Free Sample Version of www.teachingsolutions.org/nclex-pn-review

NCLEX-PN®

NCLEX-PN

Comprehensive Success System

Free Sample Version of
www.teachingsolutions.org/nclex-pn-study-guide

Don't Go Into Your NCLEX-PN Test Unprepared

Free Sample Version of www.teachingsolutions.org/nclex-pn-review

NCLEX-PN®
"*Comprehensive Success System*"

Copyright Notice: Copyright © by TeachingSolutions.org

All rights reserved. No part of this publication may be reproduced, distributed, or transmitted in any form or by any means, including photocopying, recording, or other electronic or mechanical methods, without the prior written permission of the publisher.

NOTE: Each user and anyone with this document in his/her possession is required to pay the license fee to be in compliance with the law. Authorize your use by ordering at: www.TeachingSolutions.org

Copyright © by TeachingSolutions.org. All rights reserved.

Free Sample Version of www.teachingsolutions.org/nclex-pn-review

6.) The nurse is caring for a pediatric patient who requires oxygen for a respiratory issue. The nurse enters the child's room and sees this child:

The nurse knows that:

a) The oxygen mask is too small for the patient.
b) The oxygen mask is too large for the patient.
c) The oxygen mask is the appropriate size for the patient.
d) This oxygen mask should never be used on a pediatric patient.

7.) The nurse is working in a community clinic with a Registered

Nurse and physician. A 20-year-old woman comes in with the complaint of a frothy vaginal discharge that looks gray in color. The woman takes "the pill" for birth control. The nurse suspects that this patient:

a) Has normal vaginal secretions.
b) Needs to douche regularly.
c) Should change her birth control method
d) May have a sexually transmitted disease..

Copyright © by TeachingSolutions.org. All rights reserved.

Free Sample Version of www.teachingsolutions.org/nclex-pn-review

8.) The nurse is working with a nurse's aide on a medical surgical floor. The team is receiving a patient following major abdominal surgery. To prevent postoperative pneumonia, the nurse should instruct the aide to:

a) Reposition the patient every 4 hours.
b) Have the patient take at least 5 deep breaths every hour.
c) Elevate the head of the patient's bed.
d) Suction the patient as needed.

9.) The nursing assistant reports to the nurse that a patient does not feel good. The nurse verifies that the patient's vital signs have been as follows:

Time	Blood Pressure	Pulse	Respirations
0800	142/78	88	20
1200	126/72	92	22
1600	86/50	56	24

The nurse should do all of the following EXCEPT:

a) Quickly check on the nurse's other 4 patients in order to ensure they do not need anything before spending time with this patient.
b) Take the vital signs again to verify the most current set.
c) Call the Rapid Response Team.
d) Report the change in condition to the physician.

Copyright © by TeachingSolutions.org. All rights reserved.

Free Sample Version of www.teachingsolutions.org/nclex-pn-review

10.) The nurse is working with a technician in the Emergency Department when a victim of a gunshot wound is brought to the department. The patient dies in the ED. The nurse should instruct the technician to do which of the following tasks (Select all that apply):

a) Cover the patient with a sheet.
b) Remove the endotracheal tube.
c) Call the Chaplain.
d) Move the patient's body to the morgue.
e) Notify the family of the patient's death.

11.) EMS is transporting migrant farm workers to the Emergency Department with complaints of itchy eyes, cough, sweating and constricted pupils after coming into contact with chemicals less than an hour ago. The most appropriate first intervention is to:

a) Isolate the workers away from other patients.
b) Remove the workers' clothing.
c) Place the workers in a decontamination shower.
d) Initiate oxygen per nasal cannula.

Copyright © by TeachingSolutions.org. All rights reserved.

Free Sample Version of www.teachingsolutions.org/nclex-pn-review

30.) The nurse is caring for a patient with HIV/AIDS. The patient is cachectic with a very poor appetite. In order to best meet this patient's dietary needs, the nurse should:

a) Instruct the patient's caregivers to ensure that all foods are cooked thoroughly and stored appropriately.
b) Advise the patient to eat large meals at the first sign of hunger.
c) Encourage the patient to take multivitamins every day.
d) Instruct the patient's caregiver to prepare finger food and leave it on the counter so the patient can eat throughout the day.

31.) The nurse is caring for a child with varicella. The nurse should implement:

a) Airborne precautions.
b) Contact precautions.
c) Droplet precautions.
d) No precautions are needed.

Copyright © by TeachingSolutions.org. All rights reserved.

Free Sample Version of www.teachingsolutions.org/nclex-pn-review

32.) The nurse can ensure patient safety by doing all of the following EXCEPT:

a) Performing medication reconciliation at admission, each change of place of service, and at discharge.
b) Using two patient identifiers before giving medication or performing procedures.
c) Placing patients from similar cultures together.
d) Staff training.

33.) The nurse in the Emergency Department is preparing a child for removal of a foreign body in his ear. The most appropriate restraint for this child is:

a) Have the father hold the child.
b) Arm restraints.
c) Papoose board.
d) Vest restraint.

34.) The nurse is caring for a patient who has just been diagnosed with pancreatic cancer. The patient states that he does not want any treatment and that he will decide how he wants to die. The most important initial intervention for this patient is:

a) Express concern about his feelings.
b) Have the patient's doctor order a psychiatric consult.
c) Ask the patient if he has a plan for suicide.
d) Ask the patient whether he is having suicidal thoughts.

35.) The nurse is preparing to give Cefazolin to a patient with a documented allergy to penicillin. The nurse's first response is to:

a) Give the medication with diphenhydramine.

Copyright © by TeachingSolutions.org. All rights reserved.

Free Sample Version of www.teachingsolutions.org/nclex-pn-review

b) Call the physician for clarification.
c) Ask the patient if they have taken cefazolin in the past.
d) Give the medication and observe the patient for a reaction.

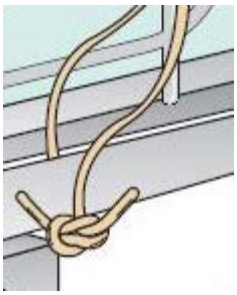
36.) The nurse in the pediatric clinic receives a call from a mother who reports that her toddler who injured his leg has become very mobile even though he is in a splint. The nurse should advise the mother to:

a) Make the area safe for the toddler and let him move around.
b) Restrict the toddler to one small area of the house.
c) Remove the splint and allow the toddler to play.
d) Call the physician for further orders.

37.) The nurse finds a sealed vial of medication in the clean utility room. The nurse should:

a) File an incident report.
b) Send the vial to the pharmacy.
c) Leave the vial where it is.
d) Discard the vial in the sharps container.

38.) The nurse is caring for a patient who has been restrained. The nurse enters the patient room for the initial visit and sees that the retraints are tied using this knot:



Copyright © by TeachingSolutions.org. All rights reserved.

Free Sample Version of www.teachingsolutions.org/nclex-pn-review

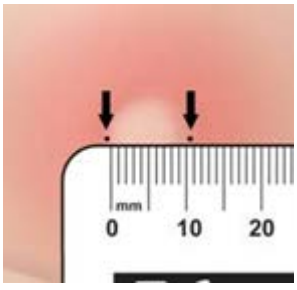
The nurse should:

a) Retie the restraints using a knot that can be easily released.
b) Ask the patient if he is comfortable.
c) Do nothing; the restraints are tied correctly.
d) Release the patient from the restraints.

39.) The LPN/LVN is working as a school nurse. The nurse has seen several children with conjunctivitis. The nurse should:

a) Call each parent to explain the situation.
b) Perform hand hygiene before and after touching any child and remind teachers to do the same.
c) Recommend closing the school for 5 days.
d) Remind parents that children should be kept home for 2 days after treatment is started.

40.) The nurse is working in a community clinic that serves the inner city housing projects. A 26 year old patient comes in to have the Mantoux test read. The patient reports that it was given 2 days ago. The nurse feels the induration and measures as seen in the picture below:



The nurse knows:

Copyright © by TeachingSolutions.org. All rights reserved.

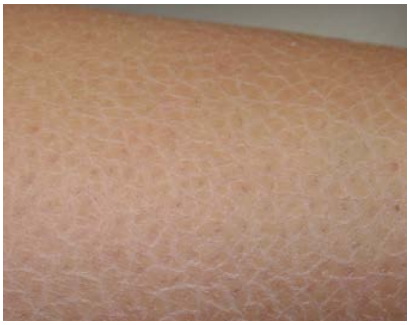
Free Sample Version of www.teachingsolutions.org/nclex-pn-review

a) The patient has tuberculosis and should be hospitalized immediately.
b) This is a positive test and the patient should be further evaluated.
c) This is a negative test and the patient should be sent home.
d) The test should be read a week after administration; it is too early to draw a conclusion.

41.) The nurse is walking down the hall on the medical unit and notices a small puddle of fluid on the floor. The first thing the nurse should do is:

a) Put on a pair of gloves and wipe up the fluid.
b) Put a "Wet Floor" sign in front of the fluid.
c) Call housekeeping to clean up the fluid.
d) Throw a rag over the fluid.

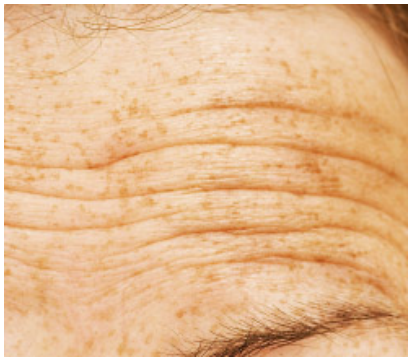
58.) The nurse is caring for an elderly patient. The condition that would be considered abnormal in the aged is:

a) 

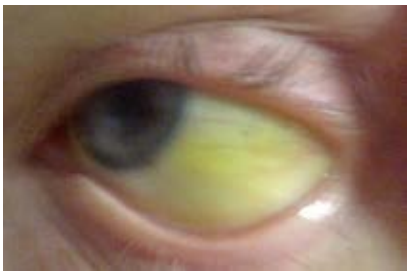
Copyright © by TeachingSolutions.org. All rights reserved.

Free Sample Version of www.teachingsolutions.org/nclex-pn-review

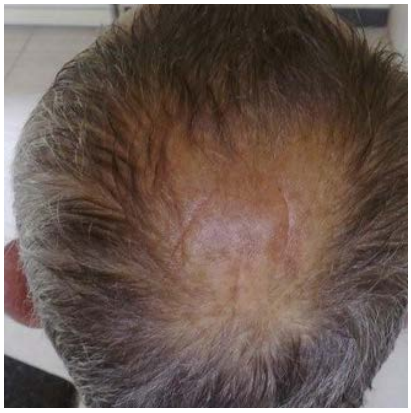
b)



c)



d)



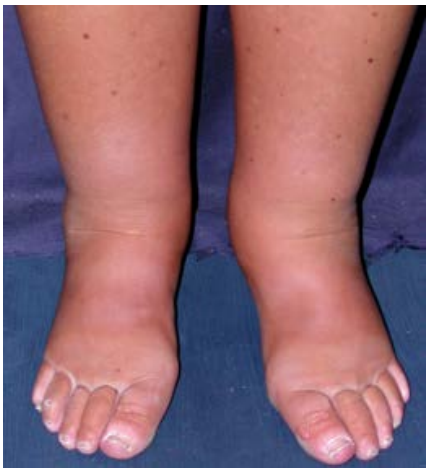
59.) The 78 year old patient has been diagnosed with herpes zoster. The nurse should be sure the patient understands that:

Copyright © by TeachingSolutions.org. All rights reserved.

Free Sample Version of www.teachingsolutions.org/nclex-pn-review

a) There are no medications that can help this disease.
b) The pain will be gone within one week.
c) The patient should be isolated until the lesions are healed.
d) Wet-to-dry dressings can be used to cover the lesions.

60.) The nurse is caring for a patient with congestive heart failure. Upon entering the room, the nurse notes that the patient is sitting up in the chair next to the bed with her legs dependent. The patient's legs look significantly different than when the nurse cared for her yesterday:



The most important goal for this patient is to:

a) Maintain normal respiratory rate and breathing pattern.
b) Maintain a normal temperature.
c) Decrease venous congestion in extremities.
d) Prevent injury to the lower extremities.

61.) The nurse is caring for a patient on complete bed rest following cardiac surgery. The nurse knows that this patient is at risk for development of:

Copyright © by TeachingSolutions.org. All rights reserved.

Free Sample Version of www.teachingsolutions.org/nclex-pn-review

a) Stress fractures.
b) Thrombophlebitis.
c) Air embolism.
d) Fat embolism.

62.) The nurse is caring for a patient with a stage 2 pressure ulcer on the right ankle above the lateral malleolus. One of the goals on the patient's plan of care is to promote and maintain tissue integrity. The nurse knows that an intervention that will help achieve this goal is to:

a) Put an over the bed linen cradle over the foot of the bed.
b) Administer pain medication as prescribed.
c) Apply lotion to the pressure ulcer.
d) Assist the patient to sit in the chair as much as possible.

63.) The nurse is caring for a patient in the Emergency Department who was involved in a motor vehicle crash. EMS personnel report that the air bag did not deploy and the patient hit his chest on the steering wheel. The nurse notes that the patient is taking very small breaths followed by bigger breaths then small breaths again. This pattern is followed by 15 seconds of apnea. The nurse knows that this breathing pattern is called:

a) Hyperventilation.
b) Obstructive sleep apnea.
c) Cheyne-Stokes respirations.
d) Bior's respirations.

64.) The nurse is caring for a patient at risk for "dumping syndrome". The nurse knows that the eating habit most likely to increase the risk for the syndrome is to:

Copyright © by TeachingSolutions.org. All rights reserved.

Free Sample Version of www.teachingsolutions.org/nclex-pn-review

a) Reduce the amount of fluids taken with meals.
b) Take meals in a quiet, relaxed environment.
c) Eat a diet high in protein and fat.
d) Eat three meals spaced throughout the day.

65.) The nurse is caring for a homosexual man who has been diagnosed with HIV/AIDS. The patient says he does not want his family or employer to know about his lifestyle or his diagnosis. The best response by the nurse is to say:

a) "Anything you tell me is confidential."
b) "You need to tell your family about your diagnosis."
c) "It is my responsibility to tell your family about your diagnosis and lifestyle."
d) "Your employer should be told about your health problems."

66.) The nurse is caring for a patient who has been diagnosed with depression. The patient says that her heart is no longer beating. The nurse knows that this statement represents a(n):

a) Delusion.
b) Hallucination.
c) Illusion.
d) Paranoid ideation.

67.) The patient has been diagnosed with major depression. He states: "Nothing matters anymore and I am done with life." The most appropriate response by the nurse is to say:

a) "You need to be positive."
b) "Why do you feel like that?"
c) "Are you considering hurting yourself?"
d) "You really shouldn't feel that way."

Copyright © by TeachingSolutions.org. All rights reserved.

Free Sample Version of www.teachingsolutions.org/nclex-pn-review

68.) The nurse is caring for a patient who is going through a detoxification program for alcohol dependency following a car crash while intoxicated. The patient continues to assert that she does not have a problem with alcohol, but is simply going through a "rough time" due to divorce. The best approach for the nurse to use with this patient is to:

a) Ask about how much alcohol the patient drinks each day.
b) Listen to the patient and ask how she plans to stay sober.
c) Explain to her that she has been admitted for alcohol detoxification.
d) Remind her that she was in an auto crash while intoxicated.

69.) The nurse is caring for a patient who has been diagnosed with acute delirium. The patient has become very anxious and begs the nurse to do something to make the anxiety stop. The most appropriate response from the nurse is to tell the patient:

a) "You need to stop worrying. Worry only makes the delirium worse."
b) "Unfortunately, there's nothing I can do until the doctor determines what is causing the delirium."
c) "Let me sit and talk with you until you calm down."
d) "The doctor is trying to determine what is causing your delirium. Let me get some medicine to help you relax."

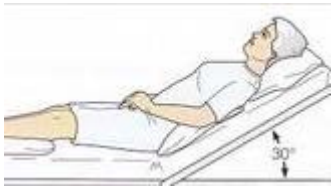
Copyright © by TeachingSolutions.org. All rights reserved.

Free Sample Version of www.teachingsolutions.org/nclex-pn-review

84.) The nurse is caring for a patient after a laryngectomy. The patient should be positioned: (ch3-4/29/ c)

a) 

b) 

c) 

d) 

85.) The nurse is caring for a febrile patient with pneumonia and a productive cough. One of the goals of the plan of care is to maintain the patient's comfort. The intervention that would directly affect this goal is to: (ch 3-4/39/a)

a) Change the patient's linen frequently.
b) Suction the patient's nose and mouth frequently.
c) Reposition the patient every 4 hours.
d) Offer the patient a bedpan every 2 hours.

Copyright © by TeachingSolutions.org. All rights reserved.

Free Sample Version of www.teachingsolutions.org/nclex-pn-review

86.) The nurse is discharging the patient with tuberculosis. Before discharge, the most important action is to: (ch3-4/57/c)

a) Arrange for other agency services.
b) Offer emotional support.
c) Reinforce the teaching about ongoing treatment.
d) Ask the patient about the sanitation of his home.

87.) The priority goal for a patient with chronic obstructive pulmonary disease is to: (ch3-4/79/c)

a) Minimize the patient's chest pain.
b) Treat infections.
c) Maintain ability to perform activities of daily living.
d) Increase the carbon dioxide levels.

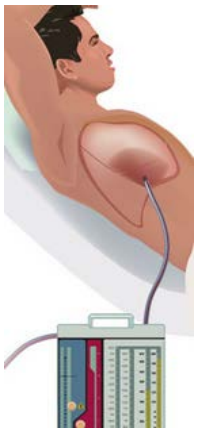
88.) The nurse is caring for a patient with chronic obstructive pulmonary disease who is preparing for discharge. At his job, he is required to routinely lift boxes from a table to a conveyor belt. In order to conserve energy, the nurse should teach the patient to lift the boxes: (ch 3-4/81/d)

a) After exhaling and before inhaling.
b) While holding his breath.
c) While inhaling through his nose.
d) While exhaling through pursed lips.

Copyright © by TeachingSolutions.org. All rights reserved.

Free Sample Version of www.teachingsolutions.org/nclex-pn-review

89.) The nurse is caring for the patient in the picture who has suffered a pneumothorax.



The nurse knows that the purpose of the tube in the picture is to: (ch 3-4/131/b)

a) Instill medications into the pleural space.
b) Remove air and fluid from the pleural space.
c) Administer oxygen.
d) Promote development of scar tissue in the lung.

90.) The nurse is part of a team caring for a patient with an endotracheal tube. The most accurate way to know that the ET tube is in the correct place is to: (ch3-4/147/c)

a) Ensure that the patient's skin is warm, dry and pink.
b) Verify that the ET tube cuff is inflated.
c) Auscultate breath sounds.
d) Monitor the patient's respiratory rate and rhythm.

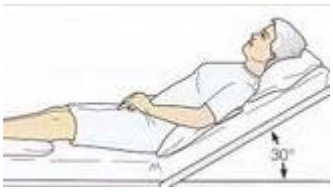
Copyright © by TeachingSolutions.org. All rights reserved.

Free Sample Version of www.teachingsolutions.org/nclex-pn-review

91.) The patient with rheumatoid arthritis is at risk for hip flexion deformities. The nurse should help the patient assume the position: (comp1/150/d)

a) 

b) 

c) 

d) 

92.) The best foods to encourage wound healing and prevent infection are: (comp2/66/b)

a) Eggs and bacon.
b) Chicken and an orange.
c) Cheeseburger and french fries.
d) Gelatin and tea.

Copyright © by TeachingSolutions.org. All rights reserved.

Free Sample Version of www.teachingsolutions.org/nclex-pn-review

93.) The nurse is caring for a child with leukemia. The intervention that would NOT be appropriate for this patient is to: (comp2/137/a)

a) Clean the teeth with a toothbrush.
b) Apply petroleum jelly to the patient's lips.
c) Rinse the mouth with a gentle mouthwash.
d) Swab the mouth with moistened swabs.

94.) The nurse uses Montgomery straps to prevent: (comp 2/170/d)

a) Falls.
b) Bruises.
c) Patient wandering.
d) Skin breakdown.

95.) The nurse is caring for a patient with hip pain secondary to rheumatoid arthritis. The nurse knows that the patient is likely to be more comfortable in which chair: (comp4/70/a)

a) 

Copyright © by TeachingSolutions.org. All rights reserved.

Free Sample Version of www.teachingsolutions.org/nclex-pn-review

b) 

c) 

d) 

96.) The nurse is caring for a patient post abdominal surgery. The intervention that is most important for managing the patient's pain is: (comp4/93/b)

a) Administering pain medication after repositioning the patient.
b) Assessing the patient's pain 30 minutes after administering pain medication.
c) Providing emotional support for the patient.

d) Ensuring that the patient uses the incentive spirometer every 2 hours.

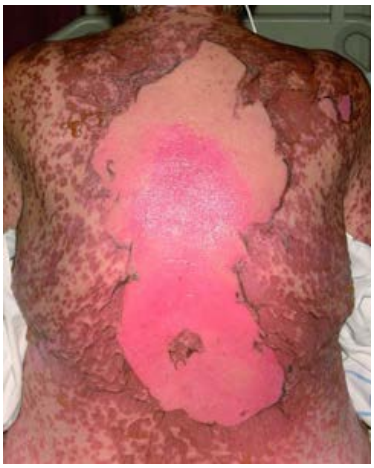
Copyright © by TeachingSolutions.org. All rights reserved.

Free Sample Version of www.teachingsolutions.org/nclex-pn-review

97.) The patient has a nasogastric (NG) tube in his right nostril. He complains that his nostril is sore from the tube. The most effective intervention to relieve the soreness is to: (comp5/46/a)

a) Apply a water soluble lubricant to the nostril.
b) Reposition the NG tube.
c) Have the patient change his position to lower the head of his bed.
d) Irrigate the NG tube with warm water.

123.) The patient has been admitted to the burn unit with the burns shown in this image:



The nurse knows that the priority action at the time of admission is:

a) Monitoring fluid and electrolyte balance.
b) Managing pain.
c) Monitoring vital signs every 30 minutes.

Copyright © by TeachingSolutions.org. All rights reserved.

Free Sample Version of www.teachingsolutions.org/nclex-pn-review

d) Preventing infection of the burns.

124.) The nurse will be assisting in a thoracentesis for a patient with a left pleural effusion. The nurse knows that the patient should be positioned:

a) 

b) 

c) 

d) 

125.) The patient with ulcer disease is admitted to the Emergency Department with a blood pressure of 92/62 and heart rate of 116. Upon arrival, he vomits coffee ground material. The nurse's first intervention should be to:

a) Administer promethazine to stop the vomiting.
b) Talk with the family to determine the amount of stress the patient has been under.
c) Prepare to insert an NG tube.

Copyright © by TeachingSolutions.org. All rights reserved.

d) Place the patient in a prone position.

126.) Two days post-operatively, the nurse notes this drainage on the patient's dressing:

Prior to this assessment, the dressing was clean, dry and intact. The most appropriate action for the nurse to take is to:

a) Reinforce the dressing.
b) Ignore the drainage since it is normal 2 days after surgery.
c) Change the dressing.
d) Take the patient's vital signs and call the surgeon.

127.) The nurse uses the "rule of nines" with a burn patient to determine:

a) Amount of fluid replacement required.
b) Amount of body surface area burned.
c) Amount of supplemental oxygen required.
d) How long rehabilitation will take.

128.) The nurse is applying an elastic bandage to the patient's sprained wrist. The correct way to apply the bandage is to:

a) Wrap from fingertips to axilla.
b) Increase tension as the wrist is wrapped.
c) Start at mid-forearm and wrap to the palm.

Copyright © by TeachingSolutions.org. All rights reserved.

Free Sample Version of www.teachingsolutions.org/nclex-pn-review

d) Start at the palm and wrap to the mid-forearm.

129.) The nurse is caring for a diabetic patient who has a low blood glucose reading an hour after taking insulin. All of the following would be acceptable choices for raising the glucose level EXCEPT:

a) A small glass of orange juice.
b) A small glass of regular soda.
c) A small serving of tuna.
d) A cup of milk.

130.) The nurse is suctioning the endotracheal tube of a patient. The nurse knows that endotracheal suction should not exceed:

a) 5-10 seconds.
b) 15-20 seconds.
c) 25-30 seconds.
d) 40-45 seconds.

131.) The nurse is preparing the patient for an intravenous pyelogram. The most important question the nurse should ask is:

a) "Do you have allergies to shellfish?"
b) "When was your last menstrual period?"
c) "Have you had an IVP in the past?"
d) "Do you have problems with urinary incontinence?"

132.) The nurse on the medical unit is caring for a patient who had a lumbar puncture. The finding that the nurse should report to the doctor is:

Copyright © by TeachingSolutions.org. All rights reserved.

a) The patient is asking about the test results.
b) The patient asked for medication for a headache.
c) The dressing on the site of the LP had a moderate amount of serous fluid.
d) The urinary output of the patient has averaged 30 milliliters each hour.

133.) The nurse in the physician's office is talking to the patient about the upper GI series that is scheduled for the next day. The nurse should remind the patient that she:

a) Should not eat or drink for 8 hours before the test.
b) Might have abdominal pain during the test.
c) Can smoke before the test.
d) Should take a stool softener before the test.

134.) The best intervention to prevent falls is to tell the patient:

a) Not to use a walker since that will reduce the patient's sense of independence.
b) To get up slowly when changing positions.
c) To keep bright lights on in the room.
d) To minimize movement of painful joints.

Answer Key And Answer Explanations:

6.) The correct response is "c".
The oxygen mask is the appropriate size for the child. An oxygen face mask should cover the patient's nose and mouth and should fit snugly against the child's chin and cheeks. A mask that is too small may obstruct the nose or mouth. A mask that is too large will cover the eyes and will not fit snugly against the chin and cheeks.

Copyright © by TeachingSolutions.org. All rights reserved.

Free Sample Version of www.teachingsolutions.org/nclex-pn-review

7.) The correct response is "d".
The nurse should suspect that the patient has a sexually transmitted disease since the vaginal discharge is frothy and looks infected. Normal vaginal secretions are clear or white in color. Women should not be instructed to douche regularly. Douching can destroy normal vaginal flora and will change the normal protective pH of the vagina. There is no indication that the symptoms are related to the patient's birth control method so there is no reason to change the method.

8.) The correct response is "a".
The nurse should instruct the nursing assistant to have the patient deep breathe and cough every hour to prevent pneumonia after abdominal surgery. The nursing assistant should help the patient to reposition every two hours. Elevating the head of the bed may help the patient be more comfortable, but it will not prevent post operative pneumonia. Suctioning a patient should NOT be delegated to a nursing assistant and is not an intervention that will prevent pneumonia.

9.) The correct response is "a".
The deteriorating vital signs indicate that this patient should be evaluated immediately. The nurse should ask another nurse or nursing assistant to check on the other four patients. The nurse should quickly take the vital signs again to verify that the current vital signs match those taken by others. If the vital signs indicate that the patient is in trouble, the nurse should call the Rapid Response Team. This team is different from a code team since the RRT intervenes before the patient codes. When the nurse has a moment, the nurse should notify the patient's physician about the change in condition.

Copyright © by TeachingSolutions.org. All rights reserved.

Free Sample Version of www.teachingsolutions.org/nclex-pn-review

10.) The correct responses are "a & d".
The nurse can delegate covering the patient and transporting the patient to the morgue. Since the patient is a victim of a gunshot wound, all tubes and lines should be left in place until the patient is examined by the coroner. The nurse should call the Chaplain and explain the situation. The nurse or the physician should notify the patient's family.

11.) The correct response is "a".
Given the available information, the nurse must protect other patients and the staff in the emergency department by keeping the patients away from other patients. Isolation of the victims will reduce the possibility of contamination of others. The victims' clothing should be removed in a decontamination room and placed in plastic bags. If a decontamination shower is available, the victims should be showered according to a specific protocol. If the victims are experiencing respiratory difficulties, oxygen therapy should be initiated.

30.) The correct response is “a”.
Any immunocompromised patient must be certain that all food is cooked thoroughly and handled in a safe manner to prevent food-borne illness. Large meals are not appetizing to a patient with a decreased appetite. Instead, the patient or family member should prepare frequent, small meals of favorite foods. Large doses of vitamins may be toxic; before making this recommendation, the nurse should be certain that the prescribing provider is aware. Preparing food to be left on the counter for ease of access may promote the growth of food-borne microorganisms that can cause illness in the immunocompromised.

Copyright © by TeachingSolutions.org. All rights reserved.

Free Sample Version of www.teachingsolutions.org/nclex-pn-review

31.) The correct response is “a”.
All patients should be treated with standard precautions. When the transmission mode is known for a particular disease, additional precautions may be necessary. In the case of varicella, the mode of transmission is airborne so the nurse should initiate airborne precautions. Contact precautions are used when the patient has draining wounds, gastroenteritis, or during any procedure that might result in contact with patient fluids. Droplet precautions should be initiated with those diseases that can be spread through droplets from a cough. Examples might include rubella, pneumonia, and whooping cough.

32.) The correct response is “c”.
Although it can be a good idea to room culturally similar patients together for mutual comfort, this intervention will not ensure the safety of the patients. Medication reconciliation should be done at admission, change of location of service, and discharge. In addition, many facilities also require reconciliation at least every day. Doing this task helps to identify missing, incorrect, or duplicate medications or doses. Using two patient identifiers is a National Patient Safety Goal. Staff training will ensure that all personnel understand safety best practices and facility policies, protocols, and procedures.

33.) The correct response is “c”.
For safety during the procedure, the nurse should place the child in a papoose board restraint that will restrain his whole body. Since the physician will be working in his ear with potential for damaging the tympanic membrane, it is critical that the child is kept still. A vest restraint will not restrain his arms or legs so will not keep him from moving during the procedure. Arm restraints will not keep his body or legs still. A parent should never be used to restrain a child.

Copyright © by TeachingSolutions.org. All rights reserved.

Free Sample Version of www.teachingsolutions.org/nclex-pn-review

34.) The correct response is “d”.
The most important first intervention is to determine if the patient is truly suicidal. Although he has given the nurse a clue, the nurse should explicitly ask if he is suicidal. After that, the nurse should determine if he has a plan. Throughout the following discussion, the nurse should work with the patient's feelings and safety. A psychiatric consult may be appropriate.

35.) The correct response is “c”.
The nurse should recognize that cephazolin is related to penicillin so there is a chance that the patient might have a sensitivity to the medication. The safest first intervention is to ask the patient if they have taken cephazolin in the past. If not, the nurse should call the physician for clarification. If the patient has taken it in the past, the nurse should inquire about any reaction. Giving the medication with diphenhydramine (Benadryl) without asking about history would not be appropriate. Giving the medication and observing the patient for a reaction might ultimately be appropriate, but would not be the safest initial intervention.

36.) The correct response is “a”.
The nurse should recognize that a toddler will adapt to a splint and will need to move around even with the splint in place. The most appropriate instruction is for the mother to be sure that the area the child is in is safe. There is no need to keep the child in one small area of the house, but the mother should ensure that any area where the child plays is safe. Being kept in a restricted area will soon lead to boredom. The mother should NOT remove the splint. If the child is moving around with the splint in place, it is obvious that he has adapted to it. Finally, there is nothing that would indicate that the mother or nurse should call the physician for any change in treatment.

Copyright © by TeachingSolutions.org. All rights reserved.

Free Sample Version of www.teachingsolutions.org/nclex-pn-review

37.) The correct response is “b”.
The nurse should send the vial to the Pharmacy. The question does not specify what medication is in the vial, but the nurse should recognize that the utility room is NOT the appropriate place for the medication and that it might be harmful if ingested or injected. The nurse should know the facility policy about completing an incident report, but this is not the most critical intervention at this time. The nurse should never leave any medication in an area that is not designated for medications, so leaving it in the clean room would not be appropriate. The medication should not be discarded in the sharps container.

38.) The correct response is “a”.
The knot on these restraints cannot be easily untied if it becomes necessary to release the patient quickly. This knot is secure but not easily released. The nurse should retie the knot into a slip knot. Although the patient might need to be released and repositioned, this is not pertinent to this question. The patient's comfort is important, but his safety is the critical point of this question. Restraints must always be tied is such a way that they are secure, but can be quickly released if necessary.

39.) The correct response is “b”.
The nurse should recognize that conjunctivitis is extremely contagious, so hand hygiene is critical for the prevention of spreading the disease. Although these precautions should always be maintained, the nurse should be particularly meticulous when conjunctivitis is suspected. The nurse may want to let parents know that conjunctivitis has been seen in the school, but this intervention will not prevent the spread. There is no reason to close the school since transmission can be controlled by hand hygiene. Finally, a child who has conjunctivitis should stay home for the first 24 hours of treatment, not 48.

Copyright © by TeachingSolutions.org. All rights reserved.

Free Sample Version of www.teachingsolutions.org/nclex-pn-review

40.) The correct response is “b”.
This patient is part of a medically underserved and, therefore, high risk population. The Mantoux test is indicating a positive test. In this population, an induration > 10 mm is considered positive. However, a positive test does not necessarily mean that the individual has tuberculosis. Prolonged exposure to tuberculosis can cause conversion of a negative test to positive even in an otherwise healthy individual. This young man should be further evaluated to rule out TB. The timing on reading the Mantoux is 48-72 hours after placement of the test.

41.) The correct response is "a".
The nurse who identifies fluid on the floor should put on gloves and wipe up the liquid. The gloves should protect the nurse against any harmful liquids. After the nurse wipes up the liquid, a wet floor sign can be put in the area and housekeeping should be called to clean the area thoroughly. Placing a cloth over the spill is a hazard and should be avoided.

58.) The correct response is "c".
Response "c" shows a patient with yellowing sclera that is probably indicative of jaundice. Jaundice is not a normal finding in any age group. Response "a" shows xerosis or skin dryness. Option "b" shows wrinkles that occur naturally as aging skin loses elasticity. Finally, option "d" shows thinning hair that can occur in men or women with age.

Copyright © by TeachingSolutions.org. All rights reserved.

Free Sample Version of www.teachingsolutions.org/nclex-pn-review

59.) The correct response is "d".
Wet-to-dry dressings may be applied to the lesions. Sometimes, topical medications may also be prescribed. There are antiviral medications that can be prescribed that may help shorten the course of the disease. Pain from shingles can last until the lesions heal, a process that may take up to a month. Even after the lesions heal, the patient may have neuralgia that lasts up to 6 months. There is no need for a patient to be isolated during the course of the disease.

60.) The correct response is "c".

This patient has significant peripheral edema secondary to her congestive heart failure and keeping the legs in a dependent position. The most important outcome for this patient is to decrease venous congestion by elevating her legs above the level of her heart. There is no indication that the patient's respiratory status or temperature has been affected. Although prevention of injury to the extremities is important, relief of venous congestion is more acutely critical.

61.) The correct response is "b".
Thrombophlebitis is inflammation of a vein due to venous blood stasis, vessel wall injury, or increased blood coagulation. Inactivity can predispose a patient to thrombophlebitis, which can result in pain, muscle tenderness and swelling. Stress fractures are not associated with bed rest. Air embolus occurs when air enters the vascular system. Fat embolus is typically associated with long bone fractures.

Copyright © by TeachingSolutions.org. All rights reserved.

Free Sample Version of www.teachingsolutions.org/nclex-pn-review

62.) The correct response is "a".
An over-the-bed cradle at the foot of the bed will ensure that bed linens are kept off the ankle. This will help prevent further injury and promote tissue integrity. Although administration of pain medication might be appropriate, that intervention will not promote tissue integrity. Applying non-medicated lotions is usually contraindicated with a pressure ulcer. Assisting the patient to sit up in a chair may be an appropriate intervention to increase activity, but it will not promote tissue integrity.

63.) The correct response is "c".
The pattern of breathing described is a typical Cheyne-Stokes pattern of respirations that is usually associated with heart failure or damage to the respiratory center of the brain. Since this patient was involved in a motor vehicle crash, the nurse should suspect damage to or pressure on the respiratory center of the brain. Hyperventilation is simply increased rate of respirations. Obstructive sleep apnea typically refers to recurring upper airway obstruction and diminished ventilation. Bior's respirations, or cluster breathing, is characterized by periods of normal breathing followed by periods of apnea.

64.) The correct response is "d".
Dumping syndrome is characterized by rapid emptying of gastric contents. Eating three, regular sized meals has been shown to increase the incidence of dumping syndrome. Instead, the patient should eat more frequent and smaller meals to put less stress on the stomach. The patient should take less fluids during meals, but should be cautioned to get extra fluids between meals. A relaxed environment can help to reduce anxiety that may increase the chance of dumping. Finally, the patient should eat a high protein and fat diet while avoiding carbohydrates.

Copyright © by TeachingSolutions.org. All rights reserved.

Psychosocial Integrity:

65.) The correct response is "a".
The nurse must let the patient know that anything about his condition or lifestyle is confidential. The other responses are not true and are not therapeutic.

66.) The correct response is "a".
This patient is suffering from a delusion which is a false belief that is not congruent with the facts. A hallucination is a false sensory perception that is not related to any external stimulus. An illusion is a misinterpretation of a real stimulus. Paranoia is suspicion of others or their actions.

67.) The correct response is "c".
The nurse should assume that this patient might be suicidal and should ask him directly whether or not he is considering hurting himself. Often, a suicidal patient will be relieved when someone finally asks if he is suicidal. It is very common for a suicidal patient to admit that he is thinking of hurting himself. Telling the patient that he should be more positive or shouldn't feel the way he does can make the patient feel that he is wrong for having the feelings he is experiencing. Asking the patient why he feels the way he does is not therapeutic since it is likely that he does not know. This may cause him to feel more inadequate.

68.) The correct response is "d".
The patient with alcohol dependence who denies a problem with alcohol should be reminded that she was in a crash while intoxicated. This fact may help to decrease the patient's denial about her alcohol problem. The amount of alcohol she drinks and asking how she plans to stay sober will allow her to use

Copyright © by TeachingSolutions.org. All rights reserved.

Free Sample Version of www.teachingsolutions.org/nclex-pn-review

rationalization and minimization to deny the problem and explain her actions.

69.) The correct response is "d".
The nurse should help the patient understand that the doctor is working on determining the cause of the delirium and that there are medications that can be given to help the symptoms until the cause is corrected. Telling the patient to stop worrying will be ineffective. It is not true that nothing can be done to help the symptoms. There are medications that can improve delirium associated anxiety. In a patient with true delirium, sitting and talking will not help calm the patient. After medicating the patient, this might be an appropriate intervention.

Physiological Integrity: Basic Care and Comfort

84.) The correct response is "c".
Post laryngectomy, the patient should be positioned in a semi-Fowler's position to ease breathing and decrease neck edema. The other pictured positions will not ease the patient's breathing or decrease edema.

85.) The correct response is "a".
In order to promote comfort in the febrile patient, it is important to keep linen clean and dry. If the patient is diaphoretic, the linens will become wet and the patient will be uncomfortable and at risk for skin breakdown. Since the patient is coughing, it is not necessary to suction his nose and mouth. The patient should be repositioned every 2 hours. There is no indication in the question that the patient requires a bedpan instead of being able to ambulate to the bathroom.

Copyright © by TeachingSolutions.org. All rights reserved.

Free Sample Version of www.teachingsolutions.org/nclex-pn-review

86.) The correct response is "c".
The most important action is to ensure that the patient understands tuberculosis and what treatment he will require on an ongoing basis. TB is a treatable disease but the patient must complete the treatment. The other responses would be appropriate for the patient with TB, but none of the are the most important at the time of discharge.

87.) The correct response is "c".
One of the primary goals for a patient with COPD is to maintain the ability to perform activities of daily living. The patient with COPD does not usually have chest pain. Although treating infections would be a goal for a patient with COPD, this would not be the priority goal. Since patients with COPD retain carbon dioxide, it would not be a goal to increase those levels.

88.) The correct response is "d".
Exhaling through pursed lips is a passive action that requires less energy. If the patient exhales while lifting, he will expend less energy. Instructing the patient to hold his breath while lifting is the same as performing the Valsalva maneuver and may lead to cardiac arrhythmia. Lifting after exhaling and before inhaling is the same as holding his breath. Inhaling is an active action that requires more energy than exhalation.

89.) The correct response is "b".
The picture depicts a chest tube. The purpose of a chest tube is to remove air and fluid from the pleural space to allow expansion of the lung. Medications and oxygen are NOT administered through a chest tube. Chest tubes are not inserted to promote development of scar tissue in the lung.

Copyright © by TeachingSolutions.org. All rights reserved.

Free Sample Version of www.teachingsolutions.org/nclex-pn-review

90.) The correct response is "c".
The most accurate way to determine the placement of the ET tube is to auscultate breath sounds in both lungs. It is also important to watch for the symmetrical rise of the chest. If the nurse notices any abnormalities, the nurse should report to the RN in charge of the patient. The patient's skin color and respiratory rate and rhythm are important in evaluating the respiratory condition of the patient, but cannot be relied on to determine ET tube placement. Whether or not the ET tube cuff is inflated will not verify ET tube placement.

91.) The correct response is "d".
Hip flexion deformities develop when the hips and knees are flexed. Maintaining the prone position several times a day will help keep those joints in extension which will help prevent deformities. The side-lying, supine and semi-Fowler's positions will not prevent hip flexion.

92.) The correct response is "b".
Protein and carbohydrates are critical in promoting wound healing and preventing infection. A meal of chicken and an orange provide both of these. Eggs and bacon and cheeseburger and fries are high in fat without providing the nutrients needed for healing. Gelatin and tea will provide minimal essential vitamins and other nutrients.

93.) The correct response is "a".
A patient with leukemia is at risk for damage to the oral mucous membranes. Oral hygiene is critical for these patients, but it is better to provide this care without using a toothbrush. Applying petroleum jelly, rinsing with a gently mouthwash, and swabbing the mouth with moistened swabs are all better alternatives than a toothbrush for the patient with leukemia.

Copyright © by TeachingSolutions.org. All rights reserved.

Free Sample Version of www.teachingsolutions.org/nclex-pn-review

94.) The correct response is "d".
This question requires that the test taker knows that Montgomery straps are used to hold dressings in place. By using these straps, there is no need to pull the tape off during dressing changes. Pulling tape off repeatedly over time can result in skin breakdown. The other responses are not correct.

95.) The correct response is "a".
The patient with rheumatoid arthritis should choose a chair that will help to support the patient's joints and will be easy for the patient to get up. The best chair for this is a straight-backed chair with a slightly elevated seat to avoid extreme hip flexion. Recliners, a couch without a back and a rocking chair will not provide the support necessary.

96.) The correct response is "b".
It is critical that the nurse assess the patient about 30 minutes after administering pain medication to determine the effectiveness of the intervention. Medication should be administered before procedures or before repositioning the patient since either activity is likely to cause discomfort. Emotional support is important, but will not help manage the patient's pain after surgery. The use of the incentive spirometer will help to prevent atelectasis and resultant pneumonia, but will not help to manage pain.

Copyright © by TeachingSolutions.org. All rights reserved.

Free Sample Version of www.teachingsolutions.org/nclex-pn-review

97.) The correct response is "a".
Applying a water soluble lubricant to the nostril will help to prevent discomfort from the NG tube. The nurse should be sure that it is water soluble to prevent infection or other problems if some of the lubricant is inhaled into the respiratory tract. Repositioning the NG tube, lowering the head of the bed and irrigating the NG tube will have no effect on the local irritation from the NG tube.

123.) The correct response is "a".
The burn shown is relatively extensive. The nurse should know that monitoring fluids and electrolytes is the most critical action during the first few days after a burn. During this time, fluids and electrolytes shift from interstitial spaces to the burn wound and are lost to the environment. Managing pain, monitoring vital signs, and preventing infection are all critical interventions, but fluid replacement must be addressed first.

124.) The correct response is "d".
The best position for a thoracentesis (if the patient is able) is to have the patient seated and leaning on a table. By seating the patient, the intercostal spaces widen and any fluid in the pleural space will collect in the base of the thorax. This allows the physician to more easily insert the catheter into the space to remove the fluid.

Copyright © by TeachingSolutions.org. All rights reserved.

Free Sample Version of www.teachingsolutions.org/nclex-pn-review

125.) The correct response is "c".
In the scenario, the presence of low blood pressure, increased pulse, and vomiting of coffee ground material should lead the nurse to suspect upper GI bleed. The first intervention should be insertion of an NG tube to relieve gastric bloating, remove blood and other gastric contents, and relieve vomiting. Promethazine might cause the already compromised blood pressure to fall even lower so might not be appropriate for this patient. Determining stressors might be appropriate after the patient is stabilized. If tolerated, the patient should be placed in a position with head slightly elevated. This will help to prevent gastric reflux and possible aspiration.

126.) The correct response is "d".
According to the scenario, this bright red bleeding appeared 2 days post-operatively in a patient who had not been bleeding previously. The best response by the nurse is to take the patient's vital signs and call the surgeon with the information. It is possible that the surgical wound has opened and further intervention will be needed. Reinforcing or changing the dressing ignores the fact that there may be a critical complication in this patient. This bleeding is not normal in a patient who has not had bleeding in the postoperative period.

127.) The correct response is "b".
The "rule of nines" is used to determine the amount of body surface area that is burned. In this rule, the front and back of the torso each equal 18%, each leg equals 18%, each arm equals 9%, the head equals 9%, and the groin area equals 1%. This rule can help the clinician determine the amount of fluids that should be given.

Copyright © by TeachingSolutions.org. All rights reserved.

Free Sample Version of www.teachingsolutions.org/nclex-pn-review

128.) The correct response is "d".
Any time an elastic bandage is applied to an extremity, it is important to start at the most distal part and wrap toward the proximal. This will ensure better venous return. In this scenario, the nurse should start wrapping at the hand and wrap toward the forearm. The tension should be kept equal as the wrist is wrapped. There is no need to wrap all the way to the axilla for a wrist injury.

129.) The correct response is "c".
Low blood glucose levels can be treated with 15 grams of carbohydrates by mouth if available. This amount of glucose can be provided with a small glass of orange juice or regular soda (not diet) or a cup of milk. Tuna will not provide immediate access to carbohydrate.

130.) The correct response is "b".
Research indicates that suctioning the endotracheal tube should not exceed 15 to 20 seconds. Less than that will not provide adequate clearance of secretions. More time may increase the risk of hypoxia by pulling oxygen out of the respiratory tract.

131.) The correct response is "a".
Iodine is used during an IVP. Shellfish contain high levels of iodine. If the patient is allergic to shellfish, he is at high risk for an allergic reaction to IVP dye. Last menstrual period and urinary continence are not related to the IVP. Asking the patient if they have had an IVP in the past is good practice but is not the most important question to avoid risk for this patient.

Copyright © by TeachingSolutions.org. All rights reserved.

Free Sample Version of www.teachingsolutions.org/nclex-pn-review

132.) The correct response is "c".
Since the LP is done by inserting a needle into the spinal canal for removal of cerebrospinal fluid, the nurse should be concerned upon seeing serous fluid on the dressing. This probably indicates leakage of CSF and should be reported to the physician. The fact that the patient is asking about the test results does not need to be reported to the physician. A mild headache is not a cause for concern after an LP, but increasing headaches should be reported. Urinary output is not related to the lumbar puncture.

133.) The correct response is "a".
The nurse should remind the patient that she should not eat or drink for at least 8 hours before the test. Most instructions will include remaining NPO after midnight of the night before. There should be no abdominal pain during the procedure. The patient should not smoke after midnight on the night before the test. Although the patient might need a laxative after the test, there is no need to take a stool softener before the test.

134.) The correct response is "b".
The patient should be instructed to change positions slowly to allow the body a chance to reach equilibrium. Particularly in older patients, rapid changes of position can result in a drop in blood pressure, which can predispose the patient to dizziness and falls. The patient should be encouraged to use a walker if needed to provide stability. The eyes of aging adults can be adversely affected by bright lights; therefore, the nurse should encourage the patient to use lighting that illuminates the room without producing glare. The nurse should encourage the patient to exercise joints in order to strengthen them and minimize the possibility of falls.

Copyright © by TeachingSolutions.org. All rights reserved.