1. A, B, E, F...discussed on webinar
2. B, C, D, F...discussed on webinar
3. B...discussed on webinar
4. C...discussed on webinar
5. B...discussed on webinar
6. A, C, E...discussed on webinar
7. D...discussed on webinar
8. C...discussed on webinar
9. C...discussed on webinar
10. D...discussed on webinar
11. 5, 1, 2, 4, 3...Here you are being asked to prioritize your nursing actions in the context of a blood transfusion reaction. The numbers go next to the order of the step, thus first thing you would do is stop the transfusion, then maintain the patent IV line with normal saline, then monitor the client’s vital signs and urine output, then send the blood bag and tubing to the blood bank, and last document the occurrence. If the question on the boards was a drop and drag, then you could move the answers and put in the correct order rather than using numbering as I have here, but the order of your actions would be the same.
12. C...This is the type of question where often new graduates make errors as the connect between how you have assessed a need and then how you would evaluate do not always match correctly. Remember that how you assess a need for intervention should direct you to a similar means of evaluating that intervention. Thus, when a nurse is assessing the need for suctioning an airway, the assessment is via breath sounds, thus you would evaluate effectiveness in that same method of assessment. If you chose A, that is more reflective of alteration in breathing patterns, thus as a patient moves from dyspnea to respirations of normal rate and rhythm as an example. If you chose B, that is more appropriate an evaluation for an oxygenation issue or changes in acid-base balance, but not suctioning. If you chose D, that is not relevant as an assessment or evaluation in this question. Nurses determine if patients require suctioning by auscultating the lungs and then if yes, suction, and then evaluate by auscultating to determine effectiveness.
13. D...The key in the question is PSYCHOSOCIAL, thus if you miss the word from not reading carefully or reading too fast you will miss the question most likely. A is wrong as we generally don’t leave patients alone to meet their psychosocial needs, esp prior to surgery. Not therapeutic. Option B is wrong as not everyone wants to be seen by clergy, esp as it may indicate an impending outcome that they may fear, thus not therapeutic. If patient asks for clergy that is up to them, not nurses ensuring this takes place. Option c is wrong as this deals with physiological needs versus psychosocial needs. Thus D is correct and discussing the meaning of the surgery with the client is the most therapeutic action by the nurse.
14. The key here is if you don’t know the answer to think about a newborn and the fact that they have immature body systems overall, thus making them more at risk for HYPO conditions, with exception of Hyperbilirubinemia (jaundice). Option A would be wrong as a HYPER condition and not a risk for a neonate and more specifically a neonate who is a product of a mother with DM. Option B is wrong as neonates are at risk for hyperbilirubinemia as described above as neonate is impacted by the breakdown of RBC of their own and mom’s esp if breast feeding (physiological or milk jaundice) or from a blood incompatibility. A neonate who is a product of a mother with diabetes mellitus, beside generally being large for gestational age, is at risk for neonatal hypoglycemia which can lead to an increased risk of seizures (remember that glucose is the energy source for the brain). Thus the only right answer can be D and it is right as neonates as explained above are most at risk for HYPO conditions.

15. You do not need to know how to run or manage a ventilator, other than the alarms as this is what any educated nurse should recognize without extra education. The three alarms you want to understand is the high pressure alarm as in this question, the low pressure alarm, and the oxygen alarm. The high pressure alarm is going to go off when the pressure gradient between the ventilator and the patient is too high. Circumstances such as A, B, C, and F....patient “fighting the vent”, increased secretions in the airway, a kink in the tubing, and the patient biting the endotrach tube. All of these instances would make the ventilator have to “work” harder to effectively aerate the patient, thus causing the high pressure alarm to go off. The nurse’s responsibility would be to manage the circumstances to alleviate the high pressure changes. Similarly, if the low pressure goes off, circumstances that would cause the ventilator not to have enough pressure to aerate the patient would be a cuff leak in the endotrach tube or a disconnect or a leak of any kind in the tubing. Lastly, the oxygen alarm would go off usually when the oxygen levels have been adjusted on the ventilator but the alarm settings were not also changed.

16. B....A Mantoux test is another name for a PPD. Remember when a PPD is administered, the reading by the nurse of the induration of the patient takes place in 2 days or 48 hours. If the induration is 10-15 mm in a non immunocompromised patient is assessed, the result is negative; if the induration is 5-10 in a immunocompromised patient is assessed, the result is negative. Remember it would take less exposure to tuberculosis for a positive result to occur in an immunocompromised patient versus a non immunocompromised patient. Anything over 10-15 in those patients or over 10 in an immunocompromised patient would be positive. In this question, an induration in a patient with no history of immunosuppressive disease would indicate a negative response. Also, a positive PPD indicates exposure, but it is not indicative of disease. Following a positive PPD, a Chest xray would be done to examine for the presence of a tubercle in the lung. If positive, then a sputum analysis would be done, which is the only method of diagnosing TB as the organisms would be present in the sputum.

17. Questions about self breast exam or teaching the same are ones you do not want to miss as breast cancer is a commonly asked about disorder on the NCLEX. The correct choices are 1, 3, 4, 6, and 7. When doing SBE, it should be done 2-3 days after period ends or could also be written 7 days from beginning of period.....these are essentially the same timeframe as most women menstruate for 5 days. Women should inspect breast before a mirror as changes in breast tissue can be visualized in this manner but not be noted from other perspectives. The same is true for inspecting when bending over at the waist as it changes the perspective of the breasts, by
palpation in the shower, and by palpating from outer to inner in small circles or in a horizontal motion in sections. Do not choose answers that state that changes or lumps, etc are of no concern, that lumps are normal or that it is not necessary to palpate the axilla or even the nipple. These are inappropriate.

18. Here you need to prioritize...so ABC; other physiological; safety and security; love and belonging; and Actual before Risk. Make sure you read through all options before choosing who is priority. The correct answer is A. This patient with newly diagnosed DM needs insulin coverage before breakfast which needs to be done by nurse and would occur at beginning of shift. While B is scheduled for OR, they would not be higher priority than someone requiring insulin as no time is given as to when and nothing to be done can not be delegated, if occurring at same time. The newly diabetic is the priority. Patient with COPD, option C, is not priority as they are not experiencing actual issues in the respiratory system, thus not a priority. Similarly, option D is a patient in sickle cell crisis, but has not actual priority issues at this time.

19. Here you have to have understanding of drainage immediately following surgery, esp chest surgery as this patient has had. In the first 24 hours, a patient may have drainage near 500cc or higher depending on the area of the body, but chest surgery is bloody, thus 200cc in the first hour is not out of the ordinary, thus document the findings, option C. If you chose option D, notify the physician, you are leaving decision making to dr when you can fully manage this.

20. C....in this question, it is imperative for you to note that A, B, and D, all entail giving the patient something to swallow. This is not recommended in a patient who might have residual dysphagia as if they are having difficulty swallowing, they could choke or aspirate. The only option that can assist with swallowing assessment but does not entail the patient having to swallow food or liquids is option C and that would be correct. From a test taking perspective, when answers are too similar, you can usually eliminate them, especially in a multiple choice question.

21. The patient is exhibiting extrapyramidal symptoms (EPS), adverse effect of many antipsychotics. This is an emergent situation and the nurse would need to give an antidote. The correct answer is D, Cogentin. But if you didn’t know that you can still get this, by using some of my strategies, and of course reading carefully each option. The fact that this is an emergency, you can eliminate option A and C, as they are PO medication orders and a PO would be too slow to work and thus inappropriate. When left with B and D, Narcan is for narcotics of which you know most of them and Prolixin is not one of them, thus eliminate it and you would be left with D and been right.

22. When patients are burned anyway in he head and neck region, the nurse’s priority is to assess for the immediacy of airway obstruction which can occur as edema is a result of a burn injury, thus option B, increased hoarseness, indicating that the patients airway may be edematous and/or closing. Options A, C, and D are not priorities as they do not address the area of the burns and thus the complications that can occur.

23. This question requires that you understand the dietary restrictions that come with renal failure and then to apply those to food choices. The correct answer is D, applesauce. Even if you did not know why, you can use process of elimination to get rid of ABC, but also, applesauce is most like baby food and when in doubt go with something that would not “hurt” a baby, thus would be good when the kidneys are failing. Bananas are high in potassium, thus if the renal function is decreased, potassium can build up in body and lead to hear alterations or dysrhythmias. Red meat is a protein and converts to nitrogen when broken down and a renal patient already has an
increased BUN (blood urea nitrogen) thus not appropriate as a good choice. Lima beans and many green veggies are high in phosphorous which can be more damaging to the body when it is not excreted. High phosphorus can cause calcium to be pulled from bones and cause bone breakages as well as alterations to heart and lungs.

24. This is a growth and development question related to the elderly. The best response is option D, that the client received meals at the senior center and have transportation to get there and home. Many elderly are socially isolated and need companionship and social interactions to continue to maintain health and a desire to live. Option A is the worst option as there is no necessity to recommend this action within this question. Option B meets the client’s nutritional needs but not their social needs. Option C meets their needs for food in house but not their need to ensure it is prepared and again not their social needs.

25. If you know that the medulla is located in the brainstem and that the medulla houses the respiratory center, you would have chosen the correct response, D. The other options are not controlled by the brainstem, thus not appropriate responses.