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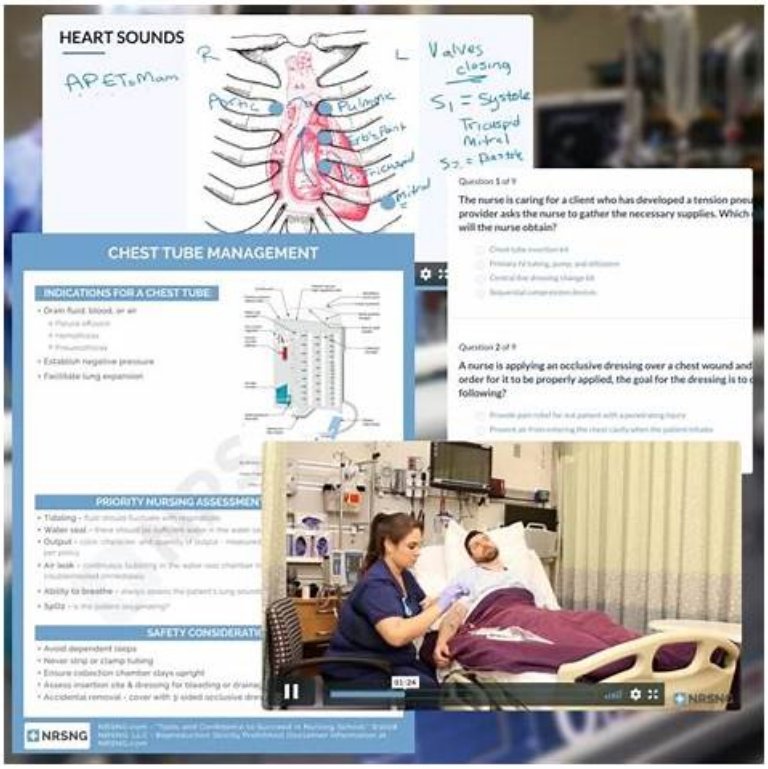

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NCLEX-RN (National Council Licensure Examination for Registered Nurses) is a standardized test that all registered nurses must pass to obtain their license to practice in the United States. NCLEX-RN exam is administered by the National Council of State Boards of Nursing (NCSBN), which is responsible for developing and maintaining the exam's content and format. Passing the NCLEX-RN is a critical step for nurses who wish to enter the workforce and begin practicing as registered nurses.

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NCLEX National Council Licensure Examination(NCLEX-RN) Sample Questions (Q571-Q576):

NEW QUESTION # 571

A client is to have a coronary artery bypass graft performed in the morning using a saphenous vein. He wants to know why the physician does not use the internal mammary artery for his bypass graft because his friend's physician uses this artery. The nurse tells the client that the internal mammary artery:

- A. Takes more time to remove
- B. Has too many valves
- C. Is smaller in diameter
- D. Has a greater risk of becoming reoccluded

Answer: A

Explanation:
Section: Questions Set D
Explanation:
(A) It does take more time to remove the internal mammary artery, and this is one reason why some physicians do not use it. (B) There is not a greater risk of reocclusion. In fact, it may actually stay patent longer. (C) The internal mammary artery is actually larger in diameter than the saphenous vein. (D) The internal mammary artery does not have too many valves.

NEW QUESTION # 572
A schizophrenic client who is experiencing thoughts of having special powers states that "I am a messenger from another planet and can rule the earth." The nurse assesses this behavior as:

- A. Ideas of reference
- B. Delusions of persecution
- C. Delusions of grandeur
- D. Thought broadcasting

Answer: C

Explanation:
Explanation/Reference:
Explanation:
(A) Clients experiencing ideas of reference believe that information from the environment (e.g., the television) is referring to them. (B) Clients experiencing delusions of persecution believe that others in the environment are plotting against them. (C) Clients experiencing thought broadcasting perceive that others can hear their thoughts. (D) Clients experiencing delusions of grandeur think that they are omnipotent and have superhuman powers.

NEW QUESTION # 573
On admission to the postpartal unit, the nurse's assessment identifies the client's fundus to be soft, 2 fingerbreadths above the umbilicus, and deviated to the right. This is most likely an indication of:

- A. An infection pain
- B. A full bladder
- C. A hemorrhage
- D. Normal involution

Answer: B

Explanation:
Explanation/Reference:
Explanation:
(A) Immediately after expulsion of the placenta, the fundus should be in the midline and remain firm. (B) A boggy displaced uterus in the immediate postpartum period is a sign of urinary distention. Because uterine ligaments are stretched, a full bladder can displace the uterus. (C) Symptoms of infection may include unusual uterine discomfort, temperature elevation, and foul-smelling lochia. The stem of this question does not address any of these factors. (D) While excessive bleeding is associated with a soft, boggy uterus, the stem of this question includes displacement of the uterus, which is more commonly associated with bladder distention.

NEW QUESTION # 574

A female client decides on hemodialysis. She has an internal vascular access device placed. To ensure patency of the device, the nurse must:

- A. Auscultate the site for a bruit
- B. Inspect the site for color, warmth, and sensation
- C. Assess the site for leakage of blood or fluids
- D. Assess the site for bruising or hematoma

Answer: A

Explanation:
(A) This is an internal device. Assessment of the site should include assessing for swelling, pain, warmth, and discoloration. This measure does not assess patency. (B) The presence of a bruit indicates good blood flow through the device. (C) The nurse should inspect the site for bruising or hematoma; however, this measure does not assure patency of the device. (D) The nurse should inspect the vascular access site frequently for signs of infection. However, this does not assure patency.

NEW QUESTION # 575
A client is diagnosed with organic brain disorder. The nursing care should include:

- A. Organized, safe environment
- B. Detailed explanations of procedures
- C. Long, extended family visits
- D. Challenging educational programs

Answer: A

Explanation:
(A) A priority nursing goal is attending to the client's safety and well-being. Reorient frequently, remove dangerous objects, and maintain consistent environment. (B) Short, frequent visits are recommended to avoid overstimulation and fatigue. (C) Short, concise, simple explanations are easier to understand. (D) Mental capability and attention span deficits make learning difficult and frustrating.

NEW QUESTION # 576
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