPIDERMAN!

- S – sepsis
- S – scarlet fever
- S – streptococcal pharyngitis
- P – parvovirus B19
- P – pneumonia
- P – pertussis
- I – influenza
- D – diphtheria (pharyngeal)
- E – epiglottitis
- R – rubella M – mumps
- M – meningitis
- M – mycoplasma or meningial pneumonia
- An – Adenovirus: Private Room or cohort Mask

CONTACT PRECAUTION

MRS.WEE

- M – multidrug resistant organism
- R – respiratory infection
- S – skin infections *
- W – wound infxn
- E – enteric infxn – clostridium difficile
- E – eye infxn – conjunctivitis

SKIN INFECTIONS

VCHIPS

- V – varicella zoster

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NCLEX-RN (National Council Licensure Examination for Registered Nurses) is one of the most important exams for aspiring nurses in the United States. NCLEX-RN exam is designed to evaluate the competency of nursing graduates and ensure that they have the necessary knowledge and skills to provide safe and effective patient care. Passing the NCLEX-RN is a requirement for obtaining a nursing license in most states.

NCLEX-RN (National Council Licensure Examination for Registered Nurses) is a standardized exam that is used to determine whether or not an individual is ready to begin practicing as a registered nurse. NCLEX-RN Exam is a crucial step for all aspiring nurses, as it is the final hurdle standing between them and their dream careers. The NCLEX-RN exam is designed to test the knowledge, skills, and abilities that are required for safe and effective nursing practice, and is used by all state boards of nursing in the United States to grant licensure to new nurses.

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NCLEX National Council Licensure Examination(NCLEX-RN) Sample Questions (Q142-Q147):

NEW QUESTION # 142

A client who has been diagnosed with anorexia nervosa reluctantly agrees to eat all prescribed meals. The most important intervention in monitoring her dietary compliance would be to:

- A. Observe behavior for 1-2 hours after meals to prevent vomiting
- B. Allow her privacy at mealtimes
- C. Encourage her to eat in moderation, choose foods that she likes, and avoid foods that she dislikes
- D. Praise her for eating everything

Answer: A

Explanation:

Section: Questions Set F

Explanation:

(A) Eating alone is not recommended for anorexic clients because they tend to hoard food instead of eating it.

(B) The client should be praised for whatever she eats, which is usually a small portion or percentage of what is served. Praise should not be withheld until she eats everything. (C) The client should be observed eye-to-eye for at least 1 hour following meals to prevent discarding food stashed in her clothing at mealtime or engaging in self-induced vomiting. (D) If offered these choices, the client would choose low-caloric foods, not a nutritious diet.

NEW QUESTION # 143

A child is to receive atropine 0.15 mg (1/400 g) as part of his preoperative medication. A vial containing atropine 0.4 mg (1/150 g)/mL is on hand. How much atropine should be given?

- A. 2.7 mL
- B. Information given insufficient to determine the amount of atropine to be administered
- C. 0.06 mL
- D. 0.38 mL

Answer: D

Explanation:

Section: Questions Set G

Explanation:

(A, C) Information was incorrectly placed in the formula, resulting in an incorrect answer. (B) The answer is correct.

$0.4 \text{ mg} = 1 \text{ mL}; 0.15 \text{ mg} = x \text{ mL}$

$0.4x = 0.15$

$x = 0.15/0.4$

$x = 0.375$ or 0.38 mL

(D) Sufficient information is provided to determine the amount of atropine to administer. The amount of atropine available and the amount of atropine ordered is required to determine the amount of atropine to be given.

NEW QUESTION # 144

A couple is experiencing difficulties conceiving a baby. The nurse explains basal body temperature (BBT) by instructing the female

client to take her temperature:

- A. Rectally at bedtime
- B. Only one time during the day as long as it is always at the same time of day
- C. Orally in the morning and at bedtime
- **D. As soon as she awakens, prior to any activity**

Answer: D

Explanation:

(A) Monitoring temperature twice a day predicts the biphasic pattern of ovulation. (B) Prediction of ovulation relies on consistency in taking temperature. (C) Nightly rectal temperatures are more accurate in predicting ovulation. (D) Activity changes the accuracy of basal body temperature and ability to detect the luteinizing hormone surge.

NEW QUESTION # 145

A 30-year-old client in the third trimester of her pregnancy asks the nurse for advice about upper respiratory discomforts. She complains of nasal stuffiness and epistaxis, most noticeable on the left side. Which reply by the nurse is correct?

- A. "This is most unusual. I'm sure your obstetrician will want you to see an ENT (ear, nose, throat) specialist."
- B. "A good vaporizer will help; avoid the cool air kind. Also, try saline nose drops, and spend less time on your left side."
- **C. "These discomforts are all a result of increased blood supply; one of the pregnancy hormones, estrogen, causes them."**
- D. "It sounds as though you are coming down with a bad cold. I'll ask the doctor to prescribe a decongestant for relief of symptoms."

Answer: C

Explanation:

Section: Questions Set F

Explanation:

(A) Decongestants may exaggerate the nasal stuffiness associated with pregnancy. Judicious use of decongestants and nasal sprays is advocated during pregnancy. (B) Cool air vaporizers and saline drops may help to relieve the nasal stuffiness. Positioning on either lateral side does not decrease nasal stuffiness or prevent epistaxis. (C) Increased estrogen levels result in nasal mucosa edema with subsequent nasal stuffiness. Estrogen also promotes vasodilation, which contributes to epistaxis. The nurse may recommend cool air vaporizers and saline drops to help with the nasal stuffiness. (D) Increased estrogen levels result in nasal mucosa edema with subsequent nasal stuffiness. Estrogen also promotes vasodilation discomforts associated with pregnancy.

NEW QUESTION # 146

A violent client remains in restraints for several hours. Which of the following interventions is most appropriate while he is in restraints?

- A. Give fluids if the client requests them.
- B. Assess skin integrity and circulation of extremities before applying restraints and as they are removed.
- C. Measure vital signs at least every 4 hours.
- **D. Release restraints every 2 hours for client to exercise.**

Answer: D

Explanation:

Explanation/Reference:

Explanation:

(A) Fluids (nourishment) should be offered at regular intervals whether the client requests (or refuses) them or not. (B) Skin integrity and circulation of the extremities should be checked regularly while the client is restrained, not only before restraints are applied and after they are removed. (C) Vital signs should be checked at least every 2 hours. If the client remains agitated in restraints, vital signs should be monitored even more closely, perhaps every 1-2 hours. (D) Restraints should be released every 2 hours for exercise, one extremity at a time, to maintain muscle tone, skin and joint integrity, and circulation.

NEW QUESTION # 147

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