NGN CASE STUDY QUESTIONS

NGN CASE STUDY 1 (Questions 1–6): Heart Failure Exacerbation

Client Scenario
A 72-year-old client arrives to the ED with **increasing shortness of breath for 2 days**, fatigue, and ankle swelling. History: **HFrEF (EF 30%)**, HTN, CAD. Medications: furosemide, lisinopril, metoprolol succinate. Assessment: **BP 168/92**, HR 104, RR 28, SpO_2 89% RA, temp 36.8°C (98.2°F). Lung sounds: **crackles bilaterally**. 2+ pitting edema. Client states: "I've been sleeping on 3 pillows."

Q1. Priority action (Multiple Choice)

Which action should the nurse perform **first**?
A. Initiate 2 L/min oxygen via nasal cannula
B. Obtain daily weight history from the client
C. Provide teaching about low-sodium diet
D. Prepare the client for an echocardiogram

Answer: A
Rationale: The client is hypoxemic (SpO_2 89%) with respiratory distress. **Airway/breathing** is the priority; oxygen should be initiated immediately while further assessment continues.

Q2. Identify concerning findings (Select All That Apply)

Which findings support **acute fluid volume overload** related to heart failure?
A. Crackles in both lungs
B. Orthopnea (3 pillows)
C. HR 104 beats/min
D. SpO_2 89% on room air
E. Temperature 36.8°C (98.2°F)

Answer: A, B, C, D
Rationale: Crackles, orthopnea, tachycardia (compensatory), and low oxygen saturation are consistent with **pulmonary congestion**. Normal temperature is not specific.

Q3. Most important to report (Multiple Choice)

Which provider order requires clarification before implementation?
A. “Administer IV furosemide now.”
B. “Start normal saline at 125 mL/hr.”
C. “Place the client on continuous pulse oximetry.”
D. “Obtain BNP and basic metabolic panel.”

Answer: B
Rationale: In **fluid overload**, routine IV fluids can worsen pulmonary edema and respiratory status. This order should be questioned unless a specific indication exists.

Q4. Expected response to intervention (Multiple Choice)

After IV furosemide, which assessment finding indicates the intervention is effective?
A. Decreased urine output
B. Increased crackles
C. Decreased dyspnea and improved SpO_2
D. Rising blood pressure

Answer: C
Rationale: Diuresis reduces pulmonary congestion, improving oxygenation and work of breathing.

Q5. Teaching evaluation (Multiple Choice)

Which statement indicates the client understands discharge teaching for heart failure self-management?
A. “I will stop my beta blocker if my heart rate is below 90.”
B. “I’ll weigh myself daily and call if I gain 2–3 lb in a day.”
C. “I can use salt substitutes freely to avoid sodium.”
D. “I only need to take my diuretic when my ankles swell.”

Answer: B
Rationale: Daily weights and reporting rapid gains is key. Beta blockers should not be stopped without guidance. Salt substitutes may contain potassium (risk with ACE inhibitors). Diuretics should be taken as prescribed.

Q6. Risk reduction (Select All That Apply)

Which instructions reduce risk of worsening heart failure?
A. Limit sodium as prescribed
B. Keep follow-up appointments
C. Increase fluid intake to prevent dehydration
D. Take NSAIDs for pain as first choice
E. Recognize early symptoms (weight gain, dyspnea)

Answer: A, B, E
Rationale: Sodium restriction, follow-up, and early recognition prevent exacerbations. Routine increased fluids can worsen volume overload. NSAIDs can cause sodium/water retention and worsen HF.

NGN CASE STUDY 2 (Questions 7–12): Postpartum Hemorrhage

Client Scenario
A 29-year-old client is **1 hour postpartum** after vaginal delivery. Fundus is **boggy**, lochia is **heavy with clots**. VS: BP 90/54, HR 128, RR 24, SpO_2 96% RA. Skin cool and pale. The client reports dizziness.

Q7. Priority nursing action (Multiple Choice)

What should the nurse do **first**?
A. Insert an indwelling urinary catheter
B. Perform fundal massage
C. Obtain a CBC and type/screen
D. Provide teaching about breastfeeding

Answer: B
Rationale: A boggy uterus indicates **uterine atony**, the most common cause of postpartum hemorrhage. **Fundal massage** is an immediate, first-line intervention to promote uterine contraction.

Q8. Anticipated orders (Select All That Apply)

Which provider orders should the nurse anticipate?
A. Oxytocin infusion
B. Large-bore IV access and isotonic fluids

C. Methylergonovine if not contraindicated
D. Trendelenburg position as definitive treatment
E. Type and crossmatch blood

Answer: A, B, C, E
Rationale: Uterotonics (oxytocin; methylergonovine if no HTN) and volume resuscitation are expected, plus blood preparation. Trendelenburg is not definitive.

Q9. Contraindication (Multiple Choice)

Which history would make **methylergonovine** inappropriate?
A. Asthma
B. Hypertension
C. Diabetes mellitus
D. Hypothyroidism

Answer: B
Rationale: Methylergonovine can cause **vasoconstriction** and significantly increase BP; it is contraindicated in hypertension/preeclampsia.

Q10. Most concerning assessment (Multiple Choice)

Which finding requires the most urgent follow-up?
A. SpO_2 96% on room air
B. HR 128 beats/min
C. RR 24 breaths/min
D. Dizziness

Answer: B
Rationale: Severe tachycardia postpartum with hypotension suggests **shock from hemorrhage**. While dizziness is concerning, the **vital sign pattern** indicates decompensation.

Q11. Evaluate effectiveness (Multiple Choice)

Which finding best indicates that interventions are working?
A. Fundus firm and midline with decreased bleeding
B. Temperature returns to normal
C. Increased urine ketones
D. Client reports hunger

Answer: A
Rationale: A firm uterus with reduced lochia indicates control of uterine atony and hemorrhage.

Q12. Patient safety (Select All That Apply)

Which actions are appropriate while managing postpartum hemorrhage?
A. Quantify blood loss (weigh pads, measure clots)
B. Maintain supine position with legs elevated as needed
C. Delay IV access until labs return
D. Monitor urine output
E. Continue fundal checks per protocol

Answer: A, B, D, E
Rationale: Accurate loss measurement, perfusion support, urine output monitoring, and ongoing uterine assessment are essential. IV access should be established immediately, not delayed.

TRADITIONAL NCLEX-RN STYLE ITEMS (Questions 13–30)

Q13. Infection control – TB (Multiple Choice)

A client suspected of pulmonary tuberculosis is admitted. Which room assignment is appropriate?
A. Semi-private room with HEPA filter
B. Private room with negative pressure
C. Private room with positive pressure
D. Semi-private room with surgical mask on client only

Answer: B
Rationale: TB requires **airborne precautions**: private **negative-pressure** room; staff wear N95/respirator.

Q14. Medication safety – Heparin (Multiple Choice)

A client on IV heparin has aPTT significantly above therapeutic range and oozing at IV sites. What is the priority?
A. Administer vitamin K
B. Stop heparin infusion and notify provider
C. Administer protamine sulfate immediately without orders
D. Increase infusion rate to maintain patency

Answer: B
Rationale: Priority is to **stop the infusion** and notify. Protamine is antidote but typically requires provider order and dosing based on heparin received.

Q15. Delegation (Multiple Choice)

Which task is appropriate for the nurse to delegate to an experienced UAP?
A. Assess pain 30 minutes after IV morphine
B. Obtain vital signs on a stable post-op client
C. Teach incentive spirometry use
D. Evaluate breath sounds after nebulizer treatment

Answer: B
Rationale: UAP can obtain routine vitals on stable clients. Assessment/teaching/evaluation remain RN responsibilities.

Q16. Prioritization – Chest pain (Multiple Choice)

Four clients arrive at the ED. Who should be seen first?
A. 22-year-old with ankle sprain, pain 8/10
B. 40-year-old with fever 39.2°C (102.6°F) and cough
C. 58-year-old with chest pressure radiating to jaw
D. 33-year-old with vomiting and diarrhea for 2 days

Answer: C
Rationale: Symptoms suggest **acute coronary syndrome**—time-sensitive, life-threatening.

Q17. Stroke care – Swallowing (Multiple Choice)

A client with an acute stroke is admitted. Which order should the nurse implement first?
A. Provide a meal tray
B. Initiate swallow screen before oral intake

C. Encourage oral fluids
D. Administer oral medications with applesauce

Answer: B
Rationale: Prevent aspiration: **swallow screening** before any PO intake.

Q18. Diabetes – Hypoglycemia (Multiple Choice)

A client with diabetes is confused, diaphoretic, and tremulous. Blood glucose is 48 mg/dL. What should the nurse do first?
A. Administer 1 mg glucagon IM
B. Give 15 g fast-acting carbohydrate if able to swallow
C. Start sliding-scale insulin
D. Encourage the client to ambulate

Answer: B
Rationale: If conscious and able to swallow: **15 g rapid carbohydrate** is first-line. Glucagon is used if unable to take PO.

Q19. Fluid/electrolytes – Potassium (Multiple Choice)

A client's potassium is 2.9 mEq/L. Which assessment is most important?
A. Lung sounds
B. Bowel sounds
C. Cardiac rhythm
D. Pupillary response

Answer: C
Rationale: Hypokalemia increases risk of **dysrhythmias**; monitor ECG/rhythm.

Q20. PPE sequencing (Multiple Choice)

Which PPE is donned first when entering a room requiring contact precautions?
A. Gloves
B. Gown
C. Mask
D. Face shield

Answer: B
Rationale: Standard sequence: **gown first**, then mask/respirator (if needed), goggles/face shield, then gloves.

Q21. Maternal-newborn – Late decelerations (Multiple Choice)

A laboring client's fetal monitor shows **late decelerations**. What is the nurse's priority action?
A. Increase oxytocin
B. Place client in left lateral position
C. Perform vaginal exam
D. Prepare for immediate cesarean without interventions

Answer: B
Rationale: Late decels = uteroplacental insufficiency. First interventions: reposition (left lateral), stop oxytocin, O_2 per policy, IV bolus, notify provider.

Q22. Psych – Therapeutic communication (Multiple Choice)

A client says, "I have nothing to live for." What is the best response?
A. "You shouldn't feel that way."
B. "Why would you say that?"
C. "Are you thinking about harming yourself?"
D. "Let's talk about something positive."

Answer: C
Rationale: Directly assesses **suicidal ideation** and safety.

Q23. SATA – Signs of opioid overdose (Select All That Apply)

Which findings are consistent with opioid overdose?
A. Pinpoint pupils
B. Respiratory depression
C. Hypertension
D. Decreased level of consciousness
E. Hyperactive bowel sounds

Answer: A, B, D
Rationale: Classic triad: **CNS depression**, **respiratory depression**, **miosis**.

Q24. Pediatrics – Dehydration (Multiple Choice)

Which finding suggests **moderate dehydration** in an infant?
A. Bulging fontanel
B. Sunken fontanel and decreased tears
C. Bradycardia and bounding pulses
D. Increased urine output

Answer: B
Rationale: Moderate dehydration: sunken fontanel, fewer tears, dry mucosa, decreased urine.

Q25. Renal – AV fistula care (Multiple Choice)

Which statement by a client with a new AV fistula indicates correct understanding?
A. “I will allow blood pressures on that arm if needed.”
B. “I will check for a thrill daily.”
C. “I will apply a tight tourniquet if it bleeds.”
D. “I will sleep on that arm to protect it.”

Answer: B
Rationale: Assess patency with **thrill/bruit**. Avoid BP/venipuncture on that arm; avoid compression.

Q26. NGN-style Bow-Tie (Text version)

Condition: The nurse suspects **sepsis** in a hospitalized client.
Choose the best options:

Most likely cause:
A. Dysrhythmia
B. Systemic infection
C. GI obstruction
D. Acute pancreatitis

Intervention:
A. Delay cultures until fever resolves
B. Begin broad-spectrum antibiotics after cultures
C. Restrict fluids and monitor only
D. Administer diuretics first

Outcome to monitor:
A. Rising lactate and decreasing urine output
B. Improved MAP and urine output
C. Increasing HR and temperature
D. Decreased SpO_2 without symptoms

Answer: B (cause), B (intervention), B (outcome)
Rationale: Sepsis is systemic infection; bundle includes cultures then **early broad-spectrum antibiotics** and fluids. Improvement includes better perfusion (MAP/urine output).

Q27. Cardiac – Digoxin toxicity (Multiple Choice)

A client taking digoxin reports nausea and sees "yellow halos." HR is 48/min. What is the priority action?
A. Give next dose with food
B. Hold digoxin and notify provider
C. Administer atropine and discharge
D. Encourage potassium restriction

Answer: B
Rationale: Bradycardia and visual changes suggest **digoxin toxicity**—hold medication and notify provider; check digoxin level and electrolytes.

Q28. Respiratory – COPD oxygen (Multiple Choice)

A client with COPD is on oxygen. Which finding indicates oxygen may be too high?
A. SpO_2 92%
B. Increased somnolence and decreased respiratory rate
C. Pink, warm skin
D. Improved dyspnea with activity

Answer: B
Rationale: In COPD retainers, excessive O_2 can reduce hypoxic drive and worsen hypercapnia, causing **CO_2 narcosis** (drowsiness, hypoventilation).

Q29. Med-Surg – Post-op hemorrhage (Multiple Choice)

A post-op client becomes restless; HR 122, BP 86/50. Dressing is saturated with blood. What should the nurse do first?

A. Reinforce dressing and document
B. Apply direct pressure and call rapid response/provider
C. Place client upright and offer fluids
D. Remove dressing to inspect incision

Answer: B
Rationale: Signs of **shock** with active bleeding: apply pressure, activate emergency response, support circulation.

Q30. SATA – Stroke warning signs (Select All That Apply)

Which are warning signs of stroke?
A. Facial droop
B. Arm weakness
C. Sudden severe headache
D. Gradual onset of chronic back pain
E. Sudden trouble speaking

Answer: A, B, C, E
Rationale: FAST/BE-FAST symptoms include facial droop, arm weakness, speech issues, and sudden severe headache (possible hemorrhagic stroke).

NGN CASE STUDY 3 (Questions 31–36): Sepsis From Pneumonia

Client Scenario
A 66-year-old client is admitted with **pneumonia**. History: type 2 diabetes, COPD. On arrival: T 39.1°C (102.4°F), HR 118, RR 26, BP 92/54, SpO_2 90% on 2 L NC. Skin warm, flushed. Mental status: “more confused than usual.” Labs: WBC 18,000/mm³, lactate 3.8 mmol/L. Urine output in last 2 hours: 20 mL.

Q31. Priority action (Multiple Choice)

What should the nurse do **first**?
A. Obtain two sets of blood cultures
B. Increase oxygen and reassess SpO_2/respiratory effort
C. Administer acetaminophen for fever
D. Encourage oral fluids

Answer: B
Rationale: Airway/breathing is the immediate priority (hypoxemia, tachypnea). Stabilize oxygenation while initiating the sepsis bundle.

Q32. Recognize sepsis indicators (Select All That Apply)

Which findings support **sepsis with hypoperfusion**?
A. Lactate 3.8 mmol/L
B. BP 92/54 mm Hg
C. WBC 18,000/mm³
D. Urine output 20 mL in 2 hours
E. SpO_2 90% on 2 L NC
F. Warm, flushed skin

Answer: A, B, C, D, E
Rationale: Elevated lactate, hypotension, leukocytosis, oliguria, and hypoxemia support sepsis with impaired perfusion/oxygenation. Warm skin can occur early but is less specific for hypoperfusion.

Q33. Most urgent provider notification (Multiple Choice)

Which order should the nurse **question/clarify** in a suspected septic client?
A. “Administer broad-spectrum antibiotics after cultures are obtained.”
B. “Give 30 mL/kg isotonic crystalloid bolus.”
C. “Administer IV furosemide now for crackles.”
D. “Measure lactate again in 2–4 hours.”

Answer: C
Rationale: In sepsis, hypotension and elevated lactate indicate the need for **rapid fluid resuscitation**, not diuresis. Crackles may reflect pneumonia, not fluid overload. This order risks worsening hypoperfusion.

Q34. Evaluate response to interventions (Multiple Choice)

After fluids and antibiotics, which finding best suggests improving perfusion?
A. HR increases from 118 to 128
B. Urine output increases to 40 mL/hr
C. Temperature rises to 39.6°C (103.3°F)
D. WBC increases to 20,000/mm³

Answer: B
Rationale: Improved urine output reflects improved renal perfusion and effective resuscitation.

Q35. NGN-style “Drag-and-drop” sequence (Text version)

Place the following sepsis bundle actions in the **most appropriate order**:

1. Obtain blood cultures
2. Administer broad-spectrum antibiotics
3. Initiate IV fluid bolus
4. Measure lactate level

Answer: 4 → 1 → 3 → 2
Rationale: Measure lactate and obtain cultures early; start fluids promptly for hypotension; antibiotics should follow cultures but must not be delayed unnecessarily.

Q36. Patient education evaluation (Multiple Choice)

Which statement by the client’s family indicates correct understanding of sepsis?
A. “Once the fever improves, sepsis is resolved.”
B. “Sepsis can cause low blood pressure and organ problems if not treated quickly.”
C. “Antibiotics are optional if oxygen levels improve.”
D. “Sepsis only occurs in people with HIV.”

Answer: B
Rationale: Sepsis is a dysregulated response to infection causing hypotension and organ dysfunction; early treatment is critical.

NGN CASE STUDY 4 (Questions 37–42): Diabetic Ketoacidosis (DKA)

Client Scenario
A 19-year-old with type 1 diabetes presents with **polyuria**, abdominal pain, and vomiting. Reports missing insulin doses due to a “stomach bug.” Assessment: dry mucous membranes, Kussmaul respirations, fruity breath. VS: HR 124, BP 98/60, RR 30, SpO_2 98% RA. Labs: glucose 560 mg/dL, pH 7.12, HCO_3^- 10 mEq/L, anion gap 24, potassium 5.6 mEq/L.

Q37. Priority intervention (Multiple Choice)

Which provider order should the nurse implement **first**?
A. Start IV regular insulin infusion
B. Begin isotonic fluid bolus (0.9% NS)
C. Administer sodium bicarbonate
D. Restrict oral intake

Answer: B
Rationale: DKA clients are severely volume depleted. **Fluids first** restore perfusion and support kidney clearance of glucose/ketones before insulin shifts electrolytes.

Q38. Expected findings in DKA (Select All That Apply)

Which findings are consistent with DKA?
A. Kussmaul respirations
B. Fruity breath odor
C. Metabolic acidosis (low pH, low HCO_3^-)
D. Narrow anion gap
E. Dehydration signs
F. Hypoglycemia

Answer: A, B, C, E
Rationale: DKA causes high anion gap metabolic acidosis, ketones, dehydration, compensatory hyperventilation. Hypoglycemia and narrow anion gap are not expected.

Q39. Potassium management (Multiple Choice)

The nurse notes potassium is 5.6 mEq/L. Which statement is most accurate?
A. “Potassium is high, so replacement will never be needed.”
B. “Insulin therapy may drive potassium into cells and cause hypokalemia.”
C. “Potassium is high; give potassium chloride immediately.”
D. “Hold fluids until potassium normalizes.”

Answer: B
Rationale: Despite initial hyperkalemia, total body potassium is depleted. Insulin shifts potassium intracellularly, risking **dangerous hypokalemia**.

Q40. Most important ongoing assessment (Multiple Choice)

During insulin infusion for DKA, what is most important for the nurse to monitor closely?
A. Bowel sounds every hour
B. Cardiac rhythm and serum potassium
C. Temperature every 8 hours
D. Pupillary response every 4 hours

Answer: B
Rationale: Insulin can precipitate hypokalemia → dysrhythmias. Continuous monitoring of rhythm and potassium is essential.

Q41. Evaluate effectiveness (Multiple Choice)

Which trend indicates DKA is resolving?
A. Anion gap decreases and bicarbonate increases
B. Potassium increases to 6.2 mEq/L
C. Respiratory rate increases to 36/min
D. Glucose drops to 70 mg/dL rapidly

Answer: A
Rationale: Resolution is measured by closing the anion gap and correction of acidosis, not glucose alone.

Q42. NGN-style teaching (Multiple Choice)

Which statement indicates the client understands “sick day” diabetes management?
A. “If I can’t eat, I should stop insulin completely.”
B. “I should check glucose and ketones more often and continue insulin as directed.”
C. “I should drink less fluid to prevent vomiting.”
D. “I should only call the provider if I have a fever.”

Answer: B
Rationale: Sick-day rules: continue insulin (often adjusted), monitor more frequently, hydrate, check ketones, and seek care early.

TRADITIONAL NCLEX-RN STYLE ITEMS (Questions 43–60)

Q43. Prioritization — Post-op airway (Multiple Choice)

A client 1 hour post-op is difficult to arouse, RR 8/min, SpO_2 88% on 2 L NC. What is the priority action?
A. Notify provider
B. Increase oxygen to 6 L NC
C. Stimulate client, ensure airway patency, and prepare to administer naloxone per protocol
D. Document findings and reassess in 30 minutes

Answer: C
Rationale: Opioid-induced respiratory depression is life-threatening. Immediate airway support and reversal preparation are priorities.

Q44. SATA — Signs of compartment syndrome (Select All That Apply)

A client with a cast after tibia fracture reports escalating pain. Which findings suggest compartment syndrome?
A. Pain out of proportion to injury
B. Paresthesia (tingling)
C. Pallor and coolness distal to injury
D. Bounding pulses and warmth
E. Pain with passive stretch

Answer: A, B, C, E
Rationale: Classic signs include severe pain, paresthesia, pallor/coolness, and pain on passive stretch. Pulses may be diminished late, not bounding.

Q45. Medication — ACE inhibitor adverse effect (Multiple Choice)

A client taking lisinopril develops facial swelling and difficulty swallowing. What is the nurse's priority action?
A. Reassure client this is expected
B. Hold dose and give oral antihistamine only
C. Activate emergency response; possible angioedema
D. Encourage fluids and rest

Answer: C
Rationale: ACE inhibitors can cause **angioedema** with airway compromise—medical emergency.

Q46. Delegation — LPN/LVN vs RN (Multiple Choice)

Which client assignment is most appropriate for the RN (not LPN/LVN)?
A. Stable client receiving oral antibiotics for UTI
B. Client with new tracheostomy 12 hours post-op
C. Client with chronic COPD needing scheduled inhaler
D. Stable post-op day 2 client needing dressing change

Answer: B
Rationale: New tracheostomy requires complex assessment and potential rapid intervention—RN-level care.

Q47. Pediatric dosing safety (Multiple Choice)

Before administering a medication to a pediatric client, which is the most important action?
A. Verify the child's allergies only
B. Use the adult dose and divide by 2
C. Calculate dose based on weight and verify safe range
D. Ask the parent if the medication is acceptable

Answer: C
Rationale: Pediatric dosing must be weight-based and checked against safe dosing ranges to prevent medication errors.

Q48. SAT A — Postpartum warning signs (Select All That Apply)

A postpartum client calls the clinic. Which symptoms require immediate evaluation?
A. Saturating a pad in 1 hour
B. Fever 38.6°C (101.5°F)
C. Foul-smelling lochia
D. Mild cramping during breastfeeding
E. Calf pain with swelling

Answer: A, B, C, E
Rationale: Heavy bleeding, fever, foul lochia (infection), and calf pain/swelling (DVT) are urgent. Mild cramps during breastfeeding are expected (afterpains).

Q49. Cardiac — STEMI care (Multiple Choice)

A client with suspected STEMI arrives. Which action should occur first?
A. Administer morphine for pain
B. Obtain a 12-lead ECG
C. Start cardiac rehab teaching
D. Schedule echocardiogram for tomorrow

Answer: B
Rationale: Rapid ECG is essential to confirm STEMI and initiate time-sensitive reperfusion.

Q50. Respiratory — Suctioning (Multiple Choice)

A tracheostomy client needs suctioning. Which action is correct?
A. Apply suction while inserting the catheter
B. Suction continuously for 30 seconds
C. Preoxygenate and limit suction passes to 10–15 seconds
D. Use tap water to rinse catheter between passes

Answer: C
Rationale: Preoxygenate to prevent hypoxia; suction is applied while withdrawing and should be brief (10–15 seconds). Use sterile technique and sterile saline per policy.

Q51. Isolation precautions — C. difficile (Multiple Choice)

A client has C. difficile infection. Which intervention is required?
A. N95 respirator
B. Alcohol-based hand rub only
C. Soap-and-water hand hygiene and contact precautions
D. Negative-pressure room

Answer: C
Rationale: C. diff spores are not reliably removed by alcohol rub alone; use soap and water plus gown/gloves.

Q52. SATA — Hypocalcemia (Select All That Apply)

Which findings are consistent with hypocalcemia?
A. Tingling around mouth
B. Muscle cramps/tetany
C. Chvostek sign

D. Bradycardia with wide QRS
E. Hyperactive reflexes

Answer: A, B, C, E
Rationale: Hypocalcemia causes neuromuscular irritability (tetany, perioral tingling, Chvostek, hyperreflexia). Wide QRS is more typical of hyperkalemia.

Q53. Safety — Restraints (Multiple Choice)

A confused client keeps pulling at the central line. Which is the best nursing action?
A. Apply restraints and document only
B. Use least restrictive alternatives first and reassess frequently
C. Apply restraints PRN without an order
D. Place the client in a room alone and close the door

Answer: B
Rationale: Restraints require least restrictive measures first, appropriate orders/policy compliance, and ongoing reassessment.

Q54. Mental health — Mania (Multiple Choice)

A client with bipolar disorder is in acute mania, pacing and speaking rapidly. Which intervention is most appropriate?
A. Encourage group socialization to burn energy
B. Provide structured environment with low stimulation and short, clear directions
C. Challenge grandiose ideas directly in front of others
D. Offer caffeinated beverages to improve focus

Answer: B
Rationale: Mania requires reduced stimuli, structure, limit setting, and concise communication. Caffeine worsens agitation.

Q55. SATA — Early signs of increased ICP (Select All That Apply)

Which findings suggest early increased intracranial pressure?
A. Change in level of consciousness
B. Vomiting
C. Widening pulse pressure with bradycardia

D. Headache
E. Restlessness/irritability

Answer: A, B, D, E
Rationale: Early signs include LOC changes, headache, vomiting, restlessness. Cushing's triad (bradycardia, widened pulse pressure, irregular respirations) is late.

Q56. Medication — Warfarin teaching (Multiple Choice)

Which food should the client limit while taking warfarin?
A. Bananas
B. Spinach
C. Chicken
D. Milk

Answer: B
Rationale: Vitamin K-rich foods (leafy greens) can reduce warfarin effect; consistency is key.

Q57. OB — Preeclampsia (Multiple Choice)

A pregnant client at 35 weeks has BP 168/110, headache, and visual changes. What is the priority action?
A. Encourage ambulation
B. Administer magnesium sulfate as ordered and institute seizure precautions
C. Limit protein intake
D. Delay assessment to reduce stimulation

Answer: B
Rationale: Severe features require seizure prophylaxis (magnesium) and seizure precautions; this is urgent.

Q58. SATA — Magnesium toxicity (Select All That Apply)

A client receiving magnesium sulfate develops toxicity. Which findings support this?
A. Decreased deep tendon reflexes
B. Respiratory depression
C. Urine output 15 mL/hr
D. Hyperactive reflexes
E. Severe hypertension

Answer: A, B, C
Rationale: Toxicity: diminished reflexes, respiratory depression, reduced urine output (mag is excreted renally). Antidote is calcium gluconate (provider order).

Q59. Nutrition — Dysphagia (Multiple Choice)

A client with dysphagia after stroke is eating. Which action reduces aspiration risk?
A. Offer thin liquids with meals
B. Place food on the affected side of the mouth
C. Keep client upright during meals and 30 minutes after
D. Encourage rapid eating to finish before fatigue

Answer: C
Rationale: Upright positioning reduces aspiration. Thin liquids increase aspiration risk; food is typically placed on the **unaffected** side; slow, small bites are encouraged.

Q60. SATA — Hypovolemic shock (Select All That Apply)

Which findings are expected in hypovolemic shock?
A. Tachycardia
B. Hypotension
C. Warm, flushed skin
D. Cool, clammy skin
E. Decreased urine output

Answer: A, B, D, E
Rationale: Hypovolemia causes compensatory tachycardia, low BP, peripheral vasoconstriction (cool/clammy), and oliguria.

NGN CASE STUDY 5 (Questions 61–66): Acute Ischemic Stroke

Client Scenario
A 70-year-old client arrives to the ED with **sudden right-sided weakness** and slurred speech that began **45 minutes ago**. History: atrial fibrillation (not consistently anticoagulated), HTN, hyperlipidemia. VS: BP 178/96, HR 102 irregular, RR 20, SpO_2 95% RA, glucose 108 mg/dL. CT head is ordered.

Q61. Priority action (Multiple Choice)

What is the nurse's priority action on arrival?
A. Offer aspirin with water
B. Perform rapid neurologic assessment and activate stroke protocol
C. Obtain a detailed dietary history
D. Position the client flat and provide oral fluids

Answer: B
Rationale: Time-sensitive stroke care requires rapid assessment and protocol activation to meet reperfusion time goals.

Q62. Identify eligible thrombolytic criteria (Select All That Apply)

Which findings support potential eligibility for IV thrombolytic therapy (e.g., alteplase), assuming no contraindications?
A. Symptom onset 45 minutes ago
B. Glucose 108 mg/dL
C. BP 178/96 mm Hg
D. Current anticoagulant use with unknown INR
E. CT head pending

Answer: A, B, C, E
Rationale: Within the treatment window and glucose is not severely abnormal. BP may need management but is not an absolute exclusion if controlled per protocol. Unknown INR with anticoagulants can be a contraindication—requires verification.

Q63. Order to question (Multiple Choice)

Which provider order should the nurse **question** until after imaging is completed?
A. "Keep NPO until swallow screen is completed."
B. "Obtain a STAT non-contrast CT head."
C. "Administer aspirin now."
D. "Initiate continuous cardiac monitoring."

Answer: C
Rationale: Aspirin is appropriate for ischemic stroke but should be delayed until intracranial hemorrhage is ruled out by CT, especially in hyperacute presentation.

Q64. Swallowing safety (Multiple Choice)

Which action best reduces aspiration risk in this client?
A. Give thickened liquids immediately
B. Perform a bedside swallow screen before any oral intake
C. Place client supine for meals
D. Administer oral meds crushed in water

Answer: B
Rationale: No PO intake until swallow safety is assessed.

Q65. NGN-style "Drag-and-drop" sequence (Text version)

Place these actions in the most appropriate order for acute stroke management:

1. Check blood glucose
2. Obtain non-contrast CT head
3. Establish IV access and draw labs
4. Perform rapid stroke assessment (NIHSS/FAST)

Answer: 4 → 1 → 3 → 2
Rationale: Rapid neuro assessment and glucose check occur immediately; IV/labs follow; CT is essential for treatment decisions.

Q66. Risk-factor teaching (Select All That Apply)

Which teaching points address the client's modifiable stroke risk factors?
A. Adherence to anticoagulation for atrial fibrillation
B. Smoking cessation if applicable
C. Avoid all physical activity
D. Blood pressure control
E. Cholesterol management

Answer: A, B, D, E
Rationale: AF anticoagulation, smoking cessation, BP and lipid control reduce stroke risk. Physical activity is generally encouraged as tolerated.

NGN CASE STUDY 6 (Questions 67–72): Acute Asthma Exacerbation

Client Scenario
A 24-year-old client with asthma arrives with **wheezing, chest tightness, and dyspnea** after cleaning a dusty room. Speaks in short phrases. VS: HR 124, RR 32, BP 138/84, SpO_2 88% RA. Breath sounds: diffuse wheezes, prolonged expiration.

Q67. Priority action (Multiple Choice)

What should the nurse do first?
A. Obtain peak expiratory flow rate before any intervention
B. Administer oxygen and a short-acting bronchodilator per protocol
C. Provide oral fluids
D. Place the client in a supine position

Answer: B
Rationale: Immediate stabilization is required: oxygen and rapid bronchodilation (SABA) are first-line for acute severe symptoms.

Q68. Identify concerning indicators (Select All That Apply)

Which findings indicate a severe asthma exacerbation?
A. SpO_2 88% on room air
B. Speaking in short phrases
C. HR 124
D. Prolonged expiration with wheezes
E. BP 138/84
F. Sudden absence of wheezing with increasing fatigue

Answer: A, B, C, D, F
Rationale: Hypoxemia, inability to speak full sentences, tachycardia, wheezing, and especially "silent chest"/fatigue can indicate impending respiratory failure.

Q69. Medication understanding (Multiple Choice)

Which order should the nurse anticipate for acute asthma that addresses airway inflammation?
A. IV antibiotics
B. Systemic corticosteroids

C. Long-acting beta agonist as rescue
D. Loop diuretic

Answer: B
Rationale: Systemic steroids reduce inflammation and prevent relapse; antibiotics are not routine unless infection is suspected. LABAs are not rescue.

Q70. Evaluate response (Multiple Choice)

Which finding indicates improvement after treatment?
A. SpO_2 increases to 94% and work of breathing decreases
B. RR increases to 40/min
C. Client becomes drowsy and less anxious
D. Peak flow decreases from baseline

Answer: A
Rationale: Improved oxygenation and decreased respiratory effort indicate response. Drowsiness can be ominous (CO_2 retention/fatigue).

Q71. NGN-style teaching (Select All That Apply)

Which statements should the nurse include in discharge teaching for asthma control?
A. Use rescue inhaler for acute symptoms only
B. Use inhaled corticosteroid daily as prescribed
C. Avoid known triggers when possible
D. Stop controller meds once symptoms improve
E. Demonstrate correct inhaler technique

Answer: A, B, C, E
Rationale: Controllers are taken consistently; rescue inhalers are for symptoms; trigger avoidance and technique matter. Stopping controllers increases risk.

Q72. Escalation of care (Multiple Choice)

Which assessment finding requires immediate escalation (rapid response/provider notification)?
A. Mild wheeze with SpO_2 95%
B. Client reports “I’m less tight”
C. Decreasing wheezing with rising CO_2 signs (drowsiness)
D. RR 20 and speaking in full sentences

Answer: C
Rationale: Decreasing wheeze plus drowsiness can indicate impending respiratory failure (fatigue/silent chest).

TRADITIONAL NCLEX-RN STYLE ITEMS (Questions 73–90)

Q73. SATA — Acute transfusion reaction (Select All That Apply)

During a PRBC transfusion, the client develops chills, back pain, and dyspnea. What should the nurse do?
A. Stop the transfusion
B. Maintain IV access with normal saline using new tubing
C. Notify the provider and blood bank
D. Restart transfusion at a slower rate once symptoms improve
E. Monitor vital signs and send blood/urine samples per protocol

Answer: A, B, C, E
Rationale: Stop transfusion immediately, keep line open with NS/new tubing, notify, monitor, and follow reaction protocol. Do not restart.

Q74. Medication — Insulin timing (Multiple Choice)

Which insulin is most appropriate to control post-meal blood glucose?
A. Glargine
B. NPH
C. Regular insulin
D. Lispro

Answer: D
Rationale: Lispro is rapid-acting and targets postprandial spikes.

Q75. Prioritization — Hyperkalemia ECG (Multiple Choice)

A client's potassium is 6.7 mEq/L with peaked T waves. What is the priority provider order to implement?

A. Administer calcium gluconate
B. Give oral potassium
C. Encourage high-potassium foods
D. Restrict sodium intake

Answer: A
Rationale: Calcium gluconate stabilizes the myocardium and is priority with ECG changes.

Q76. SATA — Signs of hypoxia (Select All That Apply)

Which findings suggest hypoxia?
A. Restlessness
B. Tachycardia
C. Cyanosis (late)
D. Bradycardia early
E. Confusion

Answer: A, B, C, E
Rationale: Early hypoxia: restlessness, tachycardia, confusion. Cyanosis is a late sign. Bradycardia is typically late.

Q77. Infection control — Neutropenia (Multiple Choice)

A client has ANC 400/mm³. Which intervention is most appropriate?
A. Fresh flowers in room
B. Private room; avoid sick visitors; meticulous hand hygiene
C. No mask needed for staff
D. Raw fruits and vegetables encouraged

Answer: B
Rationale: Protective precautions reduce infection risk. No fresh flowers; avoid raw foods depending on policy; strict hygiene.

Q78. Pediatrics — Croup (Multiple Choice)

A toddler with croup has inspiratory stridor and barking cough. What is the priority action?
A. Place in supine position
B. Keep the child calm and administer humidified oxygen as needed

C. Perform throat inspection with tongue depressor
D. Encourage vigorous coughing

Answer: B
Rationale: Agitation worsens airway obstruction. Maintain calm, support oxygenation. Avoid throat inspection (can trigger laryngospasm).

Q79. SATA — Signs of digoxin toxicity (Select All That Apply)

A client on digoxin reports symptoms. Which findings indicate possible toxicity?
A. Nausea/vomiting
B. Yellow-green visual halos
C. Bradycardia
D. Hypotension with wide pulse pressure
E. Confusion

Answer: A, B, C, E
Rationale: Classic toxicity includes GI upset, visual disturbances, bradycardia, and neuro changes.

Q80. Maternal-newborn — Newborn thermoregulation (Multiple Choice)

Which intervention best prevents heat loss in a newborn immediately after birth?
A. Delay drying until after measurements
B. Place newborn under radiant warmer and dry thoroughly
C. Bathe newborn within 10 minutes
D. Keep newborn uncovered to assess color

Answer: B
Rationale: Drying and warming prevent evaporative heat loss and hypothermia.

Q81. Safety — Anticoagulation teaching (Multiple Choice)

A client starting apixaban asks what to report immediately. Which symptom is priority?
A. Mild nausea
B. Black, tarry stools
C. Occasional headache relieved by rest
D. Increased appetite

Answer: B
Rationale: Melena indicates GI bleeding—a serious anticoagulant complication.

Q82. SATA — Pulmonary embolism (Select All That Apply)

Which findings are consistent with pulmonary embolism?
A. Sudden dyspnea
B. Pleuritic chest pain
C. Bradycardia
D. Tachycardia
E. Hemoptysis (possible)

Answer: A, B, D, E
Rationale: PE often causes sudden SOB, pleuritic pain, tachycardia, and may cause hemoptysis. Bradycardia is uncommon.

Q83. Delegation — RN vs UAP (Multiple Choice)

Which task can the RN delegate to UAP?
A. Teach new ostomy care
B. Assess for signs of DVT
C. Ambulate a stable post-op client with gait belt
D. Titrate oxygen based on ABG results

Answer: C
Rationale: Ambulation of stable clients is within UAP scope; assessment/teaching/titration decisions are RN tasks.

Q84. Psych — Panic attack (Multiple Choice)

A client is hyperventilating and says “I’m going to die.” What is the nurse’s best response?
A. “Calm down; you’re fine.”
B. “Breathe into this paper bag.”
C. “Stay with me. Try slow breathing; I will help you.”
D. “Tell me about your childhood.”

Answer: C
Rationale: Provide calm presence, reassurance, and breathing guidance. Paper bags are not recommended due to hypoxia risk.

Q85. SATA — Signs of dehydration in older adult (Select All That Apply)

Which findings suggest dehydration?
A. Tachycardia
B. Orthostatic hypotension
C. Dry mucous membranes
D. Bounding pulses
E. Decreased urine output

Answer: A, B, C, E
Rationale: Dehydration causes tachycardia, orthostasis, dry mucosa, oliguria. Bounding pulses suggest fluid overload.

Q86. Medication — Metformin safety (Multiple Choice)

Which condition requires holding metformin and notifying the provider?
A. Mild headache
B. Scheduled iodinated contrast study
C. Fasting for 6 hours
D. BMI 30

Answer: B
Rationale: Metformin should be held around iodinated contrast due to lactic acidosis risk if renal function worsens.

Q87. Med-surg — Chest tube (Multiple Choice)

A client with a chest tube has continuous bubbling in the water-seal chamber. What does this indicate?
A. Normal expected finding
B. Air leak in system
C. Tube is occluded
D. Output is too high

Answer: B
Rationale: Continuous bubbling in water-seal chamber suggests an air leak.

Q88. SATA — Post-op DVT prevention (Select All That Apply)

Which interventions reduce DVT risk after surgery?
A. Early ambulation
B. Sequential compression devices
C. Adequate hydration as ordered
D. Place pillow under knees continuously
E. Leg exercises

Answer: A, B, C, E
Rationale: Ambulation, SCDs, hydration, and exercises prevent venous stasis. Pillows under knees can impede venous return.

Q89. OB — Placenta previa (Multiple Choice)

A pregnant client at 30 weeks reports painless bright red bleeding. What is the priority action?
A. Perform a vaginal exam
B. Place client on bed rest and notify provider; anticipate ultrasound
C. Encourage intercourse to stimulate labor
D. Administer oxytocin immediately

Answer: B
Rationale: Suspect placenta previa. Avoid vaginal exams (can worsen bleeding). Notify provider and obtain ultrasound.

Q90. Prioritization — Anaphylaxis (Multiple Choice)

After receiving an antibiotic, a client develops wheezing, stridor, and hypotension. What is the priority action?
A. Obtain a 12-lead ECG
B. Administer epinephrine IM per protocol
C. Apply warm blankets
D. Give oral antihistamine only

Answer: B
Rationale: Anaphylaxis requires immediate IM epinephrine to reverse airway compromise and shock.

NGN CASE STUDY 7 (Questions 91–96): Acute Kidney Injury (AKI)

Client Scenario
A 62-year-old client is admitted with **sepsis**. History: HTN, type 2 diabetes. On day 2, urine output has declined. VS: BP 98/56, HR 110. Labs: **BUN 48 mg/dL**, **Creatinine 3.1 mg/dL** (baseline 1.0), **K^+ 5.8 mEq/L**. Urine output: 15 mL/hr.

Q91. Priority nursing action (Multiple Choice)

What is the nurse's priority action?
A. Encourage oral fluids
B. Notify provider of declining urine output and rising creatinine
C. Administer potassium supplement
D. Restrict protein intake

Answer: B
Rationale: Rapidly worsening renal function and oliguria require **immediate provider notification** and intervention.

Q92. Identify contributing factors (Select All That Apply)

Which factors increase this client's risk for AKI?
A. Sepsis
B. Diabetes mellitus
C. Hypotension
D. Hyperlipidemia
E. Exposure to nephrotoxic medications

Answer: A, B, C, E
Rationale: Sepsis, hypotension, diabetes, and nephrotoxins all predispose to AKI.

Q93. Order to question (Multiple Choice)

Which provider order should the nurse question?
A. "Strict intake and output monitoring"
B. "Avoid NSAIDs"
C. "Administer IV ketorolac for pain"
D. "Obtain daily BMP"

Answer: C
Rationale: NSAIDs are nephrotoxic and should be avoided in AKI.

Q94. Expected finding with worsening AKI (Multiple Choice)

Which finding is most concerning?
A. Decreased appetite
B. Crackles in lung bases
C. Serum potassium 5.8 mEq/L
D. Urine output 15 mL/hr

Answer: D
Rationale: Severe **oliguria** signals worsening renal failure and risk of fluid overload and electrolyte imbalance.

Q95. NGN-style "Cause–Effect" (Text version)

Match the finding to the most likely complication:

- **Hyperkalemia** →
- **Fluid retention** →
- **Uremia** →

Answer:

- Hyperkalemia → **Cardiac dysrhythmias**
- Fluid retention → **Pulmonary edema**
- Uremia → **Altered mental status**

Rationale: Elevated potassium affects cardiac conduction; fluid overload affects lungs; uremia affects neurologic status.

Q96. Teaching evaluation (Multiple Choice)

Which statement indicates correct understanding of AKI care?
A. "I should avoid over-the-counter pain relievers like ibuprofen."
B. "I can stop monitoring my urine once labs improve."

C. “High-potassium foods will help my kidneys recover.”
D. “Fluid intake should always be unrestricted.”

Answer: A
Rationale: Avoiding nephrotoxins is essential; potassium and fluid often require restriction.

NGN CASE STUDY 8 (Questions 97–102): Postoperative Pulmonary Embolism

Client Scenario
A 55-year-old client is **post-op day 3** after abdominal surgery. Suddenly develops **acute dyspnea**, chest pain, anxiety. VS: HR 132, RR 34, BP 90/52, SpO_2 86% RA.

Q97. Priority action (Multiple Choice)

What should the nurse do first?
A. Obtain a stat chest x-ray
B. Apply oxygen and activate rapid response
C. Encourage coughing and deep breathing
D. Place client in Trendelenburg position

Answer: B
Rationale: Suspected PE is a **medical emergency**—support oxygenation and activate emergency response.

Q98. Findings consistent with PE (Select All That Apply)

A. Sudden dyspnea
B. Tachycardia
C. Hypotension
D. Productive cough with thick sputum
E. Anxiety and restlessness

Answer: A, B, C, E
Rationale: PE presents with acute dyspnea, tachycardia, hypotension, and anxiety.

Q99. Anticipated orders (Select All That Apply)

Which provider orders should the nurse anticipate?
A. CT pulmonary angiography
B. IV unfractionated heparin
C. Broad-spectrum antibiotics
D. ABG analysis
E. Thrombolytic therapy (if massive PE)

Answer: A, B, D, E
Rationale: Imaging, anticoagulation, oxygenation assessment, and possibly thrombolysis are standard.

Q100. NGN-style outcome evaluation (Multiple Choice)

Which finding best indicates improvement?
A. HR decreases to 96 and SpO_2 improves to 94%
B. Client reports increased anxiety
C. BP decreases further
D. RR increases to 40

Answer: A
Rationale: Improved oxygenation and stabilized vital signs indicate response.

Q101. Prevention teaching (Select All That Apply)

Which instructions help prevent future PE?
A. Early ambulation after surgery
B. Use of sequential compression devices
C. Adequate hydration
D. Avoid all physical activity
E. Adherence to anticoagulant therapy if prescribed

Answer: A, B, C, E
Rationale: Mobility, SCDs, hydration, and anticoagulation reduce thromboembolism risk.

Q102. Discharge teaching (Multiple Choice)

Which statement indicates correct understanding?
A. “I should stop anticoagulants once I feel better.”
B. “Sudden shortness of breath should be reported immediately.”

C. “Chest pain is expected after surgery.”
D. “Compression stockings are only for the hospital.”

Answer: B
Rationale: Recurrent PE symptoms require immediate evaluation.

TRADITIONAL NCLEX-RN STYLE ITEMS (Questions 103–120)

Q103. SATA — Signs of fluid overload

Which findings indicate fluid volume excess?
A. Crackles
B. Jugular vein distention
C. Weight loss
D. Bounding pulses
E. Decreased blood pressure

Answer: A, B, D
Rationale: Fluid overload causes pulmonary congestion, JVD, and bounding pulses.

Q104. Medication safety — Morphine (Multiple Choice)

Which finding requires immediate intervention after IV morphine?
A. Nausea
B. RR 8/min
C. BP 118/70
D. Itching

Answer: B
Rationale: Respiratory depression is life-threatening.

Q105. Delegation — LPN (Multiple Choice)

Which task can be delegated to an LPN/LVN?
A. Initial admission assessment

B. Reinforcing teaching on incentive spirometer
C. Titrating IV vasopressors
D. Developing care plan

Answer: B
Rationale: LPNs may reinforce teaching and provide routine care.

Q106. Infection — Central line (Multiple Choice)

Which action reduces CLABSI risk?
A. Daily assessment of line necessity
B. Routine line replacement every 24 hours
C. Leaving dressing open to air
D. Using non-sterile technique

Answer: A
Rationale: Removing unnecessary lines and sterile care reduce infection risk.

Q107. SATA — Hypoglycemia signs

Which findings suggest hypoglycemia?
A. Diaphoresis
B. Tremors
C. Confusion
D. Polyuria
E. Tachycardia

Answer: A, B, C, E
Rationale: Adrenergic and neuroglycopenic symptoms dominate; polyuria is hyperglycemia.

Q108. Neuro — Seizure precautions (Multiple Choice)

Which intervention is appropriate?
A. Restrain during seizure
B. Pad side rails and keep suction available
C. Place tongue blade at bedside for use
D. Keep client supine at all times

Answer: B
Rationale: Safety measures reduce injury; never restrain or insert objects.

Q109. SATA — Liver failure complications

Which findings are associated with liver failure?
A. Ascites
B. Jaundice
C. Elevated ammonia
D. Hypoglycemia
E. Hypercoagulability

Answer: A, B, C, D
Rationale: Liver failure causes ascites, jaundice, hyperammonemia, and impaired glucose regulation; bleeding risk (not hypercoagulability).

Q110. OB — Uterine inversion (Multiple Choice)

A postpartum client has sudden hemorrhage and a mass protruding from the vagina. What is the priority action?
A. Apply fundal pressure
B. Administer oxytocin
C. Call for immediate assistance and prepare for manual replacement
D. Remove the mass

Answer: C
Rationale: Uterine inversion is life-threatening; immediate provider intervention is required. Do **not** apply fundal pressure.

Q111. SATA — Pressure injury prevention

Which interventions prevent pressure injuries?
A. Reposition at least every 2 hours
B. Use pressure-relieving surfaces
C. Keep skin clean and dry
D. Massage reddened bony prominences
E. Ensure adequate nutrition

Answer: A, B, C, E
Rationale: Repositioning, support surfaces, skin care, and nutrition help prevent breakdown; do not massage reddened areas.

Q112. Cardiac — Heart failure weight gain (Multiple Choice)

Which weight change should the client report?
A. 0.5 lb in one week
B. 1 lb in two weeks
C. 2–3 lb in one day
D. 3 lb in one month

Answer: C
Rationale: Rapid weight gain signals fluid retention.

Q113. SATA — Infection signs in older adults

Which findings may indicate infection in an older adult?
A. New confusion
B. Falls
C. Fever 39°C
D. Decreased appetite
E. Lethargy

Answer: A, B, D, E
Rationale: Older adults may not mount high fevers; subtle signs predominate.

Q114. Medication — Beta blockers (Multiple Choice)

Which finding requires holding the dose and notifying the provider?
A. BP 110/70
B. HR 48/min
C. Fatigue
D. Cold hands

Answer: B
Rationale: Bradycardia below parameters requires holding medication.

Q115. SATA — Signs of shock

Which findings are consistent with shock?
A. Hypotension
B. Tachycardia
C. Decreased urine output
D. Warm, flushed skin (early septic shock)
E. Increased capillary refill

Answer: A, B, C, D
Rationale: Shock presents with poor perfusion; early septic shock may have warm skin.

Q116. Safety — Fall prevention (Multiple Choice)

Which intervention best reduces fall risk?
A. Keep bed in high position
B. Use non-skid footwear
C. Restrain all confused clients
D. Dim lights at night

Answer: B
Rationale: Non-skid footwear improves traction and safety.

Q117. GI — Upper GI bleed (Multiple Choice)

Which assessment finding suggests an upper GI bleed?
A. Bright red blood per rectum
B. Coffee-ground emesis
C. Clay-colored stools
D. Yellow sclera

Answer: B
Rationale: Coffee-ground emesis indicates digested blood from upper GI tract.

Q118. SATA — Signs of respiratory failure

Which findings indicate impending respiratory failure?
A. Increasing $PaCO_2$
B. Decreasing level of consciousness

C. Severe dyspnea
D. Bradycardia early
E. Cyanosis

Answer: A, B, C, E
Rationale: CO_2 retention, altered LOC, severe dyspnea, and cyanosis are critical signs.

Q119. Oncology — Chemotherapy precautions (Multiple Choice)

Which instruction is most important for a client receiving chemotherapy?
A. Avoid crowds and sick contacts
B. Increase raw vegetable intake
C. Stop all vaccines permanently
D. Avoid physical activity

Answer: A
Rationale: Neutropenia increases infection risk.

Q120. Prioritization — GI perforation (Multiple Choice)

A client develops sudden severe abdominal pain, rigid abdomen, and hypotension. What is the priority action?
A. Administer oral analgesics
B. Prepare for emergency surgery and notify provider
C. Encourage ambulation
D. Apply heating pad

Answer: B
Rationale: Findings suggest **GI perforation** and peritonitis—surgical emergency.

Reply **"continue Set 5"** to receive **Questions 121–150**, completing the full **150-question NCLEX-RN–style exam** with NGN integration.

NGN CASE STUDY 9 (Questions 121–126): Gastrointestinal Bleeding

Client Scenario
A 68-year-old client presents with **weakness, dizziness, and black stools** for 2 days. History:

osteoarthritis (daily NSAID use), HTN. VS: BP 88/52, HR 118, RR 22, SpO_2 96% RA. Labs: Hgb 7.4 g/dL, Hct 22%.

Q121. Priority nursing action (Multiple Choice)

What should the nurse do **first**?
A. Obtain stool sample for occult blood
B. Initiate large-bore IV access and begin isotonic fluids
C. Administer oral iron
D. Provide dietary teaching

Answer: B
Rationale: Hypotension and tachycardia indicate **hemorrhagic shock**. Immediate circulation support is priority.

Q122. Findings supporting upper GI bleed (Select All That Apply)

A. Melena
B. NSAID use
C. Low hemoglobin
D. Bright red blood per rectum
E. Hypotension

Answer: A, B, C, E
Rationale: Melena and NSAIDs suggest upper GI source; anemia and hypotension reflect blood loss.

Q123. Anticipated orders (Select All That Apply)

A. Type and crossmatch blood
B. IV proton pump inhibitor
C. Colonoscopy immediately
D. Transfusion of PRBCs
E. Oral laxatives

Answer: A, B, D
Rationale: Stabilization includes blood prep/transfusion and IV PPI. Colonoscopy is not first in unstable upper GI bleed.

Q124. NGN-style outcome evaluation (Multiple Choice)

Which finding best indicates stabilization?
A. HR decreases to 88 and BP improves to 112/70
B. Stool remains black
C. Client reports hunger
D. Urine specific gravity increases

Answer: A
Rationale: Improved vital signs indicate restored perfusion.

Q125. Risk-reduction teaching (Select All That Apply)

A. Avoid NSAIDs
B. Take PPIs as prescribed
C. Increase alcohol intake
D. Report black stools promptly
E. Use aspirin daily for pain without provider approval

Answer: A, B, D
Rationale: Avoid GI irritants; adhere to therapy; report bleeding signs.

Q126. Discharge understanding (Multiple Choice)

Which statement indicates correct understanding?
A. “Black stools are normal while healing.”
B. “I will take my stomach medicine even if I feel better.”
C. “Pain relievers are all safe if taken with food.”
D. “I can stop follow-up once bleeding stops.”

Answer: B
Rationale: Adherence prevents recurrence; black stools are not normal.
