NCLEX Exam Practice

NclexMasters Audio Visual Practice

Assessment Intervention ~ Exam # 1.

15 Questions Answers and Rationales

Reading along with the instructor is suggested as the best practice.

Students must always select the best answer based on the following parameters:

1 - the best answer must be one that is 'safe and effective' intervention for a patient.

2 - identify the nursing process in the question - assessment, diagnose, planning, implementation and evaluation.

3 - eliminate first the most obvious wrong answers, select and keep in your mind the potentially best answer.

5 - questions of physical integrity must have answers of physical integrity too.

6 - remember the rules for correct delegation of patients to staff nurses and assistant personnel.

7 - guess answers only when you know that...you do not know - use guessing rules.

8 – all questions require you to identify the nursing process, the patients needs and whether interventions are of chronic or critical care.

9 – all questions require you to know clinical values for all populations.

10 – all questions require your 'critical thinking'; apply your clinical knowledge pretending intervention of a patient.

11 – remember the clinical reasoning for the correct answer; learn why other options are incorrect.

12 – keep in mind the rules for medication administration

The two most important elements when discerning the most correct answer are whether the answer is part of an intervention that is **'safe' and 'effective'**.

Students should use this as a guideline; if an answer doesn't have the two elements of a 'safe' and 'effective' intervention, whether seeking the physical or psychosocial integrity of a patient, that answer cannot be the 'best' answer and it's only partially correct and therefore the wrong answer. Only the best answer is correct.

Most questions will present the nurse with 4 multiple choice format; one answer will be obviously wrong, another one will be the best answer, two more will lack either 'safe' or the 'effective' intervention parameters, but very close in content to the best answer, and serve as 'distracting answers' that will test the nurse's clinical knowledge.

Exam content

The majority of test items are written at the application or higher levels of cognition but the exam may include items at all of the cognitive levels; mainly, memorization or recalling, knowledge, analysis and application. All nurses taking the exam must have an ample knowledge of the nursing sciences at the entry level.

The exam's content is based on client needs:

Safe Effective Care Environment

- Management of Care
- Safety and Infection Control

Health Promotion and Maintenance

Psychosocial Integrity

Physiological Integrity

- Basic Care and Comfort
- Pharmacological and Parenteral Therapies
- Reduction of Risk Potential
- Physiological Adaptation

---

1. Which interaction occurs when two drugs with the same qualitative effects produce a greater response when given together than either drug produces when given alone?

- A. Tolerance
- B. Antagonism
- C. Hyporeactivity
- D. Synergism

2. During a physical examination, the nurse asks a patient to hold the breath briefly, and then uses a stethoscope to auscultate over the carotid arteries. Which finding is normal when auscultating over these arteries?

- A. No sounds heard over either carotid artery
- B. Faint swishing sounds heard over both carotid arteries
- C. Throbbing pulsations heard bilaterally
- D. Louder sounds heard over the right carotid artery than the left carotid artery

3. When routinely evaluating a patient for any atypical signs or symptoms, the nurse should remember that:

- A. aging can reduce the body's ability to regulate body temperature
- B. aging can increase pain perception
- C. anesthesia usually causes psychotic behavior postoperatively in a geriatric patient
- D. the risk of developing emphysema is highest in the elderl

4. A child with suspected rheumatic fever is admitted to the pediatric unit. When obtaining the child's history, the nurse considers which information to be most important?

- A. A fever that started 3 days ago
- B. Lack of interest in food
- C. A recent episode of pharyngitis
- D. Vomiting for 2 days

5. A patient continues to stalk a man whom she met briefly 3 years ago. She believes he loves her and eventually will marry her and has been sending him cards and gifts. When she violates a restraining order he has obtained, a judge orders her to undergo a 10-day psychiatric evaluation. What is the most probable psychiatric diagnosis for this patient?

- A. Delusional disorder--jealous type
- B. Induced psychotic disorder
- C. Delusional disorder--erotomanic type
- D. Schizophreniform disorder

6. A patient, age 36, with paranoid schizophrenia believes the room is bugged by the Central Intelligence Agency and that a roommate is a foreign spy. The patient has never had a romantic relationship, has no contact with family members, and has not been employed for the past 14 years. Based on Erikson's theories, the nurse should recognize that this patient is in which stage of psychosocial development?

- A. Autonomy versus shame and doubt
- B. Generativity versus stagnation
- C. Integrity versus despair
- D. Trust versus mistrust

7. A patient with chronic schizophrenia who takes neuroleptic medication is admitted to the psychiatric unit. Nursing assessment reveals rigidity, fever, hypertension, and diaphoresis. These findings suggest:

- A. tardive dyskinesia
- B. dystonia
- C. neuroleptic malignant syndrome
- D. akathisia

8. An attorney who throws books and furniture around the office after losing a case is referred to the psychiatric nurse in the law firm's employee assistance program. The nurse knows that the patient's behavior represents the use of which defense mechanism?

- A. Regression
- B. Projection
- C. Reaction formation
- D. Intellectualization

9. The nurse is teaching a pregnant patient how to distinguish prelabor contractions from true labor contractions. Which statement about prelabor contractions is accurate?

- A. They are regular.
- B. They usually are felt in the abdomen.
- C. They start in the back and radiate to the abdomen.
- D. They become more intense during walking.

10. The nurse is reviewing a patient's prenatal history. Which finding indicates a genetic risk factor?

- A. The patient is 25 years old.
- B. The patient has a child with cystic fibrosis.
- C. The patient was exposed to rubella at 36 weeks' gestation.
- D. The patient has a history of preterm labor at 32 weeks' gestation.

11. A patient with human immunodeficiency virus (HIV) infection delivers a neonate. When assessing the neonate, the nurse is most likely to detect:

- A. skin vesicles
- B. limb dysmorphism
- C. conjunctivitis
- D. hepatosplenomegaly

12. A patient comes to the emergency department complaining of acute GI distress. When obtaining the patient's history, the nurse inquires about the family history. Which disorder has a familial basis?

- A. Hepatitis
- B. Iron-deficiency anemia
- C. Ulcerative colitis
- D. Chronic peritonitis

13. Which of the following is the most numerous type of white blood cells (WBCs)?

- A. Neutrophil
- B. Eosinophil
- C. Basophil
- D. Lymphocyte

14. A patient has a herniated disk in the region of the third and fourth lumbar vertebrae. On assessment, the nurse expects to note:

- A. hypoactive bowel sounds
- B. severe low back pain
- C. sensory deficits in one arm
- D. weakness and atrophy of the arm muscles

15. Family members would like to bring in birthday cake for a patient with nerve damage. What cranial nerve needs to be functioning so the patient can chew?

- A. cranial nerve II
- B. cranial nerve V
- C. cranial nerve IX
- D. cranial nerve X

Assessment Exam 1 Answers and clinical reasoning

1. The nurse is administering two drugs concomitantly to a patient. Which interaction occurs when two drugs with the same qualitative effects produce a greater response when given together than either drug produces when given alone?

   The correct answer is: D - Synergism

   REMEMBER THE CLINICAL REASONING: Synergism, or a synergistic effect, occurs when two drugs with the same qualitative effects produce a greater response when given together than either drug produces when given alone.

   THE OTHER OPTIONS ARE INCORRECT BECAUSE OF THE FOLLOWING :

   Tolerance is a decreased response or decreased sensitivity of the receptor to a drug.

   Hyporeactivity is a less-than-usual response to a normal drug dose.

   Antagonism occurs when the combined response to two drugs given together is less than the response either drug produces when given alone.

   NURSING PROCESS : Assessment

   PATIENT NEED: Physiological integrity

   TAXONOMY: Knowledge.

2. During a physical examination, the nurse asks a patient to hold the breath briefly, and then uses a stethoscope to auscultate over the carotid arteries. Which finding is normal when auscultating over these arteries?

   The correct answer is: A. No sounds heard over either carotid artery

   REMEMBER THE CLINICAL REASONING: Absence of sounds over either carotid artery indicates unobstructed blood flow. Auscultation of any sounds (bruits) is abnormal.

   NURSING PROCESS : Assessment

   PATIENT NEED: Physiological integrity

   TAXONOMY: Knowledge

3. When routinely evaluating a patient for any atypical signs or symptoms, the nurse should remember that:

   The correct answer is: A. aging can reduce the body's ability to regulate body temperature

   REMEMBER THE CLINICAL REASONING: In an assessment, the nurse should remember that aging can reduce the ability to regulate body temperature. This not only increases the geriatric patient's susceptibility to hyperthermia and heat stroke but also decreases the ability to produce a fever in response to infection. A geriatric patient may exhibit decreased (not increased) pain perception. Many medications, such as anesthetic agents and analgesics, can cause confusion or depression (not psychotic behavior) in a geriatric patient. The risk of developing emphysema is highest in smokers, regardless of age.

   NURSING PROCESS : Assessment.

   PATIENT NEED: Physiological integrity.

   TAXONOMY: Analysis

4. A child with suspected rheumatic fever is admitted to the pediatric unit. When obtaining the child's history, the nurse considers which information to be most important?

   The correct answer is: C. A recent episode of pharyngitis

   REMEMBER THE CLINICAL REASONING: A recent episode of pharyngitis is the most important factor in establishing the diagnosis of rheumatic fever. Although the child may have a history of fever or vomiting or lack interest in food, these findings are not specific to rheumatic fever.

   NURSING PROCESS : Assessment

   PATIENT NEED: Physiological integrity

   TAXONOMY: Analysis

5. A patient continues to stalk a man whom she met briefly 3 years ago. She believes he loves her and eventually will marry her and has been sending him cards and gifts. When she violates a restraining order he has obtained, a judge orders her to undergo a 10-day psychiatric evaluation. What is the most probable psychiatric diagnosis for this patient?

   The correct answer is: C. Delusional disorder--erotomanic type

   REMEMBER THE CLINICAL REASONING: In delusional disorder of the erotomanic type, the patient has an erotic delusion of being loved by another person and tries to contact the object of the delusion through such behaviors as sending gifts, calling, and stalking. The object of the undesired attention may be a complete stranger and usually is of higher status. In a delusional disorder of the jealous type, the patient has the delusion that the sexual partner is unfaithful. In a psychotic disorder, a delusion occurs within the context of a close relationship. Schizophreniform disorder involves bizarre delusions and hallucinations of less than 6 months' duration.

   NURSING PROCESS : Assessment

   PATIENT NEED: Psychosocial integrity

   TAXONOMY: Evaluation

6. A patient, age 36, with paranoid schizophrenia believes the room is bugged by the Central Intelligence Agency and that a roommate is a foreign spy. The patient has never had a romantic relationship, has no contact with family members, and has not been employed for the past 14 years. Based on Erikson's theories, the nurse should recognize that this patient is in which stage of psychosocial development?

   The correct answer is: D. Trust versus mistrust

   REMEMBER THE CLINICAL REASONING: This patient's paranoid ideation indicates difficulty trusting others. The stage of autonomy versus shame and doubt deals with separation, cooperation, and self-control. Generativity versus stagnation is the normal stage for this patient's chronologic age. Integrity versus despair is the stage for accepting the positive and negative aspects of one's life, which would be difficult or impossible for this patient.

   NURSING PROCESS : Assessment

PATIENT NEED: Psychosocial integrity

TAXONOMY:: Knowledge

7. A patient with chronic schizophrenia who takes neuroleptic medication is admitted to the psychiatric unit. Nursing assessment reveals rigidity, fever, hypertension, and diaphoresis. These findings suggest:

The correct answer is:C. neuroleptic malignant syndrome

REMEMBER THE CLINICAL REASONING: The patient's signs and symptoms suggest neuroleptic malignant syndrome, a life-threatening reaction to neuroleptic medication that requires immediate treatment. Tardive dyskinesia causes involuntary movements of the tongue, mouth, facial muscles, and arm and leg muscles. Dystonia is characterized by cramps and rigidity of the tongue, face, neck, and back muscles. Akathisia causes restlessness, anxiety, and jitteriness.

NURSING PROCESS : Assessment.

PATIENT NEED: Safe, effective care environment.

TAXONOMY: Knowledge.

8. An attorney who throws books and furniture around the office after losing a case is referred to the psychiatric nurse in the law firm's employee assistance program. The nurse knows that the patient's behavior represents the use of which defense mechanism?

The correct answer is : A. Regression

REMEMBER THE CLINICAL REASONING: An adult who throws temper tantrums, such as this one, is displaying regressive behavior--behavior that is appropriate at a younger age. In projection, the patient blames someone or something other than the source. In reaction formation, the patient acts in opposition to feelings. In intellectualization, the patient overuses rational explanations or abstract thinking to decrease the significance of a feeling or event.

NURSING PROCESS : Assessment

PATIENT NEED: Psychosocial integrity

TAXONOMY: Analysis

9. The nurse is teaching a pregnant patient how to distinguish prelabor contractions from true labor contractions. Which statement about prelabor contractions is accurate?

The correct answer is: B. They usually are felt in the abdomen.

REMEMBER THE CLINICAL REASONING: Prelabor contractions usually are felt in the abdomen. In contrast, true labor contractions start in the back and radiate to the abdomen, are regular, and become more intense during walking.

NURSING PROCESS : Assessment

PATIENT NEED: Health promotion and maintenance

TAXONOMY: Analysis

10. The nurse is reviewing a patient's prenatal history. Which finding indicates a genetic risk factor?

The correct answer is: B. The patient has a child with cystic fibrosis.

REMEMBER THE CLINICAL REASONING: Cystic fibrosis is a recessive trait; each offspring has a one in four chance of having the trait or the disorder. Maternal age is not a risk factor until age 35, when the incidence of chromosomal defects increases. Maternal exposure to rubella during the first trimester may cause congenital defects. Although a history of preterm labor may place the patient at risk for preterm labor, it does not correlate with genetic defects.

NURSING PROCESS : Assessment

PATIENT NEED: Safe, effective care environment

TAXONOMY: Knowledge

11. A patient with human immunodeficiency virus (HIV) infection delivers a neonate. When assessing the neonate, the nurse is most likely to detect:

The correct answer is: D. hepatosplenomegaly.

REMEMBER THE CLINICAL REASONING: A neonate with HIV infection typically has hepatosplenomegaly, a distinctive facial dysmorphism, interstitial pneumonia, recurrent infections, behavioral deviations, and neurologic abnormalities. The other options are not typical findings in neonates with HIV infection.

NURSING PROCESS : Assessment
PATIENT NEED: Physiological integrity

TAXONOMY: Knowledge

12. A patient comes to the emergency department complaining of acute GI distress. When obtaining the patient's history, the nurse inquires about the family history. Which disorder has a familial basis?

The correct answer is: C. Ulcerative colitis

REMEMBER THE CLINICAL REASONING: Ulcerative colitis is more common in persons who have family members with the disease. (The same is true of some types of GI cancers, ulcers, and Crohn's disease.) Hepatitis, iron-deficiency anemia, and chronic peritonitis are acquired disorders that do not run in families.

NURSING PROCESS : Assessment

PATIENT NEED: Health promotion and maintenance

TAXONOMY: Knowledge.

13. Which of the following is the most numerous type of white blood cells (WBCs)?

The correct answer is: A. Neutrophil

REMEMBER THE CLINICAL REASONING: Neutrophils are the most numerous of the WBCs, comprising about 65%. Lymphocytes are the second most abundant. Eosinophils account for about 2% while basophils are the least abundant.

NURSING PROCESS : Assessment

PATIENT NEED: Physiological integrity

TAXONOMY: Comprehension

14. A patient has a herniated disk in the region of the third and fourth lumbar vertebrae. On assessment, the nurse expects to note:

The correct answer is: B. severe low back pain

REMEMBER THE CLINICAL REASONING: The most common finding in a patient with a herniated lumbar disk is severe low back pain, which radiates to the buttocks, legs, and feet--usually unilaterally. A herniated disk also may cause sensory and motor loss (such as foot drop) in the area innervated by the compressed spinal nerve root. During later stages, it may cause weakness and atrophy of leg muscles. The condition does not affect bowel sounds or the arms.

NURSING PROCESS : Assessment

PATIENT NEED: Safe, effective care environment

15. Family members would like to bring in birthday cake for a patient with nerve damage. What cranial nerve needs to be functioning so the patient can chew?

The correct answer is: B. cranial nerve V

REMEMBER THE CLINICAL REASONING: Chewing is a function of cranial nerve V. Swallowing is a motor function of cranial nerves IX and X. Cranial nerve II does not possess a motor function.

NURSING PROCESS : Assessment

PATIENT NEED: Safe, effective care environment

TAXONOMY: Knowledge