XIII. NCLEX® STRATEGY QUESTIONS

The NCLEX item writers constantly update the rules use to write questions. You may note differences in this printed copy and the video. This printed copy is updated to the latest changes. For example, the words “complaining of” have been replaced with “reported” to remain in compliance with NCLEX® standards. NCLEX® Strategy Questions are answered with the rationale in the Resource Documents found online.

1. The nurse is caring for a client that has metabolic acidosis secondary to acute renal failure. What is the initial client response to this problem?
   - 1. Respiratory rate increases to blow off acid.
   - 2. Respiratory rate decreases to conserve acid and buffer the kidneys response.
   - 3. Kidneys will excrete hydrogen and retain bicarb.
   - 4. Sodium will shift to cells and buffer the hydrogen.

2. The daytime charge nurse identifies that a client was treated for what condition during the night after reading the following chart entries?

   Progress Notes:
   11/22/14- 0125 Restless, picking at sheets, and pulling at IV tubing. Disoriented to place and time. Dyspnea on exertion noted. Dr. Timmons notified. Stat ABGs ordered.-------Mary Minee, RN
   11/22/14- 0145 Oxygen started at 2 liters per nasal cannula. Incentive Spirometry and deep breathing exercises initiated. Head of bed elevated to 30 degrees.---------Mary Minee, RN

   Lab reports:
   pH- 7.30
   paO2- 91mmHg
   paCO2- 50 mmHg
   HCO3- 24 mEq/L
   - 1. Respiratory Alkalosis
   - 2. Respiratory Acidosis
   - 3. Metabolic Alkalosis
   - 4. Metabolic Acidosis
3. A client is hospitalized hundreds of miles from home for a bone marrow transplant. The client is in reverse isolation while undergoing total body irradiation and intense chemotherapy. The client’s sibling, who has driven a great distance, comes to visit and has obvious manifestations of an upper respiratory infection. Which nursing action would be most appropriate at this time?

- 1. Do not allow the sibling to visit, and do not upset the client by mentioning the sibling’s visit.
- 2. Allow the sibling to wave at the client through the window or door, then offer the use of the unit phone so they can talk.
- 3. Allow the sibling to visit donning a sterile gown, mask, and gloves, but prohibit physical contact.
- 4. Allow the sibling to visit after donning a sterile gown, mask, and gloves and have the client wear a mask.

4. The client has returned to your unit after an escharotomy of the forearm. What is the priority nursing assessment?

- 1. Infection
- 2. Incision
- 3. Pain
- 4. Tissue perfusion

5. A nurse caring for a cancer client is teaching the client about precautions concerning the client’s risk for bleeding problems. The nurse identifies that teaching has been successful regarding bleeding precautions when the client makes which statements? Select all that apply.

☐ 1. “I cannot shave while I am at risk for bleeding.”
☐ 2. “It is important to gargle with a commercial mouthwash three times a day.”
☐ 3. “Stool softeners will help prevent rectal bleeding.”
☐ 4. “Prior to sexual intercourse, I will use a water-based lubricant.”
☐ 5. “I will use a soft toothbrush.”
6. Following a thyroidectomy, a client is complaining of shortness of breath and neck pressure. What should the nurse do?

   o 1. Stay with the client, remove the dressing, and elevate the head of bed.
   o 2. Call a code, open the trach, set and place the client in a flat, supine position.
   o 3. Have the client say “EEE” to check for laryngeal integrity, and assess Chvostek’s sign.
   o 4. Call the primary healthcare provider, and assess vital signs.

7. Question deleted due to NCLEX® changes. We apologize for any inconvenience, but we want to make sure you have the most up to date material so that you can pass the NCLEX® the first time.

8. The manic client has just interrupted the counselor’s group session for the 4th time and states “I already know this information dealing with others when you are down.” What should the nurse do at this time?

   o 1. Engage the client to walk with you to make another pot of coffee.
   o 2. Ask the group members to reflect on the client’s behavior to determine if it inappropriate.
   o 3. Ask the group to tell the client how they feel when interrupted.
   o 4. Instruct the client to perform jumping jacks and counting aloud to get rid of some energy.
9. After examining the eyes of the following client, the nurse would expect which correlating lab work?

- 1. Elevated cortisol level
- 2. Elevated thyroxine level
- 3. Decreased parathormone level
- 4. Increased calcitonin level

10. Which client is at **highest** risk for suicide?

- 1. Seventy-six year old widower with chronic renal failure
- 2. Nineteen year old taking antidepressants
- 3. Twenty-eight year old, post-partum crying weekly
- 4. Fifty year old with obsessive-compulsive disorder (OCD)

11. The client is transferred to the rehabilitation facility following an ischemic stroke affecting the right side and causing or resulting in aphasia. Which nursing action would promote communication with the client?

- 1. Encourage client to shake head in response to questions.
- 2. Speak in a loud voice during interactions.
- 4. Encourage the use of a radio to stimulate the client.
12. The nurse is caring for a client with pneumonia. Which nursing observation would indicate a therapeutic response to the treatment for the infection?

- 1. Oral temperature of 101 degrees F. (38.3 C); increased chest pain with non-productive cough
- 2. Productive cough with thick green sputum; states feels tired
- 3. Respirations 20, with no reports of dyspnea; moderate amount of thick, white sputum
- 4. White cell count of 10,000 mm³, urine output at 40 mL/hr and no sputum

13. Following a hip replacement surgery, an elderly client is ordered to begin ambulation with a walker. Which intervention by the nurse will best help this client?

- 1. Instruct the client to sit in a low chair for ease in getting up with a walker.
- 2. Make sure rubber caps are present on all 4 legs of the walker.
- 4. Instruct the client to practice tying your shoes before using the walker.

14. A client has been admitted to the medical unit with elevated ALT, AST and bilirubin levels. Identify where the nurse should anticipate discomfort. Place an “x” in the correct location.
15. A client had surgery for cancer of the colon and a colostomy was performed. Prior to discharge, the client states that swimming will no longer be allowed. The nurse’s response would be based on which understanding?

- 1. Swimming is not recommended. The client should begin looking for other areas of interest.
- 2. Swimming is not restricted if the client wears a dressing over the stoma at all times.
- 3. The client cannot go into water that is over the stoma area, but can go into water up to the stoma area.
- 4. There are no restrictions on the activity of a client with a colostomy; all previous activities may be resumed.

16. The nurse is evaluating whether a client understands the procedure for collecting a 24 hour urine sample. The nurse recognizes that teaching was successful when the client makes which statements? **Select all that apply.**

- 1. “I should start the 24 hour urine collection at the time of my first saved urine specimen.”
- 2. “If I forget to collect any urine, I will need to start over.”
- 3. “It is important to ensure that no feces or toilet tissue mixes with the urine.”
- 4. “When the 24 hours is up, I need to void and collect that specimen.”
- 5. “The urine specimen should be stored in my refrigerator during collection.”

17. A six-year-old client has been receiving chemotherapy for two weeks. The laboratory results show a platelet count of 20,000. What is the **priority** nursing action?

- 1. Encourage quiet play.
- 2. Avoid persons with infections.
- 3. Administer oxygen PRN.
- 4. Provide foods high in iron.
18. The nurse is caring for a client that has two IV access sites. One is a 20 gauge antecubital peripheral IV that was started yesterday for blood and has normal saline (NS) at a keep vein open rate. The other is a double lumen central line catheter with one port for Total Parenteral Nutrition and the other is used for blood samples. Where is the best site for the nurse to administer 20 mEq of potassium chloride (KCL) in 100 mL of normal saline(NS) over 4 hours?

- 1. Central line port that is being used for lab draws
- 2. Same line with the Total Parenteral Nutrition
- 3. Large bore antecubital
- 4. Start another peripheral IV

19. The nurse is admitting a client with newly diagnosed diabetes mellitus. Which findings does the nurse expect while completing the medical history and physical examination of this client? Select all that apply.

- 1. History of recurrent vaginal yeast infections
- 2. Reports of intolerance to the cold
- 3. Slow, slurred speech
- 4. Prescription change for glasses needed twice in past year
- 5. Reports of wanting to eat all the time
- 6. Amenorrhea

20. A client is admitted for evaluation of cardiac arrhythmias. What would be the most important information to obtain when assessing this client?

- 1. Ability to perform isometric exercises as ordered
- 2. Changes in level of consciousness or behavior
- 3. Recent blood sugar changes
- 4. Compliance with dietary fat restrictions
21. A nurse is caring for a client diagnosed with heart failure (HF). The client currently takes furosemide 40mg every morning, potassium 20mEq daily, and digoxin 0.25mg every day. Which client comment should the nurse assess first in caring for this client?

- 1. “My fingers and feet are swollen.”
- 2. “My weight is up 1 pound.”
- 3. “There is blood in my urine.”
- 4. “I am having trouble with my vision.”

22. A client with a T4 lesion is being cared for on the neuro rehabilitation unit. The client suddenly reports a severe, pounding headache. Profuse diaphoresis is noted on the forehead. The blood pressure is 180/112 and the heart rate is 56. What interventions should the nurse initiate? Select all that apply.

- 1. Place the client supine with legs elevated.
- 3. Examine skin for pressure areas.
- 4. Eliminate drafts.
- 5. Remove triggering stimulus.
- 6. Administer hydralazine (Apresoline®) if BP does not return to normal.

23. The nurse is caring for a client in the 8th week of pregnancy. The client is spotting, has a rigid abdomen, and is on bed rest. What is the most important assessment at this time?

- 1. Protein in the urine
- 2. Fetal heart tones
- 3. Cervical dilation
- 4. Hemoglobin and hematocrit levels
24. An elderly, confused client with dehydration is admitted to your unit. Which intervention would be the best to delegate to the LPN/LVN?
   - 1. Develop a plan of care to monitor intake and output
   - 2. Reinforce the teaching plan with the client’s family
   - 3. Maintain fresh fluids at bedside
   - 4. Assess I & O for adequate fluid replacement

25. A nurse in an urgent care clinic is assisting with triage when five clients present to the clinic at the same time. Prioritize the order in which the nurse should attend to the clients.

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<tbody>
<tr>
<td>1.</td>
<td>The client who is limping after “spraining” the right ankle.</td>
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<tr>
<td>2.</td>
<td>The client who is experiencing heaviness in the chest after eating a big meal.</td>
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<tr>
<td>3.</td>
<td>The client who is running a fever and reports muscle aches and malaise.</td>
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<td>4.</td>
<td>The client who is applying pressure to the hand after sustaining a minor cut.</td>
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<tr>
<td>5.</td>
<td>The client who is having difficulty breathing after eating shellfish.</td>
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