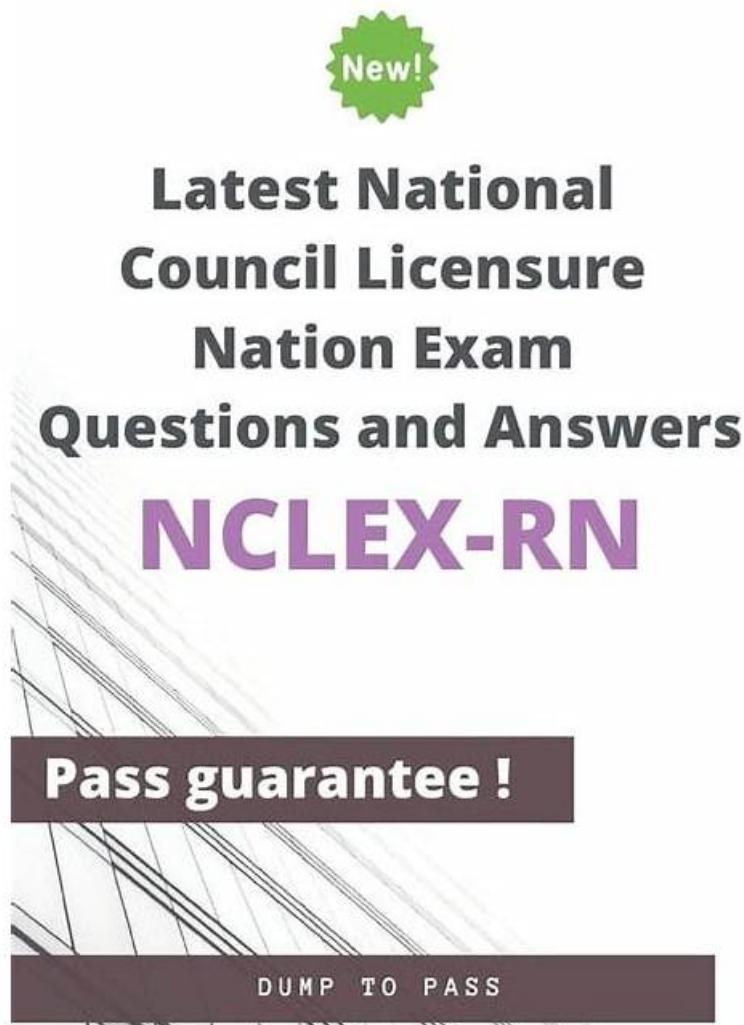


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NCLEX-RN is a standardized exam that is used to determine if a nurse is ready to begin practicing as a registered nurse (RN) in the United States. NCLEX-RN Exam is developed and administered by the National Council of State Boards of Nursing (NCSBN) and is designed to assess a nurse's knowledge, skills, and abilities in relation to the safe and effective delivery of patient care.

NCLEX National Council Licensure Examination(NCLEX-RN) Sample Questions (Q16-Q21):

NEW QUESTION # 16

A 4 year old has an imaginary playmate, which concerns the mother. The nurse's best response would be:

- A. "Try not to worry because you will just upset your child."
- B. "Just ignore the behavior and it should disappear by age 8."
- C. "I understand your concern and will assist you with a referral."
- D. "This is appropriate behavior for a preschooler and should not be a concern."

Answer: D

Explanation:

(A) This is normal for a preschooler, and a referral is not appropriate. (B) Telling a parent not to worry is unhelpful. This response does not address the mother's concern. (C) This response is incorrect. The behavior is normal and will usually disappear by the time the child enters school. (D) This behavior is normal development for a preschooler.

NEW QUESTION # 17

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

Answer: D

Explanation:

Explanation

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

0.4 mg = 1 mL
0.15 mg = 5 mL

0.4 x = 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 # 18

The nurse who is caring for a client with pneumonia assesses that the client has become increasingly irritable and restless. The nurse realizes that this is a result of:

- A. Prolonged bed rest
- B. **Cerebral hypoxia**
- C. IV fluids of 2.5-3 liters in 24 hours
- D. The client's maintaining a semi-Fowler position

Answer: B

Explanation:

Explanation

(A) Maintaining bed rest helps to decrease the O₂ needs of the tissues, which decreases dyspnea and workload on the respiratory system. (B) The semi-Fowler or high-Fowler position is necessary to aid in lessening pressure on the diaphragm from the abdominal organs, which facilitates comfort and easier breathing patterns.

(C) Cerebral hypoxia causes the client with pneumonia to be increasingly irritable and restless and results from the client not obtaining enough O₂ to meet metabolic needs. (D) Proper hydration facilitates liquefaction of mucus trapped in the bronchioles and alveoli and enhances expectoration. Unless contraindicated, a reasonable amount of IV fluids to be administered is at least 2.5-3 liters in a 24-hour period.

NEW QUESTION # 19

The nurse recognizes that a client with the diagnosis of cholecystitis and cholelithiasis would expect to have stools that are:

- A. Black
- B. Bright-red streaked
- C. Clay or gray colored
- D. Watery and loose

Answer: C

Explanation:

(A) Clients who have obstruction in the biliary tract so that bile is not released into the duodenum experience a change in stools from brown to gray or clay colored. (B) This type of stool can occur with other GI problems, such as bacterial or viral infections, and other disease problems, and is not a common finding with biliary obstructions such as cholecystitis and cholelithiasis. (C) This type of stool is usually associated with a GI or bowel problem, such as lower GI bleeding, rather than with biliary obstructions. (D) This type of stool is usually associated with a GI or bowel problem, such as upper GI bleeding, rather than with biliary obstructions.

NEW QUESTION # 20

A family is experiencing changes in their lifestyle in many ways. The invalid grandmother has moved in with them. The couple have a 2-year-old son by their marriage, and the wife has two children by her previous marriage. The older children are in high school. In applying systems theory to this family, it is important for the nurse to remember which of the following principles?

- A. The parts of a system are only minimally related.
- B. Healthy families are enmeshed.
- C. Dysfunction in one part affects every other part.
- D. A family system has no boundaries.

Answer: C

Explanation:

Explanation/Reference:

Explanation:

(A) The parts of a system are interrelated. (B) Any change in any part of the system affects all other parts.

(C) A family system, like any other system, has boundaries. (D) Healthy families are neither enmeshed nor disengaged.

NEW QUESTION # 21

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