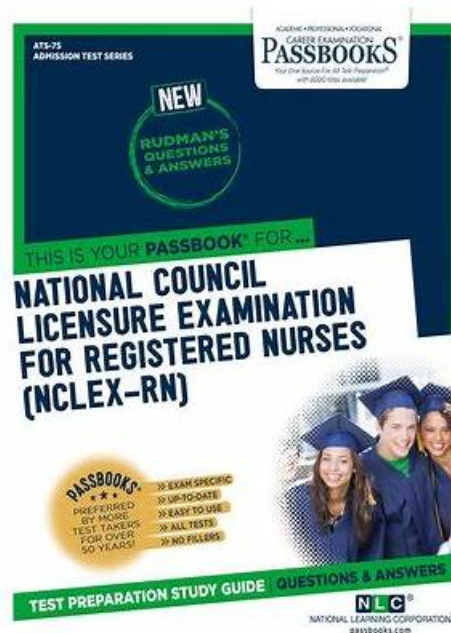


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NCLEX National Council Licensure Examination(NCLEX-RN) Sample Questions (Q355-Q360):

NEW QUESTION # 355

Three hours postoperatively, a 27-year-old client complains of right leg pain after knee reduction. The first action by the nurse will be to:

- A. Elevate the extremity
- B. Remind the client that he has a client-controlled analgesic pump, and reinstruct him on its use
- C. Perform a lower extremity neurovascular check
- D. Assess vital signs

Answer: C

Explanation:

Explanation/Reference:

Explanation:

(A) Vital signs may be altered if there is acute pain or complications related to bleeding or swelling, but they should not be assessed before checking the affected extremity. (B) The extremity will be elevated if ordered by the doctor. (C) Assessment of the postoperative area is important to determine if bleeding, swelling, or decreased circulation is occurring. (D) Reinforcement of teaching on use of the client- controlled analgesic pump is important, but not the first action.

NEW QUESTION # 356

A 70-year-old female client is admitted to the medical intensive care unit with a diagnosis of cerebrovascular accident (CVA). She is semicomatose, responding to pain and change in position. She is unable to speak or cough. In planning her nursing care for the first 24 hours following a CVA, which nursing diagnosis should receive the highest priority?

- A. Ineffective airway clearance related to immobility, ineffective cough, and decreased level of consciousness
- B. Potential for injury related to impaired mobility and seizures
- C. Altered cerebral tissue perfusion related to pathophysiological changes that decrease blood flow
- D. Impaired verbal communication related to aphasia

Answer: A

Explanation:

Section: Questions Set D

Explanation:

(A) An effective airway is necessary to prevent hypoxia and subsequent cardiac arrest. (B) Cerebral tissue perfusion is necessary to preserve remaining cerebral tissue, but this goal is secondary to maintenance of an effective airway. (C) While prevention of injury is important, it is secondary to maintaining an effective airway and cerebral tissue perfusion. (D) Impaired verbal communication is not life threatening in the acute phase of recovery. It is the lowest priority of the nursing diagnoses listed.

NEW QUESTION # 357

A 6-year-old child is attending a pediatric clinic for a routine examination. What should the nurse assess for while conducting a vision screening?

- A. Gait
- B. Hearing test
- C. Papilledema
- D. Strabismus

Answer: D

Explanation:

(A)

Hearing should be assessed separately. (B) Gait should be assessed separately. Client usually remains in one place for vision screening. Gait is part of neurological assessment.

(C)

Strabismus is crossing of eyes or outward deviation, which may cause diplopia or amblyopia. It is easily assessed during vision screening. (D) Papilledema is assessed by an ophthalmoscopic examination, which follows vision screening. It is part of neurological assessment.

NEW QUESTION # 358

The nurse is teaching a mother care of her child's spica cast. The mother states that he complains of itching under the edge of the cast. One nonpharmacological technique the nurse might suggest would be:

- A. "Gently thump on cast to dislodge dried skin that causes the itching."
- B. "Guide a towel under and through the cast and move it back and forth to relieve the itch."
- C. "Slide a ruler under the cast and scratch the area."
- D. "Blowing air under the cast using a hair dryer on cool setting often relieves itching."

Answer: D

Explanation:

Explanation

(A) Cool air will often relieve pruritus without damaging the cast or irritating the skin. (B) The nurse should never force anything under the cast, because the cast may become damaged and skin breakdown may occur.

(C) Forcing an object under the cast could lead to cast damage and skin breakdown. The object may become lodged under the cast necessitating cast removal. (D) This technique does not dislodge skin cells. It could damage the cast and cause skin breakdown.

NEW QUESTION # 359

As the nurse assesses a male adolescent with chlamydia, the nurse determines that a sign of chlamydia is:

- A. Secondary lymphadenitis
- B. Hepatomegaly
- C. Epididymitis
- D. Enlarged penis

Answer: C

Explanation:

Explanation/Reference:

Explanation:

(A) An enlarged penis is not a sign of chlamydia. (B) Secondary lymphadenitis is a complication of lymphogranuloma venereum. (C) Untreated chlamydial infection can spread from the urethra, causing epididymitis, which presents as a tender, scrotal swelling. (D) Hepatomegaly is not a complication.

NEW QUESTION # 360

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