

NCLEX-RN Labs & NCLEX-RN Test Questions

NCLEX HACK LAB VALUES		
Hemoglobin: Puberty M: 13-18 F: 12-16	WBC: Kids aged 4-11 always get sick. 4-11 K	RBC: The word blood is 5 letters, between 4 and 6. 4-6
Cholesterol: Dangerous for a car to go over 200 mph <200	Creatinine: He is a creatinine creature and I rate him 0.5-1.5 0.5-1.5	BUN: If a person has a nice BUN, they are a perfect 10. 10-20
PT: Pre-Teens are 10-12 yrs old. 10-12	aPTT: "A Proper Teaching Time" aka age of your teachers. 30-40	INR: The I in INR looks like a 1 so <1.2. <1.2
Platelets: Fancy Dinnerware Plates costs \$150-400. 150-400K	Potassium: # bananas you buy at the store. 3.5-5	Calcium: Call 9-11. 9-11

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NCLEX National Council Licensure Examination(NCLEX-RN) Sample Questions (Q173-Q178):

NEW QUESTION # 173

An infant weighing 15 lb has just been treated for severe diarrhea in the hospital. Discharge instructions by the nurse will include maintenance fluid requirements for the pediatric client. Which of the following values best indicates the nurse's understanding of normal fluid requirements for this infant?

- A. 680 mL/day
- B. 960 mL/day
- C. 330 mL/day
- D. 240 mL/day

Answer: A

Explanation:

(A, C, D) These answers are incorrect. (B) Normal fluid requirement for this pediatric client is based on the fact that 0-10 kg of weight equals 100 mL/kg per day. This infant weighs 15 pounds (6.8 kg). Thus, $100 \text{ mL} \times 6.8 = 680 \text{ mL/day}$.

NEW QUESTION # 174

A client diagnosed with severe anemia is to receive 2 U of packed red blood cells. Prior to starting the blood transfusion, the nurse must:

- A. Have the registered nurse in charge assume responsibility for verifying the client and blood product information
- B. Hang Ringer's lactate as the companion fluid
- C. Take a baseline set of vital signs
- D. Use microdrip tubing for the blood administration

Answer: C

Explanation:

Explanation/Reference:

Explanation:

(A) A baseline set of vital signs is necessary to determine if any transfusion reactions occur as the blood product is being administered. (B) The only companion fluid to be used during a blood transfusion is normal saline. The calcium in Ringer's lactate can cause clotting. (C) Only a blood administration set should be used. A microdrip tube would cause lysis of the red blood cells. (D) Proper identification of the recipient and the blood product must be validated by at least two people.

NEW QUESTION # 175

The nurse has been caring for a 16-year-old female who recently experienced date rape. After having had crisis intervention and been hospitalized for 2 weeks, the nurse knows that the client is effectively coping with the rape when she tells the nurse:

- A. "I know now that it was not my fault, but I want to continue counseling after my discharge."
- B. "I know it was my fault that it happened, because I shouldn't have been out so late."
- C. "If I had not worn that sexy dress that night, he wouldn't have raped me."
- D. "I know my date just had so much passion he couldn't handle me saying 'no.' "

Answer: A

Explanation:

(A) This response does not show any insight; the client falsely assumes that she is responsible for the rape. (B) The client continues to falsely assume responsibility for the rapist's behavior. (C) The client believes falsely that rape is an act of passion, rather than one of violence, control, and domination. (D) The client has insight into the rape; she does not believe it was her fault and shows good judgment in deciding to continue with counseling after discharge.

NEW QUESTION # 176

In addition to changing the mother's position to relieve cord pressure, the nurse may employ the following measure (s) in the event that she observes the cord out of the vagina:

- A. Cover the cord with a wet sponge.
- B. Apply a cord clamp to the exposed cord, and cover with a sterile towel.
- C. Immediately pour sterile saline on the cord, and repeat this every 15 minutes to prevent drying.

- **D. Keep the cord warm and moist by continuous applications of warm, sterile saline compresses.**

Answer: D

Explanation:

Explanation/Reference:

Explanation:

(A) Saline should be warmed; waiting 15 minutes may not keep the cord moist. (B) This choice does not specify what the sponge was "wet" with. (C) This measure would stop circulation to the fetus. (D) The cord should be kept warm and moist to maintain fetal circulation. This measure is an accepted nursing action.

NEW QUESTION # 177

A six-month-old infant has been admitted to the emergency room with febrile seizures. In the teaching of the parents, the nurse states that:

- **A. There is little risk of neurological deficit and mental retardation as sequelae to febrile seizures**
- B. Febrile seizures do not usually recur
- C. Febrile seizures are associated with diseases of the central nervous system
- D. Sustained temperature elevation over 103F is generally related to febrile seizures

Answer: A

Explanation:

Section: Questions Set A

Explanation:

(A) The temperature elevation related to febrile seizures generally exceeds 101F, and seizures occur during the temperature rise rather than after a prolonged elevation. (B) Febrile seizures may recur and are more likely to do so when the first seizure occurs in the 1st year of life. (C) There is little risk of neurological deficit, mental retardation, or altered behavior secondary to febrile seizures. (D) Febrile seizures are associated with disease of the central nervous system.

NEW QUESTION # 178

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