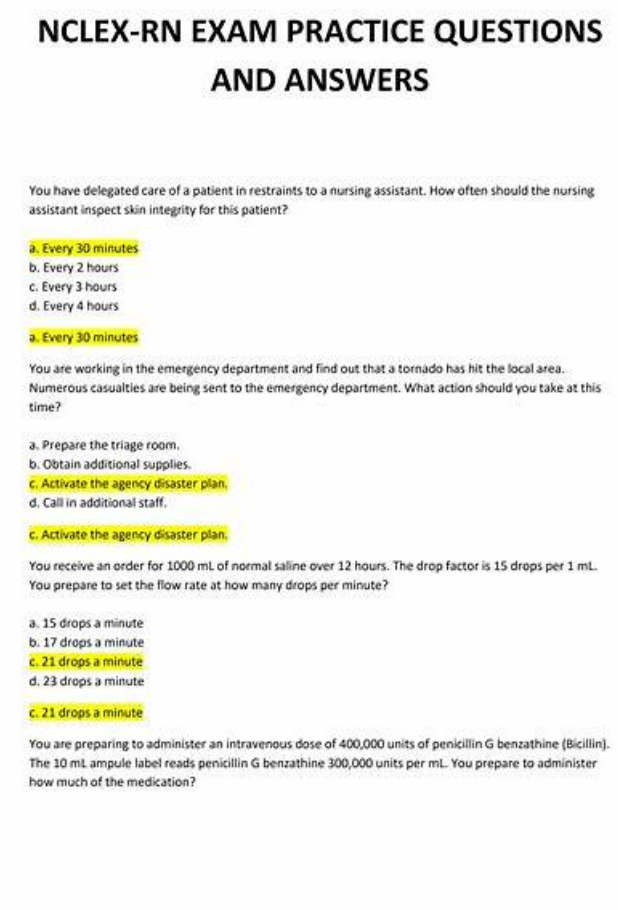
# Valid NCLEX-RN Exam Question & Study Materials NCLEX-RN Review



NCLEX-RN EXAM PRACTICE QUESTIONS AND ANSWERS

You have delegated care of a patient in restraints to a nursing assistant. How often should the nursing assistant inspect skin integrity for this patient?

a. Every 30 minutes
b. Every 2 hours
c. Every 3 hours
d. Every 4 hours

a. Every 30 minutes

You are working in the emergency department and find out that a tornado has hit the local area. Numerous casualties are being sent to the emergency department. What action should you take at this time?

a. Prepare the triage room.
b. Obtain additional supplies.
c. Activate the agency disaster plan.
d. Call in additional staff.

c. Activate the agency disaster plan.

You receive an order for 1000 mL of normal saline over 12 hours. The drop factor is 15 drops per 1 mL. You prepare to set the flow rate at how many drops per minute?

a. 15 drops a minute
b. 17 drops a minute
c. 21 drops a minute
d. 23 drops a minute

c. 21 drops a minute

You are preparing to administer an intravenous dose of 400,000 units of penicillin G benzathine (Bicillin). The 10 mL ampule label reads penicillin G benzathine 300,000 units per mL. You prepare to administer how much of the medication?

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The National Council Licensure Examination (NCLEX-RN) is a standardized test that assesses the competency of registered nurses (RNs) in the United States of America. NCLEX-RN Exam is developed and administered by the National Council of State Boards of Nursing (NCSBN). It is designed to evaluate the knowledge, skills, and abilities of entry-level RNs to ensure they are competent and safe to practice nursing.

**>> Valid NCLEX-RN Exam Question <<**

## Study Materials NCLEX-RN Review & NCLEX-RN Exam Topics Pdf

The NCLEX-RN certification is the best proof of your ability. However, it's not easy for those work officers who has less free time to prepare such an NCLEX-RN exam, and people always feel fear of the unknown thing and cannot handle themselves with a sudden change. However, our NCLEX-RN Exam Questions can stand by your side. And we are determined to devote ourselves to serving you with the superior NCLEX-RN study materials. You can have a try on the free demo of our NCLEX-RN exam questions, you can understand in detail and make a choice.

NCLEX-RN exam consists of four categories: safe and effective care environment, health promotion and maintenance, psychosocial integrity, and physiological integrity. These categories are broken down into subcategories that cover a range of topics related to nursing practice, including patient care, pharmacology, health assessment, and nursing ethics. NCLEX-RN Exam is computerized and adaptive, meaning that the difficulty of the questions will vary depending on the test-taker's performance. Passing the NCLEX-RN exam is a crucial step for individuals looking to become registered nurses and enter the workforce.

## NCLEX National Council Licensure Examination(NCLEX-RN) Sample Questions (Q440-Q445):

**NEW QUESTION # 440**
A 70-year-old client is almost finished receiving her second unit of packed red blood cells. The client, who weighs 80 lb, has started complaining of being short of breath and now has crackles in the bases of her lungs.
After slowing or stopping the transfusion, the most appropriate initial nursing action would be to:

- A. Notify the physician
- B. Raise the client's head and place her feet in a dependent position
- C. Place the client on 2 liters of O2 via nasal cannula
- D. Administer furosemide (Lasix) 20 mg IV push

**Answer: B**

Explanation:
Section: Questions Set C
Explanation:
(A) Raising the client's head and placing her feet in a dependent position is an independent nursing action that can be taken to decrease venous return and to reduce pulmonary congestion. (B) Notifying the physician is an appropriate action that should be taken after the client is positioned to maximize her respiratory status. (C) Placing the client on O2may be done with a physician's order or according to an institution's standing orders; however, other actions should be taken first. (D) Furosemide 20 mg IV push is an appropriate medication for the client, but it must be ordered by her physician.

**NEW QUESTION # 441**
A postoperative prostatectomy client is preparing for discharge from the hospital the next morning. The nurse realizes that additional instructions are necessary when he states:

- A. "The isometric exercises will help to strengthen my perineal muscles and help me control my urine."
- B. "If I feel as though I have developed a fever, I will take a rectal temperature, which is the most accurate."
- C. "If I drink 10 to 12 glasses of fluids each day, that will help to prevent any clot formation in my urine."
- D. "I do not plan to do any heavy lifting until I visit my doctor again."

**Answer: B**

Explanation:
Explanation/Reference:
Explanation:
(A) This is correct health teaching. Drinking 10-12 glasses of clear liquid will help increase urine volumes and prevent clot formation. (B) This is correct health teaching. These types of exercises are prescribed by physicians to assist postprostatectomy clients to strengthen their perineal muscles. (C) This action is not recommended post-TURP because of the close proximity of the prostate and rectum. (D) This is correct healthcare teaching. The client should limit walking long distances, lifting heavy objects, or driving a car until these activities are cleared by the physician at the first office visit.

**NEW QUESTION # 442**
A client has chronic obstructive pulmonary disease. She is slowly losing weight, and her daughter is very concerned about increasing her nutrition. The nurse helps the daughter devise a plan of care for her mother. The plan of care should include which of the following interventions to promote nutrition?

- A. Offer her oral hygiene before and after meals.
- B. Encourage her to consume milk products.
- C. Restrict her fluid intake to three glasses of water a day.

- D. Encourage her to engage in an activity before a meal to stimulate her appetite.

**Answer: A**

Explanation:
(A) Clients with respiratory diseases are generally mouth breathers. Cleaning the oral cavity may improve the client's appetite, increase her feelings of well-being, and remove the taste and odor of sputum. (B) Milk causes thick sputum; therefore, milk products would not be beneficial for this client. (C) Exercise prior to a meal would require increased O2 consumption and most likely would decrease the client's ability to eat. (D) Clients with respiratory diseases need increased fluid to liquefy secretions.

**NEW QUESTION # 443**
In a client with chest trauma, the nurse needs to evaluate mediastinal position. This can best be done by:

- A. Auscultating heart sounds
- B. Palpating for presence of crepitus
- C. Auscultating bilateral breath sounds
- D. Palpating for trachial deviation

**Answer: D**

Explanation:
(A) No change in the breath sounds occurs as a direct result of the mediastinal shift. (B) Crepitus can occur owing to the primary disorder, not to the mediastinal shift. (C) Mediastinal shift occurs primarily with tension pneumothorax, but it can occur with very large hemothorax or pneumothorax. Mediastinal shift causes trachial deviation and deviation of the heart's point of maximum impulse. (D) No change in the heart sounds occurs as a result of the mediastinal shift.

**NEW QUESTION # 444**
A 5-year-old has just had a tonsillectomy and adenoidectomy. Which of these nursing measures should be included in the postoperative care?

- A. Give warm clear liquids when fully alert.
- B. Encourage the child to cough up blood if present.
- C. Have child gargle and do toothbrushing to remove old blood.
- D. Observe for evidence of bleeding.

**Answer: D**

Explanation:
Explanation
(A) The nurse should discourage the child from coughing, clearing the throat, or putting objects in his mouth.
These may induce bleeding. (B) Cool, clear liquids may be given when child is fully alert. Warm liquids may dislodge a blood clot.
The nurse should avoid red- or brown-colored liquids to distinguish fresh or old blood from ingested liquid should the child vomit.
(C) Gargles and vigorous toothbrushing could initiate bleeding.
(D) Postoperative hemorrhage, though unusual, may occur. The nurse should observe for bleeding by looking directly into the throat and for vomiting of bright red blood, continuous swallowing, and changes in vital signs.

**NEW QUESTION # 445**
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