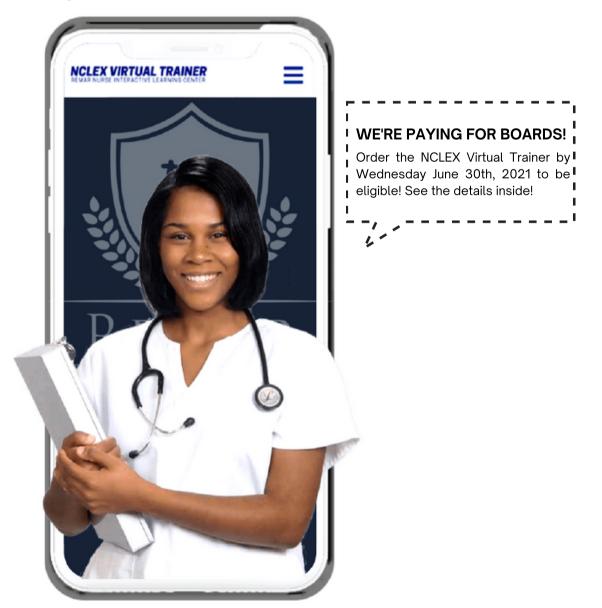


NCLEX VIRTUAL TRAINER

ReMar Nurse University Day #4 & 5

with ADDED Medication Administration Worksheets! Monday, June 21st & 28th @ 8PM EST!



Author, Educator, Mentor | Regina M. Callion CEO, MSN, RN

We're Paying for NCLEX!!!

The secret is out of the bag! Mark and I love helping the ReMar Nurses pass NCLEX and I want to see you on the other side of this NCLEX journey! I know NCLEX is expensive but I promise you're worth it! I want to help you to take the next step to get everything you need to pass NCLEX this time!

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Scan the code to join the class Monday June 21st & 28th at 8:00 pm EST via www.YouTube.com/ReMarReview

ANTIBIOTICS



	••
Medications to take with Food	
1.	
2.	

Take on an empty Stomach	
1.	
2.	
3.	
Monitor for	

Not Given Orally (eye drops, ear drops, IV)	
1.	
2.	

The most common side effect of antibiotics is: Critically think: Is C-difficle considered an antibiotic-associated diarrhea?

Clients must take the prescribed course of antibiotics even if symptoms disappear.

The 4 most commonly prescribed antibiotics to hospital patients are:

1.

- 2.
- 3.
- 4.

ANTIBIOTICS

Regina Callion MSN, RN

NCLEX PRACTICE QUESTIONS

- The nurse is caring for a client prescribed intravenous penicillin for a urinary tract infection. The nurse notices coolness and swelling around the IV insertion site. Which assessment should the nurse make **first**?
 - 1. Monitor the client for an allergic reaction.
 - 2. Evaluate if the intravenous catheter is in place.
 - 3. Notify the health care provider.
 - 4. Discontinue the penicillin antibiotic.
- 2. A client is prescribed an antibiotic that has a side effect of renal crystal formation. Which of the following is **most** important to encourage effective renal clearance?
 - 1. Consuming a low protein diet during medication therapy.
 - 2. Encouraging the client to void every 2 hours.
 - 3. Drinking 8 to 10 glasses of water a day.
 - 4. Monitoring renal function during medication therapy.
- 3. A client prescribed tetracycline states that taking a medication on an empty stomach is difficult and causes heartburn. Which is the **most** appropriate statement for the nurse to make?
 - 1. The medication can be taken with orange juice but not with food.
 - 2. Dairy will decrease the absorption of the tetracycline.
 - 3. The medication can be taken with a slice of bread to prevent heartburn.
 - 4. Food or drink will decrease the absorption rate by 50%.

BLOOD & BLOOD PRODUCTS

Regina Callion MSN, RN

1. Blood is a ______

The goal of a blood or blood product transfusion is to delivery oxygen to the tissues.

Clinical indications:

- •
- .
- _
- •
- •

Verifica	tion Checks	Verification Checks
1.	1.	
2.	2.	
3.	3.	
4.		

	Requirements
30	
15	
4	

Requirements



BLOOD & BLOOD PRODUCTS
Regina Callion MSN, RN 2. Review
Z Neview
Blood is considered atissue.
There are divisions of blood.
Α.
1.
2.
Α.
B.
C. Lymphocytes
3.
В.
1.
A. Albumin B. Immunoglobulin C. Fibrinogen

BLOOD & BLOOD PRODUCTS

Regina Callion MSN, RN

NCLEX PRACTICE QUESTIONS

1. Which of the following actions by the nurse require follow-up education? Select all that apply.

- 1. Verify a valid signed consent is placed in the client record.
- 2. If the client is an infant, verify the identity with a wristband and parent if available.
- 3. Examining the type and group number to identify the age of the blood.
- 4. Immediately stopping the transfusion and discarding the contaminated blood if an allergic reaction occurs.
- 5. Taking the client's temperature and other vital signs before retrieving blood.

2. Which of the following is the highest nursing intervention when administering a blood transfusion?

- 1. Documenting the treatment in the client's chart.
- 2. Informing the client of abnormal laboratory values.
- 3. Warming the blood prior to transfusion.
- 4. Educating the client on signs of an allergic reaction.
- 3. The nurse has initiated a transfusion of packed red blood cells. After twelve minutes the client begins to report shortness of breath, itching, and back pain. The nurse stops the blood transfusion. Which of the following is the appropriate **next** step?
 - 1. Stop all fluids from entering the client and take a urine and blood sample.
 - 2. Run normal saline at half the rate of the blood transfusion.
 - 3. Run the normal saline at a rate of 25 ml per hour.
 - 4. Run the normal saline at double the rate of blood transfusion to flush the line.

Medication Administration

from the NCLEX Virtual Trainer

Before you give medications check the rights there are many.

1. Patient	2. Drug	3. Dose	4. Route
5. Time	6. Documentation	7. Allergies (+ man	y more)

Verify _____ Before Administration

PO means by mouth NPO nothing by mouth	PO - Do not crush medications that end in: EC - ER - EX - SR - Liquid -
Ear	Ad u lt - Chil d - Medications should be How long should the nurse wait before administration drops?

Rectal	Alternative to or medication administration. Use a based lubricant <u>3 types of oral enemas</u> 1. 2. 3.Kayexalate (polystyrene sulfonate) *Please know the generic name for kayexalate
Eye	Avoid the Tell client to look up or down? Place medication in lower conjunctiva sac If eye drops and eye ointments are both prescribed which should be given first?

Gastric Tube	Check initial placement with Assess for Delayed gastric emptying. Greater than 500 hold medication. Medications should be given via Do not mix medications give them separately.
Intramuscular (IM)	Maximum medication in adult muscle: Maximum medication in child: *Do not aspirate for vaccines. Do not give IM injections: Inject at degree angle.
Topical	Applied directly to body surfaces: Is Shampoo a topical medication? Wash skin daily



BONUS WEEK #5

Join Regina's Final All-Questions Session

Monday, June 28th at 8PM EST! Live via FACEBOOK & YOUTUBE!

NCLEX PRACTICE EXAM -ALL TOPICS

Regina Callion MSN, RN

- The charge nurse working on a medical unit night shift is concerned that the float nurse is smoking marijuana on duty. On more than two occasions, the charge nurse has smelled marijuana when the float nurse arrives for night shift. Which action should the charge nurse implement first?
 - 1. Confront the float nurse with the suspicions.
 - 2. Talk with the night supervisor about the concerns.
 - 3. Ignore the situation unless the nurse cannot do her job.
 - 4. Ask to speak to the hospital ethics committee about the problem.
- 2. A new nurse graduate observes three nurse's aides yelling and arguing in the hallway. Which action should the nurse implement **first** in this situation?
 - 1. Tell the unit manager to check on the nurse's aides.
 - 2. Advise the aides to stop yelling in the hallway.
 - 3. Mediate the situation to diffuse the tension.
 - 4. Document the names of each person involved for accurate reporting.
 - 5. Ask the nurse's aides what is the issue?
- 3. A new graduate registered nurse is working with unlicensed assistive personnel (UAP) who has been an employee of the hospital for 21 years. However, tasks delegated to the UAP by the registered nurse are frequently not completed. Which action should the graduate nurse take **first**?
 - 1. Tell the charge nurse the UAP is insubordinate.
 - 2. Create a written list of assigned tasks to help emphasize their importance.
 - 3. Complete the delegated tasks as the registered nurse maintains responsibility.
 - 4. Discuss with the UAP why the delegated tasks are left incomplete.
- 4. The charge nurse informs the nursing house supervisor that one of the registered nurses is falsifying vital signs. Which action should the nursing house supervision implement first?
 - 1. Inform the unit manager of the nurse about the situation of falsifying vital signs.
 - 2. Take the assigned client's vital signs and compare with the RN documentation.
 - 3. Bring both parties together and discuss the situation in a neutral environment.
 - 4. Document the incident in the registered nurse's employee file.
- 5. The nurse hung the wrong intravenous cardiac medication for the coronary bypass client. Which intervention should the nurse implement first?
 - 1. Assess the client for any adverse reactions.
 - 2. Complete the incident or adverse occurrence report.
 - 3. Administer the correct intravenous cardiac medication.
 - 4. Notify the client's health care provider.

- 6. The registered charge nurse (RN), a licensed practical nurse (LPN), and an unlicensed assistive personnel (UAP) are caring for clients in a medical care unit. Which task would be **most** appropriate for the RN nurse to assign or delegate?
- 1. Instruct the LPN to obtain the client's serum glucose level.
- 2. Request the LPN to change the arterial line dressing.
- 3. Ask the LPN to bathe the client and change the bed linens.
- 4. Tell the UAP to obtain liquid intake for the 8-hour shift.

7. Which task should the intensive care nurse delegate to the unlicensed assistive personnel (UAP)?

- 1. Check the pulse oximeter reading for the client on a ventilator.
- 2. Take the client's blood culture to the laboratory.
- 3. Obtain the vital signs for the client in an Addisonian crisis.
- 4. Assist the HCP with performing a paracentesis at the bedside.
- 8. Which of the following clients would need the assistance of a durable power of attorney to make all healthcare decisions?
- 1. The client with a head injury who is unable to respond to external stimuli.
- 2. The client with a stroke who is unable to walk or talk.
- 3. The client in end stage renal disease who is being placed on kidney transplant list.
- 4. The client diagnosed with stage four cancer who is mentally retarded.
- 9. The nurse is caring for clients on a skilled assisted living facility. Which task should be delegated to the unlicensed assistive personnel (UAP)? Select all that apply.
- 1. Instruct the UAP to apply compression stockings to the client on complete bed rest.
- 2. Ask the UAP to assist the occupational therapist in ambulating the client.
- 3. Request the UAP to prepare the client for a thoracentesis at the bedside.
- 4. Tell the UAP to obtain the outputs (I&Os) for all the clients on the unit.
- 5. Inform the UAP to administer the prescribed topical anti-itch lotion to selected clients during the bath.
- 10. The nurse is caring for a 44-year-old male who is obese and currently has a temperature of 101.1 Fahrenheit. The client begins to complain of left side chest pain, diaphoresis, and dizziness. What is the **priority** action?
 - 1. Gather a STAT EKG.
 - 2. Administer oxygen via nasal cannula.
 - 3. Establish emergency intravenous access.
 - 4. Notify the physician.

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