

NCLEX Brain Busters



NCLEX “BRAIN BUSTER” QUESTION

The nurse provides care for a client who presents to the emergency department (ED) with restlessness, diarrhea, nausea, vomiting, and heart palpitations. The client is prescribed theophylline for the treatment of asthma. Which laboratory and/or diagnostic test should the nurse anticipate for this client? Select all that apply.

- Serum potassium level
- Serum theophylline level
- Electrocardiogram (ECG)
- Electroencephalogram (EEG)
- Computed tomography (CT) scan

Answer & Rationale

- **Ask:** Tests to anticipate
 - **Problem:** Theophylline for asthma; restless with diarrhea, nausea, vomiting, & heart palpitations
 - **Solution:** Think of the worst case scenario
 - Restlessness, N/V/D, & palpitations = S/S of theophylline toxicity
 - Lab test = theophylline level (normal range of 10-20 mcg/mL)
1. Incorrect - Theophylline does not impact potassium levels
 2. **Correct - Drug toxicity is suspected, therapeutic range is 10 to 20 mcg/mL**
 3. **Correct - Theophylline toxicity is associated with life-threatening cardiac dysrhythmia**
 4. Incorrect - While theophylline toxicity is associated with seizure activity, the current clinical data does not warrant this diagnostic test.
 5. Incorrect - A CT scan is not warranted to monitor a client for symptoms associated with theophylline toxicity.

NCLEX

“BRAIN BUSTER” QUESTION

A client who is diagnosed with congestive heart failure is scheduled to receive an intravenous push (IVP) dose of furosemide, 40 mg. As the nurse reviews the client’s morning labs, the following results are noted: Na⁺ 135 mEq/L; K⁺ 3.1 mEq/L; Ca⁺ 8.5 mg/dL; and Mg⁺ 2.1 mg/dL. Which lab result should be reported to the provider immediately?

- Na⁺
- K⁺
- Ca⁺
- Mg⁺

Answer & Rationale

- **Ask:** Lab results to report immediately
- **Problem:** Heart failure with scheduled furosemide IV push
- **Solution:** Remember furosemide leaves the body dry. Low fluid (because it makes you pee) and we lose potassium so this will decrease the potassium even further.

1. Incorrect - Na⁺ level of 135 mEq/L is within normal limits
2. **Correct - K⁺ level of 3.1 mEq/L already low; furosemide is K⁺ wasting & will further deplete potassium levels.**
3. Incorrect - Ca⁺ level of 8.5 mg/dL is within normal limits
4. Incorrect - Mg⁺ level of 2.1 mg/dL is within normal limits

“BRAIN BUSTER” QUESTION

The nurse provides care for a client who is recovering from an acute myocardial infarction (MI). The client's cardiac rhythm indicates a rate of 180 beats/minute with monomorphic, wide QRS complexes. Which rhythm does the nurse identify based on the current data?

- Bundle branch block
- Sinus tachycardia
- Ventricular pacing
- Ventricular tachycardia

Answer & Rationale

- **Ask:** Which cardiac rhythm
- **Problem:** Heart rate of 180 beats/min with wide QRS after MI
- **Solution:** Name the rhythm...Think about it - the rate is fast and it has something to do with the ventricles because the QRS complexes are wide and monomorphic

1. Incorrect - A bundle branch block is a QRS complex that is wider than 0.12 seconds.
2. Incorrect - Sinus tach is regular, normal & upright P waves before each QRS, rate faster than 100 beats BPM, QRS complexes and PR intervals are WNL
3. Incorrect - Ventricular pacing is a rhythm in which pacer spikes are noted before each QRS complex.
4. **Correct - Ventricular tachycardia has a rapid rate and wide QRS complexes that are greater than 0.12 seconds.**

“BRAIN BUSTER” QUESTION

A client newly transferred to the unit presents with a rapidly declining respiratory status after becoming septic. Which assessment finding requires the nurse to contact the healthcare provider (HCP)? See below for nurse’s notes.

- Crackles in both lung bases
- A decline in PaCO₂
- Hypoxemia unresponsive to treatment
- Temperature 102* (38.9*C)

Answer & Rationale

- **Ask:** Findings requiring HCP notification
- **Problem:** Sepsis with respiratory decline, decreasing PaO₂, & increasing CO₂
- **Solution:** Think about findings to share with the HCP that leads to the worst possible outcome. Consider hypoxia

1. Incorrect - Crackles are expected in acute respiratory syndrome and would not require contacting the HCP.
2. Incorrect - The decline in PaCO₂ is a positive finding thus does not require HCP notification
3. **Correct - Hypoxemia that does not respond to treatment is the hallmark sign of acute respiratory syndrome and has a high mortality rate.**
4. Incorrect - A temperature of 102 F is an expected finding for a client who is diagnosed with sepsis and does not need to be reported to the HCP.

NCLEX “BRAIN

BUSTER” QUESTION

The nurse provides care for a client who is diagnosed with Addison’s disease. Which clinical manifestation does the nurse anticipate for this client due to primary adrenocortical insufficiency? Select all that apply.

- Skin color that is tanned in appearance
- Anorexia and weight loss
- Increased body or facial hair
- Orthostatic hypotension
- Purple or red striae on the abdomen

Answer & Rationale

- **Ask:** Clinical Manifestations
- **Problem:** Addison’s Disease
- **Solution:** Think Addison’s = “ADD some steroid”. We have an absence of steroids so our clients appear skinny and frail with a dark tan.

1. **Correct - Tanned pigmentation of the skin is expected for the client** diagnosed with primary adrenocortical insufficiency.
2. **Correct - Anorexia with weight loss is an expected clinical manifestation.**
3. Incorrect - Hirsutism is an expected clinical manifestation for the client who is diagnosed with Cushing syndrome, not Addison’s disease.
4. **Correct - Orthostatic hypotension is an expected clinical manifestation.**
5. Incorrect - Striae on the abdomen is an expected finding for the client diagnosed with Cushing syndrome, not Addison’s disease.

NCLEX “BRAIN BUSTER” QUESTION

The nurse provides discharge instructions for a client who has been hospitalized four times in the past twelve months for complications associated with congestive heart failure (CHF). Which client statement indicates an accurate understanding of the information presented by the nurse? Select all that apply.

- “I will eat lightly salted pretzels and potato chips for snacks” “I
- can eat canned soup and a sandwich for lunch each day” “I will
- try to walk a mile each morning if it’s not raining” “I will use
- salt-substitute to maintain good potassium levels” “I will weigh
- myself every morning right after my shower”

Answer & Rationale

- **Ask:** Statements indicate understanding
- **Problem:** Teaching related to frequent hospitalizations for CHF
- **Solution:** Think of statements that show correct understanding of teaching

1. Incorrect - CHF patients should decrease Na⁺ and fluid intake. All of these food choices contain sodium.
2. Incorrect - Education for CHF must include the importance of decreasing sodium and fluid intake. Canned soup is high in sodium
3. **Correct - Education for CHF includes encouragement of regular moderate exercise.**
4. **Correct - Diuretics can cause hypokalemia & the use of salt-substitute indicates understanding. Digoxin, used to treat CHF, is impacted by serum K⁺**
5. **Correct - Education with CHF includes monitoring for symptoms indicative of worsening heart failure (e.g., fluid volume excess, weight gain, edema).**

NCLEX

“BRAIN BUSTER” QUESTION

Which education point will the registered nurse (RN) provide to the client diagnosed with peripheral neuropathy related to type 2 diabetes? Select all that apply

- “Avoid wearing socks to prevent an increase in sweating and skin irritation”
- “Keep toenails cut close to the skin to avoid breakage of the nails”
- “Check the water temperature in tubs with a thermometer prior to entering the tub”
- “Check your feet, especially between your toes, each day and report any skin changes immediately”
- “Always wear some type of shoe, even if it is sandals when walking in the home or outdoors”

Answer & Rationale

- **Ask:** Which education to provide
- **Problem:** Peripheral neuropathy related to diabetes mellitus type II
- **Solution:** Before looking at the options- Think of two things you know about peripheral neuropathy related to diabetes mellitus type II.

Memory Trick: Diabetes - Destroys the organs with THICK syrupy blood! Diabetes = Diareties - turns fingers & toes into sugary treats for bacteria peripheral neuropathy—
check feet/no heat.

- decreased sensation in the extremities
- increased risk of injury because of decreased sensation

1. Incorrect - The client should wear cotton socks to help absorb sweating and protect the feet.
2. Incorrect - The client should not cut the nails close to the skin, but should instead file the nails, avoiding the skin.
3. **Correct - The diabetic client with peripheral neuropathy has lost sensation in the extremities so a thermometer is needed to discern accurate temperature.**
4. **Correct - The client with peripheral neuropathy cannot determine if there is injury to the feet through sensation so daily inspection is necessary.**
5. Incorrect - The client should always wear shoes when ambulating, but these shoes should be closed toe/heel type shoes.

NCLEX “BRAIN

BUSTER” QUESTION

Which medication does the nurse expect the healthcare provider (HCP) to prescribe for a client who is diagnosed with heart failure and reports a nagging cough and an incident of angioedema with the use of enalapril?

- Alprazolam 0.75mg PO daily
- Guaifenesin 15 mg daily
- Captopril 40 mg PO daily
- Losartan 80 mg PO daily

Answer & Rationale

- **Ask:** Best medication substitution
- **Problem:** Nagging cough & angioedema with enalapril
 - Think side effects of ACE inhibitors end in “-pril” which are first line drugs for HIGH blood pressure.

ARBs “-Sartan” is SSSecond line drug

- **Solution:** Substitution for ACE medication

1. Incorrect - “-pam” and “-lam” are benzos, nothing to do with blood pressure
2. Incorrect - guaifenesin is a cough medication, nothing to do with blood pressure
3. Incorrect - “-pril” which is another ACE
4. Correct - Sartans are used SSSecond, after ACE inhibitors if the side effects **are too much**

NCLEX

“BRAIN BUSTER” QUESTION

Which clinical manifestation does the nurse anticipate when providing care for a client who is diagnosed with Graves' disease?
Select all that apply.

- Hand tremors
- Irregular heart rhythm
- Increased perspiration
- Insomnia and anxiety
- Exophthalmos
- Obesity

Answer & Rationale

- **Ask:** Anticipated clinical manifestations
- **Problem:** Graves' Disease
- **Solution:** Think Graves' Disease means Gains Disease. HYPERthyroidism.

Everything is high & hot so consider clinical manifestations that fall in this hyper and hot state.

1. Correct - Tremors of the fingers and the hands are an expected clinical manifestation for a **client who is diagnosed with Graves' disease.**
2. Correct - Heart palpitations or AFib are both clinical manifestations associated with Graves' disease.
3. Correct - Increased metabolic rate caused by an increase in thyroid hormones causes heat intolerance and increased perspiration.
4. Correct - Insomnia and anxiety are the direct result of the hypermetabolic rate that is caused by the increases in thyroid hormones.
5. Correct - Hyperthyroidism causes tissue expansion of the muscle fibers located in the eye which **causes exophthalmos and a lag in the eyelid.**
6. Incorrect - The increased metabolic rate associated with Graves' disease causes a decreased appetite leading to weight loss, not weight gain or obesity.

“BRAIN BUSTER” QUESTION

The nurse is assessing a client who has been taking levothyroxine for two months for hypothyroidism. Which client statements should the nurse report? Select all that apply.

- “I take my levothyroxine each morning with my coffee or a full glass of grapefruit juice.”
- “I eat breakfast about 30-60 minutes after taking levothyroxine each morning.”
- “I will notify my healthcare provider immediately if I develop a sore throat/fever.”
- “The extreme fatigue I was experiencing seems to be improving.”
- “Each morning, I take levothyroxine, biotin, and a multivitamin.”

Answer & Rationale

- **Ask:** Incorrect statements
- **Problem:** Taking levothyroxine for two months
- **Solution:** Remember LEVothyroxine LEAVES those thyroid hormones in the body which makes everything amped up

1. Correct - Coffee and grapefruit juice inhibit the absorption of levothyroxine.
2. Incorrect - Levothyroxine should be taken at the same time each morning, with a full glass of water, on an empty stomach, 30-60 minutes prior to breakfast.
3. Incorrect - Agranulocytosis is an adverse effect of antithyroid medication and the client should be instructed to notify the health care provider about symptoms of infection.
4. Incorrect - Extreme fatigue would indicate the client was still experiencing hypothyroid symptoms.
5. **Correct - Multivitamins, when taken concurrently with levothyroxine, inhibit the absorption of levothyroxine and administered at least 4 hours apart.**

“BRAIN BUSTER” QUESTION

The nurse provides discharge instructions to a client who is diagnosed with peripheral arterial disease (PAD). Which client statement indicates a need for further instruction from the nurse? Select all that apply.

- “A heating pad should be used to restore circulation”
- “Anytime I am resting, I should elevate my legs”
- “I will begin walking around the neighborhood”
- “Moisturizing lotion should be applied to my legs daily”
- “Swelling is an expected finding with this disorder”

Answer & Rationale

- **Ask:** Statements needing clarification
- **Problem:** Discharge teaching for PAD
- **Solution:** Think about incorrect statements by the patient for PAD

1. **Correct - Due to peripheral neuropathy, the client may be unable to detect burning of the skin.**
2. **Correct - Clients with PAD should not elevate their legs for long periods as this further decreases circulation to the extremities.**
3. Incorrect - Moderate physical activity promotes circulation and should be encouraged for clients with PAD.
4. Incorrect - Daily skin care, including moisturizing the extremities with lotion, is included in the plan of care for clients with PAD.
5. Correct - Edema is expected in clients with peripheral venous insufficiency; however, this is not an expected finding in clients with PAD

NCLEX

“BRAIN BUSTER” QUESTION

A client reports calf pain when walking from the car to the supermarket. The pain stops when walking stops. Which assessment should the nurse perform?

Select all that apply.

- Assess both ankles for venous stasis ulcers and dermatitis
- Determine color and temperature of the lower extremities
- Establish if the client monitors their blood pressure daily
- Palpate presence and quality of dorsalis pedis pulses

Answer & Rationale

- **Ask:** Assessments to perform
- **Problem:** Client complaining of calf pain when walking from the car to the market and it stops when walking stops
- **Solution:** Think about intermittent claudication (calf pain) think intermittent “CALVE-ication”. When you’re walking, you have low oxygen to the muscles.

1. Incorrect - Ankle edema, venous stasis ulcers, and dermatitis indicate PVD, These symptoms are indicative of intermittent claudication indicating peripheral PAD.
2. Correct -The nurse should immediately check for blood flow by monitoring **color, temperature changes & other PAD symptoms.**
3. Incorrect - This is not relevant to determine if the client is experiencing intermittent claudication and PAD.
4. Correct - The nurse should immediately check for blood flow by checking **the most distal pulses.**

NCLEX “BRAIN BUSTER” QUESTION

The nurse provides medication teaching for a client who is newly prescribed citalopram for major depressive disorder. Which client statement indicates a correct understanding of the education provided by the nurse for this medication? Select all that apply.

- “I should expect some confusion as a result of this medication.”
- “If I miss a dose, I should not double my next dose.”
- “I will eat a well balanced diet and exercise to control weight gain.”
- “I won’t stop this medication abruptly.”
- “I might experience issues with sexual dysfunction.”
- “When I begin to feel better, I can stop taking this medication.”

Answer & Rationale

- **Ask:** Correct client statement
- **Problem:** Education about citalopram
- **Solution:** Look for remarks that are true Remember the S’s. We don’t take St. John’s Wort with SSRIs. SSRIs can increase the Suicidal ideations and often causes Sexual dysfunction

1. Incorrect - Confusion, a symptom associated with serotonin syndrome, is an adverse reaction to medication, not an expected side effect.
2. **Correct - The client should not take a double dose if the medication is missed due to the increased risk for serotonin syndrome.**
3. **Correct- This medication is associated with increased appetite which can cause weight gain.**
4. **Correct- Stopping this medication abruptly may cause withdrawal symptoms.**
5. Correct - Many selective serotonin reuptake inhibitors (SSRIs) may cause sexual dysfunction.
6. Incorrect -This medication should not be stopped when symptoms of depression are better.

“BRAIN BUSTER” QUESTION

Which information should the nurse include when providing medication teaching for a client who is newly prescribed rifampin 300 mg PO twice daily?
Select all that apply.

- Avoid wearing prescription contacts during treatment
- Limit alcohol intake to only a few times per week
- Report any red discoloration of urine and other body fluids to the HCP immediately
- Stop the medication if two sputum cultures come back negative
- Use non-hormonal forms of birth control while taking this medication

Answer & Rationale

- **Ask:** Information to include
- **Problem:** Education about Rifampin 300 mg po twice daily
- **Solution:** Think about teaching. With Rifampin, think RED like a reef, “REEF-ampin”. Bodily fluids can turn red.

1. **Correct - Rifampin causes an orange-red discoloration of bodily secretions, including tears, which can permanently discolor contact lenses**
2. Incorrect -The consumption of alcohol is contraindicated for the client who is prescribed rifampin due to the increased risk of hepatotoxicity.
3. Incorrect - This is an expected side effect.
4. Incorrect - Three negative sputum cultures and a negative chest x-ray indicate medication effectiveness.
5. **Correct - Rifampin can interact with oral hormonal contraceptives causing them to be ineffective for the prevention of pregnancy.**

“BRAIN BUSTER” QUESTION

Which action should the nurse implement first **when providing care for a client being admitted to the unit following stent placement for treatment of an ST segment elevation myocardial infarction (STEMI)?**

- Assess heart and lung sounds
- Assess blood pressure first then other vitals
- Obtain serial troponin levels
- Place the client on telemetry

Answer & Rationale

- **Ask:** First action to implement
 - **Problem:** Admission with STEMI
 - **Solution:** Think about priority actions on monitoring cardiac rhythm and circulatory function.
1. Incorrect - Initiating telemetry = immediate priority action on arrival to the unit.
 2. Incorrect - Telemetry is first priority action; vital signs should be monitored closely after.
 3. Incorrect - Critical need to continue monitoring the client for dysrhythmias immediately after STEMI so this is not the priority.
 4. **Correct - This is the priority action on arrival to unit post STEMI; VFib = most common & lethal arrhythmia after MI.**

NCLEX “BRAIN BUSTER” QUESTION

A client with a head injury develops syndrome of inappropriate antidiuretic hormone (SIADH). Which clinical manifestations should the nurse expect when assessing this client? Select all that apply.

- Decreased urine output
- Elevated serum osmolality
- Elevated urine specific gravity
- Decreased serum osmolality
- Decreased serum sodium

Answer & Rationale

- **Ask:** Clinical manifestations
- **Problem:** SIADH
- **Solution:** Think SIADH - SI we have a lot of water in the body... ADH it adds the H₂O. SIADH results in elevated levels of antidiuretic hormone. Elevated ADH, hypervolemia and decrease in serum osmolality and sodium. Think “S” for SIADH as Soaked inside.

1. **Correct - Urine output is decreased for the client who experiences SIADH.**
2. Incorrect - The increase in total body water that occurs as a result of SIADH causes a low serum osmolality due to dilution.
3. Correct - As antidiuretic hormone (ADH) continues to be secreted and water is retained, the client experiences a high specific gravity of the urine.
4. **Correct - Due to the increased total body water that is dilute, low serum osmolality is expected for the client who is diagnosed with SIADH.**
5. **Correct - Due to the increased total body water that is dilute, decreased serum sodium is expected for the client who is diagnosed with SIADH.**

“BRAIN BUSTER” QUESTION

The nurse provides care for a pediatric client who is diagnosed with central diabetes insipidus (DI). Which is the priority action by the nurse in the provision of care for this child?

- Assessing the child’s daily activity
- Monitoring intake & output (I&O)
- Instructing the family on medication administration
- Educating the child’s caregivers on symptoms of water intoxication

Answer & Rationale

- **Ask:** Priority action
- **Problem:** Central Diabetes Insipidus (DI)
- **Solution:** Memory trick for DI: The “D” is draining fluid from the body into the potty, leading to “D” for dehydration & dry Inside. Nursing interventions: measuring I&Os and preventing dehydration

1. Incorrect - This is not the priority action by the nurse.
2. **Correct - I&O provides essential information used to determine the need to adjust medications; therefore, this is the priority action by the nurse.**
3. Incorrect - The medication dose is based on the child’s I&O, thus is not the priority action by the nurse.
4. Incorrect - Monitoring I&O is the priority nursing action as this information is required for the therapeutic management of this disease process.

“BRAIN BUSTER” QUESTION

A client who is diagnosed with type 1 diabetes mellitus (DM) reports abdominal pain, appears weak, and is displaying Kussmaul respirations at 30 breaths/minute. What prescription should the nurse implement in the provision of care for this client? Select all that apply.

- Dextrose 50% by intravenous (IV) push
- Draw blood for the prescribed serum potassium level
- Obtain a STAT capillary blood glucose measurement
- Regular insulin by IV infusion
- Start an IV line and begin an infusion of 0.9% sodium chloride

Answer & Rationale

- **Ask:** Prescription to implement
 - **Problem:** Type 1 diabetes with abdominal pain, weakness, & Kussmaul respirations
 - **Solution:** Think about what could kill the client fastest. With type 1 diabetes, it's typically DKA. Memory trick for treatment of DKA: the DRY first, KILL the sugar with insulin, and ALWAYS add potassium.
1. Incorrect - Intravenous administration of dextrose is not appropriate for the alert client experiencing hyperglycemia.
 2. **Correct - A serum k⁺ level should be assessed at the start of insulin therapy because insulin promotes k⁺ entrance in the cells causing further imbalances.**
 3. **Correct - It is appropriate for the nurse to obtain a capillary blood glucose measurement to confirm the probable diagnosis of diabetic ketoacidosis (DKA).**
 4. **Correct - Insulin administration to treat hyperglycemia by IV infusion is an expected medical prescription for the client who experiences DKA.**
 5. **Correct - This priority intervention is implemented prior to infusion of regular insulin to correct hypovolemia and serum glucose levels.**

NCLEX “BRAIN BUSTER” QUESTION

The nurse notes that a client is prescribed amitriptyline. Which reasons should the nurse suspect this medication was prescribed for this client?
Select all that apply

- Urinary Retention
- Neuropathic pain
- Depression
- Mood-stabilizer
- Dysrhythmia

Answer & Rationale

- **Ask:** Reasons for medication
- **Problem:** Amitriptyline prescribed
- **Solution:** Amitriptyline is a TCA used to treat neuropathic pain, depression, and insomnia. Memory trick: Amitriptyline sounds like “Amy trips on things.” Side effects include falls, urinary retention, constipation, blurred vision, dry eyes, & dysrhythmias.

1. Incorrect - Urinary retention is a side effect of amitriptyline, not an indication for use.
2. **Correct - Amitriptyline is used to treat neuropathic pain.**
3. **Correct - Amitriptyline is used to treat insomnia.**
4. **Correct - Amitriptyline is used to treat mood disorders.**
5. Incorrect - Dysrhythmia is a side effect of amitriptyline, not an indication for use.

“BRAIN BUSTER” QUESTION

A client receiving an intravenous (IV) infusion of heparin has the following lab values: admission platelet count of 210,000/mm³ (210 x 10⁹/L) 48 hours ago and a current platelet count of 90,000/mm³ (90 x 10⁹/L). Which action should the nurse implement first based on the current data?

- Stop the heparin infusion
- Reconfirm the results with a new blood specimen
- Report the results to the healthcare provider (HCP)
- Perform a head to toe assessment

Answer & Rationale

- **Ask:** Priority action
- **Problem:** Infusion of IV heparin w/ massive platelet drop
- **Solution:** Think huge bleed risk. Memory trick: anything less than 150 is very iffy and anything less than 50 is very risky. Think about interventions to prevent bleeding.

3. Correct - Stopping the infusion is the priority action due to potential heparin-induced thrombocytopenia (HIT).

2. Incorrect - While it is appropriate to monitor platelet count, this action is not the priority and allows the heparin to continue to infuse which increases the risk for bleeding.

3. Incorrect - The results should be reported to the HCP; however, the priority action is to stop the heparin infusion.

4. Incorrect - While it is appropriate to conduct an assessment, this action is not the priority and allows the heparin to continue to infuse which increases the risk for bleeding.

NCLEX

“BRAIN BUSTER” QUESTION

The nurse provides care for a hospitalized client who is diagnosed with type 1 diabetes mellitus (DM). Which prescription should the nurse clarify with the healthcare provider (HCP)?

- 8 units of regular insulin by IV infusion for serum glucose greater than 300 mg/dL
- 12 units of subcutaneous detemir insulin daily at 2000
- 16 units of subcutaneous lispro insulin daily at 1000 before breakfast
- 18 units of NPH insulin PO daily at 0700 for blood glucose greater than 80 mg/dL

Answer & Rationale

- **Ask:** Incorrect prescription order
- **Problem:** Insulin dependent type 1 diabetic
- **Solution:** Think about insulin orders that are not right

1. Incorrect - Regular insulin is a short-acting insulin that is prescribed to treat hyperglycemia.
2. Incorrect - Detemir insulin is a long-acting insulin that is prescribed and administered one time per day to treat type 1 DM.
3. Incorrect - Lispro insulin is a fast-acting insulin that begins to work 15 minutes post administration.
4. **Correct - NPH insulin is an intermediate acting insulin with an onset of action of 1 hour. Insulin is not administered orally.**

“BRAIN BUSTER” QUESTION

A client who is newly diagnosed with asthma is prescribed inhaled albuterol and beclomethasone. Which statements should the nurse include when providing instruction on the proper use of the prescribed medications? Select all that apply.

- “If you need both inhalers use the albuterol first to open the airway.”
- “Rinse your mouth and swallow the water after use of beclomethasone.”
- “Use the beclomethasone inhaler as a rescue medication if it is hard to breathe.”
- “Wash the mouthpiece of albuterol inhaler at least once a week.”
- “Wash the mouthpiece of the beclomethasone inhaler daily to reduce risk of thrush.”
- “Do not use the beclomethasone if albuterol provides you with symptom relief.”

Answer & Rationale

- **Ask:** Statements to include in teaching
- **Problem:** New prescriptions for albuterol & beclomethasone
- **Solution:** Remember that albuterol should be used before steroids. Bronchodilating airways allows the steroids to get into the lower airways. Think: “Steroid sink.”

1. **Correct - Albuterol is a rescue inhaler that opens the client’s airways.**
2. Incorrect - It is appropriate to rinse the mouth after, but not swallow the water.
3. Incorrect - Beclomethasone is a maintenance, not rescue medication.
4. **Correct - The mouthpiece of the inhaler should be washed weekly to decrease the risk for bacterial growth.**
5. **Correct - Beclomethasone can increase the client’s risk for developing fungal infections (e.g., thrush) in the mouth.**
6. Incorrect - Beclomethasone is a medication that is used daily for maintenance and is not a rescue medication.

“BRAIN BUSTER” QUESTION

Which factor should the nurse recognize as a potential contributor to the high pressure alarm on a client who is mechanically ventilated? Select all that apply.

- An air leak in the endotracheal (ET) tube
- Obstruction in endotracheal tube
- Client biting down on endotracheal tube
- Client coughing vigorously
- Ventilator tubing is kinked

Answer & Rationale

- **Ask:** Potential cause
- **Problem:** High pressure alarm on mechanical ventilator
- **Solution:** Think high pressure alarm is high blockage, then determine what's blocking the flow

1. Incorrect - A leak in the ET tube will decrease airway resistance & trigger the low-pressure, not high-pressure limit alarm.
2. **Correct - The accumulation of secretions within the ET tube can obstruct the airway and increase airway resistance.**
3. **Correct - Biting down on the ET tube can cause an obstruction or kink the tubing.**
4. **Correct - Excessive coughing or bronchospasms decrease lung compliance & increase the resistance & set off the high pressure alarm.**
5. **Correct - Ventilator tubing kinks can increase airway resistance & obstruct airflow, causing high pressure alarm.**

NCLEX “BRAIN BUSTER” QUESTION

The nurse provides care for a client who is prescribed carbidopa-levodopa for the treatment of Parkinson’s disease. Which assessment finding indicates that the medication is having the desired effect?

- Delusional episodes are minimal
- Decreased episodes of syncope
- Steady gait with movements that are fluid
- Undisturbed sleep patterns

Answer & Rationale

- **Ask:** Assessment findings
- **Problem:** Desired effects of Carbidopa-levodopa
- **Solution:** Think: -dopa is for dopamine; it treats uncontrolled movements with Parkinson’s disease. Desired outcome: less crazy movements.

1. Incorrect - Delusions are not common for clients diagnosed with Parkinson’s disease.
2. Incorrect - Syncope is not a common manifestation associated with Parkinson’s disease
- 3. Correct - Parkinson’s disease causes tremors and rigidity which leads to gait instability.**
4. Incorrect - Disturbed sleep patterns is not a common manifestation associated with Parkinson’s disease.

“BRAIN BUSTER” QUESTION

A client with a patient-controlled analgesia (PCA) pump receives 0.2 mg of hydromorphone every 5 minutes. The client states, “My lower back hurts. I am pushing the button every 5 minutes.” Which is a priority nursing action for continued pain despite the use of the prescribed PCA pump? Select all that apply.

- Contact the healthcare provider for an additional pharmacologic pain medication
- Complete a thorough pain evaluation
- Request a prescription for a higher dosage of the current pain medication
- Review correct usage of the PCA pump with the client
- Apply an ice pack to the client’s lower back
- Document the data in the client’s medical record

Answer & Rationale

- **Ask:** Priority nursing action
- **Problem:** Persisting pain after using PCA pump
- **Solution:** Persistent pain. Assessment of pain. Think of the best option to do.

1. Incorrect - The nurse should implement nonpharmacologic pain management interventions before contacting the HCP.
2. **Correct - It is essential for the nurse to complete a thorough pain evaluation so that the plan of care can be adjusted.**
3. Incorrect -This action can be implemented after a thorough pain evaluation and the administration of non pharmacological pain management strategies.
4. Incorrect - The PCA is being used correctly. In addition, education is not likely to be comprehended by the client who is experiencing unrelieved acute pain.
5. **Correct - The addition of non pharmacological strategies may provide the client with pain relief and should be implemented prior to any medication changes.**
6. Incorrect - Addressing the client’s pain with the implementation of nonpharmacologic interventions is the priority action by the nurse.

“BRAIN BUSTER” QUESTION

Which data requires intervention by the nurse when providing care for a client who is prescribed both vancomycin and tobramycin? Select all that apply.

- Blood urea nitrogen (BUN) of 12 mg/dL
- Creatinine over 1.3mg/dL
- Erythropenia
- Ecchymosis
- Red spotted petechiae around chest

Answer & Rationale

- **Ask:** Which data requires intervention
- **Problem:** Prescribed vancomycin and tobramycin
- **Solution:** (Think: it's a sin to give a -mycin. It kills the kidneys, leading to nephrotoxicity and ototoxicity. Consider the type of toxicity.)

1. Incorrect - While an elevated BUN level can indicate nephrotoxicity, this BUN is within normal range; therefore, this data does not require intervention by the nurse.
2. **Correct - These medications are nephrotoxic and the normal range for serum creatinine is 0.6 to 1.2 mg/dL (53 to 106 mmol/L).**
3. Incorrect - Ecchymosis is indicative of bleeding. The prescribed medications are not associated with an increased risk for hemorrhage.
4. Incorrect - The prescribed medications are not associated with hepatotoxicity, an issue that would impact the production of RBCs.
5. Incorrect - The prescribed medications are not associated with an increased risk for hemorrhage.

NCLEX

“BRAIN BUSTER” QUESTION

Which intravenous fluid (IV) fluid prescription should the nurse clarify with the client’s healthcare provider (HCP)?

- Hypotonic IV fluids for a client with syndrome of inappropriate antidiuretic hormone
- Isotonic IV fluids for a client with significant blood loss after a trauma
- Isotonic IV fluids to be given as 1,000mL bolus for a client with septic shock
- Ringer’s lactate solution infusion for a client with hypovolemic shock from a burn injury

Answer & Rationale

- **Ask:** Prescription requires clarification
- **Problem:** IV fluids ordered
- **Solution:** Look at the orders or prescriptions that are wrong

1. **Correct - Hypotonic IV solutions are contraindicated in clients with SIADH because these solutions will further dilute the client’s blood.**
2. Incorrect - Isotonic fluids such as normal saline are expected and appropriate for hypovolemia due to a bleed.
3. Incorrect - Fluid volume deficit & decreased BP can be treated with an isotonic solution bolus of 0.9% NS as this expands the vascular volume and increases blood pressure.
4. Incorrect - Lactated Ringer’s is often prescribed to replace fluid and electrolyte imbalances caused by burn injuries.

NCLEX “BRAIN BUSTER” QUESTION

A client is admitted for the treatment of pleural effusion. **Which is the priority nursing action, based on the assessment data below, when the client’s chest tube has drained 240 mL of bright red drainage the past hour? Client assessment: A&O x 3; pain is 7 of 10 using a numeric scale; pulse oximetry 90% on 2 L/min nasal cannula (NC); heart rate is 92 beats/minute; blood pressure is 100/62 mm Hg; and respiration rate is 22 breaths/minute.**

- Administer prescribed morphine 4 mg by the IV route for pain
- Contact the healthcare provider (HCP)
- Immediately raise the level of the client’s chest tube
- Continue to monitor the client’s chest tube drainage

Answer & Rationale

- **Ask:** Priority action
 - **Problem:** Pleural effusion; 240 mL bright red drainage from chest tube in hour; O₂ 90% on 2L/min
 - **Solution:** Think excessive blood loss. Anything greater than 100mL per hour is very alarming. Consider interventions to prevent that worst possible outcome.
1. Incorrect - Pain is expected after insertion of a chest tube and administration of pain medication is not the priority.
 2. Correct - Drainage that is red, free-flowing or in large amounts greater than 100 mL per hour is indicative of hemorrhage.
 3. Incorrect - A chest tube drainage system must always be placed below the level of the chest and secured in an upright position.
 4. Incorrect - While this is required as a normal nursing assessment as per facility protocol, this is not the priority action based on the current data.

“BRAIN BUSTER” QUESTION

Which laboratory tests will the nurse anticipate to receive orders to monitor a client taking metformin for type 2 diabetes? Select all that apply.

- Glycated hemoglobin (HgbA1c)
- Cardiac enzymes
- Liver enzymes
- Creatinine
- Brain natriuretic peptide (BNP)

Answer & Rationale

- **Ask:** Which labs to monitor
- **Problem:** Metformin for type 2 diabetes
- **Solution:** Think about a few things about monitoring a client on metformin like glucose-related labs, labs that reflect toxicity (i.e. liver & kidney)

1. Correct - Glycated hemoglobin (HgbA1c) is used to monitor the effectiveness of the medication.
2. Incorrect - Cardiac enzymes are not affected by this medication.
3. Correct - A major adverse effect of this drug is liver toxicity.
4. Correct - A major adverse effect of this drug is kidney toxicity.
5. Incorrect - This answer is not correct because the brain natriuretic peptide (BNP) blood test is used to determine the extent of heart failure.

NCLEX

“BRAIN BUSTER” QUESTION

Which action implemented by the novice nurse in the provision of care for a client who is intubated and mechanically ventilated requires intervention by the nurse preceptor? Select all that apply.

- Administers the prescribed PRN IV lorazepam 1mg to help the client’s restlessness
- Activates suctioning while placing the catheter in the endotracheal (ET) tube
- Preoxygenates client and increases oxygen during suctioning
- Suctions the ET tube for at least 20 seconds per pass
- Suctions client when the high-pressure alarm is sounding
- Suctions client when rhonchi and visible secretions are present

Answer & Rationale

- **Ask:** Actions requiring intervention
- **Problem:** Intubated and on mechanical ventilation
- **Solution:** Looking for the incorrect actions by the new graduate nurse so think about the wrong actions.

1. Incorrect - Restlessness can cause the client to fight the ventilator assisting with breathing thus resulting in decreased oxygen exchange.
2. **Correct - When suctioning a client’s ET tube, the nurse activates the suction when removing the catheter and not with insertion.**
3. Incorrect - Evidence-based practice (EBP) guidelines support oxygen supplementation prior to and during suctioning.
4. Correct - Evidence-based practice (EBP) guidelines indicate that suctioning **should only occur for 10-15 seconds per pass.**
5. Incorrect - The high pressure alarm may alert for a client whose airway is occluded due to thick secretions.
6. Incorrect - This action by the novice nurse assists with airway clearance allowing for adequate oxygenation.

“BRAIN BUSTER” QUESTION

Which fetal heart rate monitor tracings indicates a need for priority nursing intervention when providing care to a laboring mother?

- Early accelerations
- Early decelerations
- Fetal heart rate of 176 beats per minute
- Sinusoidal fetal heart rate

Answer & Rationale

- **Ask:** Priority intervention
 - **Problem:** Fetal heart rate monitor tracing
 - **Solution:** To identify the need for priority intervention, apply the characteristics of various heart rate monitoring tracing. Consider normal vs abnormal; late decels typically are worse.
1. Incorrect - Early accelerations are category I.
 2. Incorrect - Early decelerations are category I.
 3. Incorrect - This is category II. While not predictive of abnormal fetal acid-base status, this finding requires continued surveillance, but not priority intervention by the nurse.
 4. **Correct - The true sinusoidal pattern is rare, but associated with increased rates of fetal mortality and is the priority intervention.**

NCLEX

“BRAIN BUSTER” QUESTION

The nurse has several medications that are all due at 0900. Determine what order the nurse should administer medications to the following clients. Label the clients 1-4 with 1 being the first priority and 4 being the last priority.

- ① Inhaled steroid for chronic obstructive pulmonary disease; client's oxygen saturation is 92%
- ② Blood pressure medication for hypertension; client's blood pressure is 146/88 mm Hg
- ③ Breathing treatment for asthma; client is displaying wheezing and labored breathing
- ④ Scheduled ophthalmic drops for glaucoma; client is reporting dry eyes

Answer & Rationale

- **Ask:** Order of priority
- **Problem:** Medication administration for multiple clients
- **Solution:** Think of two things you know about prioritization. Look for ABC issues first, then safety. Also consider if needs are acute or chronic when deciding priority

Answer: 3124

#3. Acute problems take priority over chronic problems and this is the only acute client.

#1. Airway is priority, but this client is chronic with a stable O₂ saturation.

#2. Blood pressure is a circulation issue and clients with airway/breathing issues are prioritized first.

#4. ABC issues should be addressed before the client with scheduled eye drops for glaucoma

NCLEX “BRAIN

BUSTER” QUESTION

Which action can be delegated appropriately to an experienced unlicensed assistive personnel (UAP)?

Select all that apply.

- Applying a barrier cream to the skin after assessing a client with bathing
- Notify the healthcare provider of critical labs
- Provide preoperative teaching about pain management
- Perform sterile dressing changes to a client’s stage 3 pressure injury
- Assuring bed is locked and height is at its lowest position

Answer & Rationale

- **Ask:** Appropriate delegation
- **Problem:** Delegating actions to the UAP
- **Solution:** Think about the UAP’s scope of practice. Remember, unstable clients, assessments, teachings, and medication administration cannot be delegated.

1. **Correct - The UAP scope of practice is to assist with procedures that do not require critical thinking or assessment and with activities of daily living.**
2. Incorrect - This is outside the scope of practice for a UAP.
3. Incorrect - This action can only be performed by a registered nurse (RN) according to the nurse practice act, RNs provide teaching to the client.
4. Incorrect - This is outside of the scope of practice for a UAP.
5. **Correct - The UAP assists and supports the nursing staff by making sure safety measures are in place before leaving a client’s room.**

“BRAIN BUSTER” QUESTION

A client, with a family history of breast cancer, is hesitant to take hormone replacement therapy (HRT) to address hot flashes caused by menopause. Which vitamin or herbal preparation is a potential alternative to HRT to address the client’s hot flashes?

- Garlic
- Saw palmetto
- Black cohosh
- Niacin

Answer & Rationale

- **Ask:** Which vitamin/herbal preparation
 - **Problem:** Menopausal with hot flashes; desires alternative treatment to HRT
 - **Solution:** Think about alternative therapies. Black cohosh can lessen the severity of hot flashes. It’s best for the client to discuss any herbal remedies with their practitioner before use of any herbal remedies.
1. Incorrect - Garlic is an herbal remedy that boosts immunity, decreases inflammation, and improves heart health.
 2. Incorrect - Saw palmetto is an herbal remedy that is often used to promote prostate health for male clients and may cause or exacerbate hot flashes in menopause.
 3. Correct - Clients have found relief from hot flashes that are associated with **menopause through use of black cohosh, a herbal root remedy.**
 4. Incorrect - Niacin is a dietary supplement that may cause facial flushing which could exacerbate hot flashes in menopause.

NCLEX

“BRAIN BUSTER” QUESTION

Which nursing action is appropriate for a client who is admitted to the medical unit for a worsening myasthenia gravis? Select all that apply.

- Administer neostigmine 1 mg IM before meals, as prescribed
- Contact the continence specialist for bowel training
- Encourage foods such as scrambled eggs and milkshakes
- Prepare to administer atropine 2 mg by IV push now
- Remind the client of the importance of getting the pneumonia vaccination

Answer & Rationale

- **Ask:** Appropriate nursing action
- **Problem:** Worsening myasthenia gravis
- **Solution:** Memory trick: for myasthenia gravis, think MG = Muscle Gravity issue, where the body becomes weak, causing neuromuscular dysfunction.

1. **Correct - Neostigmine is an anticholinesterase medication prescribed to treat the symptoms of MG by decreasing the breakdown of acetylcholine.**
2. Incorrect - Muscles that control bowel and bladder function are not affected with a diagnosis of myasthenia gravis.
3. **Correct - Since MG causes weakness in the muscles used for chewing, clients are encouraged to eat foods that are easily chewed and swallowed.**
4. Incorrect - Anticholinergic medication such as atropine would further decrease the availability of ACh and worsen muscle weakness associated with MG..
5. **Correct - Stress that is caused by physical illness can lead to myasthenic crisis so clients should receive all recommended vaccinations.**

NCLEX “BRAIN

BUSTER” QUESTION

The nurse provides care for a client who is diagnosed with multiple sclerosis (MS) and newly prescribed interferon beta. Which instruction is most important to include in the medication teaching session due to the client’s increased risk for infection?

- “Be sure to cleanse your skin with alcohol at least once a day”
- “Fatigue and flu-like symptoms are expected with this medication”
- “Avoid crowds and be sure to perform hand hygiene often”
- “Report for an influenza screening immediately if you notice yellowing of your skin.”

Answer & Rationale

- **Ask:** Which instruction is the most important to include
 - **Problem:** A client with MS newly prescribed interferon
 - **Solution:** Memory trick INTERFEREon interferes with the immune system leading to an increased risk of infection & Flu-like s/s.
1. Incorrect - The use of alcohol on the skin is likely to cause impaired integrity which increases the risk for infection.
 2. Incorrect - These are adverse reactions to the prescribed medication thus the client is taught to immediately report these findings should they occur.
 3. **Correct - Interferon beta causes immunosuppression so the client is taught to avoid crowds and implement hand hygiene to decrease the risk for infection.**
 4. Incorrect - Jaundice of the skin and yellowing of the sclera are indicators for hepatotoxicity, not influenza.

NCLEX

“BRAIN BUSTER” QUESTION

The nurse collects health history data for a client who is newly diagnosed with Parkinson’s disease and prescribed benztropine. Which client statement indicates a contraindication for the administration of the prescribed medication?

- “I have a family history of psychosis”
- “I have a history of migraine headaches”
- “I was diagnosed with narrow-angle glaucoma last year”
- “I was diagnosed with peripheral neuropathy earlier this year”

Answer & Rationale

- **Ask:** Statement indicates contraindication for medication
- **Problem:** Newly diagnosed with Parkinson’s Disease and prescribed benztropine
- **Solution:** Memory trick: with benztropine, think: “It’s like you’ve been tripping.” This medication acts on blocking ACH in the central nervous system and can cause falls; contraindicated in glaucoma, peptic ulcers, duodenal & pyloric obstructions.

1. Incorrect - A family history of psychosis is not a contraindication for the prescribed benztropine.
2. Incorrect - Based on the information given, this is not contraindicated even though certain migraine medications have a risk of serotonin syndrome.
3. **Correct - Benztropine is contraindicated in clients with narrow-angle glaucoma as the medication increases intraocular pressure and worsens glaucoma.**
4. Incorrect - Peripheral neuropathy is not a contraindication to the use of benztropine for the treatment of PD.

“BRAIN BUSTER” QUESTION

A young adult client is prescribed esomeprazole 40 mg PO daily for gastroesophageal reflux disease (GERD) for the past three years. The client has a history of frequent gastritis within the last year; therefore, the health care provider (HCP) discontinues the prescribed esomeprazole. When the client asks the nurse why the medication is being discontinued, which response by the nurse is appropriate?

- “You require antibiotic therapy for your gastritis and esomeprazole is contraindicated.”
- “The prescribed esomeprazole can increase your risk for frequent infections.”
- “An H-2 receptor antagonist is a better medication than esomeprazole.”
- “Misoprostol is a better medication for managing your condition.”

Answer & Rationale

- **Ask:** Appropriate response
- **Problem:** GERD with frequent gastritis; client questions discontinuation of esomeprazole
- **Solution:** Think about two things you know. It ends in -prazole, a PPI, that inhibits stomach acid and increases the risk of GI infection such as gastritis.

1. Incorrect - The provider discontinued esomeprazole due to gastritis, not due to a need for antibiotic therapy.
2. **Correct - PPIs like esomeprazole decrease the production of the gastric acids that can help protect the client from gastrointestinal infections.**
3. Incorrect - This response fails to answer the client’s question; additionally, H2-receptor antagonists also increase the risk for infection by decreasing gastric acid production.
4. Incorrect - The nurse should address the client’s concern, not suggest another medication; misoprostol is prescribed for NSAID induced peptic ulcer disease (PUD), not GERD.

“BRAIN BUSTER” QUESTION

Which action should the nurse initiate to prepare a client who is diagnosed with end-stage kidney disease for hemodialysis? Select all that apply.

- Administer the client’s morning dose of metoprolol and enalapril
- Assess heart and lung sounds and obtain present weight
- Give subcutaneous heparin during dialysis to decrease clotting
- Feel the fistula for the presence of a thrill and listen for a bruit
- Review the client’s medical record for last post-dialysis weight

Answer & Rationale

- **Ask:** Action to take
- **Problem:** Preparing for hemodialysis
- **Solution:** Consider interventions to complete prior to the treatment.

1. Incorrect - The client could develop hypotension during dialysis and then uncontrolled hypertension due to decreased drug concentrations post-dialysis.
2. **Correct - Heart and lung sounds are always assessed and the client’s weight** provides information about how much fluid was removed during dialysis.
3. Incorrect - Once the client is connected to a dialysis machine, IV heparin is added to the client’s blood to decrease the likelihood of clotting that can occur.
4. Correct - The fistula is assessed for a palpable thrill and/or audible bruit which indicates patency. A lack of these findings could indicate thrombosis.
5. **Correct - The client’s post-dialysis weight subtracted from pre-dialysis weight** determines the amount of fluid that is removed.

NCLEX “BRAIN

BUSTER” QUESTION

While providing education for implementing home peritoneal dialysis (PD) to the client and spouse, which priority intervention will the nurse stress to the client?

- Keep a record of weight daily
- Follow sterile technique when caring for a PD catheter
- Measure weight before and after performing PD
- Adhere to the nutritional restrictions ordered

Answer & Rationale

- **Ask:** Priority intervention
- **Problem:** Implementing home peritoneal dialysis
- **Solution:** Think of the most important considerations for PD: safety and infection prevention = priorities. Compliance means following fluid & diet restrictions (protein and phosphorus)

1. Incorrect - This is a secondary intervention the nurse will instruct the client to implement.
2. **Correct - Following sterile technique when caring for the PD catheter helps prevent peritonitis, the leading complication of peritoneal dialysis.**
3. Incorrect - This is a secondary intervention the nurse will instruct the client to implement.
4. Incorrect - This is a secondary intervention the nurse will instruct the client to implement.

“BRAIN BUSTER” QUESTION

The nurse provides care for a client who is prescribed fluorouracil for the treatment of cancer. Which is a priority system for the nurse to assess when monitoring for complications associated with the prescribed chemotherapeutic agent?

- Respiratory
- Integumentary
- Cardiovascular
- Gastrointestinal

Answer & Rationale

- **Ask:** Priority system to assess
 - **Problem:** Prescribed fluorouracil for cancer treatment
 - **Solution:** Two general actions of chemotherapy: decreases bone marrow and leads to potential GI toxicity and damaged intestinal mucosa
1. Incorrect - The prescribed medication is not toxic to the client's respiratory system.
 2. Incorrect - While skin changes can occur with most chemotherapeutic agents, the prescribed medication is not toxic to the integumentary system.
 3. Incorrect - The prescribed medication is not cardiotoxic.
 4. **Correct - The prescribed medication can cause gastrointestinal toxicity which often manifests with massive diarrhea.**

“BRAIN BUSTER” QUESTION

The nurse provides care for a client who is diagnosed with heart failure (HF) and is experiencing the following symptoms: bilateral lower extremity edema that is 4+ and a 5 pound (2.3 kg) weight gain in the past 48 hours. Which medication does the nurse anticipate an immediate dosage change based on the current data?

- Furosemide 40mg PO once daily
- Valsartan 40mg PO once daily
- Metoprolol 100mg PO once daily
- Isosorbide mononitrate 60mg PO once daily

Answer & Rationale

- **Ask:** Anticipated immediate medication dosage change
 - **Problem:** Exacerbation of heart failure with severe edema weight gain
 - **Solution:** Remember HF for heart fluid is HF for heavy fluid. The body is retaining too much fluid. The #1 drug given for heavy fluid is -ide ending diuretics. -ides make the body dry
1. Correct - This drug decreases fluid volume overload. During exacerbations, the **dosage is increased to enhance the impact & speed.**
 2. Incorrect - This medication is an angiotensin 2 receptor blocker and will not immediately address the client's fluid retention.
 3. Incorrect - This medication is a beta blocker and will not immediately address the fluid retention.
 4. Incorrect - This medication is a nitrate and it will not immediately address the client's fluid retention.

NCLEX

“BRAIN BUSTER” QUESTION

Which clinical finding should the nurse expect when assessing an infant with a left-to-right-sided heart shunt? Select all that apply.

- Clubbing of the fingers
- Crackles and a heart murmur
- Circumoral cyanosis when feeding
- Decreased number of wet diapers
- Diaphoresis during feedings

Answer & Rationale

- **Ask:** Expected clinical findings
- **Problem:** Left-to-right-sided heart shunt
- **Solution:** Think about infants with heart defects: oxygenation and oxygenation becomes lower when feeding.

1. Incorrect - Clubbing of the fingers is associated with long-term cyanosis; however, this is not an expected finding for an infant with a left-to-right-sided heart shunt.
2. **Correct - Crackles are anticipated with a L to R shunt due to CHF resulting from overloading the heart with extra blood. A murmur is heard due to the turbulence.**
3. Incorrect - Mild cyanosis is sometimes associated with right-to-left heart shunts but not left-to-right sided shunts. Left-to-right sided heart shunts are considered acyanotic.
4. **Correct - Decreased output occurs in a L to R sided heart shunt due to decreased cardiac output causing decreased perfusion to the kidneys.**
5. **Correct - Sympathetic stimulation produces compensatory responses such as diaphoresis during feedings; therefore, this is anticipated.**

NCLEX “BRAIN

BUSTER” QUESTION

A client is prescribed beclomethasone/formoterol for the treatment of chronic obstructive pulmonary disease (COPD). When providing medication teaching to the client, which statement indicates to the nurse that additional instruction is warranted? Select all that apply.

- “I might experience joint or muscle pain as a side effect.”
- “I will not smoke or use any tobacco products.”
- “I will check with my doctor before taking any new medications.”
- “I might have trouble sleeping because of this medication.”
- “I will take this medication as soon as I have had trouble breathing.”
- “I will wash my mouth with water and swallow for maximum effectiveness.”

Answer & Rationale

- **Ask:** Incorrect statement
- **Problem:** Teaching for beclomethasone/formoterol
- **Solution:** Think this is a steroid and bronchodilator combination

1. Incorrect - Joint or muscle pain may be common side effects associated with the prescribed medication, so this statement is accurate.
2. Incorrect - Smoking and the use of any tobacco products is avoided with the prescribed medication.
3. Incorrect - Due to the risk for drug to drug interactions, this statement indicates a correct understanding of the information presented by the nurse.
4. Incorrect - Insomnia is an expected side effect of this medication.
5. **Correct - Beclomethasone/formoterol is a maintenance medication and should not be used as not a rescue medication.**
6. **Correct - It is not appropriate to swallow the water.**

NCLEX

“BRAIN BUSTER” QUESTION

Which clinical manifestation noted in the provision of client care should the nurse immediately report to the health care provider (HCP) due to the concern of respiratory failure?
Select all that apply.

- Inward chest movement on inspiration
- Mental status changes
- No sound of air movement on auscultation
- An inability to speak more than one word without pausing to breathe
- A PaO₂ level of 50mmHg and dyspnea
- A PaCO₂ level of 60mmHg and lethargy

Answer & Rationale

- **Ask:** Which manifestation to report immediately
- **Problem:** Respiratory failure
- **Solution:** Consider signs and symptoms of ineffective ventilation

1. **Correct - Paradoxical breathing is a manifestation of respiratory failure that indicates respiratory muscle fatigue.**
2. **Correct - Mental status changes may occur for clients who are at risk for respiratory failure due to a lack of perfusion to the brain.**
3. **Correct - No sound of air movement on auscultation may be referred to as “silent chest” & indicates that air is trapped in the lung & respiratory failure.**
4. **Correct - SOB that occurs with respiratory failure is often manifested with an inability to speak more than one word without stopping to breathe.**
5. **Correct - Hypoxemia and dyspnea are indicators of impending respiratory failure.**
6. **Correct - Hypercapnia can eventually progress to respiratory acidosis.**

NCLEX

“BRAIN BUSTER” QUESTION

A client in end stage renal failure taking oral calcium acetate with meals wants to take the medication after eating. Which response should the nurse make?

- “That is fine as long as you take it after every meal”
- “That is the best time to take it because it can irritate your stomach otherwise”
- “It works best if you take it right before eating”
- “If you take it in the middle of your meal, you will have fewer side effects”

Answer & Rationale

- **Ask:** Appropriate response
- **Problem:** Oral calcium for end stage renal failure taken after eating
- **Solution:** Calcium acetate is used to bind to phosphates in food and is best absorbed on an empty stomach.

1. Incorrect - This answer is not correct because the absorption of the calcium acetate is impaired by a full stomach, which decreases effectiveness.
2. Incorrect - Calcium acetate is not particularly known for causing gastric upset, and this timing of the medication decreases the absorption of it.
3. **Correct - It is prescribed to be taken right before meals because this is when phosphate is ingested, best absorbed & most effective.**
4. Incorrect - Taking the medication in the middle of the meal decreases absorption.

NCLEX

“BRAIN BUSTER” QUESTION

The critical care nurse provides care for a client who is admitted for the treatment of head trauma and prescribed mannitol to reduce intracranial pressure (ICP). Which electrolyte is the priority for the nurse to monitor?

- Potassium
- Chloride
- Magnesium
- Sodium

Answer & Rationale

- **Ask:** Priority electrolyte to monitor
- **Problem:** Head trauma; prescribed mannitol to reduce ICP.
- **Solution:** Think about what you know about mannitol and which electrolyte to monitor. Mannitol is an osmotic diuretic with rapid fluid shifts from the cell into the vascular space. It can cause a loss of sodium and water.

1. Incorrect - Mannitol is an osmotic diuretic that causes the loss of sodium and water so monitoring serum potassium levels is not a priority nursing action.
2. Incorrect - Mannitol is an osmotic diuretic that causes the loss of sodium and water so monitoring serum chloride levels is not a priority nursing action.
3. Incorrect - Mannitol is an osmotic diuretic that causes the loss of sodium and water; so monitoring serum magnesium levels is not a priority nursing action.
4. **Correct - Mannitol causes the diuresis of sodium and water through the urination; therefore, the nurse monitors the client's serum sodium levels.**

NCLEX “BRAIN BUSTER” QUESTION

The nurse provides care for a client with a history of bipolar affective disorder who has become increasingly lethargic and less responsive through the shift after being admitted in acute mania. Which is the nurse’s priority when planning care for this client based on the current data?

- Altered thought process
- Self-care deficit
- Risk for dehydration
- Risk for social isolation

Answer & Rationale

- **Ask:** Priority
 - **Problem:** History of bipolar mania; increasingly lethargic
 - **Solution:** Identify the most appropriate nursing diagnosis. Remember behavior associated with bipolar mania and manifestations. Identify the nursing diagnosis with the greatest risks.
1. Incorrect - The client’s physical needs take precedence over psychological needs.
 2. Incorrect - This nursing diagnosis is appropriate for a client with bipolar affective disorder; however, it is not the priority diagnosis at this time
 3. **Correct - A client who is diagnosed with BPAD may cycle through periods of mania followed by depression and is at risk for malnutrition and dehydration.**
 4. Incorrect - Impaired social isolation is an appropriate nursing diagnosis, but this is not the priority diagnosis.

“BRAIN BUSTER” QUESTION

The nurse is caring for a client taking a conventional antipsychotic for schizophrenia. Which statement(s) by the client’s family indicates teaching about the medication is required?

Select all that apply.

- “Length of treatment with this medication is usually 2-3 weeks.”
- “Full therapeutic effect is expected in 4-6 weeks.”
- “It is most probable that treatment with an antipsychotic will be life-long.”
- “Conventional antipsychotics have less severe side effects than newer medications.”
- “Foods high in tyramine should be avoided while on this class of medication.”

Answer & Rationale

- **Ask:** Statement indicates teaching required
- **Problem:** Taking conventional antipsychotic for schizophrenia
- **Solution:** Consider the key details around conventional antipsychotics.

Remember these kind of drugs take 4-6 weeks to take their full effect and have more notable and severe side effects.

1. **Correct - This answer is correct because treatment with conventional antipsychotics for schizophrenia is longer than 2 to 3 weeks.**
2. Incorrect - Full therapeutic effects of conventional antipsychotics are expected in 4-6 weeks.
3. Incorrect - This answer is not correct because treatment will most likely be life-long.
4. Correct - Generally conventional antipsychotics have more severe side effects, **such as EPS.**
5. **Correct - Foods high in tyramine should be avoided with monoamine oxidase inhibitors (MAOIs), not typical antipsychotics.**

“BRAIN BUSTER” QUESTION

A client who is diagnosed with major depressive disorder was hospitalized twice in the past 4 months for suicidal tendencies. The client tells the nurse, “I’m unemployed, overweight, have no health insurance, feel alone, and I just can’t do this anymore.” The client is currently prescribed paroxetine but has not kept appointments with the health care provider (HCP). Which nursing diagnosis is most important for this client?

- Chronic low self-esteem
- Disturbed thought process
- Risk for self-harm
- Risk for violence

Answer & Rationale

- **Ask:** Priority nursing diagnosis
 - **Problem:** Major depressive disorder; two hospitalizations for suicidal tendencies in 4 months
 - **Solution:** Remember that safety is top priority! Look for statements that point to findings that can harm or kill the client.
1. Incorrect - This is an appropriate nursing diagnosis but it is not the most important given the situation.
 2. Incorrect - This is an appropriate nursing diagnosis but it is not the most important given the situation.
 3. **Correct - The nurse’s priority in the provision of client care is to ensure safety; therefore, this is the most appropriate nursing diagnosis.**
 4. Incorrect - This is an appropriate nursing diagnosis but it is not the most important given the situation.

NCLEX

“BRAIN BUSTER” QUESTION

Which action should the nurse take to promote therapeutic communication when providing medication teaching to a client? Select all that apply.

- Explain the medication then leave the room
- Assess both verbal and nonverbal cues of the client
- Interrupt the client to provide more information about the medication
- Sit down and asks the client to provide more information about the medication
- Ask the client to share specific feelings about the diagnosis and medications

Answer & Rationale

- **Ask:** Action to promote therapeutic communication
- **Problem:** Medication teaching
- **Solution:** Think of key things to consider with therapeutic communication. For example, allowing the client to provide their own feelings, active listening, clarifying insights, and understanding the client.

1. Incorrect - Abrupt departure prevents allowing the client time to ask questions or express feelings, so this action does not facilitate therapeutic communication.
2. **Correct - Therapeutic communication is an active form of listening that requires respect and assessment of both nonverbal and verbal client cues.**
3. Incorrect - This answer is not correct because interrupting shuts communication down and is not therapeutic.
4. **Correct - Therapeutic communication is active listening and requires time for the client to express feelings in an unrushed and non-judgmental manner.**
5. **Correct - This allows the client time to express feelings about the disease process and helps facilitate therapeutic communication.**

NCLEX

“BRAIN BUSTER” QUESTION

Which immunization is anticipated for a child who is human immunodeficiency virus (HIV)-positive with a CD4 cell count of 500/mm³?

Select all that apply.

- Measles
- Mumps
- Pneumococcal conjugate
- Rubella
- Varicella

Answer & Rationale

- **Ask:** Anticipated immunization in child
- **Problem:** HIV positive with a CD4 count of 500
- **Solution:** A child who is HIV positive is immunocompromised, so avoid live vaccines.

1. Incorrect - The measles vaccine is a live virus and should not be administered to this client due to their compromised immune system.
2. Incorrect - The mumps vaccine is a live virus and should not be administered to this client due to their compromised immune system.
3. Correct - Pneumococcal conjugate vaccine (PCV) is not a live virus and may be **administered to this client due to their compromised immune system.**
4. Incorrect - The rubella vaccine is a live virus and should not be administered to this client due to their compromised immune system.
5. Incorrect - The varicella vaccine is a live virus and should not be administered to this client due to their compromised immune system.

NCLEX

“BRAIN BUSTER” QUESTION

Which vaccine is appropriate for a 1-year-old pediatric client who is recovering from Kawasaki disease and recently received intravenous immunoglobulin (IVIG) a few months ago?
Select all that apply

- Haemophilus influenzae type b (Hib)
- Hepatitis B (HepB)
- Measles, Mumps, and Rubella (MMR)
- Pneumococcal (PCV)
- Varicella

Answer & Rationale

- **Ask:** Appropriate vaccines for 1-year old
- **Problem:** Recovering from Kawasaki disease and recently received IVIG
- **Solution:** Identify the age-appropriate vaccine and apply what you know about Kawasaki treatment and timeline.

1. **Correct - The HIB vaccine is inactivated and not live; therefore, it can be administered to this child.**
2. **Correct - The hep B vaccine is inactivated and not live; therefore, it can be administered to this child.**
3. **Incorrect - The MMR vaccine is live; therefore, it cannot be administered to this child.**
4. **Correct - The PCV vaccine is inactivated and not live; therefore, it can be administered to this child.**
5. **Incorrect - The varicella vaccine is live; therefore, it cannot be administered to this child.**

“BRAIN BUSTER” QUESTION

Which is a developmentally-appropriate nursing action in the provision of care for a 10-year-old client awaiting an appendectomy?
Select all that apply.

- Focus on any concerns about the appearance of the scar after the surgery
- Help the child understand the long-term positive effects of the surgery
- Help the child understand the procedure by showing simple pictures
- Inform the client about the surgery 30 minutes before the procedure
- Use correct terminology when referring to the anatomical parts of the child

Answer & Rationale

- **Ask:** Developmentally appropriate activities
- **Problem:** 10 year old awaiting an appendectomy
- **Solution:** Identify developmentally appropriate actions. Apply what you know about the milestones of a 10 year old and present age developmentally appropriate materials of the procedure.

1. Incorrect - Scar appearance is not a big concern for a school-age client.
2. Incorrect - The school-age client is not concerned with long-term positive effects of the surgery. Formal operational thinking occurs at age 12 (not 10).
3. **Correct - Showing simple pictures to a school-age child appeals to concrete thinking and is developmentally appropriate.**
4. Incorrect - A school-age child should be provided with ample time to prepare for a surgical procedure thus allowing comprehension and clarification.
5. **Correct - This age group needs concrete communication to enhance comprehension, such as the use of correct terminology.**

NCLEX

“BRAIN BUSTER” QUESTION

The nurse develops a plan of care for a preschool-age client who requires medication administration. Which action by the nurse is appropriate? Select all that apply.

- Ask the child, “Will you take your medicine now?”
- Involve the child’s parents when administering an injection
- Ask the child, “Do you want water or juice with your medicine?”
- Allow the child to play with the syringe that is used to measure the medication
- Consult with the child’s practitioner to change the route of the prescribed acetaminophen from rectal to oral

Answer & Rationale

- **Ask:** Appropriate action
- **Problem:** Medication administration to preschool aged client
- **Solution:** Think of 2 things we know about med admin for preschool age children
-Involving caregivers in the process and allow the preschooler to make simple and safe choices

1. Incorrect - Asking a preschool-age client if they will take medication now is likely to result in a response of no thus is counterproductive to the administration process.
2. **Correct - Parental involvement often facilitates cooperation when administering medication to a preschool-age client.**
3. **Correct - Providing the preschool-age child with simple choices in the process is an appropriate action as it facilitates cooperation.**
4. **Correct - Allowing the child to play with equipment that is used in the process facilitates familiarity thus enhances cooperation.**
5. **Correct - The rectal route can cause preschool-age children to experience distress due to fear of bodily intrusion & mutilation.**

NCLEX “BRAIN

BUSTER” QUESTION

The pediatric nurse provides care for an infant who is diagnosed with tetralogy of Fallot (ToF). Which nursing action is appropriate when the infant becomes cyanotic while being fed?

- Administer albuterol 0.1mg/kg per nebulizer, as prescribed
- Give humidified oxygen at 6 L/min via bi-nasal cannula, as prescribed
- Position the client with the knees drawn to the chest
- Place the client in left lateral Sims position

Answer & Rationale

- **Ask:** Appropriate nursing action
- **Problem:** Tetralogy of Fallot; becoming cyanotic while being fed
- **Solution:** Think of what you know about cardiac defects and ToF. With any cardiac defects, the biggest problem is oxygenation. The heart is having problems pushing blood forward.

1. Incorrect - This is not an appropriate nursing action to address cyanosis during a feeding for an infant who is diagnosed with ToF.
2. Incorrect - This nursing action will not adequately address the infant’s cyanosis during feedings; therefore, this nursing action is not appropriate.
3. **Correct - An infant who is diagnosed with ToF may experience hypercyanotic or “Tet” spells, during feedings and this position alleviates cyanosis.**
4. Incorrect - This position would not address the infant’s cyanosis; therefore, the child would remain cyanotic if placed in the left lateral Sims position.

“BRAIN BUSTER” QUESTION

The nurse provides care for a client who is in the second stage of labor. The nurse notes that the fetal head retracts back into the vagina after the birth of the head. Which intervention by the nurse is appropriate based on current data?

- Administration of IV terbutaline 2.5mcg/min, as prescribed
- Obtain the vacuum extractor and call for another nurse to assist
- Place downward pressure on the client’s symphysis pubis
- Apply pressure on the fundus during contractions

Answer & Rationale

- **Ask:** Appropriate intervention
- **Problem:** Fetal head retracts back into the vagina after the birth of the head
- **Solution:** Identify the expected intervention and determine the cause of the head retraction.

1. Incorrect - This may be prescribed to stop or delay preterm labor but is not appropriate based on the current clinical data.
2. Incorrect - Obtaining a vacuum extractor to assist with the birth at this point would not allow for the head control that is required when shoulder dystocia occurs.
3. **Correct - This is an appropriate intervention to help with the complication of shoulder dystocia, as the current data indicates.**
4. Incorrect - This does nothing to control the head as it descends out of the birth canal and will not allow for widening of the pelvis which is required with shoulder dystocia.

NCLEX

“BRAIN BUSTER” QUESTION

The nurse provides care for a laboring client who is receiving intravenous (IV) oxytocin at 20 mU/min. Which nursing intervention is appropriate for this client when late decelerations are noted on the continuous fetal monitor? Select all that apply.

- Call the lab for the prescribed STAT nitrazine test
- Administer methylergonovine 0.2mg by mouth, as prescribed
- Inform the healthcare provider (HCP) of the current client data
- Move the client onto her back
- Suspend the infusion of the prescribed IV oxytocin

Answer & Rationale

- **Ask:** Specific intervention
 - **Problem:** Oxytocin infusion and late decels
 - **Solution:** Remember it's never good to be LATE with late decels. Identify inappropriate actions and identify probable causes of late decels. Which action is contraindicated for the probable cause?
1. Incorrect - There is no need for this test at this time as it is prescribed early in the labor process to determine if the amniotic bag of fluid has ruptured.
 2. Incorrect - Methylergonovine is often prescribed to decrease the likelihood of postpartum hemorrhage.
 3. **Correct - The laboring client who experiences late deceleration requires further assessment by the HCP.**
 4. Incorrect - Late decels often indicate poor oxygenation. To enhance oxygenation to the fetus, the laboring mother is placed on her left side, not on her back.
 5. **Correct - This will stop any continued decelerations of the fetal heart rate until the situation can be analyzed and stabilized by the healthcare provider.**

NCLEX

“BRAIN BUSTER” QUESTION

The nurse completes an assessment for a newborn client. Which manifestation should the nurse report to the healthcare provider (HCP) immediately? Select all that apply.

- A positive Babinski
- Large, bluish discoloration on the lower back
- Posterior fontanel is triangular, soft, and flat
- Sudden and loud noises do not startle the neonate
- Thin, white vaginal discharge and swelling of the labia
- White pinpoint papules on the neonate's nose

Answer & Rationale

- **Ask:** Manifestations to report immediately
- **Problem:** Assessment of newborn client
- **Solution:** Think about related clinical manifestations when assessing newborns, expected/not expected

1. Incorrect - A positive Babinski reflex is an expected finding for the newborn client.
2. Incorrect - This finding is indicative of a Mongolian spot. This is an abnormal finding but not indicative of a potential complication.
3. Incorrect - This is an expected finding regarding the posterior fontanel.
4. Correct - A positive startle reflex is an expected finding. This neonate exhibits a negative startle reflex which may be indicative of a neurological **complication**.
5. Incorrect - Vaginal discharge and an edematous labia are findings in female newborn clients in response to maternal hormones.
6. Incorrect - This finding is indicative of milia, a common finding on the newborn's skin.

NCLEX “BRAIN BUSTER” QUESTION

The nurse provides care for a newborn client immediately following birth. The neonate’s assessment data is as follows: skin is blue; heart rate is 112 beats/minute; regular crying noted; movement and flexion of extremities is noted; and whimpers when nares are suctioned. Based on this data, which Apgar score is appropriate for the nurse to assign to this newborn?

- An Apgar score of 6
- An Apgar score of 7
- An Apgar score of 8
- An Apgar score of 9

Answer & Rationale

- **Ask:** Appropriate APGAR score for newborn
 - **Problem:** Blue skin, HR 112, regular cry, movement noted, whimpers with nasal suction
 - **Solution:** Think about APGAR score and apply knowledge related to a healthy newborn with a higher score, then do calculations of score.
1. Incorrect - This is not an accurate Apgar score for this newborn based on the clinical data.
 2. **Correct - Appearance = 0; Pulse = 2; Grimace = 1; Activity = 2; and Respirations = 2; therefore, the Apgar score is $0 + 2 + 1 + 2 + 2 = 7$.**
 3. Incorrect - This is not an accurate Apgar score for this newborn.
 4. Incorrect - This is not an accurate Apgar score for this newborn.

NCLEX

“BRAIN BUSTER” QUESTION

Which statement is true when the nurse provides care to a client with an obstetric history of G5T1P2A1L2? Select all that apply.

- The client has a history of 2 births at or before 37 weeks 0 days gestation
- The client has a history of two pregnancies
- The client has 2 living children
- The client had one pregnancy that ended before 20 weeks
- The client is not pregnant at this time

Answer & Rationale

- **Ask:** Which statement is true
- **Problem:** Obstetric history
- **Solution:** Remember what is true about each letter of GTPAL and combine that knowledge to select the correct statements about the client’s obstetric history

1. **Correct - Childbirth at or before 37 full weeks’ gestation is considered preterm; P2 indicates that this client has a hx of 2 births at or before 37 weeks, 0 days.**
2. Incorrect - Based on the current clinical data, this client has a history of 5, not 2 pregnancies as indicated by G5.
3. **Correct - The client has 2 living children as indicated by L2.**
4. **Correct - The client has had one abortion, either elective or spontaneous, as indicated by A1.**
5. Incorrect - Adding T (1), P (2), and A (1) indicates that the client has had 4 pregnancies. Based on the G5 listed, this client must be pregnant at this time.

NCLEX

“BRAIN BUSTER” QUESTION

The nursing supervisors make rounds to the assigned nursing units for the evening shift. Which scenario requires the nursing supervisor to intervene to protect client confidentiality? Select all that apply.

- During a client’s admission assessment the nurse privately asks, “Do you have a history of any mental illness?”
- A nurse who reports diagnostic testing results to the person who accompanies a client to the hospital
- A nurse reviews the medical record for a client previously cared for but not assigned for the present shift
- A nurse tells a transporter, “This client has weakness in the arms and legs due to severe opioid abuse and alcohol withdrawal, so be cautious when providing assistance from the bed to the wheelchair.”
- The nurse writes a client’s last name and medical record number on a piece of paper and posts to the front of the door to the room

Answer & Rationale

- **Ask:** Supervisor intervention
- **Problem:** Protecting client confidentiality
- **Solution:** Think about protecting client confidentiality and identifiers of incidents that give too much information and think about the understanding and implementation of HIPAA laws and privacy

1. Incorrect - This is not a violation of confidentiality but rather it is a necessary portion of the admission history that is completed by the admitting nurse.
2. **Correct - The person who accompanies a client to the hospital does not “need to know” the results of a client’s diagnostic study results.**
3. **Correct - Only essential personnel who are directly involved in the care of a client should review a client’s medical record.**
4. **Correct - While it is appropriate for the transporter that the client has weakness in the arms and legs, there is no reason to tell this individual WHY.**
5. **Correct - Listing a client’s last name and medical record and posting this information in a central location is a violation of client confidentiality.**

NCLEX “BRAIN BUSTER” QUESTION

The nurse is caring for an elderly client with urinary incontinence. The nurse angrily tells the client, “If you can’t stop making messes, I’m going to put in a catheter.” The nurse’s actions may be considered which type(s) of legal violation(s)? Select all that apply.

- Battery
- Assault
- Malpractice
- Intentional Tort
- Libel

Answer & Rationale

- **Ask:** Which type of legal violation
 - **Problem:** Nurse angry due to incontinence; “If you can’t stop I’m going to put in a catheter.”
 - **Solution:** Look at the legal violations. The nurse angrily threatened the client. Assault occurs when someone threatens physical or psychological harm.
1. Incorrect - Battery in nursing consists of physically touching an individual without consent.
 2. **Correct - Assault occurs when someone threatens physical or psychological harm that causes the client to be fearful.**
 3. Incorrect - Malpractice is considered a non-intentional tort and is composed of six elements.
 4. **Correct - The nurse’s statement is an example of assault which is an example of an intentional tort.**
 5. Incorrect - Libel occurs when someone uses false written statements to defame another’s character.

“BRAIN BUSTER” QUESTION

A client with an indwelling urinary catheter reports leakage around the insertion site. Which intervention should the nurse perform next?

- Inspect the catheter tubing for kinks or obstructions
- Ask the charge nurse to assess the client’s catheter
- Discontinue the catheter and replace it with a larger size
- Inject the catheter balloon with additional sterile saline

Answer & Rationale

- **Ask:** Next intervention
 - **Problem:** Indwelling urinary catheter leaking around insertion site
 - **Solution:** Assess the client, then assess the catheter tube. Remember, assessment is always first in the nursing process.
1. Correct - Assessment is the first step of the nursing process and leakage is **often caused by obstruction**.
 2. Incorrect - The nurse who is assigned to provide care to the client is able to assess the client’s catheter, not the charge nurse.
 3. Incorrect - This action is appropriate after assessing the indwelling catheter system for kinks and other obstructions.
 4. Incorrect - Sterile water is used because saline crystallizes, resulting in incomplete deflation of the balloon at the time of removal.

NCLEX

“BRAIN BUSTER” QUESTION

The nurse is caring for a client who is 6 hours postoperative following a nephrectomy. When assessing the client, the nurse notes that the client grimaces and/or groans every time he moves. Which priority action does the nurse take first?

- Assess the client’s pain level and location
- Assist the client to reposition
- Administer hydrocodone pain medication
- Assist the client to deep breathe and cough

Answer & Rationale

- **Ask:** Priority action
- **Problem:** 6 hours post-op for nephrectomy; grimacing/groaning with movement
- **Solution:** Always #1 assess the client first and determine if the client is in pain and include the pain level and location. Then, do an intervention and address the problem

1. Correct - This answer is correct because assessment is the first step in the **nursing process**.
2. Incorrect - The nurse should first assess the client’s pain level and location, then intervene.
3. Incorrect - The nurse should first assess the client’s pain level and location, then intervene.
4. Incorrect - The client is demonstrating signs of being in pain. Once the pain is addressed, the client will be more willing and able to deep breathe and cough.

NCLEX “BRAIN

BUSTER” QUESTION

Which client statement indicates an accurate understanding of the medication teaching provided by the nurse related to the use of a new prescription for apixaban as medical management for deep vein thrombosis (DVT)? Select all that apply.

- “It is okay to eat green leafy vegetables each night for dinner”
- “It is not ok for me to eat foods that are rich in vitamin K”
- “I will take frequent resting periods every 2 hours”
- “I can take aspirin, ibuprofen, and naproxen for aches and pains while taking this medication”
- “I can take acetaminophen for headaches while on this medication”

Answer & Rationale

- **Ask:** Indicates understanding
- **Problem:** Teaching for new prescription (apixaban for management of DVT)
- **Solution:** Think of remarks by the patient that are true regarding this medication. Remember, apixaban is an anticoagulant. Even if you don’t know what the medication was, look at DVT with any anticoagulant, big bleed risk.

1. Correct - A benefit of this medication to treat DVT is that there is no drug **to food interactions related to vitamin K.**
2. Incorrect - This medication does not interact with foods rich in vitamin K.
3. Incorrect - The client with a DVT is taught to move around every 2 hours to enhance circulation.
4. Incorrect - The client is taught to avoid any medication that increases the risk for bleeding while prescribed an anticoagulant agent.
- 5. Correct - Acetaminophen does not increase the client’s risk for bleeding.**

“BRAIN BUSTER” QUESTION

Which nursing action upholds client safety guidelines regarding safe medication administration? Select all that apply.

- Check the medication against the original prescription before administration
- Do not give medications with out-of-date labels
- Don clean gloves when touching unopened medication dose packages
- Open all medication packages while at the client bedside just before administration
- Review the relevant coagulation studies before giving heparin, if it is ordered

Answer & Rationale

- **Ask:** Correct action
- **Problem:** Safe medication administration
- **Solution:** Always think about safety and rights of medication administration. DICE the drugs-dose, integrity, clarity, expiration date. Think about actions that protect the client from medication harm.

1. **Correct - The nurse checks the medication against the original prescription ensuring that it is the right drug for safety.**
2. **Correct - Medications that are expired should not be administered to a client as the potency cannot be guaranteed.**
3. **Incorrect - Gloves are not required when handling medication that is unopened.**
4. **Correct - Medications are administered individually and placed in a medication cup for administration while at the client's bedside.**
5. **Correct - While heparin may be prescribed for the client, it is inappropriate to administer if coagulation studies indicate that there's a bleeding risk.**

NCLEX “BRAIN BUSTER” QUESTION

The nurse provides care for a client who is prescribed intravenous (IV) norepinephrine (NE). Which nursing action is appropriate when the IV administration of the prescribed medication causes the client to report shooting pain and the skin is noted to be pale along the vein pathway? Select all that apply.

- Flush the line with normal saline and give PRN IV meperidine
- Discontinue infusion promptly and disconnect IV tubing
- Document findings as normal
- Slow the infusion of norepinephrine and reassess in 15 minutes
- Remove the IV line while aspirating the drug from the vein

Answer & Rationale

- **Ask:** Correct interventions
- **Problem:** Pain while administering IV norepinephrine; pale skin noted along vein pathway
- **Solution:** Consider the right action to do for the client right now and consider extravasation

1. Incorrect - The client is likely experiencing infiltration or extravasation. The prescribed medication is a known vesicant; therefore, the IV line is immediately discontinued.
2. Correct - When symptoms of infiltration and/or extravasation occur, this **should be done to avoid further damage to the tissues.**
3. Incorrect - Shooting pain and pale skin along the vein pathway are not normal findings.
4. Incorrect - This allows the medication to continue to infuse outside of the vein which increases the risk for tissue damage as this medication is a known vesicant.
5. Correct - This should be done when infiltration and/or extravasation occur **to prevent further damage to the tissues.**

NCLEX “BRAIN BUSTER” QUESTION

The nurse provides care for a client who presents to the emergency department (ED) with restlessness, diarrhea, nausea, vomiting, and heart palpitations. The client is prescribed theophylline for the treatment of asthma. Which laboratory and/or diagnostic test should the nurse anticipate for this client? Select all that apply.

- Serum potassium level
- Serum theophylline level
- Electrocardiogram (ECG)
- Electroencephalogram (EEG)
- Computed tomography (CT) scan

Answer & Rationale

- **Ask:** Tests to anticipate
- **Problem:** Theophylline for asthma; restless with diarrhea, nausea, vomiting, & heart palpitations
- **Solution:** Think of the worst case scenario
 - Restlessness, N/V/D, & palpitations = S/S of theophylline toxicity
 - Lab test = theophylline level (normal range of 10-20 mcg/mL)

1. Incorrect - Theophylline does not impact potassium levels
2. **Correct - Drug toxicity is suspected, therapeutic range is 10 to 20 mcg/mL**
3. **Correct - Theophylline toxicity is associated with life-threatening cardiac dysrhythmia**
4. Incorrect - While theophylline toxicity is associated with seizure activity, the current clinical data does not warrant this diagnostic test.
5. Incorrect - A CT scan is not warranted to monitor a client for symptoms associated with theophylline toxicity.

NCLEX

“BRAIN BUSTER” QUESTION

A client who is diagnosed with congestive heart failure is scheduled to receive an intravenous push (IVP) dose of furosemide, 40 mg. As the nurse reviews the client’s morning labs, the following results are noted: Na⁺ 135 mEq/L; K⁺ 3.1 mEq/L; Ca⁺ 8.5 mg/dL; and Mg⁺ 2.1 mg/dL. Which lab result should be reported to the provider immediately?

- Na⁺
- K⁺
- Ca⁺
- Mg⁺

Answer & Rationale

- **Ask:** Lab results to report immediately
- **Problem:** Heart failure with scheduled furosemide IV push
- **Solution:** Remember furosemide leaves the body dry. Low fluid (because it makes you pee) and we lose potassium so this will decrease the potassium even further.

1. Incorrect - Na⁺ level of 135 mEq/L is within normal limits
2. **Correct - K⁺ level of 3.1 mEq/L already low; furosemide is K⁺ wasting & will further deplete potassium levels.**
3. Incorrect - Ca⁺ level of 8.5 mg/dL is within normal limits
4. Incorrect - Mg⁺ level of 2.1 mg/dL is within normal limits

“BRAIN BUSTER” QUESTION

The nurse provides care for a client who is recovering from an acute myocardial infarction (MI). The client’s cardiac rhythm indicates a rate of 180 beats/minute with monomorphic, wide QRS complexes. Which rhythm does the nurse identify based on the current data?

- Bundle branch block
- Sinus tachycardia
- Ventricular pacing
- Ventricular tachycardia

Answer & Rationale

- **Ask:** Which cardiac rhythm
- **Problem:** Heart rate of 180 beats/min with wide QRS after MI
- **Solution:** Name the rhythm...Think about it - the rate is fast and it has something to do with the ventricles because the QRS complexes are wide and monomorphic

1. Incorrect - A bundle branch block is a QRS complex that is wider than 0.12 seconds.
2. Incorrect - Sinus tach is regular, normal & upright P waves before each QRS, rate faster than 100 beats BPM, QRS complexes and PR intervals are WNL
3. Incorrect - Ventricular pacing is a rhythm in which pacer spikes are noted before each QRS complex.
4. **Correct - Ventricular tachycardia has a rapid rate and wide QRS complexes that are greater than 0.12 seconds.**

“BRAIN BUSTER” QUESTION

A client newly transferred to the unit presents with a rapidly declining respiratory status after becoming septic. Which assessment finding requires the nurse to contact the healthcare provider (HCP)? See below for nurse’s notes.

- Crackles in both lung bases
- A decline in PaCO₂
- Hypoxemia unresponsive to treatment
- Temperature 102* (38.9*C)

Answer & Rationale

- **Ask:** Findings requiring HCP notification
- **Problem:** Sepsis with respiratory decline, decreasing PaO₂, & increasing CO₂
- **Solution:** Think about findings to share with the HCP that leads to the worst possible outcome. Consider hypoxia

1. Incorrect - Crackles are expected in acute respiratory syndrome and would not require contacting the HCP.
2. Incorrect - The decline in PaCO₂ is a positive finding thus does not require HCP notification
3. **Correct - Hypoxemia that does not respond to treatment is the hallmark sign of acute respiratory syndrome and has a high mortality rate.**
4. Incorrect - A temperature of 102 F is an expected finding for a client who is diagnosed with sepsis and does not need to be reported to the HCP.

NCLEX “BRAIN BUSTER” QUESTION

The nurse provides care for a client who is diagnosed with Addison’s disease. Which clinical manifestation does the nurse anticipate for this client due to primary adrenocortical insufficiency? Select all that apply.

- Skin color that is tanned in appearance
- Anorexia and weight loss
- Increased body or facial hair
- Orthostatic hypotension
- Purple or red striae on the abdomen

Answer & Rationale

- **Ask:** Clinical Manifestations
- **Problem:** Addison’s Disease
- **Solution:** Think Addison’s = “ADD some steroid”. We have an absence of steroids so our clients appear skinny and frail with a dark tan.

1. **Correct - Tanned pigmentation of the skin is expected for the client** diagnosed with primary adrenocortical insufficiency.
2. **Correct - Anorexia with weight loss is an expected clinical manifestation.**
3. Incorrect - Hirsutism is an expected clinical manifestation for the client who is diagnosed with Cushing syndrome, not Addison’s disease.
4. **Correct - Orthostatic hypotension is an expected clinical manifestation.**
5. Incorrect - Striae on the abdomen is an expected finding for the client diagnosed with Cushing syndrome, not Addison’s disease.

NCLEX “BRAIN BUSTER” QUESTION

The nurse provides discharge instructions for a client who has been hospitalized four times in the past twelve months for complications associated with congestive heart failure (CHF). Which client statement indicates an accurate understanding of the information presented by the nurse? Select all that apply.

- “I will eat lightly salted pretzels and potato chips for snacks”
- “I can eat canned soup and a sandwich for lunch each day”
- “I will try to walk a mile each morning if it’s not raining”
- “I will use salt-substitute to maintain good potassium levels”
- “I will weigh myself every morning right after my shower”

Answer & Rationale

- **Ask:** Statements indicate understanding
- **Problem:** Teaching related to frequent hospitalizations for CHF
- **Solution:** Think of statements that show correct understanding of teaching

1. Incorrect - CHF patients should decrease Na⁺ and fluid intake. All of these food choices contain sodium.
2. Incorrect - Education for CHF must include the importance of decreasing sodium and fluid intake. Canned soup is high in sodium
3. **Correct - Education for CHF includes encouragement of regular moderate exercise.**
4. **Correct - Diuretics can cause hypokalemia & the use of salt-substitute indicates understanding. Digoxin, used to treat CHF, is impacted by serum K⁺**
5. **Correct - Education with CHF includes monitoring for symptoms indicative of worsening heart failure (e.g., fluid volume excess, weight gain, edema).**

NCLEX

“BRAIN BUSTER” QUESTION

Which education point will the registered nurse (RN) provide to the client diagnosed with peripheral neuropathy related to type 2 diabetes? Select all that apply

- “Avoid wearing socks to prevent an increase in sweating and skin irritation”
- “Keep toenails cut close to the skin to avoid breakage of the nails”
- “Check the water temperature in tubs with a thermometer prior to entering the tub”
- “Check your feet, especially between your toes, each day and report any skin changes immediately”
- “Always wear some type of shoe, even if it is sandals when walking in the home or outdoors”

Answer & Rationale

- **Ask:** Which education to provide
- **Problem:** Peripheral neuropathy related to diabetes mellitus type II
- **Solution:** Before looking at the options- Think of two things you know about peripheral neuropathy related to diabetes mellitus type II.

Memory Trick: Diabetes - Destroys the organs with THICK syrupy blood! Diabetes = Diareties - turns fingers & toes into sugary treats for bacteria peripheral neuropathy—
check feet/no heat.

- decreased sensation in the extremities
- increased risk of injury because of decreased sensation

1. Incorrect - The client should wear cotton socks to help absorb sweating and protect the feet.
2. Incorrect - The client should not cut the nails close to the skin, but should instead file the nails, avoiding the skin.
3. **Correct - The diabetic client with peripheral neuropathy has lost sensation in the extremities so a thermometer is needed to discern accurate temperature.**
4. **Correct - The client with peripheral neuropathy cannot determine if there is injury to the feet through sensation so daily inspection is necessary.**
5. Incorrect - The client should always wear shoes when ambulating, but these shoes should be closed toe/heel type shoes.

NCLEX “BRAIN BUSTER” QUESTION

Which medication does the nurse expect the healthcare provider (HCP) to prescribe for a client who is diagnosed with heart failure and reports a nagging cough and an incident of angioedema with the use of enalapril?

- Alprazolam 0.75mg PO daily
- Guaifenesin 15 mg daily
- Captopril 40 mg PO daily
- Losartan 80 mg PO daily

Answer & Rationale

- **Ask:** Best medication substitution
- **Problem:** Nagging cough & angioedema with enalapril
 - Think side effects of ACE inhibitors end in “-pril” which are first line drugs for HIGH blood pressure.

ARBs “-Sartan” is SSSecond line drug

- **Solution:** Substitution for ACE medication
1. Incorrect - “-pam” and “-lam” are benzos, nothing to do with blood pressure
 2. Incorrect - guaifenesin is a cough medication, nothing to do with blood pressure
 3. Incorrect - “-pril” which is another ACE
 4. Correct - Sartans are used SSSecond, after ACE inhibitors if the side effects **are too much**

NCLEX

“BRAIN BUSTER” QUESTION

Which clinical manifestation does the nurse anticipate when providing care for a client who is diagnosed with Graves' disease?
Select all that apply.

- Hand tremors
- Irregular heart rhythm
- Increased perspiration
- Insomnia and anxiety
- Exophthalmos
- Obesity

Answer & Rationale

- **Ask:** Anticipated clinical manifestations
- **Problem:** Graves' Disease
- **Solution:** Think Graves' Disease means Gains Disease. HYPERthyroidism.

Everything is high & hot so consider clinical manifestations that fall in this hyper and hot state.

1. Correct - Tremors of the fingers and the hands are an expected clinical manifestation for a **client who is diagnosed with Graves' disease**.
2. Correct - Heart palpitations or AFib are both clinical manifestations associated with Graves' disease.
3. Correct - Increased metabolic rate caused by an increase in thyroid hormones causes heat intolerance and increased perspiration.
4. Correct - Insomnia and anxiety are the direct result of the hypermetabolic rate that is caused by the increases in thyroid hormones.
5. Correct - Hyperthyroidism causes tissue expansion of the muscle fibers located in the eye which **causes exophthalmos and a lag in the eyelid**.
6. Incorrect - The increased metabolic rate associated with Graves' disease causes a decreased appetite leading to weight loss, not weight gain or obesity.

“BRAIN BUSTER” QUESTION

The nurse is assessing a client who has been taking levothyroxine for two months for hypothyroidism. Which client statements should the nurse report? Select all that apply.

- “I take my levothyroxine each morning with my coffee or a full glass of grapefruit juice.”
- “I eat breakfast about 30-60 minutes after taking levothyroxine each morning.”
- “I will notify my healthcare provider immediately if I develop a sore throat/fever.”
- “The extreme fatigue I was experiencing seems to be improving.”
- “Each morning, I take levothyroxine, biotin, and a multivitamin.”

Answer & Rationale

- **Ask:** Incorrect statements
- **Problem:** Taking levothyroxine for two months
- **Solution:** Remember LEVothyroxine LEAVES those thyroid hormones in the body which makes everything amped up

1. Correct - Coffee and grapefruit juice inhibit the absorption of levothyroxine.
2. Incorrect - Levothyroxine should be taken at the same time each morning, with a full glass of water, on an empty stomach, 30-60 minutes prior to breakfast.
3. Incorrect - Agranulocytosis is an adverse effect of antithyroid medication and the client should be instructed to notify the health care provider about symptoms of infection.
4. Incorrect - Extreme fatigue would indicate the client was still experiencing hypothyroid symptoms.
5. **Correct - Multivitamins, when taken concurrently with levothyroxine, inhibit the absorption of levothyroxine and administered at least 4 hours apart.**

“BRAIN BUSTER” QUESTION

The nurse provides discharge instructions to a client who is diagnosed with peripheral arterial disease (PAD). Which client statement indicates a need for further instruction from the nurse? Select all that apply.

- “A heating pad should be used to restore circulation”
- “Anytime I am resting, I should elevate my legs”
- “I will begin walking around the neighborhood”
- “Moisturizing lotion should be applied to my legs daily”
- “Swelling is an expected finding with this disorder”

Answer & Rationale

- **Ask:** Statements needing clarification
- **Problem:** Discharge teaching for PAD
- **Solution:** Think about incorrect statements by the patient for PAD

1. **Correct - Due to peripheral neuropathy, the client may be unable to detect burning of the skin.**
2. **Correct - Clients with PAD should not elevate their legs for long periods as this further decreases circulation to the extremities.**
3. Incorrect - Moderate physical activity promotes circulation and should be encouraged for clients with PAD.
4. Incorrect - Daily skin care, including moisturizing the extremities with lotion, is included in the plan of care for clients with PAD.
5. Correct - Edema is expected in clients with peripheral venous insufficiency; however, this is not an expected finding in clients with PAD

NCLEX

“BRAIN BUSTER” QUESTION

A client reports calf pain when walking from the car to the supermarket. The pain stops when walking stops. Which assessment should the nurse perform?

Select all that apply.

- Assess both ankles for venous stasis ulcers and dermatitis
- Determine color and temperature of the lower extremities
- Establish if the client monitors their blood pressure daily
- Palpate presence and quality of dorsalis pedis pulses

Answer & Rationale

- **Ask:** Assessments to perform
- **Problem:** Client complaining of calf pain when walking from the car to the market and it stops when walking stops
- **Solution:** Think about intermittent claudication (calf pain) think intermittent “CALVE-ication”. When you’re walking, you have low oxygen to the muscles.

1. Incorrect - Ankle edema, venous stasis ulcers, and dermatitis indicate PVD, These symptoms are indicative of intermittent claudication indicating peripheral PAD.
2. Correct -The nurse should immediately check for blood flow by monitoring **color, temperature changes & other PAD symptoms.**
3. Incorrect - This is not relevant to determine if the client is experiencing intermittent claudication and PAD.
4. Correct - The nurse should immediately check for blood flow by checking **the most distal pulses.**

NCLEX “BRAIN BUSTER” QUESTION

The nurse provides medication teaching for a client who is newly prescribed citalopram for major depressive disorder. Which client statement indicates a correct understanding of the education provided by the nurse for this medication? Select all that apply.

- “I should expect some confusion as a result of this medication.”
- “If I miss a dose, I should not double my next dose.”
- “I will eat a well balanced diet and exercise to control weight gain.”
- “I won’t stop this medication abruptly.”
- “I might experience issues with sexual dysfunction.”
- “When I begin to feel better, I can stop taking this medication.”

Answer & Rationale

- **Ask:** Correct client statement
- **Problem:** Education about citalopram
- **Solution:** Look for remarks that are true Remember the S’s. We don’t take St. John’s Wort with SSRIs. SSRIs can increase the Suicidal ideations and often causes Sexual dysfunction

1. Incorrect - Confusion, a symptom associated with serotonin syndrome, is an adverse reaction to medication, not an expected side effect.
2. **Correct - The client should not take a double dose if the medication is missed due to the increased risk for serotonin syndrome.**
3. **Correct- This medication is associated with increased appetite which can cause weight gain.**
4. **Correct- Stopping this medication abruptly may cause withdrawal symptoms.**
5. Correct - Many selective serotonin reuptake inhibitors (SSRIs) may cause sexual dysfunction.
6. Incorrect -This medication should not be stopped when symptoms of depression are better.

“BRAIN BUSTER” QUESTION

Which information should the nurse include when providing medication teaching for a client who is newly prescribed rifampin 300 mg PO twice daily?
Select all that apply.

- Avoid wearing prescription contacts during treatment
- Limit alcohol intake to only a few times per week
- Report any red discoloration of urine and other body fluids to the HCP immediately
- Stop the medication if two sputum cultures come back negative
- Use non-hormonal forms of birth control while taking this medication

Answer & Rationale

- **Ask:** Information to include
- **Problem:** Education about Rifampin 300 mg po twice daily
- **Solution:** Think about teaching. With Rifampin, think RED like a reef, “REEF-ampin”. Bodily fluids can turn red.

1. **Correct - Rifampin causes an orange-red discoloration of bodily secretions, including tears, which can permanently discolor contact lenses**
2. Incorrect -The consumption of alcohol is contraindicated for the client who is prescribed rifampin due to the increased risk of hepatotoxicity.
3. Incorrect - This is an expected side effect.
4. Incorrect - Three negative sputum cultures and a negative chest x-ray indicate medication effectiveness.
5. **Correct - Rifampin can interact with oral hormonal contraceptives causing them to be ineffective for the prevention of pregnancy.**

“BRAIN BUSTER” QUESTION

Which action should the nurse implement first **when providing care for a client being admitted to the unit following stent placement for treatment of an ST segment elevation myocardial infarction (STEMI)?**

- Assess heart and lung sounds
- Assess blood pressure first then other vitals
- Obtain serial troponin levels
- Place the client on telemetry

Answer & Rationale

- **Ask:** First action to implement
 - **Problem:** Admission with STEMI
 - **Solution:** Think about priority actions on monitoring cardiac rhythm and circulatory function.
1. Incorrect - Initiating telemetry = immediate priority action on arrival to the unit.
 2. Incorrect - Telemetry is first priority action; vital signs should be monitored closely after.
 3. Incorrect - Critical need to continue monitoring the client for dysrhythmias immediately after STEMI so this is not the priority.
 4. **Correct - This is the priority action on arrival to unit post STEMI; VFib = most common & lethal arrhythmia after MI.**

NCLEX “BRAIN BUSTER” QUESTION

A client with a head injury develops syndrome of inappropriate antidiuretic hormone (SIADH). Which clinical manifestations should the nurse expect when assessing this client? Select all that apply.

- Decreased urine output
- Elevated serum osmolality
- Elevated urine specific gravity
- Decreased serum osmolality
- Decreased serum sodium

Answer & Rationale

- **Ask:** Clinical manifestations
- **Problem:** SIADH
- **Solution:** Think SIADH - SI we have a lot of water in the body... ADH it adds the H₂O. SIADH results in elevated levels of antidiuretic hormone. Elevated ADH, hypervolemia and decrease in serum osmolality and sodium. Think “S” for SIADH as Soaked inside.

1. **Correct - Urine output is decreased for the client who experiences SIADH.**
2. **Incorrect -** The increase in total body water that occurs as a result of SIADH causes a low serum osmolality due to dilution.
3. **Correct -** As antidiuretic hormone (ADH) continues to be secreted and water is retained, the client experiences a high specific gravity of the urine.
4. **Correct - Due to the increased total body water that is dilute, low serum osmolality is expected for the client who is diagnosed with SIADH.**
5. **Correct - Due to the increased total body water that is dilute, decreased serum sodium is expected for the client who is diagnosed with SIADH.**

“BRAIN BUSTER” QUESTION

The nurse provides care for a pediatric client who is diagnosed with central diabetes insipidus (DI). Which is the priority action by the nurse in the provision of care for this child?

- Assessing the child’s daily activity
- Monitoring intake & output (I&O)
- Instructing the family on medication administration
- Educating the child’s caregivers on symptoms of water intoxication

Answer & Rationale

- **Ask:** Priority action
- **Problem:** Central Diabetes Insipidus (DI)
- **Solution:** Memory trick for DI: The “D” is draining fluid from the body into the potty, leading to “D” for dehydration & dry Inside. Nursing interventions: measuring I&Os and preventing dehydration

1. Incorrect - This is not the priority action by the nurse.
2. **Correct - I&O provides essential information used to determine the need to adjust medications; therefore, this is the priority action by the nurse.**
3. Incorrect - The medication dose is based on the child’s I&O, thus is not the priority action by the nurse.
4. Incorrect - Monitoring I&O is the priority nursing action as this information is required for the therapeutic management of this disease process.

“BRAIN BUSTER” QUESTION

A client who is diagnosed with type 1 diabetes mellitus (DM) reports abdominal pain, appears weak, and is displaying Kussmaul respirations at 30 breaths/minute. What prescription should the nurse implement in the provision of care for this client? Select all that apply.

- Dextrose 50% by intravenous (IV) push
- Draw blood for the prescribed serum potassium level
- Obtain a STAT capillary blood glucose measurement
- Regular insulin by IV infusion
- Start an IV line and begin an infusion of 0.9% sodium chloride

Answer & Rationale

- **Ask:** Prescription to implement
 - **Problem:** Type 1 diabetes with abdominal pain, weakness, & Kussmaul respirations
 - **Solution:** Think about what could kill the client fastest. With type 1 diabetes, it's typically DKA. Memory trick for treatment of DKA: the DRY first, KILL the sugar with insulin, and ALWAYS add potassium.
1. Incorrect - Intravenous administration of dextrose is not appropriate for the alert client experiencing hyperglycemia.
 2. **Correct - A serum k⁺ level should be assessed at the start of insulin therapy because insulin promotes k⁺ entrance in the cells causing further imbalances.**
 3. **Correct - It is appropriate for the nurse to obtain a capillary blood glucose measurement to confirm the probable diagnosis of diabetic ketoacidosis (DKA).**
 4. **Correct - Insulin administration to treat hyperglycemia by IV infusion is an expected medical prescription for the client who experiences DKA.**
 5. **Correct - This priority intervention is implemented prior to infusion of regular insulin to correct hypovolemia and serum glucose levels.**

NCLEX “BRAIN BUSTER” QUESTION

The nurse notes that a client is prescribed amitriptyline. Which reasons should the nurse suspect this medication was prescribed for this client?
Select all that apply

- Urinary Retention
- Neuropathic pain
- Depression
- Mood-stabilizer
- Dysrhythmia

Answer & Rationale

- **Ask:** Reasons for medication
- **Problem:** Amitriptyline prescribed
- **Solution:** Amitriptyline is a TCA used to treat neuropathic pain, depression, and insomnia. Memory trick: Amitriptyline sounds like “Amy trips on things.” Side effects include falls, urinary retention, constipation, blurred vision, dry eyes, & dysrhythmias.

1. Incorrect - Urinary retention is a side effect of amitriptyline, not an indication for use.
2. **Correct - Amitriptyline is used to treat neuropathic pain.**
3. **Correct - Amitriptyline is used to treat insomnia.**
4. **Correct - Amitriptyline is used to treat mood disorders.**
5. Incorrect - Dysrhythmia is a side effect of amitriptyline, not an indication for use.

“BRAIN BUSTER” QUESTION

A client receiving an intravenous (IV) infusion of heparin has the following lab values: admission platelet count of 210,000/mm³ (210 x 10⁹/L) 48 hours ago and a current platelet count of 90,000/mm³ (90 x 10⁹/L). Which action should the nurse implement first based on the current data?

- Stop the heparin infusion
- Reconfirm the results with a new blood specimen
- Report the results to the healthcare provider (HCP)
- Perform a head to toe assessment

Answer & Rationale

- **Ask:** Priority action
- **Problem:** Infusion of IV heparin w/ massive platelet drop
- **Solution:** Think huge bleed risk. Memory trick: anything less than 150 is very iffy and anything less than 50 is very risky. Think about interventions to prevent bleeding.

3. Correct - Stopping the infusion is the priority action due to potential heparin-induced thrombocytopenia (HIT).

2. Incorrect - While it is appropriate to monitor platelet count, this action is not the priority and allows the heparin to continue to infuse which increases the risk for bleeding.

3. Incorrect - The results should be reported to the HCP; however, the priority action is to stop the heparin infusion.

4. Incorrect - While it is appropriate to conduct an assessment, this action is not the priority and allows the heparin to continue to infuse which increases the risk for bleeding.

NCLEX

“BRAIN BUSTER” QUESTION

The nurse provides care for a hospitalized client who is diagnosed with type 1 diabetes mellitus (DM). Which prescription should the nurse clarify with the healthcare provider (HCP)?

- 8 units of regular insulin by IV infusion for serum glucose greater than 300 mg/dL
- 12 units of subcutaneous detemir insulin daily at 2000
- 16 units of subcutaneous lispro insulin daily at 1000 before breakfast
- 18 units of NPH insulin PO daily at 0700 for blood glucose greater than 80 mg/dL

Answer & Rationale

- **Ask:** Incorrect prescription order
- **Problem:** Insulin dependent type 1 diabetic
- **Solution:** Think about insulin orders that are not right

1. Incorrect - Regular insulin is a short-acting insulin that is prescribed to treat hyperglycemia.
2. Incorrect - Detemir insulin is a long-acting insulin that is prescribed and administered one time per day to treat type 1 DM.
3. Incorrect - Lispro insulin is a fast-acting insulin that begins to work 15 minutes post administration.
4. **Correct - NPH insulin is an intermediate acting insulin with an onset of action of 1 hour. Insulin is not administered orally.**

“BRAIN BUSTER” QUESTION

A client who is newly diagnosed with asthma is prescribed inhaled albuterol and beclomethasone. Which statements should the nurse include when providing instruction on the proper use of the prescribed medications? Select all that apply.

- “If you need both inhalers use the albuterol first to open the airway.”
- “Rinse your mouth and swallow the water after use of beclomethasone.”
- “Use the beclomethasone inhaler as a rescue medication if it is hard to breathe.”
- “Wash the mouthpiece of albuterol inhaler at least once a week.”
- “Wash the mouthpiece of the beclomethasone inhaler daily to reduce risk of thrush.”
- “Do not use the beclomethasone if albuterol provides you with symptom relief.”

Answer & Rationale

- **Ask:** Statements to include in teaching
- **Problem:** New prescriptions for albuterol & beclomethasone
- **Solution:** Remember that albuterol should be used before steroids. Bronchodilating airways allows the steroids to get into the lower airways. Think: “Steroid sink.”

1. **Correct - Albuterol is a rescue inhaler that opens the client’s airways.**
2. Incorrect - It is appropriate to rinse the mouth after, but not swallow the water.
3. Incorrect - Beclomethasone is a maintenance, not rescue medication.
4. **Correct - The mouthpiece of the inhaler should be washed weekly to decrease the risk for bacterial growth.**
5. **Correct - Beclomethasone can increase the client’s risk for developing fungal infections (e.g., thrush) in the mouth.**
6. Incorrect - Beclomethasone is a medication that is used daily for maintenance and is not a rescue medication.

“BRAIN BUSTER” QUESTION

Which factor should the nurse recognize as a potential contributor to the high pressure alarm on a client who is mechanically ventilated? Select all that apply.

- An air leak in the endotracheal (ET) tube
- Obstruction in endotracheal tube
- Client biting down on endotracheal tube
- Client coughing vigorously
- Ventilator tubing is kinked

Answer & Rationale

- **Ask:** Potential cause
- **Problem:** High pressure alarm on mechanical ventilator
- **Solution:** Think high pressure alarm is high blockage, then determine what's blocking the flow

1. Incorrect - A leak in the ET tube will decrease airway resistance & trigger the low-pressure, not high-pressure limit alarm.
2. **Correct - The accumulation of secretions within the ET tube can obstruct the airway and increase airway resistance.**
3. **Correct - Biting down on the ET tube can cause an obstruction or kink the tubing.**
4. **Correct - Excessive coughing or bronchospasms decrease lung compliance & increase the resistance & set off the high pressure alarm.**
5. **Correct - Ventilator tubing kinks can increase airway resistance & obstruct airflow, causing high pressure alarm.**

NCLEX “BRAIN

BUSTER” QUESTION

The nurse provides care for a client who is prescribed carbidopa-levodopa for the treatment of Parkinson’s disease. Which assessment finding indicates that the medication is having the desired effect?

- Delusional episodes are minimal
- Decreased episodes of syncope
- Steady gait with movements that are fluid
- Undisturbed sleep patterns

Answer & Rationale

- **Ask:** Assessment findings
- **Problem:** Desired effects of Carbidopa-levodopa
- **Solution:** Think: -dopa is for dopamine; it treats uncontrolled movements with Parkinson’s disease. Desired outcome: less crazy movements.

1. Incorrect - Delusions are not common for clients diagnosed with Parkinson’s disease.
2. Incorrect - Syncope is not a common manifestation associated with Parkinson’s disease
- 3. Correct - Parkinson’s disease causes tremors and rigidity which leads to gait instability.**
4. Incorrect - Disturbed sleep patterns is not a common manifestation associated with Parkinson’s disease.

“BRAIN BUSTER” QUESTION

A client with a patient-controlled analgesia (PCA) pump receives 0.2 mg of hydromorphone every 5 minutes. The client states, “My lower back hurts. I am pushing the button every 5 minutes.” Which is a priority nursing action for continued pain despite the use of the prescribed PCA pump? Select all that apply.

- Contact the healthcare provider for an additional pharmacologic pain medication
- Complete a thorough pain evaluation
- Request a prescription for a higher dosage of the current pain medication
- Review correct usage of the PCA pump with the client
- Apply an ice pack to the client’s lower back
- Document the data in the client’s medical record

Answer & Rationale

- **Ask:** Priority nursing action
- **Problem:** Persisting pain after using PCA pump
- **Solution:** Persistent pain. Assessment of pain. Think of the best option to do.

1. Incorrect - The nurse should implement nonpharmacologic pain management interventions before contacting the HCP.
2. **Correct - It is essential for the nurse to complete a thorough pain evaluation so that the plan of care can be adjusted.**
3. Incorrect -This action can be implemented after a thorough pain evaluation and the administration of non pharmacological pain management strategies.
4. Incorrect - The PCA is being used correctly. In addition, education is not likely to be comprehended by the client who is experiencing unrelieved acute pain.
5. **Correct - The addition of non pharmacological strategies may provide the client with pain relief and should be implemented prior to any medication changes.**
6. Incorrect - Addressing the client’s pain with the implementation of nonpharmacologic interventions is the priority action by the nurse.

“BRAIN BUSTER” QUESTION

Which data requires intervention by the nurse when providing care for a client who is prescribed both vancomycin and tobramycin? Select all that apply.

- Blood urea nitrogen (BUN) of 12 mg/dL
- Creatinine over 1.3mg/dL
- Erythropenia
- Ecchymosis
- Red spotted petechiae around chest

Answer & Rationale

- **Ask:** Which data requires intervention
- **Problem:** Prescribed vancomycin and tobramycin
- **Solution:** (Think: it's a sin to give a -mycin. It kills the kidneys, leading to nephrotoxicity and ototoxicity. Consider the type of toxicity.)

1. Incorrect - While an elevated BUN level can indicate nephrotoxicity, this BUN is within normal range; therefore, this data does not require intervention by the nurse.
2. **Correct - These medications are nephrotoxic and the normal range for serum creatinine is 0.6 to 1.2 mg/dL (53 to 106 mmol/L).**
3. Incorrect - Ecchymosis is indicative of bleeding. The prescribed medications are not associated with an increased risk for hemorrhage.
4. Incorrect - The prescribed medications are not associated with hepatotoxicity, an issue that would impact the production of RBCs.
5. Incorrect - The prescribed medications are not associated with an increased risk for hemorrhage.

NCLEX

“BRAIN BUSTER” QUESTION

Which intravenous fluid (IV) fluid prescription should the nurse clarify with the client’s healthcare provider (HCP)?

- Hypotonic IV fluids for a client with syndrome of inappropriate antidiuretic hormone
- Isotonic IV fluids for a client with significant blood loss after a trauma
- Isotonic IV fluids to be given as 1,000mL bolus for a client with septic shock
- Ringer’s lactate solution infusion for a client with hypovolemic shock from a burn injury

Answer & Rationale

- **Ask:** Prescription requires clarification
- **Problem:** IV fluids ordered
- **Solution:** Look at the orders or prescriptions that are wrong

1. **Correct - Hypotonic IV solutions are contraindicated in clients with SIADH because these solutions will further dilute the client’s blood.**
2. Incorrect - Isotonic fluids such as normal saline are expected and appropriate for hypovolemia due to a bleed.
3. Incorrect - Fluid volume deficit & decreased BP can be treated with an isotonic solution bolus of 0.9% NS as this expands the vascular volume and increases blood pressure.
4. Incorrect - Lactated Ringer’s is often prescribed to replace fluid and electrolyte imbalances caused by burn injuries.

NCLEX “BRAIN BUSTER” QUESTION

A client is admitted for the treatment of pleural effusion. **Which is the priority nursing action, based on the assessment data below, when the client’s chest tube has drained 240 mL of bright red drainage the past hour? Client assessment: A&O x 3; pain is 7 of 10 using a numeric scale; pulse oximetry 90% on 2 L/min nasal cannula (NC); heart rate is 92 beats/minute; blood pressure is 100/62 mm Hg; and respiration rate is 22 breaths/minute.**

- Administer prescribed morphine 4 mg by the IV route for pain
- Contact the healthcare provider (HCP)
- Immediately raise the level of the client’s chest tube
- Continue to monitor the client’s chest tube drainage

Answer & Rationale

- **Ask:** Priority action
 - **Problem:** Pleural effusion; 240 mL bright red drainage from chest tube in hour; O₂ 90% on 2L/min
 - **Solution:** Think excessive blood loss. Anything greater than 100mL per hour is very alarming. Consider interventions to prevent that worst possible outcome.
1. Incorrect - Pain is expected after insertion of a chest tube and administration of pain medication is not the priority.
 2. Correct - Drainage that is red, free-flowing or in large amounts greater than 100 mL per hour is indicative of hemorrhage.
 3. Incorrect - A chest tube drainage system must always be placed below the level of the chest and secured in an upright position.
 4. Incorrect - While this is required as a normal nursing assessment as per facility protocol, this is not the priority action based on the current data.

“BRAIN BUSTER” QUESTION

Which laboratory tests will the nurse anticipate to receive orders to monitor a client taking metformin for type 2 diabetes? Select all that apply.

- Glycated hemoglobin (HgbA1c)
- Cardiac enzymes
- Liver enzymes
- Creatinine
- Brain natriuretic peptide (BNP)

Answer & Rationale

- **Ask:** Which labs to monitor
 - **Problem:** Metformin for type 2 diabetes
 - **Solution:** Think about a few things about monitoring a client on metformin like glucose-related labs, labs that reflect toxicity (i.e. liver & kidney)
1. Correct - Glycated hemoglobin (HgbA1c) is used to monitor the effectiveness of the medication.
 2. Incorrect - Cardiac enzymes are not affected by this medication.
 3. Correct - A major adverse effect of this drug is liver toxicity.
 4. Correct - A major adverse effect of this drug is kidney toxicity.
 5. Incorrect - This answer is not correct because the brain natriuretic peptide (BNP) blood test is used to determine the extent of heart failure.

NCLEX

“BRAIN BUSTER” QUESTION

Which action implemented by the novice nurse in the provision of care for a client who is intubated and mechanically ventilated requires intervention by the nurse preceptor? Select all that apply.

- Administers the prescribed PRN IV lorazepam 1mg to help the client's restlessness
- Activates suctioning while placing the catheter in the endotracheal (ET) tube
- Preoxygenates client and increases oxygen during suctioning
- Suctions the ET tube for at least 20 seconds per pass
- Suctions client when the high-pressure alarm is sounding
- Suctions client when rhonchi and visible secretions are present

Answer & Rationale

- **Ask:** Actions requiring intervention
- **Problem:** Intubated and on mechanical ventilation
- **Solution:** Looking for the incorrect actions by the new graduate nurse so think about the wrong actions.

1. Incorrect - Restlessness can cause the client to fight the ventilator assisting with breathing thus resulting in decreased oxygen exchange.
2. **Correct - When suctioning a client's ET tube, the nurse activates the suction when removing the catheter and not with insertion.**
3. Incorrect - Evidence-based practice (EBP) guidelines support oxygen supplementation prior to and during suctioning.
4. Correct - Evidence-based practice (EBP) guidelines indicate that suctioning **should only occur for 10-15 seconds per pass.**
5. Incorrect - The high pressure alarm may alert for a client whose airway is occluded due to thick secretions.
6. Incorrect - This action by the novice nurse assists with airway clearance allowing for adequate oxygenation.

“BRAIN BUSTER” QUESTION

Which fetal heart rate monitor tracings indicates a need for priority nursing intervention when providing care to a laboring mother?

- Early accelerations
- Early decelerations
- Fetal heart rate of 176 beats per minute
- Sinusoidal fetal heart rate

Answer & Rationale

- **Ask:** Priority intervention
- **Problem:** Fetal heart rate monitor tracing
- **Solution:** To identify the need for priority intervention, apply the characteristics of various heart rate monitoring tracing. Consider normal vs abnormal; late decels typically are worse.

1. Incorrect - Early accelerations are category I.
2. Incorrect - Early decelerations are category I.
3. Incorrect - This is category II. While not predictive of abnormal fetal acid-base status, this finding requires continued surveillance, but not priority intervention by the nurse.
4. **Correct - The true sinusoidal pattern is rare, but associated with increased rates of fetal mortality and is the priority intervention.**

NCLEX

“BRAIN BUSTER” QUESTION

The nurse has several medications that are all due at 0900. Determine what order the nurse should administer medications to the following clients. Label the clients 1-4 with 1 being the first priority and 4 being the last priority.

- ① Inhaled steroid for chronic obstructive pulmonary disease; client's oxygen saturation is 92%
- ② Blood pressure medication for hypertension; client's blood pressure is 146/88 mm Hg
- ③ Breathing treatment for asthma; client is displaying wheezing and labored breathing
- ④ Scheduled ophthalmic drops for glaucoma; client is reporting dry eyes

Answer & Rationale

- **Ask:** Order of priority
- **Problem:** Medication administration for multiple clients
- **Solution:** Think of two things you know about prioritization. Look for ABC issues first, then safety. Also consider if needs are acute or chronic when deciding priority

Answer: 3124

- #3. Acute problems take priority over chronic problems and this is the only acute client.
 #1. Airway is priority, but this client is chronic with a stable O₂ saturation.
 #2. Blood pressure is a circulation issue and clients with airway/breathing issues are prioritized first.
 #4. ABC issues should be addressed before the client with scheduled eye drops for glaucoma

NCLEX “BRAIN

BUSTER” QUESTION

Which action can be delegated appropriately to an experienced unlicensed assistive personnel (UAP)?

Select all that apply.

- Applying a barrier cream to the skin after assessing a client with bathing
- Notify the healthcare provider of critical labs
- Provide preoperative teaching about pain management
- Perform sterile dressing changes to a client’s stage 3 pressure injury
- Assuring bed is locked and height is at its lowest position

Answer & Rationale

- **Ask:** Appropriate delegation
- **Problem:** Delegating actions to the UAP
- **Solution:** Think about the UAP’s scope of practice. Remember, unstable clients, assessments, teachings, and medication administration cannot be delegated.

1. **Correct - The UAP scope of practice is to assist with procedures that do not require critical thinking or assessment and with activities of daily living.**
2. Incorrect - This is outside the scope of practice for a UAP.
3. Incorrect - This action can only be performed by a registered nurse (RN) according to the nurse practice act, RNs provide teaching to the client.
4. Incorrect - This is outside of the scope of practice for a UAP.
5. **Correct - The UAP assists and supports the nursing staff by making sure safety measures are in place before leaving a client’s room.**

NCLEX

“BRAIN BUSTER” QUESTION

A client, with a family history of breast cancer, is hesitant to take hormone replacement therapy (HRT) to address hot flashes caused by menopause. Which vitamin or herbal preparation is a potential alternative to HRT to address the client’s hot flashes?

- Garlic
- Saw palmetto
- Black cohosh
- Niacin

Answer & Rationale

- **Ask:** Which vitamin/herbal preparation
 - **Problem:** Menopausal with hot flashes; desires alternative treatment to HRT
 - **Solution:** Think about alternative therapies. Black cohosh can lessen the severity of hot flashes. It’s best for the client to discuss any herbal remedies with their practitioner before use of any herbal remedies.
1. Incorrect - Garlic is an herbal remedy that boosts immunity, decreases inflammation, and improves heart health.
 2. Incorrect - Saw palmetto is an herbal remedy that is often used to promote prostate health for male clients and may cause or exacerbate hot flashes in menopause.
 3. Correct - Clients have found relief from hot flashes that are associated with **menopause through use of black cohosh, a herbal root remedy.**
 4. Incorrect - Niacin is a dietary supplement that may cause facial flushing which could exacerbate hot flashes in menopause.

“BRAIN BUSTER” QUESTION

Which nursing action is appropriate for a client who is admitted to the medical unit for a worsening myasthenia gravis? Select all that apply.

- Administer neostigmine 1 mg IM before meals, as prescribed
- Contact the continence specialist for bowel training
- Encourage foods such as scrambled eggs and milkshakes
- Prepare to administer atropine 2 mg by IV push now
- Remind the client of the importance of getting the pneumonia vaccination

Answer & Rationale

- **Ask:** Appropriate nursing action
- **Problem:** Worsening myasthenia gravis
- **Solution:** Memory trick: for myasthenia gravis, think MG = Muscle Gravity issue, where the body becomes weak, causing neuromuscular dysfunction.

1. **Correct - Neostigmine is an anticholinesterase medication prescribed to treat the symptoms of MG by decreasing the breakdown of acetylcholine.**
2. Incorrect - Muscles that control bowel and bladder function are not affected with a diagnosis of myasthenia gravis.
3. **Correct - Since MG causes weakness in the muscles used for chewing, clients are encouraged to eat foods that are easily chewed and swallowed.**
4. Incorrect - Anticholinergic medication such as atropine would further decrease the availability of ACh and worsen muscle weakness associated with MG..
5. **Correct - Stress that is caused by physical illness can lead to myasthenic crisis so clients should receive all recommended vaccinations.**