NCLEX RN

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Practice Questions

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

1. You are assisting the physician with removal of a chest tube. The nurse should instruct the patient to:

A. Inhale and exhale quickly.
B. Remain very still.
C. Exhale slowly.
D. Perform the Valsalva’s maneuver.

**2. A client with a forceful, pounding heartbeat is diagnosed with mitral valve prolapse.

This client should avoid which of the following?**

A. High volumes of fluid intake
B. Foods rich in protein
C. Aerobic exercise programs
D. Caffeine-containing products

3. Which should the nurse anticipate including in the care plan for a client the first 24 hours post thyroidectomy?

A. Loosen the neck dressing as the swelling increases.
B. Keep emergency thoracentesis equipment readily available.
C. Suction oral secretions as necessary.

4. The diet for your patient who is suffering from uremic syndrome would include all of the following EXCEPT:

A. High nitrogen foods
B. Limited sodium
C. Limited high-quality protein diet

**5. The nurse is providing education for a client scheduled for a myringotomy.

Which statement made by the client indicates an understanding of the information?**

A. "I will avoid bending over for the next three weeks."
B. "I will avoid blowing my nose with my mouth open."
C. "I will report any drainage to my health care provider."
D. "I will drink through a straw for the first few weeks."

6. A nurse carries out the physician’s order for a 24-hour urine collection. After explaining the procedure to the client, which of the following actions of the client indicates they understood the instructions?

A. Collects the first voided urine after perineal care.
B. Submits the first voided urine for urinalysis.
C. Collects the first voided urine in a separate container for submission later.
D. Discards the first voided urine.

7. The nurse understands that medications are excreted by which of the following routes?

A. The vestibular system
B. The circulatory system
C. The gastrointestinal system by way of urine
D. The lymphatic system

**8. How a patient metabolizes a medication is important to choosing the form that is best for the patient. Patients with issues, will need added attention. Phase 1 of the metabolism of medicine in the body, occurs in three major processes.

Which of the below choices is not one of those processes?**

A. Evaporation.
B. Oxidation.
C. Hydrolysis.
D. Reduction.

**9. A nurse is preparing to administer digoxin to a client who suffers from heart failure.

What must the nurse consider before administering this medication?**

A. The presence of pitting edema in the lower extremities
B. The presence of jaundiced skin
C. The sound of rales on lung auscultation
D. The rate of the apical pulse

**10. A nurse is preparing to administer an enteral feeding through a gastrostomy tube. Before administering the feeding, the nurse aspirates some stomach contents and checks the pH. The result is 3.9.

What is the next action of the nurse?**

A. Administer the feeding as ordered
B. Flush the feeding tube with 60 cc of water
C. Pull the feeding tube out approximately 3 cm
D. Contact the physician

**11. Your patient has been diagnosed with Parkinson's disease. He has been taking Parcopa orally for 10 days and is concerned that it is not helping to control his symptoms.

What would be the appropriate response to his concern?**

A. Immediately notify his health care provider that the medication has not been effective.
B. Make sure that the patient is taking the medication properly.
C. Ask the patient if he is adhering to the recommended diet.
D. Tell the patient that it takes 1 to 2 months before the medication is effective in controlling symptoms.

12. Which of the following medications would NOT be an appropriate prn medication for use during an episode of aggression or violence for the patient with a psychiatric diagnosis?

A. Meperidine
B. Haloperidol
C. Olanzapine
D. Ziprasidone

**13. A 47-year-old female is admitted due to cellulitis of the right leg. Medical history reveals that the client was diagnosed with diabetes mellitus four years ago and that she has hypertension.

Which of the following is the most appropriate intervention to reduce and manage the swelling in the right leg?**

A. Apply warm compress on the affected leg.
B. Immobilize the leg.
C. Elevate the affected leg on one pillow with the head of bed elevated.
D. Administer prescribed antibiotics.

14. In the postictal period, the nurse must give highest priority to which aspect of patient care?

A. Patient satisfaction
B. Patient comfort
C. Family education
D. Patient safety

**15. You are assessing a patient for fluid volume deficit.

Which of the following is a cause of this type of deficit?**

A. Vomiting
B. Renal failure

16. How often should a patient be encouraged to perform incentive spirometry?

A. 1 time per hour
B. 2-3 times every few hours
C. 10 times per hour while awake
D. Twice a day

17. A collection is <code>_____</code>.

A. the process of collecting fluid into the surgical drainage bag
B. redness around the drain site
C. when you have a combination of temperature of > 98.6 F or 37 C, and the presence of increasing pain
D. when fluids are trapped inside the body and form a pocket of infection

18. How can having an open-door policy create progress monitoring opportunities?

A. It does not allow for adequate progress monitoring.
B. Employees are required to stop in regularly and give updates.
C. You are always available for an update or questions.
D. It eliminates the need for other forms of check-in.

**19. A 50-year-old male is admitted to the hospital with a stroke.

Which of the following actions should the nurse delegate to a nursing assistant?**

A. Assess the client for deep vein thrombosis
B. Ausculate the client’s breath sounds every 4 hours to maintain patent airways
C. Offer the client a bedpan every 2 hours
D. Administer prescribed medication

**20. A nurse is caring for an elderly client with dementia.

The client asks the nurse the same question repeatedly because she cannot remember if she had asked the nurse the question previously.

The nurse becomes angry with the client, tells the client "shut up already. You have asked me that question. I am tired of telling you the same answer over and over."

The client asks the nurse the same question 10 minutes later.

The nurse slaps the client and says, "maybe this will help you remember the answer."

The nurse could be charged with a**

A. Misdemeanor
B. Inquest
C. Malpractice
D. Euthanasia

**21. You have been assigned to triage patients today.

Which patient would get the highest priority?**

A. A patient who injured their finger while cutting vegetables
B. A patient with a headache, fever and nasal congestion
C. A patient who complains of ankle pain when ambulating
D. A patient who ate spicy pizza who is now complaining of chest pain

22. You are caring for a patient who has been involuntarily admitted to the hospital because of violent behavior. The patient is demanding to leave the hospital. The nurse understands that keeping the patient will lead to:

A. Charges of slander
B. Charges of imprisonment
C. No charges because the nurse's actions are reasonable.
D. Charges of assault

23. Moana the New Nurse is caring for a 78-year-old client, a Cambodian immigrant. The client has end-stage ovarian cancer. Some members of the family have begun a round-the-clock bedside vigil, while others bring assorted homemade dishes to the client's room. The family is heard softly chanting at times. The client's grandson notified Moana the New Nurse that the family would like an hour of undisturbed privacy today; they wish to perform a traditional Cambodian ceremony to help loved ones pass to the next life easily. Moana the New Nurse agrees and makes her team aware. She also tries not to assign the other bed in the room in order to allow privacy and space for the family. What, if anything, did Moana the New Nurse do wrong?

A. Moana the New Nurse should not allow performance of unknown rituals on her client.
B. Moana the New Nurse should not allow the client to eat food from home.
C. Moana the New Nurse is correct.
D. Moana the New Nurse should not keep an available bed open.

**24. The nurse is preparing discharge instructions for Beth, a patient recently diagnosed with diabetes. Beth will be starting a new medication to help manage her elevated blood sugars and needs effective teaching on what the medication is for.

Which of the following is an example of therapeutic communication when providing this education to Beth?**

A. 'Your blood sugar is high.'
B. 'You've been diagnosed with diabetes.'
C. 'The doctor has prescribed glipizide, which is a medication that will help your pancreas produce insulin and lower your blood sugar.'
D. 'The discharge includes your new medications.'

25. Which of the following diets is suggested for the client with AIDS?

A. High calorie, high fat
B. Low calorie, low protein
C. High calorie, high protein
D. High calorie, high carbohydrate

26. Which of the following foods should be avoided by clients who are prone to develop heartburn as a result of gastroesophgeal reflux disease (GERD)?

A. butterscotch
B. lettuce
C. eggs
D. chocolate

**27. A patient on a medical-surgical unit who was admitted for chest pain, past medical history includes: DMII, COPD, CHF, and Atrial fibrillation. The following information is obtained upon assessment: VS: T- 99.9, P-62, R-20, BP-100/90, Sp02-91% on RA. Patient has diminished lung sounds in the bases and +3 edema in the lower extremities. The patient is currently receiving 80ml/hr of NS through a peripheral IV. He has a foley catheter that has put out 45 ml in the last two hours, however he had 70ml of urine output the two hours prior.

Which of the following is most concerning that the nurse should notify the physician immediately?**

A. temp of 99.9
B. diminished lung sounds in the bases
C. 45 ml of urine output in two hours
D. +3 edema in the lower extremities

28. Mary, a newly registered nurse, is working in a physician's office. She is assisting the physician to perform blood extraction. When disposing of these materials, in which color-coded bag should the nurse place the used vacutainer?

A. In a puncture-proof container
B. In a red bag together with the bandages and cotton rolls
C. In a black bag, for hazardous materials
D. In a green bag

29. The nurse is caring for a 35 year old client with cirrhosis. The nurse should instruct the client to avoid

A. Sitting upright for more than 30 minutes at a time
B. Drinking more than 1 glass of alcohol each day
C. Eating a high protein diet
D. Blowing his nose

30. The nurse expects to observe an infant transferring an object from one hand to another at which age?

A. 12 months
B. 6 months
C. 9 months
D. 4 months

Answer Key & Explanations

1. D — Perform the Valsalva’s maneuver.
The nurse should instruct the patient to perform the Valsalva’s maneuver (take a deep breathe, exhale and bear down). Then the tube would be quickly removed and an airtight dressing placed. An alternative would be to ask the patient to take a deep breathe and hold the breath while the tube is removed.

2. D — Caffeine-containing products
Caffeine is a stimulant, which can exacerbate palpitations, and should be avoided by a client with symptomatic mitral valve prolapse. High-fluid intake helps maintain adequate preload and cardiac output. Aerobic exercise helps increase cardiac output and decrease heart rate. Protein-rich foods are not restricted but high-calorie foods are.

3. C — Suction oral secretions as necessary.
Oral secretions may need to be suctioned following a thyroidectomy.

A pillow is used to support the head and neck after surgery, and the client should avoid neck extension because it may disrupt the surgical site.

The client may experience a moderate amount of serosanguinous drainage in the first 24 hours.

The client will place both hands behind their neck before coughing to support the neck and reduce tension on the suture line.

If the dressing around the neck becomes too tight (choice C), this may be an indication of a complication that could impede the airway.

The client should immediately be assessed for hemorrhage or any respiratory compromise and the health care provider notified immediately.

Emergency tracheostomy equipment (not thoracentesis equipment as choice D indicates) should be kept immediately available.

4. A — High nitrogen foods
Nitrogen and potassium would be limited. The patient would be provided a limited but high-quality protein diet and a limited sodium, nitrogen, potassium, and phosphate diet.

5. A — "I will avoid bending over for the next three weeks."
The client making the statement in choice B understands the information the nurse has provided.

The client should not bend over for the following three weeks to avoid increasing middle ear pressure, which may disrupt the surgical site.

Further education may be necessary if the client makes the statements in choices A, C, and D.

The client should be instructed to avoid drinking through a straw because the increased pressure may disrupt the surgical site.

Some drainage is an expected finding for the first few days post-surgery.

The client will be instructed to change the dressing every 24 hours and immediately report excessive drainage.

The client will be instructed to avoid blowing his or her nose with the mouth closed to prevent an increase in the pressure.

6. D — Discards the first voided urine.
The first voided urine should be discarded when collecting a 24-hour urine specimen. A 24-hour urine test is done to determine the total volume of urine the client’s body can produce in 24 hours. The urine is also tested for certain substances such as protein, urea nitrogen, and aldosterone. The other remaining options are incorrect steps that would result in inaccurate results.

7. C — The gastrointestinal system by way of urine
Systems such as the gastrointestinal system by way of feces and urine as well as the respiratory system play a role in the excretion of medication. The circulatory system and lymphatic system are comprised of routes such as the nose and blood that work to distribute medication throughout the body and does not play a role in excreting medication.

8. A — Evaporation.
There are three major processes that can occur in the metabolism of medicines in the body.
Oxidation is the most important, undertaken by the enzymes of the body.
The other two processes are reduction and hydrolysis, these processes effect the levels of vital fluids in the blood stream, such as plasma and water, effecting the use and elimination of the drug.

9. D — The rate of the apical pulse
Digoxin is a drug that works to increase cardiac contractility among clients who suffer from conditions such as heart failure, atrial fibrillation, or atrial flutter. Because digoxin may work to slow a rapid heart rate, the nurse should check an apical pulse before administering this medication.

10. A — Administer the feeding as ordered
Checking the pH before administering an enteral feeding verifies placement that the gastrostomy tube is in the correct position. A pH of 4 or less indicates that the tube is in the stomach and the nurse may continue with the enteral feeding.

11. D — Tell the patient that it takes 1 to 2 months before the medication is effective in controlling symptoms.
It takes at least 1 to 2 months for this medication to be effective. Sometimes it takes as much as 6 months. The patient is not likely to see any improvement in symptoms in 10 days. Reminding the patient that it takes a while for the medication to be effective would be the appropriate response to his concern.

12. A — Meperidine
Meperidine is an opioid used to treat pain, and is not an appropriate medication to use to treat aggressive or violent behavior. Second-generation anti-psychotic medications such as olanzapine and ziprasidone, as well as traditional anti-psychotics such as haloperidol are effective agents, with or without the concurrent use of a benzodiazepine.

13. D — Administer prescribed antibiotics.
Administering prescribed antibiotics is the most proper intervention to reduce the swelling and inflammation of the leg.

Avoid applying warm compresses to the affected leg because this can cause further tissue injury.

In addition, the client has diabetes that may significantly decrease the client’s perception of heat.

Immobilizing the leg is unnecessary; however, the nurse must gently handle the extremity because this can be extremely painful for the client.

Ideally, the affected leg should be elevated above the heart level.

14. D — Patient safety
While all of the above are important aspects of care, patient safety must be assured before focusing on comfort, satisfaction or education.

15. A — Vomiting
Fluid volume deficit may be caused by gastrointestinal problems such as vomiting, diarrhea and GI suctioning.

It can also be caused by a decrease in fluid intake or an increase in fluid output. Renal failure would be the cause of fluid volume overload not fluid volume deficit.

16. C — 10 times per hour while awake
Patients should be encouraged to perform incentive spirometry ten times per hour while awake, but to stop and rest if they become dizzy or lightheaded. Consistent use of an incentive spirometer will lead to better overall patient outcomes.

17. D — when fluids are trapped inside the body and form a pocket of infection
When body fluid, blood and/or pus gets trapped inside the body and forms a pocket of infection, this is referred to as a collection.

18. C — You are always available for an update or questions.
An open-door policy as a manager can be an effective way to monitor progress because it works on your availability for updates or questions.

19. C — Offer the client a bedpan every 2 hours
Interventions that help the client with activities of daily living is a task the nurse can delegate to the nursing assistant because this activity is within the nursing assistant's educational level and practice.

However, assessing the client, such as assessing for deep vein thrombosis, along with medication administration and assessing the client to ensure airway management is outside of a nursing assistant's scope of practice.

These activities require additional training and education of a licensed nurse.

20. A — Misdemeanor
A misdemeanor is a type of crime.

A crime is an act that is performed that violates the law.

A crime can either be a misdemeanor or a felony.

A misdemeanor is a less serious crime because it does not involve murder.

However, the nurse can be charged with a misdemeanor for physically harming the client by slapping her.

Most states have laws that address physical violence.

21. D — A patient who ate spicy pizza who is now complaining of chest pain
A patient who is complaining of chest pain should get the highest priority. Patients with trauma, chest pain, respiratory distress and cardiac arrest would get the highest priority on the list. Patients with minor injuries, cold symptoms or sprains would fall next.

22. C — No charges because the nurse's actions are reasonable.
No charges will be filed against the nurse, because the actions of the nurse are reasonable. False imprisonment is an act with intent to confine a person to a specific area. This could be charged against the nurse if the patient had been voluntarily admitted to the hospital.

23. C — Moana the New Nurse is correct.
Moana the New Nurse understands that providing a culturally sensitive environment is the most helpful thing she can do for her client and the client's family. Keeping the other bed in the room open provides privacy, space, and comfort for the client and family, without disturbing other clients on the unit. If no other beds were available, this would not be an option. Nurses balance the cultural needs of clients with the guidelines and regulations of the facility.

24. C — 'The doctor has prescribed glipizide, which is a medication that will help your pancreas produce insulin and lower your blood sugar.'
The response 'The doctor has prescribed glipizide, which is a medication that will help your pancreas produce insulin and lower your blood sugar.' is therapeutic because it utilizes lay terms, explains the situation, and teaches the patient about how the medication works. The remaining responses are incorrect because they don't use lay terminology or do not teach the patient in a meaningful way.

25. C — High calorie, high protein
The suggested diet for the client with AIDS is one that is high calorie and high protein.

26. D — chocolate
Ingestion of chocolate can reduce lower esophageal sphincter (LES) pressure leading to reflux and clinical symptoms of GERD.

27. C — 45 ml of urine output in two hours
Urine output should be at least 30 ml an hour. If urine output is less than 30ml/hr for two hours, the physician should be notified. Urine output of less than 30ml/hr becomes a cause for concern especially when it is a change from the patient's baseline.

28. A — In a puncture-proof container
All sharp items, including needles and glass tubes, should be placed in a puncture resistance container to prevent spread of infection. These sharp items are treated as hazardous materials. Other hazardous and infectious materials should be placed in a red bag.

29. D — Blowing his nose
Cirrhosis is the last stage of liver disease.

Individuals with cirrhosis may be at risk for bleeding because their bodies are not able to properly coagulate the blood.

Also, complications of cirrhosis such as gastritis and enlarged veins in the esophagus that can rupture can further put the client at risk for bleeding.

Therefore, it is important to inform clients to not blow the nose too hard to avoid bleeding.

Additional precautions the nurse should discuss with the client include not having the temperature taken rectally, avoid enemas, avoid injections, use soft toothbrushes to not bruise the gums and to avoid straining when passing feces.

30. B — 6 months
An infant typically transfers objects from one hand to another between ages 6 and 7 months. The infant can grasp a rattle in the hands at age 4 months, bang objects together between ages 9 and 10 months, and place objects in a container by age 12 months.

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