NCLEX PN

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Practice Questions

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

1. The nurse works on a medical/surgical unit that has a shift with an unusually high number of admissions, discharges, and call bells ringing. A nurse's aide, who looks increasingly flustered and overwhelmed with the workload, finally announces "This is impossible! I quit!" and stomps toward the break room. The best statement, if made by the nurse to the nurse's aide, is <code>_____</code>.

A. "I can understand why you're upset, but I'm tired too and I'm not quitting."
B. "Fine, we're better off without you anyway."
C. "Why don't you take a dinner break and come back? It will seem more manageable with normal blood sugar."
D. "It seems to me that you feel frustrated.

What can I help you with to care for our patients?"

2. Which of the following terms is defined as when an individual believes that which was previously known as reality has been altered or completely done away with?

A. Delirium.
B. Akathisia.
C. Dementia.
D. Derealization.

**3. Bleuler's four A's are used to help remember the important characteristics of schizophrenia.

Which of the following is NOT one of the four A's?**

A. Autism
B. Affect
C. Actualities
D. Associations

4. Which of the following would you expect to see with second- and third-degree burns in the emergent phase?

A. Increased urinary output
B. Increased blood pressure
C. Elevated hematocrit levels
D. Decreased heart rate

**5. You are teaching your nursing students about maintaining an acid-base balance in the body. Part of maintaining this balance is the chemical buffer system.

Which of the following will you tell them is the main chemical buffer?**

A. Protein
B. Hemoglobin
C. Bicarbonate-carbonic acid
D. Phosphate

6. Which behavior is most healthful for a client with arterial insufficiency?

A. Wear loose fitting socks.
B. Cross legs at the knee for only one hour per day.
C. Walk barefoot outside, weather permitting.
D. Cross legs only at ankles for a maximum of two hrs. per day.

**7. The nurse is caring for a client undergoing chemotherapy who develops thrombocytopenia.

Which of the following interventions should the nurse give the highest priority?**

A. Provide list of foods high in iron
B. Monitor for bleeding in the gums
C. Encourage the client to ambulate at least 3 times a day
D. Maintaining reverse isolation at all times

8. A nurse is assigned to monitor a client who is prescribed clozapine (Clozaril). The occurrence of which signs and symptoms should alert the nurse to contact the RN or physician immediately?

A. Blood pressure of 110/72, staring at other clients
B. Mouth dryness, singing inappropriately
C. Sleepiness, nausea
D. Fever, sore throat

**9. A 24 year old pregnant client presents for her initial antepartum visit. She has a 1-year-old son born at 39 weeks and a 4-year-old son born at 37 weeks.

The client had a spontaneous abortion 7 years ago at 8 weeks.

By using the GTPAL format, the nurse can determine the client's pregnancy history as:**

A. G3 T2 A1 L2
B. G3 T2 A0 L2
C. G4 T2 A0 L2
D. G4 T2 A1 L2

10. The nurse teaches a 20-year-old female how to carry out SBE (self-breast exams). Of the following instructions, which one is incorrect if given by the nurse?

A. “Remember that breast tissue may feel tender at times, and this is normal.”
B. “Use your index, pointer, and ring fingers to firmly palpate the breast in a circular motion.”
C. “The best time to perform your SBE is at the end of the month.”
D. “The first position you will use to inspect your breasts is to stand with your arms at your sides.”

11. The nurse is caring for an elderly patient and providing education. Of the following, which one would be least appropriate?

A. The nurse speaks in a loud voice.
B. The nurse breaks up the education into multiple shorter sessions.
C. The nurse provides supplemental written resources.
D. The nurse allows additional time after each instruction to allow the patient to process.

**12. A 13-year-old female client tells the PN/VN that she is worried because she has not started her period.

Which response should the nurse the provide to the client?**

A. "Have you experienced any abdominal cramping?"
B. "I will ask your health care provider to check your hormone levels."
C. "You may start your period over the next few years."
D. "Are you currently taking any medication?"

13. A busy, harried-looking physician comes onto the floor and writes out four orders in less than one minute. He leaves, shoving over a stack of the nurse's charting on the way out the door. Of the following four orders, which one should the nurse question?

A. Sitz bath for a patient recovering from an episiotomy.
B. Cold compresses and elevation for a patient whose IV infiltrated two hours ago.
C. Heating pad for a patient with rheumatoid arthritis.
D. Heating pad for a diabetic patient with a foot ulcer.

**14. A nurse is tasked to care for a client with a body temperature of 94.8^OF.

Which of the following nursing actions by the nurse is the most effective in relieving hypothermia?**

A. Place the client in a tepid bath
B. Remove caps or turbans
C. Give cold fluids
D. Keep the client's limbs close to the body

15. Which of the following components of nutrition is primarily used as the source of energy for the human body?

A. Folate.
B. Protein.
C. Vitamin K.
D. Carbohydrate.

16. Abraham Maslow considered the most basic of needs in his hierarchy of needs to be which of the following?

A. Safety and security
B. Physiological needs
C. Love, affection, and belonging
D. Esteem needs and self-respect

**17. A nurse is caring for a child on seizure precautions.

Which of the following pieces of equipment should the nurse place at the client's bedside?**

A. Airway equipment
B. Tongue blade
C. Pulse oximeter
D. Pair of scissors

18. The doctor orders 24-hour ambulatory electrocardiography using a Holter monitor for a client with frequent fainting spells. To prevent electrical interference with the Holter monitor, which of the following should the nurse instruct the client to avoid?

A. Standing close to a microwave oven.
B. Using a cellular telephone.
C. Driving under overhead power lines.
D. Shaving with an electric razor.

**19. The PN/VN prepares for the admission of the new client with herpes zoster. The nurse is unsure which isolation technique is the most effective.

The nurse uses which location to find the best isolation requirement?**

A. Facility formulary
B. FDA.org
C. Informationonline.com
D. CDC.org

**20. A nurse is monitoring a client who was recently admitted to the unit after a cardiac catheterization.

Which of the following ordered assignments is the nurse's priority?**

A. Assess pulses distal to insertion site
B. Monitor the client's urinary output
C. Assess pulses proximal to the insertion site
D. Assess the client's heart rate

**21. A nurse is caring for a client with emphysema.

Which of the following interventions is the priority of the nurse when caring for the client?**

A. Maintain oxygen flow rate at 2 L/min
B. Offer foods high in carbohydrate and protein
C. Maintain the client's fluid intake to no less than 1500 mL per day
D. Reinforce deep diaphragmatic breathing and pursed-lip breathing

**22. The PN/VN receives report on the postoperative client.

Which fact provided to the nurse requires immediate follow-up?**

A. "Pain rated 4 on a scale of 1 to 10."
B. "Dressing removed, small amount of serous drainage noted."
C. "Out of bed to chair for 45 minutes."
D. "Indwelling catheter discontinued at 8 a.m., has not voided."

**23. The PN/VN is preparing to obtain a nutritional history on a client.

Which question should the nurse ask the client?**

A. "Have you experienced any significant changes in your appetite?"
B. "Do you have access to adequate food sources?"
C. "Can you recall what you had to eat in the past 24 hours?"
D. "Have you experienced any weight loss?"

**24. The nurse is inserting a nasogastric tube in an adult client. The nurse is having difficulty in inserting the tube.

Which of the following actions should the nurse do first?**

A. Coach the client to swallow while inserting the tube
B. Notify the physician immediately and have the physician insert the tube
C. Remove the tube and reinsert in the opposite nostril
D. Ask the client to extend their neck while the tube is being inserted

25. Which of the following solutions may consist of water in oil (w/o) or oil in water (o/w)?

A. Ointment
B. Lotion
C. Emulsion
D. Suspension

26. A female client at 28 weeks gestation is admitted after experiencing abrupt and painless bleeding. The nurse should expect the following interventions in the care plan developed by the RN except:

A. Inspect the perineum for bleeding
B. Continuous assessment of blood pressure every 15 minutes
C. Prepare the oxygen equipment at bedside
D. Perform pelvic examination

**27. A patient’s religion should be taken into account in terms of how the patient views illness and healing.

The religion that uses the sacrament of the sick is which of the following?**

A. Islam
B. Hinduism
C. Roman Catholic
D. Christian Science

**28. The PN/VN is reviewing the bones that support and protect the pelvic contents.

Which should the nurse identify as the sacrum?

<img src="asset:assets/questions/1fc02a9a8161cf62.png">**

A. A
B. D
C. C
D. B

**29. The PN/VN is discussing legal responsibilities of health care providers.

Which responsibility should the nurse include when discussing minimizing the risk of being charged with battery?**

A. Review the plan for treatment with the client.
B. Explain the initial plan of care for treatment.
C. Ensure the consent forms are signed prior to treatment.
D. Obtain the consent for treatment.

30. A client is admitted due to stimulant intoxication. The nurse caring for the client determines that the client is experiencing stimulant withdrawal if which of the following signs and symptoms are noted on assessment:

A. Pupil constriction, decreased respirations, hypotension
B. Yawning, rhinorrhea, diarrhea
C. Fatigue, insomnia, craving
D. Respiratory distress, body temperature of 108OF, seizures

Answer Key & Explanations

**1. D — “It seems to me that you feel frustrated.

What can I help you with to care for our patients?”**
This statement uses reflection and offers assistance to a fellow member of the patient care team. Do not refer back to yourself or offer a break. Offer to directly alleviate the cause of the problem.

2. D — Derealization.
Dementia is defined as a state of having several cognitive deficits that usually include memory issues. Akathisia is defined as being restless with regard to the motor system. Delirium deals with changes in cognition that take place over time.

3. C — Actualities
When faced with a question about schizophrenia use Bleuler’s four A’s to remember the characteristics of schizophrenia. They are: autism (preoccupied with self); affect (flat); associations (loose); and ambivalence (difficulty making decisions). Actualities is not one of the characteristics.

4. C — Elevated hematocrit levels
One would expect to find elevated hamatocrit levels in a patient in the emergent phase of second- or third-degree burns. 48 to 72 hours after injury, the emergent phase ends with the restoration of capillary permeability. Hemoconcentration from large fluid shifts leads to increased hematocrit.

5. C — Bicarbonate-carbonic acid
The main chemical buffer is the bicarbonate-carbonic acid system. Normally there are 20 parts of bicarbonate to 1 part carbonic acid. If this 20:1 ratio is altered the pH is changed. Other buffer systems are hemoglobin, protein and phosphate.

6. A — Wear loose fitting socks.
Loose fitting socks will promote good circulation. Crossing the legs at any point is detrimental to circulation.

7. B — Monitor for bleeding in the gums
Thrombocytopenia indicates a decrease in the number of platelets, leading to high risk of bleeding. The nursing intervention should focus on preventing and monitoring for bleeding.

Option A is an intervention for leukopenia, or a decrease in white blood cells.

Options B and D are not related to thrombocytopenia.

8. D — Fever, sore throat
The nurse should immediately contact the RN or physician if the client complains of fever, sore throat, and flu-like symptoms, as these could indicate agranulocytosis, a severe complication of clozapine.

9. D — G4 T2 A1 L2
GTPAL is used to show information about a female's pregnancy history. The approach is expressed in acronyms such as G-gravida which is associated with the total number of pregnancies; P-preterm, which is associated with all the children that were born early, before 37 weeks of gestation but after 20 weeks; A

identifies the number of abortions and L indicates the number of children who are presently living.

Now, for our example of the 24 year old female client, the nurse would express the client's pregnancy history as G4 T2 A1 L2 which identifies the following: The total number of pregnancies are 4 (G4). The total number of termed births where the baby was born after 37 weeks of gestatation are 2 (T2). The client had 1 abortion (A1). The client has a total of 2 children living (L2).

10. C — “The best time to perform your SBE is at the end of the month.”
One week after the onset of the woman’s menstrual period, when hormones are at the lowest, is the best time to perform SBE. It is normal for hormonal changes during the month to make breast tissue tender or enlarged. The other options are correct as well.

11. A — The nurse speaks in a loud voice.
The nurse should not speak in a loud voice just because the patient is elderly.

The nurse should assess the patient for hearing impairment to see if additional assistance is demanded.

Nevertheless, elderly patients tend to demand more time to process information, as their reaction time is slower, and they may advantage from more frequent, shorter sessions as they fatigue easily.

Elderly patients are usually capable of absorbing supplemental written resources.

12. C — "You may start your period over the next few years."
The normal range of menarche is from 10½ to 15 years of age.

Abdominal cramping (choice A) is not associated with the onset of menarche.

There is no reason hormone levels should be evaluated (choice C).

Assessing the client's medication (choice D) should not be related to the concern of delayed menstruation.

13. D — Heating pad for a diabetic patient with a foot ulcer.
The diabetic patient might have neuropathy and be not able to correctly sense the temperature of the heating pad, resulting in a burn.

14. D — Keep the client’s limbs close to the body
The goal of the treatment in clients with hypothermia is to conserve body heat.

This is achieved by keeping the client’s limbs close to the boy, wearing of caps and turbans, intake of warm fluids, and providing a warm environment for the client.

15. D — Carbohydrate.
Vitamin K is necessary in order to have proper blood clotting. Folate is especially important in pregnant women. It helps prevent neural tube defects. Protein helps with tissue growth and repair.

16. B — Physiological needs
Physiological needs are a person’s most basic needs and must be met. These needs include oxygen, food, water, shelter, and freedom from pain.

17. A — Airway equipment
The nurse should make sure that airway equipment is placed at the client’s bedside at all times. If the child has a seizure and requires a patent airway, the airway equipment can be used. The other options are not appropriate.

18. D — Shaving with an electric razor.
Using electrical devices, such as electric razors and toothbrushes, may alter the data recorded with a Holter monitor. The other activities are not known to cause electrical interference with a Holter monitor.

19. D — CDC.org
The CDC.org is the gold standard for all isolation questions and guidelines.

20. A — Assess pulses distal to insertion site
After the procedure, the client is at risk of clot formation. Weakened or absent pulses distal to the insertion site may suggest its occurrence.

Options A and B are also assessed, but assessment of the pulses distal to the insertion site is the priority.

Option D is not correct.

21. A — Maintain oxygen flow rate at 2 L/min
The priority of the nurse is to maintain the oxygen flow rate between 1 and 2 L/min. Clients with emphysema are stimulated by low partial pressure of oxygen to breathe, instead of increasing partial pressure of carbon dioxide. The other interventions are appropriate, but they are not the nurse’s priority.

22. D — "Indwelling catheter discontinued at 8 a.m., has not voided."
A pain rating of 4 on a scale of 10 is not usually a cause for immediate action. Getting out of bed and the dressing change finding are both routine. A client who has not voided for 7 hours requires prompt assessment and intervention.

23. C — "Can you recall what you had to eat in the past 24 hours?"
A nutritional history usually includes a 24-hour dietary recall of food intake. Changes in appetite, weight loss, and inquiring about access to adequate food sources are part of a health history.

24. A — Coach the client to swallow while inserting the tube
Swallowing facilitates relaxation of the esophageal muscles and closing of the epiglottis.

Options A and B are unnecessary.

Option D is incorrect. The client should bend the head forward to close the epiglottis and open the esophagus.

25. C — Emulsion
An emulsion is a solution in which one liquid is dispersed in another liquid. It may be water in oil or oil in water. Emulsions are stabilized though the use of an emulsifying agent.

26. D — Perform pelvic examination
Pelvic examinations must be avoided when caring for clients with placenta previa. This type of examination during the last trimester can agitate the cervix and may initiate hemorrhage. The other options are appropriate.

27. C — Roman Catholic
Roman Catholics have the sacrament of the sick. This was previously known as “last rites.” Islam uses herbal remedies and faith healing; Christian Science practices spiritual healing; and Hinduism practices faith healing.

28. C — C
The sacrum connects the hip bones and is important in forming a strong pelvis. The sacrum is a wedge-shaped bone that is below the fifth lumbar vertebrae of the base of the spine. The sacrum is made up of five vertebrae that fuse into one single bone.

29. C — Ensure the consent forms are signed prior to treatment.
Battery is actual physical contact with another person without that person's consent. The risk for a charge of battery can be minimized by having the client sign a consent form prior to treatment.

The healthcare provider must explain and obtain consent prior to treatment.

It is the duty of the nurse to

review the treatment plan of care with the client after consent has been obtained.

30. C — Fatigue, insomnia, craving
Fatigue, insomnia, and cravings are signs of stimulant withdrawal. Items in option A show stimulant intoxication, items in option C display signs of opioid intoxication, and items in option D demonstrate opioid withdrawal.

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