

# Accurate NCLEX-RN Test & NCLEX-RN Exam Material

## NCLEX RN TEST 1 EXAM UPDATED 2025/2026 | 180 VERIFIED QUESTIONS AND ACCURATE ANSWERS – GUARANTEED SUCCESS

1. The nurse is assessing a client who had a colon resection 2 days ago. The client states, 'I feel like my stitches have burst loose.' Upon further assessment, dehiscence of the wound is noted. What should the nurse do?
  - Wrap the abdomen with an ACE bandage
  - Place the client in the prone position
  - Administer atropine to decrease abdominal secretions
  - Apply a sterile, saline-moistened dressing to the wound**
2. If a client with a C4 spinal cord injury develops signs of infection at the pin sites, what should the nurse prioritize in their care plan?
  - Administering pain medication for headaches.
  - Implementing strict aseptic technique during pin care.**
  - Elevating the head of the bed to 90°.
  - Increasing the frequency of traction release.
3. Describe the significance of measuring pulmonary artery pressure in a clinical setting.
  - It is used to evaluate blood glucose levels.
  - Measuring pulmonary artery pressure helps assess the hemodynamic status of the heart and lungs.**

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Consider sitting for an National Council Licensure Examination(NCLEX-RN) exam and discovering that the practice materials you've been using are incorrect and useless. The technical staff at ActualCollection has gone through the NCLEX certification process and knows the need to be realistic and exact. Hundreds of professionals worldwide examine and test every NCLEX NCLEX-RN Practice Exam regularly. These practice tools are developed by professionals who work in fields impacting NCLEX National Council Licensure Examination(NCLEX-RN), giving them a foundation of knowledge and actual competence.

NCLEX-RN, or National Council Licensure Examination for Registered Nurses, is a standardized exam that all nursing graduates must pass in order to become licensed and practice as a registered nurse in the United States. NCLEX-RN exam is administered by the National Council of State Boards of Nursing (NCSBN) and is designed to test the knowledge, skills, and abilities necessary for safe and effective nursing practice. It is a computerized adaptive test (CAT), meaning that the difficulty of the questions adapts to the test-taker's level of knowledge and ability, and it can take anywhere from 75 to 265 questions to complete.

NCLEX-RN (National Council Licensure Examination for Registered Nurses) is a standardized exam that is used to determine whether a nurse is qualified to practice as a registered nurse. It is administered by the National Council of State Boards of Nursing and is required in all 50 states in the United States. NCLEX-RN Exam is designed to test the knowledge, skills, and abilities necessary for safe and effective nursing practice.

NCLEX-RN exam is computer-adaptive, meaning that the difficulty of the questions adapts to the test-taker's performance. NCLEX-RN exam consists of a minimum of 75 questions and a maximum of 265 questions, with the number of questions varying

depending on the test-taker's performance. NCLEX-RN exam covers a wide range of topics, including pharmacology, patient care, nursing ethics, and health promotion.

>> Accurate NCLEX-RN Test <<

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### NCLEX National Council Licensure Examination(NCLEX-RN) Sample Questions (Q817-Q822):

#### NEW QUESTION # 817

A 6-month-old infant has developmental delays. His weight falls below the 5th percentile when plotted on a growth chart. A diagnosis of failure to thrive is made. What behaviors might indicate the possibility of maternal deprivation?

- A. Finicky eater, easily pacified, cuddly
- B. Responsive to touch, wants to be held
- C. Maintains eye-to-eye contact
- D. Uncomforted by touch, refuses bottle

**Answer: D**

Explanation:

Explanation

(A) Normal infant attachment behaviors include responding to touch and wanting to be held. (B) Maternal deprivation behaviors include poor feeding, stiffening and refusal to eat, and inconsistencies in responsiveness.

(C) Attachment behavior includes maintaining eye contact. (D) Maternal deprivation behaviors include displeasure with touch and physical contact.

#### NEW QUESTION # 818

A 40-year-old client has been admitted to the hospital with severe substernal chest pain radiating down his left arm. The nurse caring for the client establishes the following priority nursing diagnosis - Alteration in comfort, pain related to:

- A. Increased excretion of lactic acid due to myocardial hypoxia
- B. Increased blood flow through the coronary arteries
- C. Decreased stimulation of the sympathetic nervous system
- D. Decreased secretion of catecholamines secondary to anxiety

**Answer: A**

Explanation:

Section: Questions Set G

Explanation:

(A) Anaerobic metabolism results because the decreased blood supply to the myocardium causes a release of lactic acid. Lactic acid is an irritant to the myocardial neural receptors, producing chest pain. (B) Chest pain is caused by a decrease in the O<sub>2</sub> supply to the myocardial cells. Treatment modalities for chest pain are aimed toward increasing the blood flow through coronary arteries.

(C) Chest pain causes an increase in the stimulation of the sympathetic nervous system. This stimulation increases the heart rate and blood pressure, causing an increase in myocardial workload aggravating the chest pain. (D) Chest pain and anxiety cause increased secretion of catecholamines by stimulating the sympathetic nervous system. This stimulation increases chest pain by increasing the workload of the heart.

#### NEW QUESTION # 819

The nurse is teaching a 10-year-old insulin-dependent diabetic how to administer insulin. Which one of the following steps must be

taught for insulin administration?

- A. Pinch the skin up to form a subcutaneous pocket.
- B. Never use abdominal site for a rotation site.
- C. Avoid applying pressure after injection.
- D. Change needles after injection.

**Answer: A**

Explanation:

Explanation

(A) Sites for injection need to be rotated, including abdominal sites, to enhance insulin absorption. (B) The pinch technique is the most effective method for obtaining skin tightness to allow easy entrance of the needle to subcutaneous tissues. (C) Massaging the site of injection facilitates absorption of the insulin. (D) Changing the needle will break the sterility of the system. It has become acceptable practice to reuse disposable needles and syringes for 3-7 days.

#### NEW QUESTION # 820

A client experiencing delusions states, "I came here because there were people surrounding my house that wanted to take me away and use my body for science." The best response by the nurse would be:

- A. "I need more information on why you think others want to use your body for science."
- B. "I know that must be frightening for you; let the staff know when you are having thoughts that trouble you."
- C. "There were no people surrounding your house, your relatives brought you here, and no one really wants your body for science."
- D. "Describe the people surrounding your house that want to take you away."

**Answer: B**

Explanation:

Explanation

(A) Focusing on the delusional content does not reinforce reality. (B) Pursuing details or more information on the delusion reinforces the false belief and further distances the client from reality. (C) Challenging the client's delusional system may force the client to defend it, and you cannot change the delusion through logic. (D) Focusing on the feeling can reinforce reality and discourage the false belief. Seeking out staff when thoughts are troublesome can help to decrease anxiety.

#### NEW QUESTION # 821

When assessing fetal heart rate status during labor, the monitor displays late decelerations with tachycardia and decreasing variability. What action should the nurse take?

- A. Continue monitoring because this is a normal occurrence.
- B. Decrease IV fluids.
- C. Report to physician or midwife.
- D. Turn client on right side.

**Answer: C**

Explanation:

(A) This is not a normal occurrence. Late decelerations need prompt intervention for immediate infant recovery. (B) To increase O<sub>2</sub> perfusion to the unborn infant, the mother should be placed on her left side. (C) IV fluids should be increased, not decreased. (D) Immediate action is warranted, such as reporting findings, turning mother on left side, administering O<sub>2</sub>, discontinuing oxytocin (Pitocin), assessing maternal blood pressure and the labor process, preparing for immediate cesarean delivery, and explaining plan of action to client.

#### NEW QUESTION # 822

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