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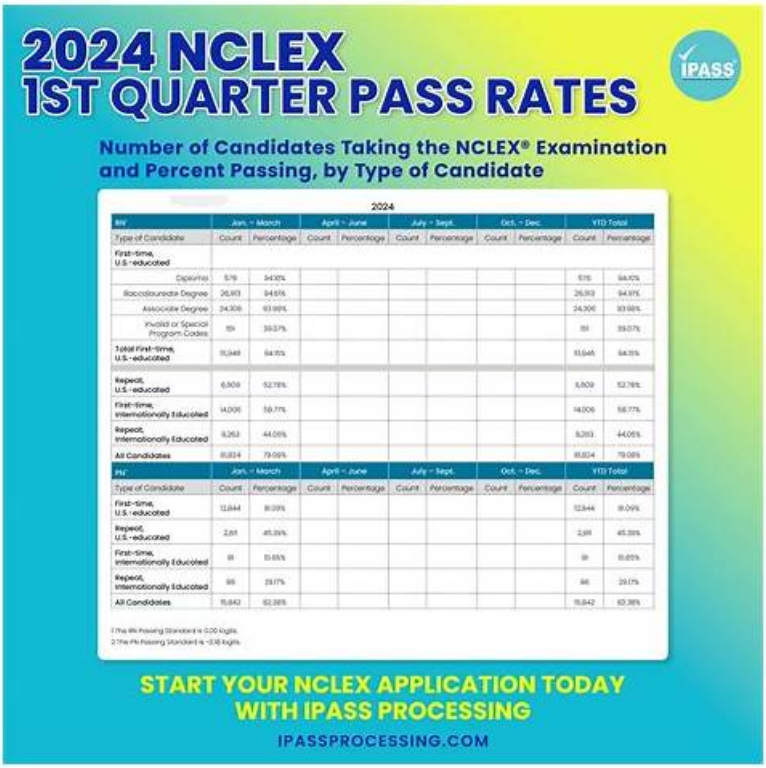

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NCLEX-RN exam is a high-stakes exam that requires significant preparation. Many nursing programs offer NCLEX-RN review courses and study materials to help students prepare for the exam. Some students also choose to use third-party study materials, such as review books, flashcards, or online courses. It is important to note that while preparation is crucial, the exam is designed to test the skills and knowledge acquired through nursing education, so a solid foundation in nursing theory and practice is essential.

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NCLEX National Council Licensure Examination(NCLEX-RN) Sample Questions (Q309-Q314):

NEW QUESTION # 309
Nursing care for the parents of a child with a congenital heart defect would include:

- A. Identifying anger and resentment as destructive emotions that serve no purpose
- B. Acknowledging the fear and concern surrounding their child's health and assisting the parents through the grieving process as they mourn the loss of their fantasized healthy child
- C. Expressing to the parents after the corrective surgery has been completed successfully that all their grief feelings will resolve
- D. Encouraging the parents not to tell the child about the seriousness of the congenital heart defect, so the child will function as normally as possible

Answer: B

Explanation:
(A) It is important to discuss with parents the need to treat the child as they would any other children, but they must be truthful and honest with the child about the heart defect. As the child grows older, explanations can go into greater depth. (B) Parents of children with congenital heart defects go through a grieving process over the loss of their "healthy" child. The nurse needs to recognize these feelings and give the parents a role in the child's care when they are ready. (C) Anger and resentment are normal feelings that must be dealt with appropriately. (D) Parents may go through a second grieving process after the repair of the cardiac defect. During this grieving period, they mourn the loss of the "defective" child who now may be essentially "normal."

NEW QUESTION # 310
A 20-year-old female client delivers a stillborn infant. Following the delivery, an appropriate response by the labor nurse to the question, "Why did this happen to my baby?" is:

- A. "It's God's will. It was probably for the best. There was something probably wrong with your baby."
- B. "I know your other children will be a great comfort to you."
- C. "I can see you're upset. Would you like to see and hold your baby?"
- D. "You're young. You can have other children later."

Answer: C

Explanation:
Section: Questions Set F
Explanation:
(A) The mother and the father require support; the nurse should not minimize their grief in this situation. (B) Attachment to this infant occurs during the pregnancy for both the mother and father. Another child cannot replace this child. (C) Attachment to this infant occurs during the pregnancy for both the mother and father.
Siblings will not replace their feelings or minimize their loss of this infant. (D) Holding and viewing the infant decreases denial and may facilitate the grief process. The nurse should prepare family members for how the infant appears ("she is bruised") and provide support.

NEW QUESTION # 311
A 14-year-old boy has had diabetes for 7 years. He takes 30 U of NPH insulin and 10 U of regular insulin every morning at 7 AM. He eats breakfast at 7:30 AM and lunch at noon. What time should he expect the greatest risk for hypoglycemia?

- A. 3 PM
- B. 11 AM
- C. 1 PM
- D. 9 AM

Answer: B

Explanation:
Explanation/Reference:
Explanation:
(A) This time is incorrect because regular insulin would peak after the teenager has eaten breakfast. (B) This time is incorrect because it is after lunch when the NPH peaks. (C) Regular insulin peaks in 2-3 hours and has a duration of 4-6 hours. NPH insulin's onset is 4-6 hours and peaks in 8-16 hours. Blood sugar would peak after meals and be lowest before meals and during the night. (D) This time is incorrect because it is before the NPH and after the regular insulin peak times.

NEW QUESTION # 312
A client presents to the psychiatric unit crying hysterically. She is diagnosed with severe anxiety disorder.
The first nursing action is to:

- A. Ask what is the problem
- B. Demand that she relax
- C. Give her something to do
- D. Stand or sit next to her

Answer: D

Explanation:
Explanation/Reference:
Explanation:
(A) This nursing action is too controlling and authoritative. It could increase the client's anxiety level. (B) In her anxiety state, the client cannot rationally identify a problem. (C) This nursing action conveys a message of caring and security. (D) Giving the client a task would increase her anxiety. This would be a late nursing action.

NEW QUESTION # 313
Which nursing implication is appropriate for a client undergoing a paracentesis?

- A. Have the client void before the procedure.
- B. Observe the client for hypertension following the procedure.
- C. Place the client on the right side following the procedure.
- D. Keep the client NPO.

Answer: A

Explanation:
Explanation/Reference:
Explanation:
(A) A full bladder would impede withdrawal of ascitic fluid. (B) Keeping the client NPO is not necessary. (C) The client may exhibit signs and symptoms of shock and hypertension. (D) No position change is needed after the procedure.

NEW QUESTION # 314
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