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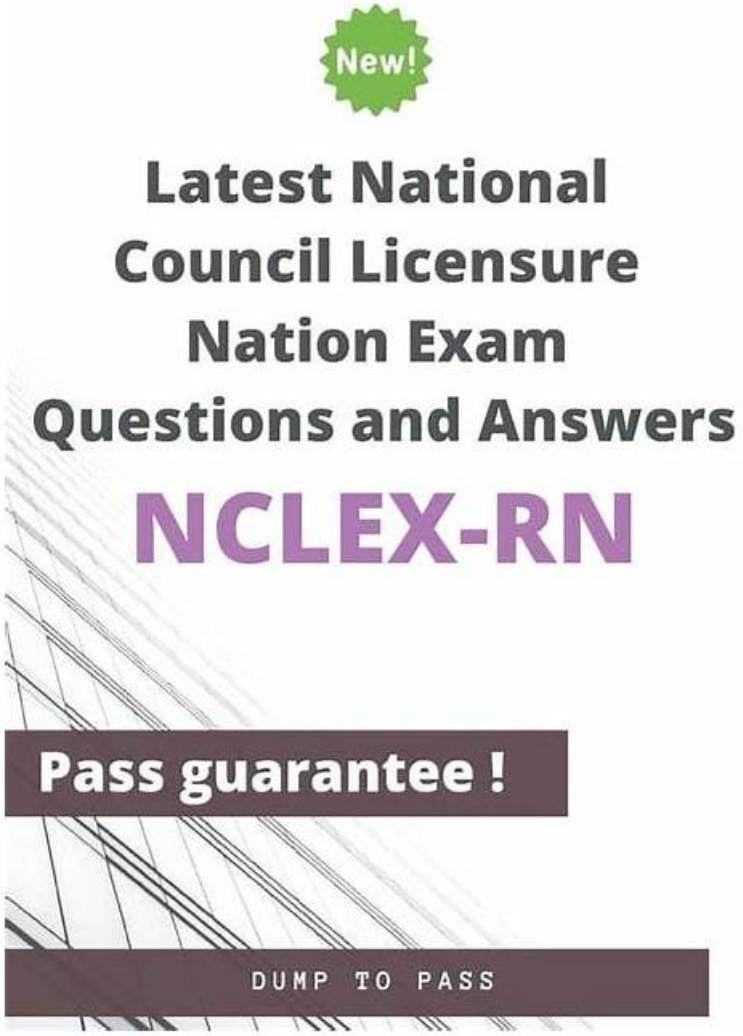

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NCLEX-RN, or National Council Licensure Examination for Registered Nurses, is a standardized test that must be passed in order for a nurse to obtain a license to practice in the United States. NCLEX-RN Exam is designed to evaluate the knowledge, skills, and

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NCLEX-RN exam is a computerized adaptive test that is designed to provide a precise measurement of the candidate's nursing knowledge and skills. It is a comprehensive exam that covers a broad range of topics related to nursing practice, including patient care, safety, pharmacology, and nursing procedures.

NCLEX National Council Licensure Examination(NCLEX-RN) Sample Questions (Q652-Q657):

NEW QUESTION # 652
In working with mental health clients who are prescribed medication that must be taken on a routine basis, it is important for education to begin when the drug therapy is initiated. One of the first steps in the teaching process is to:

- A. Explain the side effects of the medication
- B. Explore the client's perception regarding medication therapy
- C. Discuss the danger of overmedication
- D. Distribute written material to supplement verbal instructions

Answer: B

Explanation:
Section: Questions Set D
Explanation:
(A, B, C) The nurse must first obtain information regarding the client's perception of the medication regimen.
(D) The first step in the teaching process is to determine the client's perception.

NEW QUESTION # 653
A 42-year-old client on an inpatient psychiatric unit comments that he was brought to the hospital by his wife because he had taken too many pills and states, "I just couldn't take it anymore." The nurse's best response to this disclosure would be:

- A. "I'm sure you probably didn't mean to kill yourself."
- B. "How long have you been in the hospital."
- C. "You shouldn't do things like that, just tell someone you feel bad."
- D. "Tell me more about what you couldn't take anymore."

Answer: D

Explanation:
Explanation
(A) Disapproving gives the impression that the nurse has a right to pass judgment on the client's thoughts, actions, or ideas. (B) Giving a broad opening gives the client encouragement to continue with verbalization.
(C) Failing to acknowledge the client's feelings conveys a lack of understanding and empathy. (D) Changing the subject takes the conversation away from the client and is indicative of the nurse's anxiety or insensitivity.

NEW QUESTION # 654
A six-month-old infant is receiving ribavirin for the treatment of respiratory syncytial virus. Ribavirin is administered via which one of the following routes?

- A. IV
- B. Oral
- C. Aerosol
- D. IM

Answer: C

Explanation:
Explanation/Reference:
Explanation:
(A) Ribavirin is not supplied in an oral form. (B) Ribavirin is administered by aerosol in order to decrease the duration of viral shedding within the infected tissue. (C) Ribavirin is not approved for IV use to treat respiratory syncytial virus. (D) Ribavirin is a synthetic antiviral agent supplied as a crystalline powder that is reconstituted with sterile water. A Small Aerosol Particle Generator unit aerosolizes the medication for delivery by oxygen hood, croup tent, or aerosol mask.

NEW QUESTION # 655
The nurse enters the playroom and finds an 8-year-old child having a grand mal seizure. Which one of the following actions should the nurse take?

- A. Restrain the child so he will not injure himself.
- B. Move furniture out of the way and place a blanket under his head.
- C. Place a tongue blade in the child's mouth.
- D. Go to the nurses station and call the physician.

Answer: B

Explanation:
Explanation/Reference:
Explanation:
(A) The nurse should not put anything in the child's mouth during a seizure; this action could obstruct the airway. (B) Restraining the child's movements could cause constrictive injury. (C) Staying with the child during a seizure provides protection and allows the nurse to observe the seizure activity. (D) The nurse should provide safety for the child by moving objects and protecting the head.

NEW QUESTION # 656
Assessment of a client reveals a 30% loss of preillness weight, lanugo, and cessation of menses for 3 months.
Her vital signs are BP 90/50, P 96 bpm, respirations 30, and temperature 97 oF. She admits to the nurse that she has induced vomiting 3 times this morning, but she had to continue exercising to lose "just 5 more lb." Her symptoms are consistent with:

- A. Gastritis
- B. Bulimia
- C. Anorexia nervosa
- D. Pregnancy

Answer: C

Explanation:
Section: Questions Set F
Explanation:
(A) Presenting behaviors collectively are inconsistent with depression. (B) A preillness weight loss of 30%, lanugo, and cessation of menses are inconsistent with bulimia. (C) Symptoms and vital signs do not indicate the presence of infection. (D) All symptoms and vital signs are consistent with anorexia nervosa.

NEW QUESTION # 657
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