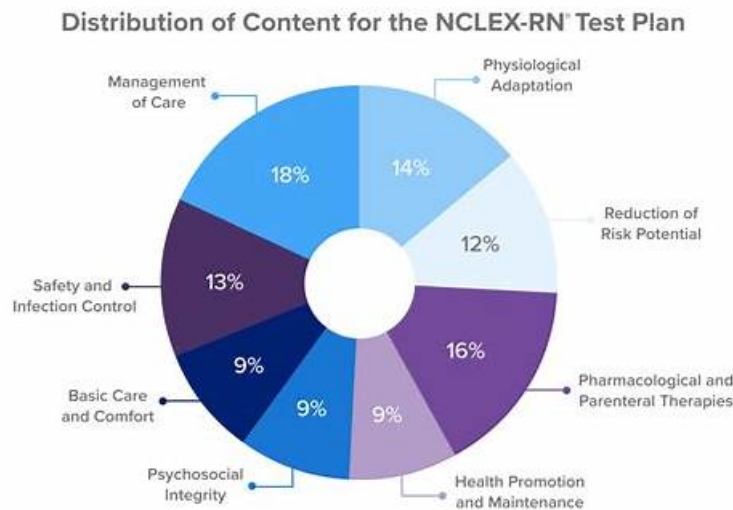


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The National Council Licensure Examination for Registered Nurses (NCLEX-RN) is a standardized exam used by state boards of nursing across the United States to assess the competency of registered nurses. NCLEX-RN Exam is designed to ensure that nurses possess the necessary knowledge and skills to provide safe and effective care to patients.

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NCLEX-RN, or National Council Licensure Examination for Registered Nurses, is a standardized test that must be passed in order for a nurse to obtain a license to practice in the United States. NCLEX-RN exam is designed to evaluate the knowledge, skills, and abilities of entry-level registered nurses to ensure that they are prepared to provide safe and effective care to patients.

NCLEX-RN exam consists of four categories: Safe and Effective Care Environment, Health Promotion and Maintenance, Psychosocial Integrity, and Physiological Integrity. Each category is further divided into subcategories, covering a broad range of nursing knowledge and skills. NCLEX-RN Exam is typically administered in a multiple-choice format, although some questions may require a different type of response.

NCLEX National Council Licensure Examination (NCLEX-RN) Sample Questions (Q761-Q766):

NEW QUESTION # 761

A client's record from the ED indicates that she overdosed on phenelzine sulfate (Nardil), a monoamine oxidase (MAO) inhibitor.

Which diet would be the most appropriate at this time?

- A. 1 g sodium
- **B. Tyramine-free**
- C. High protein, high carbohydrate
- D. High carbohydrate, low cholesterol

Answer: B

Explanation:

Explanation

(A) There are no data to support the need for increased carbohydrates or decreased cholesterol in the diet. (B) There is no data to support the need for increased protein or increased carbohydrates in the diet. (C) There is no assessment or laboratory data indicating that sodium should be restricted in the diet. (D) Tyramine is an amino acid activated by MAO in the liver and intestinal wall. It is released as proteins are hydrolyzed through aging, pickling, smoking, or spoilage of foods. When MAO is inhibited, tyramine levels rise, stimulating the adrenergic system to release large amounts of norepinephrine, which can produce a hypertensive crisis.

NEW QUESTION # 762

A nasogastric (NG) tube inserted preoperatively is attached to low, intermittent suction. A client with an NG tube exhibits these symptoms: He is restless; serum electrolytes are Na 138, K 4.0, blood pH 7.53. This client is most likely experiencing:

- A. Metabolic acidosis
- **B. Metabolic alkalosis**
- C. Hyponatremia
- D. Hyperkalemia

Answer: B

Explanation:

(A) Sodium level is within normal limits. (B) Sodium level is within normal limits. (C) pH level is consistent with alkalosis. (D) With an NG tube attached to low, intermittent suction, acids are removed and a client will develop metabolic alkalosis.

NEW QUESTION # 763

A term neonate has experienced no distress at birth and has an Apgar score of 9. Her mother has asked to breastfeed her following delivery. Immediately after birth, the neonate was most susceptible to heat loss. The most appropriate intervention to conserve heat loss and promote bonding is to:

- A. Dry her with blankets
- **B. Place her to her mother's breast**
- C. Place her under the radiant warmer
- D. Place her on a heated pad

Answer: B

Explanation:

Section: Questions Set E

Explanation:

(A) A radiant warmer maintains an optimal thermal environment by use of a thermal skin sensor taped to the infant. The warmer limits parental attachment, so, although appropriate, it is not an intervention that promotes infant attachment. (B) Warmed blankets prevent heat loss in the neonate by conduction. In addition, tactile stimuli promote crying and lung expansion. This intervention does not promote attachment, however. (C) Skin-to-skin contact is an effective way to conserve heat after delivery and promotes parental attachment following birth in the healthy term infant. The first period of reactivity lasts approximately 30 minutes following birth. A strong sucking reflex and an active, awake newborn characterize this period. (D) Surfaces of objects warmer than the infant promote overheating by conduction, and neonatal hyperthermia may result.

NEW QUESTION # 764

A 16-year-old client comes to the prenatal clinic for her monthly appointment. She has gained 14 lb from her

7th to 8th month; her face and hands indicate edema. She is diagnosed as having PIH and referred to the high- risk prenatal clinic. The client's weight increase is most likely due to:

- A. Overeating and subsequent obesity
- B. Hypertension due to kidney lesions
- C. Fluid retention
- D. Obesity prior to conception

Answer: C

Explanation:

Section: Questions Set B

Explanation

Explanation:

(A) Overeating can lead to obesity, but not to edema. (B) There is no indication of obesity prior to pregnancy.

PIH is more prevalent in the underweight than in the obese in this age group. (C) Hypertension can be due to kidney lesions, but it would have been apparent earlier in the pregnancy. (D) The weight gain in PIH is due to the retention of sodium ions and fluid and is one of the three cardinal symptoms of PIH.

NEW QUESTION # 765

A 45-year-old male client was admitted to a chemical dependency treatment center following legal problems related to alcohol abuse. He states, "I know that alcohol is a problem for some people, but I can stop whenever I want to. I'm never sick or miss work, and no one can complain about me." During the initial assessment, the best response by the nurse would be:

- A. "It's good that you can stop drinking when you want to."
- B. "I understand it took strength to admit yourself to the unit, and I will do my part to help you to stay alcohol- free."
- C. "The fact is you are an alcoholic or you wouldn't be here."
- D. "If you can stop drinking when you want to, why don't you stop?"

Answer: B

Explanation:

Explanation/Reference:

Explanation:

(A) Direct confrontation initially is nontherapeutic and may result in the client becoming frustrated and wanting to leave. (B) A positive, supportive attitude builds trust, and identifying positive strength raises self- esteem. Offering help allows the client to feel that he is not alone in dealing with problems. (C) Asking the client why or to give an explanation for his behavior puts him in a position of having to justify his behavior to the nurse. (D) Giving approval or placing a value on feelings or a behavior may limit the client's freedom to behave in a way that may displease another. This response may lead to seeking praise instead of progress.

NEW QUESTION # 766

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