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Practice Questions

Try all 30 first, then check the answer key at the back.

1. A nurse is preparing to administer a medication. Which of the following is the correct order of the Five Rights of medication administration?

A. Right patient, right drug, right dose, right route, right time
B. Right drug, right patient, right time, right dose, right route
C. Right patient, right drug, right dose, right route, right time
D. Right route, right time, right drug, right dose, right patient

2. A patient is receiving IV heparin therapy. Which laboratory value should the nurse monitor to assess therapeutic effect?

A. aPTT (activated partial thromboplastin time)
B. PT/INR
C. Platelet count
D. Hemoglobin level

3. A patient presents with crushing chest pain radiating to the left arm, diaphoresis, and nausea. These findings are most consistent with:

A. Acute myocardial infarction (MI)
B. Stable angina pectoris
C. Gastroesophageal reflux disease
D. Pulmonary embolism

4. A nurse is monitoring a fetal heart rate (FHR) during labor. The normal baseline FHR for a term fetus is:

A. 80–100 bpm
B. 110–160 bpm
C. 160–180 bpm
D. 60–100 bpm

5. A nurse is assessing a 6-month-old infant. Which vital sign values are within the normal range for this age?

A. Heart rate 65, RR 14, BP 110/70
B. Heart rate 130, RR 34, BP 75/50
C. Heart rate 55, RR 10, BP 120/80
D. Heart rate 160, RR 50, BP 95/65

6. A nurse is communicating with a depressed patient who says, 'What's the point? Nobody cares if I live or die.' Which response demonstrates therapeutic communication?

A. 'Don't talk like that — of course people care about you.'
B. 'I understand. Life can be very hard sometimes.'
C. 'It sounds like you're feeling very alone and hopeless. Can you tell me more about what you're feeling?'
D. 'You should think about all the good things in your life.'

7. A nurse is donning PPE before entering a contact precaution room. What is the correct order for putting on PPE?

A. Mask, goggles, gown, gloves
B. Gloves, gown, mask, goggles
C. Gown, mask/respirator, goggles/face shield, gloves
D. Goggles, gown, gloves, mask

8. A patient scheduled for major surgery tells the nurse, 'The doctor explained the procedure but I don't really understand it. I just signed the consent form.' What should the nurse do?

A. The consent is valid since the patient signed it; proceed with pre-operative preparation
B. Notify the surgeon — the patient does not have informed consent; surgery should not proceed until the patient fully understands the procedure, risks, benefits, and alternatives
C. Re-explain the procedure to the patient and co-sign the consent form
D. Ask the patient's family to make the decision instead

9. Which client is most appropriate to assign to a Licensed Practical Nurse (LPN)?

A. Client 6 hours post-op from hip replacement requiring blood transfusion
B. Client with new diabetes diagnosis needing insulin education
C. Client scheduled for discharge needing medication review
D. Client with chronic pressure ulcer needing sterile dressing change

10. When performing hand hygiene using an alcohol-based hand rub, how long should the nurse rub their hands together?

A. 5–10 seconds
B. 20–30 seconds
C. 1–2 minutes
D. 60 seconds

11. A nurse is preparing to administer NPH insulin. Which of the following is the correct description of NPH insulin?

A. Rapid-acting; onset 15 minutes, peak 1–2 hours
B. Short-acting (regular); onset 30–60 minutes, peak 2–4 hours
C. Intermediate-acting; onset 2–4 hours, peak 4–12 hours
D. Long-acting; onset 1–2 hours, no peak

12. A patient with heart failure has a new order for furosemide 40 mg IV. Which assessment finding indicates the medication is having the desired effect?

A. Blood pressure rises from 130/80 to 160/95 mmHg
B. Patient reports increased thirst
C. Urine output increases to 200 mL in 30 minutes and lung crackles decrease
D. Serum potassium rises from 3.6 to 4.8 mEq/L

13. A newborn has the following Apgar assessment at 1 minute: heart rate 110 (2), strong cry (2), active motion (2), cries when stimulated (2), body pink/extremities blue (1). What is the total Apgar score and what action is indicated?

A. Score 7 — no intervention needed
B. Score 10 — perfect score
C. Score 9 — normal; routine care, reassess at 5 minutes
D. Score 5 — immediate resuscitation required

14. A 2-year-old is brought to the emergency department with a barking cough, stridor, and low-grade fever. Which condition does the nurse suspect?

A. Epiglottitis — do not examine the throat
B. Bronchiolitis — caused by RSV
C. Pneumonia — productive cough
D. Croup (laryngotracheobronchitis) — caused by parainfluenza virus; barking cough and inspiratory stridor

15. A nurse is assessing suicide risk. Which finding represents the HIGHEST risk for completed suicide?

A. Specific lethal plan with access to means, previous attempt, and social isolation
B. Vague ideation with no plan and strong family support
C. Passive ideation ('I wish I were dead') with no intent
D. Feeling sad and hopeless but denying any suicidal thoughts

16. A patient is admitted with active pulmonary tuberculosis (TB). Which type of isolation is required?

A. Airborne precautions: negative-pressure private room, N95 respirator for staff, surgical mask for patient when outside room
B. Droplet precautions: private room, surgical mask for staff
C. Contact precautions: gloves and gown, private room
D. Standard precautions only: no special room required

17. A patient with terminal cancer has a valid Do-Not-Resuscitate (DNR) order in their chart. The patient goes into cardiac arrest. What should the nurse do?

A. Begin CPR immediately while checking the chart
B. Initiate CPR for 5 minutes and then check the DNR
C. Call the physician to get verbal permission before honoring the DNR
D. Honor the DNR order — do not initiate CPR; provide comfort measures, notify the physician and family, and document

18. A nurse is administering warfarin to a client with atrial fibrillation. The client's most recent INR is 4.5. What is the nurse's priority action?

A. Administer the warfarin as ordered
B. Hold the dose and notify the physician
C. Prepare to administer protamine sulfate
D. Check the client's latest PTT level

19. A patient is at risk for pressure ulcers. Which nursing intervention is most effective in prevention?

A. Applying moisturizer to bony prominences
B. Massaging reddened areas over bony prominences
C. Keeping the head of bed elevated at 90 degrees
D. Repositioning the patient every 2 hours

20. A patient is prescribed metoprolol (a beta-1 selective blocker). Which condition is a contraindication to this medication?

A. Hypertension
B. Stable angina
C. Cardiogenic shock with heart rate 42 bpm
D. Atrial fibrillation with rapid ventricular response

21. A nurse is caring for a patient with COPD who is receiving 2 L/min oxygen. The patient becomes drowsy and respiratory rate decreases. What is the most likely cause?

A. The oxygen flow rate is too low to correct hypoxia
B. High-flow oxygen has suppressed the hypoxic drive, leading to hypercapnia and CO2 narcosis
C. The patient is experiencing a panic attack due to dyspnea
D. The patient has developed pneumonia as a complication

22. A pregnant patient at 34 weeks presents with sudden painless bright red vaginal bleeding. What is the most likely diagnosis and the nurse's priority action?

A. Placental abruption — administer pain relief and prepare for vaginal delivery
B. Normal bloody show — reassure the patient and monitor
C. Preterm labor — administer tocolytics and bed rest
D. Placenta previa — do NOT perform vaginal examination; maintain bed rest, notify physician, prepare for possible emergency cesarean

23. A 5-year-old child develops a fever of 39.5°C and a generalized tonic-clonic seizure lasting 2 minutes. After the seizure, the child is drowsy but responsive. The parents are frightened. What does the nurse tell them?

A. Febrile seizures are common in children 6 months to 5 years; most are benign, self-limiting, and do not cause brain damage; fever control and safety are the priorities
B. This child has epilepsy and needs lifelong anticonvulsant therapy
C. Febrile seizures always indicate meningitis; lumbar puncture is required immediately
D. The seizure caused permanent brain damage; the child needs an urgent MRI

24. A patient with schizophrenia is admitted and reports hearing voices telling them to hurt themselves. The nurse's priority action is:

A. Challenge the hallucinations by telling the patient the voices are not real
B. Ensure patient safety, maintain a calm non-threatening approach, administer antipsychotics as ordered, and notify the physician of command hallucinations
C. Leave the patient alone to avoid further stimulation
D. Ask the patient to describe the voices in detail before taking any action

25. A nurse sustains a needlestick injury from a patient's used IV needle. What is the immediate priority action?

A. Apply a tourniquet above the puncture site to prevent spread
B. Wash the wound thoroughly with soap and water, allow it to bleed freely, report to occupational health immediately, and initiate post-exposure protocol
C. Squeeze the wound to remove contaminated blood
D. Apply alcohol only and monitor for symptoms

26. A nurse makes a medication error that caused a patient mild harm. The patient was given the wrong dose, noticed no serious symptoms, and has recovered. What is the nurse's legal and ethical obligation?

A. Report the error through the facility's incident reporting system, document accurately in the medical record, inform the patient, notify the physician, and monitor for adverse effects
B. Document that the medication was given correctly to protect oneself from liability
C. Only tell the nurse manager privately; no documentation is required for minor errors
D. Wait to see if the patient develops symptoms before reporting

27. A client is diagnosed with bacterial meningitis. Which type of isolation precaution should the nurse implement?

A. Standard Precautions
B. Contact Precautions
C. Droplet Precautions
D. Airborne Precautions

28. A nurse is assessing a patient's oxygen saturation (SpO2). Which reading indicates mild hypoxemia requiring intervention?

A. 98%
B. 93%
C. 99%
D. 96%

29. A patient is started on lisinopril (ACE inhibitor) for hypertension. Which adverse effect should the nurse teach the patient to monitor and report?

A. Bradycardia and hypoglycemia
B. Persistent dry cough and hyperkalemia
C. Tachycardia and hypokalemia
D. Weight loss and polyuria

30. A patient with type 2 diabetes is confused and diaphoretic. Blood glucose is 48 mg/dL (2.7 mmol/L). The patient is conscious but disoriented. What is the nurse's priority intervention?

A. Administer insulin per sliding scale
B. Hold all oral intake and call the physician
C. Give 1 mg glucagon IM and reassess
D. Give 15–20 g of fast-acting oral carbohydrates (e.g., 4 oz juice), wait 15 minutes, and recheck glucose

Answer Key & Explanations

1. C — Right patient, right drug, right dose, right route, right time
The Five Rights of medication administration are: right patient, right drug, right dose, right route, and right time. These must be verified before every medication administration to ensure patient safety.

2. A — aPTT (activated partial thromboplastin time)
aPTT is used to monitor IV heparin therapy. The therapeutic range is typically 1.5–2.5 times the control value. PT/INR is used to monitor warfarin (oral anticoagulant) therapy.

3. A — Acute myocardial infarction (MI)
Classic MI symptoms include crushing or squeezing chest pain (often radiating to left arm, jaw, or back), diaphoresis, nausea, and dyspnea. Unlike stable angina, MI pain is not relieved by nitroglycerin and lasts >20 minutes. Immediate ECG and troponin levels are priorities.

4. B — 110–160 bpm
Normal baseline fetal heart rate is 110–160 bpm. Bradycardia is defined as FHR <110 bpm for ≥10 minutes; tachycardia is >160 bpm for ≥10 minutes. Late decelerations (FHR drops after contraction peak) indicate uteroplacental insufficiency and require immediate intervention (oxygen, left lateral position, stop oxytocin, notify physician).

5. B — Heart rate 130, RR 34, BP 75/50
Normal vital signs for a 6-month-old: Heart rate 80–160 bpm; Respiratory rate 30–60 breaths/min; Blood pressure systolic 70–100 mmHg. Normal ranges change with age — neonates have the highest HR and RR. As age increases, HR and RR decrease and BP increases. Always compare to age-appropriate norms.

6. C — 'It sounds like you're feeling very alone and hopeless. Can you tell me more about what you're feeling?'
Therapeutic communication techniques include: active listening, reflecting, open-ended questions, and validating feelings. Option C reflects the patient's feelings and invites elaboration without minimizing or redirecting. Options A and D minimize/dismiss feelings (non-therapeutic). Option B is too vague. The nurse should also assess for suicidal ideation directly after establishing rapport.

7. C — Gown, mask/respirator, goggles/face shield, gloves
Standard PPE donning order (CDC/WHO): (1) Gown first (protects clothing/skin); (2) Mask or respirator (N95 for airborne); (3) Goggles or face shield; (4) Gloves last (over gown cuffs). Doffing (removal) order is REVERSE: (1) Gloves (most contaminated); (2) Goggles/face shield; (3) Gown; (4) Mask/respirator. Perform hand hygiene between each doffing step. The order protects from self-contamination.

8. B — Notify the surgeon — the patient does not have informed consent; surgery should not proceed until the patient fully understands the procedure, risks, benefits, and alternatives
Valid informed consent requires: (1) Disclosure of relevant information (procedure, risks, benefits, alternatives, consequences of refusal); (2) Patient comprehension (understanding); (3) Voluntariness (no coercion); (4) Decision-making capacity. A signature without understanding is NOT valid informed consent.

The nurse's role: assess understanding, act as patient advocate, notify the physician. The nurse does NOT re-obtain consent — that is the physician's responsibility.

9. D — Client with chronic pressure ulcer needing sterile dressing change
Sterile dressing changes for a chronic, stable wound fall within LPN scope of practice. The other clients require RN-level assessment or teaching skills.

10. B — 20–30 seconds
WHO guidelines recommend rubbing hands with an alcohol-based hand rub for 20–30 seconds (about 6 steps) until hands are dry. This duration ensures adequate coverage and antiseptic effect.

11. C — Intermediate-acting; onset 2–4 hours, peak 4–12 hours
NPH (Neutral Protamine Hagedorn) is an intermediate-acting insulin with onset 2–4 hours, peak 4–12 hours, and duration 12–18 hours. It appears cloudy and must be gently rolled (not shaken) before use.

12. C — Urine output increases to 200 mL in 30 minutes and lung crackles decrease
Furosemide is a loop diuretic used in heart failure to reduce fluid overload. The desired effect is increased urine output (diuresis) and decreased signs of fluid overload such as pulmonary crackles and peripheral edema. Monitor for hypokalemia, hyponatremia, and hypotension as adverse effects.

13. C — Score 9 — normal; routine care, reassess at 5 minutes
Apgar scoring: Heart rate (0–2) + Respiratory effort (0–2) + Muscle tone (0–2) + Reflex irritability (0–2) + Color (0–2) = 2+2+2+2+1 = 9. Scores 7–10 = normal (routine newborn care); 4–6 = mild depression (stimulation, O2); 0–3 = severe depression (immediate resuscitation). Acrocyanosis (blue extremities with pink body) is normal in the first few minutes and scores 1 for color.

14. D — Croup (laryngotracheobronchitis) — caused by parainfluenza virus; barking cough and inspiratory stridor
Croup (laryngotracheobronchitis) typically affects children 6 months to 3 years, usually caused by parainfluenza virus. Classic: barking seal-like cough, inspiratory stridor, low-grade fever, and worsens at night. Treatment: cool mist humidifier, dexamethasone (reduces airway edema), nebulized epinephrine for severe cases. Do NOT lay child flat (increases distress). Epiglottitis presents with high fever, drooling, tripod position, muffled voice.

15. A — Specific lethal plan with access to means, previous attempt, and social isolation
Highest suicide risk factors: (1) Specific detailed plan (method, time, place); (2) Access to lethal means (firearms, medications); (3) Previous suicide attempt (strongest predictor); (4) Social isolation; (5) Male gender; (6) Substance abuse. The nurse must perform direct suicide risk assessment, not avoid the topic. Document and notify the physician/psychiatrist. Implement a safety plan and environment (remove sharps, secure medications).

16. A — Airborne precautions: negative-pressure private room, N95 respirator for staff, surgical mask for patient when outside room
TB is transmitted via airborne droplet nuclei (tiny particles that remain suspended in air for long periods). Required: Airborne Infection Isolation Room (AIIR) with negative air pressure (at least 6–12 air exchanges/hour, air exhausted outside or HEPA filtered), N95 respirator for healthcare workers (not surgical mask), and a surgical mask for the patient when outside the room. Patient should be immunocompetent contacts minimized.

17. D — Honor the DNR order — do not initiate CPR; provide comfort measures, notify the physician and family, and document
A valid DNR order must be honored. DNR means: do not initiate CPR (chest compressions, defibrillation, intubation) in the event of cardiac or respiratory arrest. However, DNR does NOT mean withholding all treatment — continue comfort care (pain management, oxygen for comfort, emotional support). The nurse documents the time of event, absence of resuscitation per DNR, and notification of the physician. Verify DNR validity per facility policy (signature, date, scope).

18. B — Hold the dose and notify the physician
Therapeutic INR for atrial fibrillation is 2.0–3.0. An INR of 4.5 is supratherapeutic, placing the client at high risk of bleeding. The nurse should hold the dose and notify the physician. Protamine sulfate reverses heparin, not warfarin.

19. D — Repositioning the patient every 2 hours
Regular repositioning every 2 hours is the most effective pressure ulcer prevention strategy. It relieves pressure on bony prominences. Note: Massaging reddened areas is contraindicated as it can damage fragile capillaries.

20. C — Cardiogenic shock with heart rate 42 bpm
Beta-blockers are contraindicated in cardiogenic shock (severe systolic dysfunction with hypotension), significant bradycardia (<60 bpm), second- or third-degree AV block (without pacemaker), and decompensated heart failure. They are used therapeutically for hypertension, stable angina, and rate control in atrial fibrillation.

21. B — High-flow oxygen has suppressed the hypoxic drive, leading to hypercapnia and CO2 narcosis
Patients with severe COPD may rely on hypoxic drive (low O2 stimulating breathing) rather than the normal hypercapnic drive (high CO2 stimulating breathing). Excessive oxygen can eliminate this drive, causing hypoventilation, CO2 retention (hypercapnia), and eventually CO2 narcosis (drowsiness, confusion). Titrate O2 to keep SpO2 88–92% in COPD.

22. D — Placenta previa — do NOT perform vaginal examination; maintain bed rest, notify physician, prepare for possible emergency cesarean
Painless bright-red vaginal bleeding in the third trimester is classic for placenta previa (placenta overlying the cervical os). KEY: NEVER perform a digital vaginal examination (can cause life-threatening hemorrhage). Management: hospitalize, bed rest, IV access, blood typing and crossmatch, electronic fetal monitoring, and possible cesarean delivery depending on gestation and severity.

23. A — Febrile seizures are common in children 6 months to 5 years; most are benign, self-limiting, and do not cause brain damage; fever control and safety are the priorities
Simple febrile seizures: occur in 2–5% of children aged 6 months to 5 years; typically generalized, last <15 min, occur once in 24 hours. Triggered by rapid rise in temperature (not height of fever). Most do NOT require anticonvulsant therapy. Parents need reassurance and education. Complex febrile seizures (focal, >15 min, or recurrent within 24 hr) require further evaluation.

24. B — Ensure patient safety, maintain a calm non-threatening approach, administer antipsychotics as ordered, and notify the physician of command hallucinations
Command hallucinations (voices commanding self-harm or harm to others) are a psychiatric emergency.

Priority: SAFETY. Do NOT argue about whether the voices are real (non-therapeutic, may escalate). Maintain a calm, non-threatening environment. Administer ordered antipsychotics. Notify physician. Remove potential means of self-harm. Stay with the patient (do not leave alone). Document command content precisely.

25. B — Wash the wound thoroughly with soap and water, allow it to bleed freely, report to occupational health immediately, and initiate post-exposure protocol
Needlestick protocol: (1) Wash wound thoroughly with soap and water (allow free bleeding — do NOT squeeze/suck); (2) Report immediately to supervisor and occupational health; (3) Document the incident; (4) Source patient: test for HIV, HBV, HCV (with consent); (5) Exposed worker: baseline labs; (6) Post-exposure prophylaxis (PEP) for HIV must start within 72 hours (ideally within 2 hours); (7) HBV immunoglobulin if worker is not vaccinated. Report within 4 hours ideally.

26. A — Report the error through the facility's incident reporting system, document accurately in the medical record, inform the patient, notify the physician, and monitor for adverse effects
All medication errors, regardless of severity, must be: (1) Reported through incident/adverse event reporting system (improves system safety); (2) Documented accurately in the medical record (what happened, assessment, physician notification, patient response — do NOT document 'incident report filed'); (3) Patient informed (ethical obligation of transparency/disclosure); (4) Physician notified; (5) Monitored for adverse effects. Covering up errors violates ethical principles and is grounds for disciplinary action and loss of license.

27. C — Droplet Precautions
Bacterial meningitis (Neisseria meningitidis) is transmitted via respiratory droplets. Droplet precautions—private room and surgical mask within 3 feet—are required.

28. B — 93%
SpO2 of 93% indicates mild hypoxemia (normal ≥ 95%). Values below 90% indicate severe hypoxemia. The nurse should increase supplemental oxygen and notify the physician if SpO2 does not improve.

29. B — Persistent dry cough and hyperkalemia
ACE inhibitors commonly cause a persistent dry cough (due to accumulation of bradykinin in the lung) — the most common reason for discontinuation. They also cause hyperkalemia (potassium retention due to decreased aldosterone). Other adverse effects: angioedema (a serious complication), first-dose hypotension, and elevated creatinine.

30. D — Give 15–20 g of fast-acting oral carbohydrates (e.g., 4 oz juice), wait 15 minutes, and recheck glucose
The 15-15 rule for mild-to-moderate hypoglycemia in a conscious patient: give 15 g of fast-acting carbohydrates (4 oz juice, glucose tablets), wait 15 minutes, recheck blood glucose. Glucagon IM is for unconscious patients who cannot swallow. Insulin would worsen hypoglycemia.

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