NCLEX PN

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Practice Questions

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

1. A client tells the LPN/LVN that he has a living will stating he does not want resuscitation. Which action by the LPN/LVN is most appropriate?

A. Reassure the client that his wishes will automatically be honored.
B. Contact the physician without notifying the RN.
C. Immediately write a do-not-resuscitate order in the chart.
D. Inform the supervising RN and document the client's statement.

2. When delegating a task to unlicensed assistive personnel (UAP), which client is MOST appropriate for the LPN/LVN to assign to UAP for morning care?

A. A client admitted overnight with a new diagnosis of stroke.
B. A client who returned from abdominal surgery two hours ago.
C. A client with stable chronic heart failure awaiting discharge.
D. A client receiving IV insulin for diabetic ketoacidosis.

3. A client scheduled for a surgical procedure states he does not fully understand what the surgeon explained. Which action is correct for the LPN/LVN?

A. Obtain the client's signature on the informed consent form and note the concern.
B. Explain the surgical procedure in detail to satisfy the client's questions.
C. Notify the surgeon that the client needs further explanation before signing consent.
D. Ask the client's family member to sign on the client's behalf.

4. According to Maslow's hierarchy of needs, which client should the LPN/LVN assess FIRST?

A. A client who is anxious about a scheduled biopsy.
B. A client whose oxygen saturation has dropped to 88%.
C. A client requesting pain medication rated 4 out of 10.
D. A client asking for help ambulating to the bathroom.

5. A client asks the LPN/LVN to share his diagnosis with his adult daughter who is visiting. The LPN/LVN should:

A. Decline because all health information is always strictly confidential from family.
B. Share the diagnosis only after confirming the client has given permission.
C. Refer the daughter directly to the medical records department.
D. Share the diagnosis because the daughter is immediate family.

6. An LPN/LVN working in a long-term care facility receives assignments for four residents. Using ABCs prioritization, which resident should be assessed FIRST?

A. A resident with osteoarthritis who rates hip pain as 6 out of 10.
B. A resident with COPD who is using accessory muscles to breathe.
C. A resident with a urinary tract infection who reports burning on urination.
D. A resident with type 2 diabetes who skipped breakfast.

7. The LPN/LVN is caring for a client and recognizes a pattern of worsening assessment data. Which step of the nursing process does this represent?

A. Planning
B. Implementation
C. Evaluation
D. Diagnosis

8. An LPN/LVN discovers that a confused, non-English-speaking client signed a surgical consent form without an interpreter present. The LPN/LVN should:

A. Document that the client appeared to understand the consent process.
B. Notify the RN and surgeon immediately so consent can be obtained properly.
C. Ask a bilingual family member to re-explain the procedure and witness the signature.
D. Proceed with pre-operative care because the form has already been signed.

9. Which task falls WITHIN the scope of practice of the LPN/LVN and should NOT be delegated upward to the RN?

A. Performing the initial comprehensive nursing assessment on a newly admitted client.
B. Administering a scheduled oral medication to a stable client and documenting the outcome.
C. Interpreting a client's complex change-of-condition data to modify care plan goals.
D. Developing and updating the individualized nursing care plan.

10. A client with terminal cancer has a valid do-not-resuscitate (DNR) order. During the shift the client becomes pulseless. The LPN/LVN should:

A. Begin CPR while calling the RN to confirm the DNR order.
B. Call the physician for a verbal order to confirm the DNR before withholding CPR.
C. Withhold CPR, notify the RN immediately, and provide comfort measures.
D. Ask the family present at the bedside to decide whether to resuscitate.

11. The LPN/LVN suspects a colleague is diverting controlled substances. What is the MOST appropriate initial action?

A. Report the suspicion to the charge nurse or nurse manager following facility policy.
B. Continue observing for additional evidence before taking any action.
C. Document personal observations in the client's medical record.
D. Confront the colleague directly and ask for an explanation.

12. An LPN/LVN is caring for four clients. Which situation requires the LPN/LVN to contact the RN FIRST, applying both ABCs and scope-of-practice principles?

A. A client with a chest tube who suddenly develops absent breath sounds on the affected side and increasing respiratory distress.
B. A client with chronic renal failure whose potassium level is 5.2 mEq/L on the morning lab report.
C. A post-operative client who rates incision pain as 5 out of 10 and is due for an oral analgesic.
D. A client with stable hypertension whose blood pressure is 148/90 mmHg, unchanged from yesterday.

13. A client with decision-making capacity refuses a blood transfusion that the care team believes is life-saving. The LPN/LVN should:

A. Document the refusal, notify the RN and physician, and ensure the client received information about consequences.
B. Administer the transfusion anyway because the physician ordered it to prevent death.
C. Obtain an emergency court order to compel treatment before notifying the team.
D. Ask the family to override the client's refusal given the seriousness of the situation.

14. The LPN/LVN is reviewing priorities for a group of clients. Which combination of principles BEST justifies why a newly admitted client with an acute exacerbation of asthma is prioritized over a client with a newly diagnosed stage II pressure injury?

A. Acute respiratory compromise threatens immediate oxygenation (ABCs), while a stage II pressure injury, though urgent, does not present an immediate airway or breathing threat.
B. Maslow's safety needs outrank physiological needs when a wound is present.
C. The asthmatic client has a longer expected hospital stay, justifying more nursing time.
D. Pressure injuries are managed solely by wound-care specialists, removing them from LPN/LVN priority.

15. A client is admitted with a diagnosis of active pulmonary tuberculosis (TB). Which type of transmission-based precaution should the LPN implement?

A. Contact precautions with gown and gloves
B. Droplet precautions with a surgical mask
C. Protective (reverse) isolation with a HEPA-filtered room
D. Airborne precautions with a negative-pressure room and N95 respirator

16. When should the LPN perform hand hygiene using alcohol-based hand rub instead of soap and water?

A. After caring for a client with Clostridioides difficile (C. diff) diarrhea
B. Before performing a sterile dressing change on a surgical wound
C. After visibly soiling hands with blood during a dressing change
D. After removing gloves following contact with a client who has norovirus

17. A client recovering from abdominal surgery needs a wound dressing change. Which action by the LPN best demonstrates correct clean technique?

A. Using sterile forceps to handle all supplies, including the new tape
B. Opening sterile supplies on the client's overbed table without establishing a sterile field
C. Washing hands before the procedure and using clean gloves to remove the old dressing
D. Wearing sterile gloves throughout the entire procedure

18. The LPN is preparing a sterile field for urinary catheter insertion. Which action would contaminate the sterile field?

A. Placing the sterile drape by holding only the corners and allowing it to unfold downward
B. Reaching across the sterile field to arrange supplies on the far side
C. Dropping sterile supplies onto the field from a distance of 1 inch above the package
D. Opening the catheter package by peeling back the edges away from the center

19. A fire breaks out in a client's room from an overheated electric blanket. Using the RACE acronym, what is the LPN's FIRST action?

A. Rescue any clients in immediate danger
B. Confine the fire by closing all doors and windows
C. Extinguish the fire using the nearest fire extinguisher
D. Activate the fire alarm

20. A client on a medical-surgical unit is confused and attempts to climb out of bed repeatedly. The nurse has tried multiple non-restraint alternatives without success. Before applying a physical restraint, the LPN must obtain which of the following?

A. A written order from the licensed provider that includes the clinical justification
B. Verbal consent from the client's roommate as a witness
C. A signed release form from the client's family waiving liability
D. Permission from the charge nurse who has deemed it appropriate

21. The LPN is caring for a client in contact precautions for methicillin-resistant Staphylococcus aureus (MRSA) wound infection. In what order should the LPN don personal protective equipment (PPE) before entering the room?

A. Gloves, gown, mask, eye protection
B. Gloves first, then gown, then mask last
C. Mask, gown, then gloves
D. Gown, mask or eye protection (if indicated), then gloves

22. An older adult client is assessed as high risk for falls. Which intervention is MOST important for the LPN to implement?

A. Ensuring the call light is within reach and explaining how to use it before leaving the room
B. Keeping all four side rails raised at all times to prevent the client from getting up
C. Applying wrist restraints to prevent the client from ambulating without assistance
D. Placing the client in the room farthest from the nursing station for a quieter environment

23. While handling a chemotherapy spill on the floor, the LPN should follow which hazardous material safety principle?

A. Don chemotherapy-rated (chemo-safe) PPE and use a designated spill kit per facility protocol
B. Clean up the spill immediately using standard housekeeping supplies and report it afterward
C. Dilute the chemotherapy agent with water before wiping it up to reduce concentration
D. Absorb the spill with paper towels, dispose them in a regular waste bin, and wash hands

24. A client develops a needlestick injury after the LPN recaps a used syringe. What should the LPN do FIRST after the injury?

A. Notify the client whose blood was on the needle
B. Complete an incident report and notify the supervisor
C. Wash the site thoroughly with soap and water
D. Immediately obtain baseline blood work for HIV and hepatitis

25. A client diagnosed with varicella (chickenpox) is admitted to the hospital. Which precaution type(s) does the LPN anticipate implementing?

A. Droplet precautions with a surgical mask worn by staff
B. Airborne AND contact precautions simultaneously
C. Standard precautions only, because varicella is spread only by direct contact
D. Contact precautions only, because the virus lives on surfaces

26. The LPN is assisting with a procedure that requires a sterile field. After setting up the field, the LPN notices that the sterile drape has become wet from spilled sterile saline. Which action is correct?

A. Continue using the field because sterile saline cannot introduce pathogens
B. Place a dry sterile towel over the wet area and proceed
C. Blot the wet area dry with a sterile gauze from the field and continue
D. Consider the entire sterile field contaminated and set up a new one

27. A client on droplet precautions for influenza needs to be transported to radiology. Which action by the LPN demonstrates correct infection control during transport?

A. The transport is cancelled until the client is no longer contagious
B. Transport staff must wear full airborne PPE including an N95 in the hallway
C. The client wears a surgical mask during transport and staff follow standard precautions
D. The LPN wears a gown and gloves during transport; no mask is needed in the hallway

28. The LPN discovers that a colleague disposed of a used lancet in a regular trash bin rather than a sharps container. Using the correct chain of reporting, which action should the LPN take FIRST?

A. Retrieve the lancet from the trash and place it in a sharps container to correct the error
B. Report the unsafe practice to the charge nurse and follow facility incident-reporting protocol
C. Document the incident in the client's medical record as a nursing note
D. Immediately confront the colleague publicly at the nursing station

29. A practical nurse is reinforcing teaching about recommended immunizations for a healthy 2-month-old infant. Which vaccine is routinely administered at this visit?

A. Measles, mumps, and rubella (MMR)
B. Human papillomavirus (HPV)
C. Diphtheria, tetanus, and acellular pertussis (DTaP)
D. Varicella

30. A nurse is collecting data on a 4-year-old child's developmental milestones. Which behavior is expected at this age?

A. Riding a two-wheeled bicycle without training wheels
B. Drawing a person with at least four body parts
C. Reading simple three-letter words
D. Tying shoelaces independently

Answer Key & Explanations

1. D — Inform the supervising RN and document the client's statement.
The LPN/LVN's role is to report and document client statements regarding advance directives to the RN, who then coordinates follow-through with the physician and facility policy.

2. C — A client with stable chronic heart failure awaiting discharge.
Delegation to UAP is appropriate for stable clients with predictable care needs; a stable client with chronic heart failure awaiting discharge poses the lowest risk of acute deterioration during routine morning care.

3. C — Notify the surgeon that the client needs further explanation before signing consent.
Informed consent is the physician's responsibility; the LPN/LVN must notify the surgeon when a client does not understand the procedure so that adequate information can be provided before consent is obtained.

4. B — A client whose oxygen saturation has dropped to 88%.
Oxygenation is the most fundamental physiological need at the base of Maslow's hierarchy, making a drop in oxygen saturation the highest priority over pain, anxiety, or mobility.

5. B — Share the diagnosis only after confirming the client has given permission.
Under HIPAA, a competent adult client must explicitly consent before protected health information is disclosed to family members, even those who are present at the bedside.

6. B — A resident with COPD who is using accessory muscles to breathe.
Use of accessory muscles indicates impaired breathing (the 'B' in ABCs), placing this resident at immediate risk for respiratory failure and requiring priority assessment over infection, a missed meal, or chronic pain.

7. C — Evaluation
Evaluation involves comparing the client's current response to expected outcomes and identifying changes or trends, which guides revision of the care plan.

8. B — Notify the RN and surgeon immediately so consent can be obtained properly.
Valid informed consent requires that the client understand the information provided; when a language barrier and altered cognition are present, the nurse must escalate to ensure legally and ethically valid consent is obtained.

9. B — Administering a scheduled oral medication to a stable client and documenting the outcome.
Administering scheduled medications to stable clients and documenting the response is a core LPN/LVN competency, whereas initial assessment, care plan development, and complex clinical interpretation are RN-level responsibilities.

10. C — Withhold CPR, notify the RN immediately, and provide comfort measures.
A valid, signed DNR order is a legally binding directive; the LPN/LVN must honor it by withholding resuscitation, promptly notifying the RN, and focusing on comfort-oriented care.

11. A — Report the suspicion to the charge nurse or nurse manager following facility policy.
Nurses have a legal and ethical obligation to report suspected diversion through the proper chain of command; the nurse manager or charge nurse is the appropriate first contact per standard facility policy and professional codes of conduct.

12. A — A client with a chest tube who suddenly develops absent breath sounds on the affected side and increasing respiratory distress.
Absent breath sounds with a chest tube and worsening respiratory distress indicate a potential tension pneumothorax — an airway and breathing emergency that requires immediate RN notification and physician intervention beyond LPN/LVN independent action.

13. A — Document the refusal, notify the RN and physician, and ensure the client received information about consequences.
A competent client's right to refuse treatment is a fundamental legal and ethical principle; the nurse's responsibility is to document the informed refusal, ensure the client understands the consequences, and notify the responsible provider — not to override the decision.

14. A — Acute respiratory compromise threatens immediate oxygenation (ABCs), while a stage II pressure injury, though urgent, does not present an immediate airway or breathing threat.
ABCs prioritization places airway and breathing above integumentary concerns; an acute asthma exacerbation represents an immediate threat to oxygenation, whereas a stage II pressure injury, while requiring timely care, does not pose an immediate life-threatening risk.

15. D — Airborne precautions with a negative-pressure room and N95 respirator
Pulmonary TB is transmitted via airborne particles (droplet nuclei smaller than 5 microns), requiring airborne precautions that include placement in an airborne infection isolation (negative-pressure) room and use of an N95 or higher-level respirator by caregivers.

16. B — Before performing a sterile dressing change on a surgical wound
Alcohol-based hand rub is appropriate when hands are not visibly soiled; however, soap and water must be used when hands are visibly contaminated, after contact with C. diff spores, and after contact with norovirus, because alcohol does not reliably destroy bacterial spores or non-enveloped viruses.

17. C — Washing hands before the procedure and using clean gloves to remove the old dressing
Clean (medical aseptic) technique requires hand hygiene and clean gloves for removing soiled dressings; sterile technique is reserved for the application of new dressings onto open wounds, but the removal step uses clean technique.

18. B — Reaching across the sterile field to arrange supplies on the far side
Reaching across a sterile field allows non-sterile clothing or skin to pass over sterile items, which contaminates the field; the LPN must always work within the sterile zone without crossing over it.

19. A — Rescue any clients in immediate danger
The RACE mnemonic stands for Rescue, Alarm, Confine, Extinguish; rescuing clients in immediate danger is the priority because human life takes precedence over all other actions.

20. A — A written order from the licensed provider that includes the clinical justification
Regulatory standards (TJC and CMS) require a licensed provider's written order specifying the clinical indication before a physical restraint is applied; the charge nurse's approval and family consent are not

substitutes for a provider order.

21. D — Gown, mask or eye protection (if indicated), then gloves
CDC donning sequence is gown first (to protect clothing), then mask/eye protection if needed, then gloves last so that gloves can cover the gown cuffs and remain the outermost layer touching contaminated surfaces.

22. A — Ensuring the call light is within reach and explaining how to use it before leaving the room
Call-light accessibility and client education are foundational fall-prevention measures; raising all four side rails is considered a restraint and can increase fall risk if the client attempts to climb over them, while restraints require a provider order and are a last resort.

23. A — Don chemotherapy-rated (chemo-safe) PPE and use a designated spill kit per facility protocol
Chemotherapy agents are hazardous drugs (NIOSH definition) and require dedicated PPE including double chemotherapy-rated gloves, a gown, and eye protection, along with a designated cytotoxic spill kit for containment and disposal in a labeled hazardous waste container.

24. C — Wash the site thoroughly with soap and water
The immediate first action after a needlestick is to wash the wound thoroughly with soap and water to mechanically reduce pathogen load; reporting, testing, and follow-up care are performed after initial wound management.

25. B — Airborne AND contact precautions simultaneously
Varicella-zoster virus is transmitted both via airborne particles (requiring N95 and negative-pressure room) and via direct contact with skin lesions, so both airborne and contact precautions are required concurrently per CDC guidelines.

26. D — Consider the entire sterile field contaminated and set up a new one
A wet sterile field is considered contaminated because moisture creates a pathway for microorganisms to wick through (strike-through contamination), even if the liquid itself was sterile; the entire field must be discarded and a new one established.

27. C — The client wears a surgical mask during transport and staff follow standard precautions
When transporting a client on droplet precautions, the client places a surgical mask over their nose and mouth to contain respiratory secretions; transport staff and radiology personnel then observe standard precautions, as the mask on the client limits source transmission.

28. B — Report the unsafe practice to the charge nurse and follow facility incident-reporting protocol
Improper sharps disposal is a patient-safety and bloodborne-pathogen incident that must be escalated through the chain of command (charge nurse) and documented via the facility's incident-reporting system; retrieving the sharp without proper PPE creates additional exposure risk, and charting it in the client's record is inappropriate.

29. C — Diphtheria, tetanus, and acellular pertussis (DTaP)
DTaP is part of the primary immunization series given at 2, 4, and 6 months; MMR and varicella are not given until 12–15 months, and HPV is not recommended until ages 11–12 years.

30. B — Drawing a person with at least four body parts
By age 4, most children can draw a person with four or more recognizable body parts, which is a well-established fine-motor and cognitive milestone for this age group.

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