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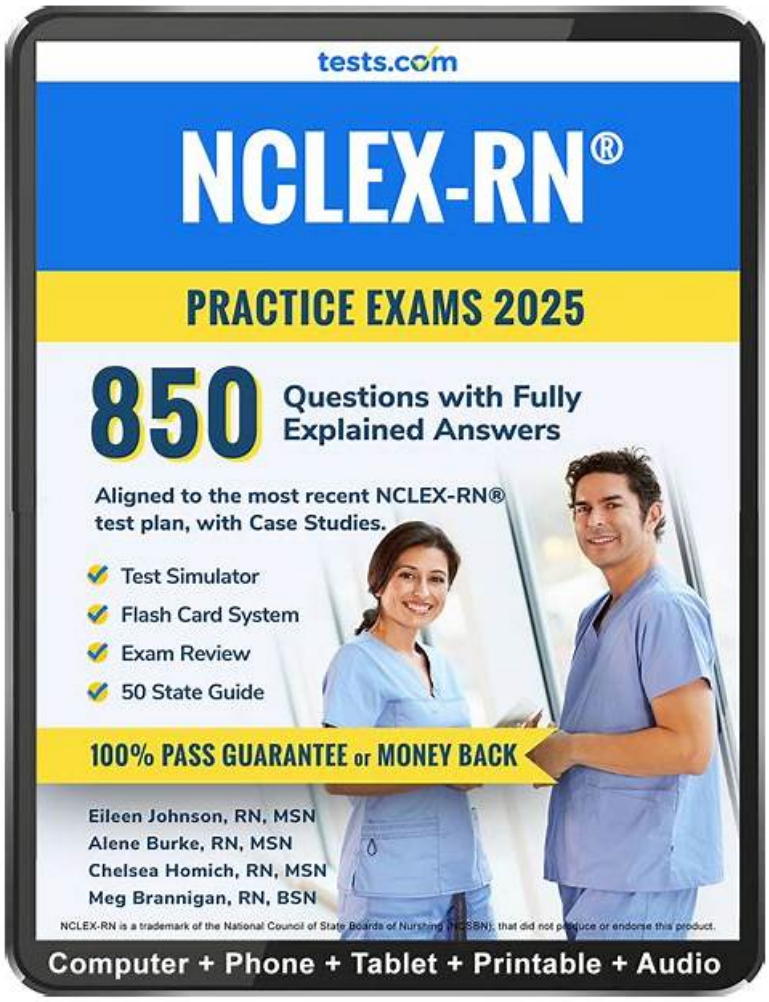

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NCLEX National Council Licensure Examination(NCLEX-RN) Sample Questions (Q203-Q208):

NEW QUESTION # 203
An 8-week-old infant has been diagnosed with gastroesophageal reflux. The nurse is teaching the infant's mother to care for the infant at home. Which one of the following statements by the nurse is appropriate regarding the infant's home care?

- A. "Antacids need to be given an hour before feeding."
- B. "Play activities should be carried out before instead of after feedings."
- C. "Lay the infant flat on her left side after feeding."
- D. "Feed the infant every 4 hours with half-strength formula."

Answer: B

Explanation:
Explanation
(A) Elevating the child's head to a 30-degree angle is the recommended position for gastroesophageal reflux.
The supine position predisposes the child to aspiration. (B) Small, frequent feedings with thickened formula are recommended to minimize vomiting. (C) Antacids should be given at the same time as the feeding to improve their buffering action. (D) The infant should be kept still after feedings to reduce the risk of vomiting and aspiration. Vigorous activities should be carried out before feedings.

NEW QUESTION # 204
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. The client's maintaining a semi-Fowler position
- B. Cerebral hypoxia
- C. IV fluids of 2.5-3 liters in 24 hours
- D. Prolonged bed rest

Answer: B

Explanation:
Section: Questions Set D
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 # 205
A 26-year-old female client presents at 10 weeks' gestation. She currently is a G3 1-0-1-1. Her mother and grandmother have heart disease. Her grandmother also has insulin-dependent diabetes. The client's previous delivery was a term female infant weighing 9 lb 13 oz. The client is 5 ft 6 inches tall and her current weight is
130 lb. Based on her history, she is at risk for developing diabetes in pregnancy. Which of the following factors places her at risk for gestational diabetes?

- A. Age>25 years

- B. Family history of heart disease
- C. Maternal weight
- D. Previous birth of an infant weighing>9 lb

Answer: D

Explanation:
Explanation
(A) Maternal age older than 30 years is an identified risk factor for diabetes. Age younger than 30 years is insignificant for diabetes unless there is a familial history of diabetes. (B) The client's weight is appropriate for her height. Obesity or pregnancy weight >20% of the ideal weight is a contributing factor to the development of gestational diabetes. (C) The birth of an infant weighing >9 lb (4000 g) is an identified risk factor for gestational diabetes. (D) A familial history of heart disease is insignificant in the development of diabetes. However, a familial history of type II diabetes mellitus is identified as a risk factor in the development of diabetes during pregnancy.

NEW QUESTION # 206
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. Assess vital signs
- B. Perform a lower extremity neurovascular check
- C. Elevate the extremity
- D. Remind the client that he has a client-controlled analgesic pump, and reinstruct him on its use

Answer: B

Explanation:
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 # 207
Three weeks following discharge, a male client is readmitted to the psychiatric unit for depression. His wife stated that he had threatened to kill himself with a handgun. As the nurse admits him to the unit, he says, "I wish I were dead because I am worthless to everyone; I guess I am just no good." Which response by the nurse is most appropriate at this time?

- A. "I don't think you are worthless. I'm glad to see you, and we will help you."
- B. "I know with your wife and new baby that you do have a lot to live for."
- C. "Don't you think this is a sign of your illness?"
- D. "You've been feeling sad and alone for some time now?"

Answer: D

Explanation:
Explanation/Reference:
Explanation:
(A) This response does not acknowledge the client's feelings.
(B) This is a closed question and does not encourage communication.
(C) This response negates the client's feelings and does not require a response from the client. (D) This acknowledges the client's implied thoughts and feelings and encourages a response.

NEW QUESTION # 208
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