NCLEX-RN

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Practice Questions

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

1. A registered nurse (RN) is making client care assignments for the shift. Which task is most appropriate to delegate to unlicensed assistive personnel (UAP)?

A. Performing the admission assessment on a new client
B. Developing the plan of care for a postoperative client
C. Assisting a stable client with morning hygiene and ambulation
D. Teaching a client how to self-administer insulin

2. The nurse receives shift report on four clients. Which client should the nurse assess first?

A. A client with new-onset shortness of breath and oxygen saturation of 88%
B. A client requesting pain medication for chronic back pain
C. A client scheduled for discharge teaching this afternoon
D. A client who needs assistance with a meal tray

3. A client is scheduled for surgery and asks the nurse to explain the risks of the procedure. What is the nurse's most appropriate response?

A. Describe the surgical risks in detail to the client
B. Notify the surgeon that the client has questions before signing consent
C. Tell the client the risks are minimal and to sign the form
D. Witness the consent and proceed with preoperative care

4. Which situation requires the nurse to complete an incident (occurrence) report?

A. A client refuses a prescribed medication after teaching
B. A client is transferred to another unit per provider order
C. A family member asks to speak with the charge nurse
D. A client falls while walking to the bathroom unassisted

5. The nurse is caring for a client who has a living will. The client's adult child insists that 'everything be done.' What should guide the nurse's actions?

A. The wishes expressed by the adult child
B. The unit's standard resuscitation policy
C. The client's documented advance directive
D. The nurse's personal judgment about prognosis

6. An RN is supervising a licensed practical/vocational nurse (LPN/LVN). Which assigned client is most appropriate for the LPN/LVN?

A. A stable client receiving a scheduled oral antibiotic
B. A client requiring an initial nursing assessment on admission
C. A client receiving the first dose of IV chemotherapy
D. A client requiring discharge teaching about a new diagnosis

7. The nurse discovers that a colleague accessed the electronic health record of a client they are not caring for. What is the nurse's priority action?

A. Discuss the concern privately with the colleague only
B. Report the breach of confidentiality through the proper channel
C. Ignore it because no harm appears to have occurred
D. Document the colleague's name in the client's chart

8. Four clients are awaiting care in the emergency department. Using triage principles, which client should be seen first?

A. An adult with a sprained ankle and intact pulses
B. An adult with a 2-day history of nasal congestion
C. An adult with crushing chest pain and diaphoresis
D. An adult requesting a prescription refill

9. The nurse is creating the plan of care for a client. Which action best reflects appropriate client advocacy?

A. Making health decisions on behalf of the competent client
B. Persuading the client to accept the provider's recommendation
C. Withholding information that may upset the client
D. Ensuring the client has the information needed to make decisions

10. A nurse is delegating to a UAP. Which instruction reflects the most appropriate delegation communication?

A. Report the client's blood pressure to me immediately if it is below 90/60
B. Take care of the client in room 4 this morning
C. Do whatever the client needs while I am at lunch
D. Help out wherever you think you are needed

11. The nurse is prioritizing care for a group of clients. Which principle should guide the order of care?

A. Care for the clients in the order rooms are numbered
B. Address actual life-threatening problems before potential ones
C. Complete all tasks for one client before seeing any other
D. Begin with the client who has the most family present

12. A client tells the nurse they want to leave the hospital against medical advice (AMA). What is the nurse's first action?

A. Physically prevent the client from leaving the unit
B. Tell the client they cannot leave until the provider arrives
C. Notify the provider and explain the risks of leaving to the client
D. Remove the client's IV and escort them out immediately

13. Which client problem is the highest priority for the nurse to address using Maslow's hierarchy of needs?

A. A client expressing anxiety about an upcoming test
B. A client who feels isolated from family members
C. A client wanting to discuss long-term goals
D. A client with an obstructed airway after vomiting

14. The charge nurse is reviewing documentation. Which entry by a staff nurse requires follow-up?

A. Client appears to be in a lot of pain and is probably faking discomfort
B. Client rates pain 8/10 and is grimacing while guarding the abdomen
C. Client received acetaminophen 650 mg by mouth at 0900
D. Client ambulated 50 feet in the hallway with a steady gait

15. A nurse is coordinating discharge for a client who will need home oxygen and physical therapy. Which action best supports continuity of care?

A. Wait for the client to arrange services after discharge
B. Initiate a referral to case management and home care services
C. Give the client a list of phone numbers to call later
D. Document that the client is independent and needs no services

16. The nurse is assigned to care for several clients. Which task should the nurse perform personally rather than delegate?

A. Obtaining a routine set of vital signs on a stable client
B. Assisting a client to the bathroom
C. Evaluating a client's response to a newly started medication
D. Recording the client's intake and output

17. A nurse is caring for a client on contact precautions for Clostridioides difficile infection. Which action is correct?

A. Use alcohol-based hand rub after removing gloves
B. Wash hands with soap and water after providing care
C. Wear an N95 respirator when entering the room
D. Place the client in a negative-pressure room

18. Which client requires placement in an airborne infection isolation (negative-pressure) room?

A. A client with a methicillin-resistant Staphylococcus aureus wound infection
B. A client with influenza
C. A client with active pulmonary tuberculosis
D. A client with a urinary tract infection

19. Before administering medication, the nurse should verify the client's identity using which method?

A. Two client identifiers, such as name and date of birth
B. The room number where the client is located
C. The client's verbal statement of their diagnosis
D. The medication list posted at the bedside

20. A nurse is applying a restraint to a confused client who is pulling at a critical IV line. Which action is appropriate?

A. Tie the restraint to the movable side rail of the bed
B. Use the tightest knot possible so it cannot be removed
C. Apply restraints first, then obtain a provider order later if time allows
D. Ensure two fingers fit under the restraint and assess skin regularly

21. The nurse is teaching about fall prevention for an older adult at home. Which instruction is most important?

A. Keep the home brightly lit only during the daytime
B. Remove loose throw rugs and clutter from walkways
C. Wear loose, open-back slippers when walking
D. Rise quickly from a seated position to save time

22. A nurse discovers a small electrical fire in a client's room. Using the RACE protocol, what is the first action?

A. Activate the fire alarm
B. Use a fire extinguisher on the flames
C. Rescue and remove the client from immediate danger
D. Close all doors to contain the fire

23. Which personal protective equipment (PPE) should the nurse remove first when exiting a client's room?

A. Gloves
B. Gown
C. N95 respirator
D. Goggles

24. A nurse prepares to administer a high-alert medication. Which safety practice is most appropriate?

A. Calculate the dose quickly to avoid delays
B. Administer based on the previous nurse's calculation
C. Round the dose to make it easier to draw up
D. Have a second nurse independently verify the dose

25. The nurse notes a client's wristband indicates a latex allergy. Which action is appropriate?

A. Use powdered latex gloves for quick procedures only
B. Ensure latex-free supplies are used for all care
C. Limit latex precautions to invasive procedures
D. Remove the allergy band to avoid alarming the client

26. A nurse is reviewing safe practices for preventing catheter-associated urinary tract infections. Which action is most effective?

A. Irrigate the catheter routinely with sterile saline
B. Disconnect the drainage bag periodically to measure output
C. Remove the indwelling catheter as soon as it is no longer needed
D. Place the drainage bag above the level of the bladder

27. A client receiving a blood transfusion develops chills, fever, and low back pain 15 minutes after it begins. What is the nurse's first action?

A. Stop the transfusion immediately
B. Slow the transfusion rate and continue monitoring
C. Administer an antipyretic and reassess in 30 minutes
D. Document the findings and complete the transfusion

28. Which action best demonstrates correct use of standard precautions?

A. Wearing gloves only when caring for clients with known infections
B. Recapping needles by hand to prevent spills
C. Reusing gowns between clients to conserve supplies
D. Performing hand hygiene before and after every client contact

29. A nurse is caring for a client with neutropenia. Which intervention is appropriate?

A. Encourage fresh flowers and plants in the room
B. Avoid serving raw fruits and vegetables
C. Allow visitors with mild upper respiratory infections
D. Take the client to crowded common areas for socialization

30. The nurse is preparing to move a heavy, immobile client up in bed. Which action protects both the nurse and the client?

A. Bend at the waist and lift the client alone
B. Pull the client by grasping under the arms
C. Use a friction-reducing device and ask for assistance
D. Lower the head of the bed and lift quickly

Answer Key & Explanations

1. C — Assisting a stable client with morning hygiene and ambulation
Assisting a stable client with hygiene and ambulation is within the UAP scope of practice. Assessment, care planning, and client teaching require the clinical judgment of the RN and cannot be delegated.

2. A — A client with new-onset shortness of breath and oxygen saturation of 88%
Airway and breathing take priority (ABCs). New shortness of breath with a saturation of 88% signals a potentially life-threatening problem and must be assessed first. The other needs are important but not immediately life-threatening.

3. B — Notify the surgeon that the client has questions before signing consent
Obtaining informed consent — including explaining risks, benefits, and alternatives — is the surgeon's responsibility. The nurse witnesses the signature and ensures the client understands; unanswered questions must be referred to the surgeon before consent is signed.

4. D — A client falls while walking to the bathroom unassisted
An incident report documents events that are not consistent with routine care, such as a client fall, regardless of injury. A medication refusal that is documented in the record, a routine transfer, and a family request are part of normal care.

5. C — The client's documented advance directive
A valid advance directive (living will) expresses the client's own wishes and legally directs care. The client's documented decisions take precedence over family preferences. The nurse should support the family while honoring the client's directive.

6. A — A stable client receiving a scheduled oral antibiotic
LPNs/LVNs may care for stable clients and administer many routine medications such as scheduled oral antibiotics. Initial assessments, complex first-dose IV chemotherapy, and teaching about a new diagnosis require the RN.

7. B — Report the breach of confidentiality through the proper channel
Accessing a record without a care-related need is a breach of confidentiality (and HIPAA). The nurse is obligated to report the breach through the appropriate institutional channel. Charting accusations in the client record is inappropriate.

8. C — An adult with crushing chest pain and diaphoresis
Triage prioritizes the most life-threatening condition. Crushing chest pain with diaphoresis suggests an acute coronary event and must be seen first. The other clients are stable or non-urgent.

9. D — Ensuring the client has the information needed to make decisions
Advocacy means supporting the client's right to make informed, autonomous decisions. The nurse ensures the client has accurate information; it does not mean deciding for the client or steering them toward a particular choice.

10. A — Report the client's blood pressure to me immediately if it is below 90/60
Effective delegation is specific and includes the expected outcome and what to report back. Telling the UAP exactly what value to report demonstrates clear, measurable direction; vague instructions risk errors.

11. B — Address actual life-threatening problems before potential ones
Prioritization is guided by urgency: actual, life-threatening problems (airway, breathing, circulation) come before potential problems and lower-acuity needs. Room order, family presence, and task batching do not determine priority.

12. C — Notify the provider and explain the risks of leaving to the client
A competent adult has the right to refuse treatment and leave. The nurse should notify the provider, ensure the client understands the risks, and document the discussion. Restraining a competent client is false imprisonment.

13. D — A client with an obstructed airway after vomiting
Physiological needs — especially airway — are the foundation of Maslow's hierarchy and take priority over safety, love/belonging, and self-actualization needs. An obstructed airway is an immediate physiological threat.

14. A — Client appears to be in a lot of pain and is probably faking discomfort
Documentation must be objective and free of judgmental or unsupported conclusions. Stating that a client is 'faking' is subjective and inappropriate. The other entries are objective and measurable.

15. B — Initiate a referral to case management and home care services
Coordinating referrals to case management and home care before discharge ensures needed equipment and services are in place, supporting safe continuity of care. Leaving arrangements entirely to the client risks gaps in care.

16. C — Evaluating a client's response to a newly started medication
Evaluating a client's response to therapy requires nursing assessment and judgment and cannot be delegated. Routine vital signs, ambulation assistance, and recording I&O on stable clients may be delegated to UAP.

17. B — Wash hands with soap and water after providing care
C. difficile spores are not reliably killed by alcohol-based rubs, so hands must be washed with soap and water. Contact precautions require gown and gloves; an N95 and negative-pressure room are for airborne precautions.

18. C — A client with active pulmonary tuberculosis
Active pulmonary tuberculosis spreads via airborne droplet nuclei and requires a negative-pressure room and N95 respirator. MRSA wounds need contact precautions and influenza needs droplet precautions; a UTI requires standard precautions.

19. A — Two client identifiers, such as name and date of birth
The Joint Commission requires at least two client identifiers (e.g., name and date of birth) that are not the room number. This prevents administering medication to the wrong client.

20. D — Ensure two fingers fit under the restraint and assess skin regularly
Restraints must allow two fingers underneath to avoid compromising circulation, be secured to the bed frame

(not side rails), use quick-release knots, and require a provider order and frequent assessment. Restraints are a last resort after less restrictive measures fail.

21. B — Remove loose throw rugs and clutter from walkways
Removing throw rugs and clutter eliminates common tripping hazards. Adequate lighting should be available day and night, footwear should be non-skid and secure, and rising slowly prevents orthostatic dizziness.

22. C — Rescue and remove the client from immediate danger
RACE stands for Rescue, Alarm, Confine, Extinguish. The first priority is to rescue/remove anyone in immediate danger, then activate the alarm, confine the fire by closing doors, and finally extinguish if safe.

23. A — Gloves
When doffing PPE, gloves are removed first because they are most contaminated. The recommended order is gloves, then goggles/face shield, then gown, then mask/respirator (removed last, outside the room).

24. D — Have a second nurse independently verify the dose
High-alert medications (e.g., insulin, heparin, opioids) carry a heightened risk of harm. An independent double-check by a second qualified nurse reduces dosing errors. Doses should never be rushed, copied, or rounded for convenience.

25. B — Ensure latex-free supplies are used for all care
A documented latex allergy requires latex-free supplies for all care to prevent a potentially life-threatening allergic reaction. The allergy band must remain in place to alert all staff.

26. C — Remove the indwelling catheter as soon as it is no longer needed
Early removal of an unnecessary catheter is the single most effective measure to prevent CAUTI. Routine irrigation and unnecessary disconnection introduce pathogens, and the bag must stay below bladder level to prevent backflow.

27. A — Stop the transfusion immediately
These signs suggest an acute transfusion reaction. The nurse must stop the transfusion immediately to limit exposure, keep the IV line open with normal saline, and notify the provider and blood bank. Continuing the transfusion could be fatal.

28. D — Performing hand hygiene before and after every client contact
Standard precautions apply to all clients regardless of diagnosis; hand hygiene before and after every contact is foundational. Needles are never recapped by hand, gowns are not reused between clients, and gloves are used whenever contact with body fluids is possible.

29. B — Avoid serving raw fruits and vegetables
Neutropenic clients are highly susceptible to infection. Raw produce, fresh flowers/plants, ill visitors, and crowds all introduce pathogens and should be avoided (neutropenic precautions).

30. C — Use a friction-reducing device and ask for assistance
Using a friction-reducing device (e.g., a draw sheet or slide sheet) with additional staff reduces injury risk for both the nurse and client. Bending at the waist, lifting alone, and pulling under the arms cause injury.

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