NCLEX-RN Practice Questions Set-1

Q1. A nurse receives report on four clients. Which client should the nurse assess first?
A. Client with COPD who reports chronic productive cough in the morning
B. Client with heart failure who has new-onset confusion and restlessness
C. Client with type 2 diabetes with blood glucose 180 mg/dL (10 mmol/L) before dinner
D. Client 1 day postoperative who reports pain level 6/10

Answer: B

Q2. A client on warfarin therapy for atrial fibrillation has an INR of 4.8. Which action should the nurse anticipate?
A. Administer the scheduled warfarin dose
B. Hold the dose and notify the provider
C. Give vitamin K immediately without notification
D. Encourage increased green leafy vegetables

Answer: B

Q3. A nurse teaches a first-trimester pregnant client about folic acid. Which statement indicates understanding?
A. “I only need folic acid in the last trimester.”
B. “Folic acid helps prevent problems with the baby’s spinal cord.”
C. “Folic acid is only needed if I have anemia.”
D. “I should stop folic acid after 12 weeks.”

Answer: B

Q4. A client with major depressive disorder states, “Nothing will ever get better.” What is the nurse’s best response?
A. “You shouldn’t feel that way; things will improve soon.”
B. “Tell me more about what you mean when you say nothing will get better.”
C. “Let’s focus on something positive instead.”
D. “You just need to try harder to think positively.”

Answer: B

Q5. A bedbound client is at high risk for pressure injuries. Which nursing action is most important?

A. Offer oral fluids every 4 hours
B. Reposition the client at least every 2 hours
C. Keep the head of the bed elevated at 60° at all times
D. Massage reddened areas over bony prominences twice daily

Answer: B

Q6. Which task is appropriate for the nurse to delegate to an experienced unlicensed assistive personnel (UAP)?

A. Teaching incentive spirometer use
B. Assessing pedal pulses
C. Feeding a stable client with Parkinson disease who has a safe swallow evaluation
D. Monitoring response to pain medication

Answer: C

Q7. A client with acute decompensated heart failure has crackles in both lung bases, dyspnea at rest, and oxygen saturation 88% on room air. Which action should the nurse take first?

A. Obtain a 12-lead ECG
B. Apply oxygen via nasal cannula
C. Weigh the client
D. Check the most recent potassium level

Answer: B

Q8. A nurse is preparing to administer IV potassium chloride to a client with hypokalemia. Which action is essential?

A. Administer undiluted IV push over 2 minutes
B. Use an infusion pump to deliver the dose
C. Hang the solution as a secondary piggyback by gravity
D. Shake the bag vigorously before hanging

Answer: B

Q9. A school-age child with asthma uses an albuterol inhaler as needed. Which finding indicates the medication is effective?
A. Heart rate decreases from 88 to 60/min
B. Wheezing increases after inhalation
C. The child reports less chest tightness and can play longer
D. The child's cough becomes dry and nonproductive

Answer: C

Q10. The nurse is caring for a client with schizophrenia who is pacing and shouting, "They're coming to get me!" What is the priority action?
A. Confront the delusion and state it is not real
B. Tell the client to stop pacing and sit down
C. Move the client to a quieter area with fewer stimuli
D. Ask detailed questions about who is coming

Answer: C

Q11. A client with chronic kidney disease reports severe generalized itching. Which instruction is most appropriate?
A. Take hot showers twice daily
B. Use mild soap and apply emollient after bathing
C. Increase protein intake
D. Expose skin to direct sunlight daily

Answer: B

Q12. A nurse reinforces teaching about digoxin with a client who has heart failure. Which statement indicates understanding?
A. "If my pulse is below 60, I will still take the medication."
B. "Blurred or yellow vision may mean I am taking too much."
C. "I should take this medication with high-fiber meals."
D. "I can double the dose if I miss one."

Answer: B

Q13. A client with chronic obstructive pulmonary disease (COPD) is on 2 L/min oxygen via nasal cannula. Which finding should the nurse report immediately?

A. Productive cough of thick white sputum
B. Oxygen saturation 89%
C. New-onset lethargy and difficult arousal
D. Respiratory rate 22/min

Answer: C

Q14. A nurse is counseling a client who recently experienced the death of a spouse and states, "I don't see any reason to keep living." What is the priority action?
A. Ask, "Are you thinking about harming yourself?"
B. Suggest joining a grief support group
C. Encourage the client to start new hobbies
D. Offer to call the client's family

Answer: A

Q15. A client receiving total parenteral nutrition (TPN) suddenly develops shortness of breath, chest pain, and anxiety. Which action is the nurse's priority?
A. Check blood glucose level
B. Slow the TPN infusion rate
C. Clamp the TPN line and place client on left side with head down
D. Obtain a stat chest x-ray

Answer: C

Q16. A postpartum client is Rh negative and delivered an Rh-positive infant 36 hours ago. Which finding indicates Rho(D) immune globulin was effective?
A. Negative Coombs test in the newborn
B. Newborn bilirubin within reference range
C. Absence of maternal Rh antibodies on future screenings
D. Maternal hemoglobin within reference range

Answer: C

Q17. A nurse cares for a client with Alzheimer disease who wanders at night. Which intervention is most appropriate?
A. Restrain the client in bed at night
B. Place a motion sensor or bed alarm on the client

C. Lock the client's door from the outside
D. Provide sedative medication every evening

Answer: B

Q18. A client is prescribed furosemide for heart failure. Which lab result should the nurse monitor most closely?
A. Sodium
B. Potassium
C. Hemoglobin
D. Platelets

Answer: B

Q19. A nurse cares for a client 1 hour after thyroidectomy who reports a "tight feeling" in the throat and difficulty swallowing. Which action is priority?
A. Encourage small sips of water
B. Place the client in high Fowler's position
C. Assess for stridor and prepare for possible airway obstruction
D. Offer throat lozenges

Answer: C

Q20. A client with chronic pain asks for their prescribed opioid medication 30 minutes early and appears anxious. What is the nurse's best response?
A. "You must wait until the scheduled time."
B. "Tell me more about your pain and what you're feeling right now."
C. "You are probably becoming addicted to your medication."
D. "I will ask the provider to discontinue your opioid."

Answer: B

Q21. A nurse prepares to administer an enteral feeding via nasogastric tube. Which step is most important for client safety?
A. Flush the tube with 10 mL of water
B. Confirm tube placement per facility policy before feeding
C. Warm the formula to body temperature in the microwave
D. Elevate the head of the bed to 15°

Answer: B

Q22. A client with pneumonia has an order for sputum culture. Which action should the nurse include in instructions?
A. “Rinse your mouth with antiseptic mouthwash before you cough.”
B. “Use the specimen cup after you eat breakfast.”
C. “Take several deep breaths and then cough deeply into the container.”
D. “Save your sputum from the tissue after you cough.”

Answer: C

Q23. A nurse evaluates the effectiveness of teaching about diabetic foot care. Which client statement requires further teaching?
A. “I will inspect my feet every day.”
B. “I’ll wear cotton socks and well-fitting shoes.”
C. “I will use a heating pad to warm my feet at night.”
D. “I’ll trim my toenails straight across.”

Answer: C

Q24. A client prescribed MAOI therapy asks which foods to avoid. Which choice shows correct understanding?
A. “I will avoid aged cheeses and cured meats.”
B. “I will avoid bananas and citrus fruits.”
C. “I will avoid milk and yogurt.”
D. “I will avoid rice and pasta.”

Answer: A

Q25. A nurse is assessing a 4-month-old infant. Which finding should be reported to the provider?
A. Able to roll from prone to supine
B. Follows objects with eyes
C. Has a head lag when pulled to sitting
D. Laughs aloud

Answer: C

Q26. A client receiving heparin infusion develops blood in the urine. What is the nurse's priority action?
A. Stop the infusion and notify the provider
B. Decrease the infusion rate by half
C. Document the finding and continue infusion
D. Give aspirin for discomfort

Answer: A

Q27. A nurse is preparing to administer packed red blood cells. Which action is correct?
A. Use a 24-gauge IV catheter
B. Hang with 0.9% normal saline using blood tubing
C. Begin infusion within 6 hours of removal from blood bank
D. Infuse each unit over at least 6 hours

Answer: B

Q28. A client with chronic obstructive pulmonary disease is being discharged. Which instruction is priority?
A. "Weigh yourself daily at the same time."
B. "Avoid receiving any vaccines."
C. "Stop walking if you feel short of breath."
D. "Receive an annual influenza vaccine."

Answer: D

Q29. A nurse reviews the medication list of an older adult with osteoarthritis. Which medication should be questioned?
A. Acetaminophen 650 mg every 6 hours as needed
B. Ibuprofen 800 mg three times daily for 3 months
C. Topical diclofenac gel applied to knees
D. Lidocaine patch applied to lower back

Answer: B

Q30. A client with type 1 diabetes becomes confused and diaphoretic. The bedside glucose reading is 48 mg/dL (2.7 mmol/L). Which is the nurse's priority?
A. Notify the provider
B. Administer IV regular insulin
C. Provide 15 g of fast-acting carbohydrate
D. Recheck glucose in 30 minutes without treatment

Answer: C

Q31. A nurse cares for a client with increased intracranial pressure (ICP). Which action should be avoided?
A. Keeping the head midline and elevated 30°
B. Suctioning frequently and vigorously for thick secretions
C. Administering stool softeners as prescribed
D. Minimizing environmental stimuli

Answer: B

Q32. A client with chronic alcohol use disorder is admitted for detoxification. Which finding requires immediate intervention?
A. Tremors and diaphoresis
B. Blood pressure 168/92 mm Hg
C. Visual hallucinations
D. Anxiety and irritability

Answer: C

Q33. A nurse is teaching a client about sublingual nitroglycerin use. Which statement indicates correct understanding?
A. "I can take up to three tablets, five minutes apart, for chest pain."
B. "I will swallow the tablet with water."
C. "If I feel tingling, I should spit the pill out."
D. "I can take this medication to prevent headache."

Answer: A

Q34. A client 1 day postpartum is saturating a perineal pad with bright red blood every 15 minutes and has a boggy uterus. What is the nurse's priority action?

A. Call the rapid response team
B. Massage the uterine fundus firmly
C. Start a second large-bore IV line
D. Obtain a complete blood count

Answer: B

Q35. A nurse is caring for four clients. Which situation requires contact precautions?
A. Influenza
B. Varicella
C. MRSA-infected wound
D. Pulmonary tuberculosis

Answer: C

Q36. A client with heart failure is on sodium restriction. Which meal choice indicates understanding?
A. Ham sandwich with pickles and chips
B. Grilled chicken, brown rice, and steamed vegetables
C. Canned soup and crackers
D. Frozen pizza and soda

Answer: B

Q37. A nurse cares for a client with Parkinson disease who has difficulty initiating movement. Which intervention is best?
A. Encourage the client to walk quickly
B. Use a metronome or rhythm to help start steps
C. Instruct the client to tilt the head back while walking
D. Discourage assistive devices

Answer: B

Q38. A suicidal adolescent is admitted to the psychiatric unit. Which room assignment is most appropriate?
A. Private room at the end of the hall
B. Semi-private room near the nurses' station

C. Room with bathroom door that locks
D. Seclusion room

Answer: B

Q39. A nurse is giving preoperative teaching to a client scheduled for colostomy. The client begins to cry and says, “I don’t want this surgery.” What is the best response?
A. “You’ll get used to the ostomy quickly.”
B. “Why didn’t you say something sooner?”
C. “Tell me what worries you most about the surgery.”
D. “Let’s focus on the positive aspects of your recovery.”

Answer: C

Q40. A client receiving morphine IV for postoperative pain has a respiratory rate of 8/min and is difficult to arouse. What should the nurse do first?
A. Administer naloxone as prescribed
B. Call the provider
C. Increase IV fluid rate
D. Document the findings

Answer: A

Q41. A client taking lithium for bipolar disorder reports severe diarrhea and vomiting. What is the priority action?
A. Encourage oral fluids
B. Hold the dose and notify the provider
C. Administer prescribed antidiarrheal
D. Schedule the next lithium level in 1 week

Answer: B

Q42. A nurse is teaching parents about prevention of sudden infant death syndrome (SIDS). Which statement indicates correct understanding?
A. “We’ll place the baby on the back to sleep.”
B. “We can use soft pillows as long as the baby is on the side.”
C. “We’ll keep the room very warm at night.”
D. “The baby can sleep in our bed for the first few months.”

Answer: A

Q43. The nurse notes that a client with indwelling urinary catheter has cloudy, foul-smelling urine. What is the priority action?
A. Irrigate the catheter with sterile water
B. Send a urine specimen for culture and sensitivity as ordered
C. Remove the catheter immediately
D. Increase client's fluid intake to 3 L/day without consultation

Answer: B

Q44. During a blood transfusion, a client develops chills, fever, and back pain. What is the nurse's first action?
A. Stop the transfusion and keep the IV line open with saline
B. Administer acetaminophen
C. Notify the provider
D. Collect a urine sample

Answer: A

Q45. A nurse is caring for a client receiving vancomycin IV. Which finding requires immediate intervention?
A. Mild flushing of the neck and face
B. Tinnitus and hearing loss
C. Nausea and decreased appetite
D. Increased creatinine from 0.7 to 0.9 mg/dL (62–80 µmol/L)

Answer: B

Q46. A client with cirrhosis has ascites and dyspnea. Which position will best promote comfort and breathing?
A. Supine with legs elevated
B. High Fowler's with legs dependent
C. Prone with head flat
D. Trendelenburg

Answer: B

Q47. A nurse administers 2 units of regular insulin instead of the prescribed 12 units. The client's blood glucose is 210 mg/dL (11.7 mmol/L). What is the nurse's priority action?
A. Notify the provider and monitor blood glucose
B. Give the missing 10 units immediately
C. Complete incident report and do nothing else
D. Inform the client's family

Answer: A

Q48. A client with suspected stroke arrives in the emergency department. Which assessment is priority?
A. Blood pressure and heart rate
B. Time of symptom onset
C. Past medical history
D. Family contact information

Answer: B

Q49. A client on long-term corticosteroid therapy is scheduled for surgery. Which finding is most concerning?
A. Blood glucose 182 mg/dL (10.1 mmol/L)
B. Mild facial rounding
C. Blood pressure 150/88 mm Hg
D. Potassium 3.0 mEq/L (3.0 mmol/L)

Answer: D

Q50. A nurse teaching a client with heart failure about daily weights should include which instruction?
A. "Weigh yourself once a week."
B. "Weigh yourself each morning after voiding, using the same scale."
C. "Weigh yourself at night after dinner."
D. "Weigh yourself before and after exercise."

Answer: B

Q51. A client with newly diagnosed HIV asks how to reduce the risk of transmitting the virus to others. Which response is most important?
A. “Avoid sharing eating utensils.”
B. “Use condoms consistently and correctly with every sexual encounter.”
C. “Avoid hugging or kissing.”
D. “You must isolate yourself from others.”

Answer: B

Q52. A nurse is assessing an older adult for elder abuse. Which finding is most concerning?
A. Occasional forgetfulness
B. Multiple bruises in various stages of healing
C. Decreased appetite
D. Mild hearing loss

Answer: B

Q53. A client with diabetic neuropathy reports burning pain in both feet. Which medication is most appropriate?
A. Ibuprofen
B. Acetaminophen
C. Gabapentin
D. Aspirin

Answer: C

Q54. A nurse teaches a client with heart disease about a low-cholesterol diet. Which food should the client choose?
A. Fried chicken
B. Baked salmon
C. Bacon and eggs
D. Cheeseburger

Answer: B

Q55. A client receiving chemotherapy has a WBC count of 1,200/mm³ (1.2 × 10^9/L). Which instruction is priority?
A. “Avoid raw fruits and vegetables.”

B. “Increase your fluid intake.”
C. “Perform daily weight checks.”
D. “Exercise vigorously each day.”

Answer: A

Q56. A nurse cares for a client with acute pancreatitis. Which assessment finding requires immediate intervention?
A. Severe epigastric pain
B. Grey-blue discoloration around the umbilicus
C. Nausea and vomiting
D. Low-grade fever

Answer: B

Q57. A client with chronic heart failure is prescribed ACE inhibitor therapy. Which adverse effect should the nurse report?
A. Mild fatigue
B. Dry, persistent cough
C. Increased urine output
D. Decreased blood pressure from 150/90 to 130/80

Answer: B

Q58. A nurse caring for a client with dementia notes that the client becomes more confused in the evening. This is best described as:
A. Aphasia
B. Sundowning
C. Delusion
D. Perseveration

Answer: B

Q59. A client with a chest tube for pneumothorax accidentally disconnects the drainage tubing from the collection system. What should the nurse do first?
A. Clamp the chest tube near the client
B. Place the tubing in a container of sterile water

C. Call the provider
D. Apply an occlusive dressing

Answer: B

Q60. A nurse is teaching a client with peptic ulcer disease about omeprazole. Which statement indicates understanding?
A. “This medication will neutralize the acid already in my stomach.”
B. “I should take this medicine with antacids at the same time.”
C. “This medication reduces acid production in my stomach.”
D. “I will stop this medication once I feel better.”

Answer: C

CASE STUDY 1 (6 Questions – Q61–Q66)

This reflects an NGN-style clinical judgment case study: one unfolding scenario with multiple linked items.

Scenario:
Mr. Lopez, a 68-year-old man, is admitted with shortness of breath, orthopnea, and swelling of the ankles. He has a history of hypertension, coronary artery disease, and type 2 diabetes. On admission, he is alert but appears fatigued and anxious.

Vital signs:

- BP 162/94 mm Hg
- HR 112/min, irregular
- RR 26/min
- SpO_2 88% on room air
- Temp 37.2°C (99.0°F)

Lung sounds: bilateral crackles in lower lobes.
Peripheral edema: 3+ in both ankles.
Current medications: furosemide, lisinopril, metoprolol, metformin.

Q61. Which assessment finding is most important for the nurse to report immediately?
A. 3+ edema in both ankles
B. SpO_2 88% on room air with RR 26/min
C. Fatigue and anxiety
D. History of type 2 diabetes

Answer: B

Q62. The provider prescribes 2 L/min oxygen via nasal cannula and IV furosemide. Which nursing action should the nurse take first?
A. Administer IV furosemide
B. Place the client in high Fowler's position and start oxygen
C. Obtain a urine specimen
D. Check the client's blood glucose

Answer: B

Q63. After interventions, Mr. Lopez's lung sounds improve, but his blood pressure is now 92/54 mm Hg, and he reports dizziness when sitting up. Which is the nurse's best action?
A. Continue current plan; this is expected
B. Lower the head of the bed and reassess blood pressure
C. Give an extra dose of metoprolol
D. Encourage the client to ambulate

Answer: B

Q64. Which lab value would be most important for the nurse to monitor in response to the IV furosemide?
A. Serum potassium
B. Hemoglobin
C. Platelets
D. Serum amylase

Answer: A

Q65. Mr. Lopez asks, "Why do I keep getting this fluid in my lungs?" Which response by the nurse best explains the condition?
A. "Your kidneys are not making enough urine."

B. “Your heart is not pumping effectively, causing fluid to back up into your lungs.”
C. “You are drinking too many fluids.”
D. “Your blood pressure medications are causing fluid retention.”

Answer: B

Q66. Which discharge teaching priority will best help prevent readmission for heart failure?
A. “Weigh yourself daily and report a gain of more than 2–3 pounds in a day.”
B. “Increase your sodium intake to keep your blood pressure up.”
C. “Avoid all physical activity.”
D. “Take extra furosemide when you feel short of breath without telling your provider.”

Answer: A

(End of Case Study 1)

Q67. A nurse teaches a client with osteoporosis about alendronate. Which instruction is most important?
A. “Take it at bedtime with a snack.”
B. “Take it in the morning with a full glass of water and remain upright for 30 minutes.”
C. “Take it with orange juice to increase absorption.”
D. “Crush the tablet and mix it with applesauce.”

Answer: B

Q68. A client with a history of IV drug use is admitted with infective endocarditis and a temperature of 39.2°C (102.6°F). Which finding is most concerning?
A. Petechiae on the chest
B. New onset of confusion and difficulty speaking
C. Fatigue and weakness
D. Anorexia

Answer: B

Q69. A nurse is assessing a client in active labor. The fetal heart rate baseline is 150/min with moderate variability, and occasional variable decelerations that return quickly to baseline. What is the nurse’s best action?

A. Prepare for emergency cesarean birth
B. Apply oxygen at 10 L/min via nonrebreather mask
C. Reposition the client and continue to monitor
D. Discontinue oxytocin and call the provider immediately

Answer: C

Q70. A client with generalized anxiety disorder is starting buspirone. Which teaching point is most important?
A. “This medication may cause immediate relief of anxiety.”
B. “Avoid grapefruit juice while taking this medication.”
C. “You may become dependent on this medication.”
D. “Take it only when you feel anxious.”

Answer: B

Q71. A nurse is caring for a client with a newly created arteriovenous fistula for hemodialysis. Which assessment finding requires immediate intervention?
A. Palpable thrill and audible bruit
B. Slight edema around the site
C. Cool, pale hand distal to the fistula
D. Blood pressure 130/78 mm Hg

Answer: C

Q72. A client taking clopidogrel after a stent placement reports black, tarry stools. What is the nurse’s priority action?
A. Reassure the client this is normal
B. Notify the provider immediately
C. Schedule a routine stool test
D. Administer antidiarrheal medication

Answer: B

Q73. A nurse is preparing to administer a unit of blood to a client who is Jehovah’s Witness. The client’s spouse says, “Go ahead and give it; I consent.” What is the nurse’s best action?
A. Administer the blood with spouse’s consent
B. Clarify the client’s wishes regarding blood products

C. Ask the provider to obtain consent from the spouse
D. Contact the ethics committee without involving the client

Answer: B

Q74. A client reports chest pain rated 8/10, pressure-like, radiating to the left arm, and unrelieved by rest. The nurse's first action is to:
A. Obtain a 12-lead ECG
B. Administer sublingual nitroglycerin
C. Check vital signs
D. Notify the provider

Answer: C

Q75. A nurse is teaching a group of older adults about medication safety. Which statement indicates understanding?
A. "I'll store all my medications together in one unlabeled container."
B. "I should bring all my medications to each provider visit."
C. "I can share my medications with my spouse if we have the same symptoms."
D. "I should stop a medication if I feel better after a few days."

Answer: B

Q76. A nurse cares for a client 24 hours after vaginal delivery. Which finding requires immediate intervention?
A. Fundus firm at the level of the umbilicus, midline
B. Lochia rubra with a few small clots
C. Saturation of one perineal pad in 10 minutes with bright red blood
D. Mild cramping controlled with ibuprofen

Answer: C

Q77. A 12-month-old infant is seen in the clinic. Which immunization is appropriate for the nurse to administer?
A. First dose of MMR
B. First dose of HPV
C. First dose of Tdap
D. Second dose of varicella at this visit

Answer: A

Q78. A client with type 1 diabetes presents with fruity breath, Kussmaul respirations, and blood glucose of 520 mg/dL (28.9 mmol/L). Which prescription should the nurse implement first?
A. IV infusion of 0.9% normal saline
B. IV infusion of dextrose 5% in water
C. Subcutaneous long-acting insulin
D. Oral rehydration solution

Answer: A

Q79. A nurse cares for a client on mechanical ventilation. The high-pressure alarm sounds. Which cause should the nurse consider first?
A. Disconnection from the ventilator tubing
B. Client biting on the endotracheal tube
C. Empty humidifier chamber
D. Low oxygen supply in the wall unit

Answer: B

Q80. A client scheduled for surgery says, “I’m not sure I really want this operation.” What is the nurse’s best response?
A. “You already signed the consent, so the surgery must proceed.”
B. “Tell me more about your concerns about the operation.”
C. “You’re just nervous; everything will be fine.”
D. “You should talk to your family instead of the surgeon.”

Answer: B

Q81. A nurse is assessing a toddler with possible lead poisoning. Which question is most important for the nurse to ask the parents?
A. “Does anyone in the home smoke?”
B. “Does your child attend daycare?”
C. “Do you live in a home built before 1978?”
D. “Has your child traveled outside the country?”

Answer: C

Q82. A client is prescribed subcutaneous enoxaparin. Which instruction should the nurse give?
A. “Massage the site after injection.”
B. “Inject into the muscle of the thigh.”
C. “Avoid aspirin and NSAIDs unless approved by your provider.”
D. “Use the same site each time for consistency.”

Answer: C

Q83. A client with COPD is receiving oxygen at 6 L/min via nasal cannula. The nurse notes increasing drowsiness and CO_2 retention. Which action is priority?
A. Decrease oxygen to 2 L/min as prescribed range allows
B. Turn the client to the supine position
C. Encourage coughing and deep breathing with current oxygen level
D. Discontinue oxygen therapy completely

Answer: A

Q84. A nurse cares for a client with suspected appendicitis. Which assessment finding requires immediate notification of the provider?
A. Nausea and anorexia
B. Localized pain at McBurney’s point
C. Sudden relief of pain followed by rigid abdomen
D. Low-grade fever

Answer: C

Q85. A client on long-term phenytoin therapy for seizures is seen in the clinic. Which finding should the nurse report?
A. Gingival overgrowth and bleeding gums
B. Mild drowsiness
C. Occasional dizziness on standing
D. Serum level 12 mcg/mL (48 µmol/L)

Answer: A

Q86. A nurse admits a client with suspected pulmonary embolism. Which prescription should the nurse implement first?
A. Obtain arterial blood gases

B. Start IV heparin infusion
C. Apply oxygen via nonrebreather mask
D. Obtain chest CT angiography

Answer: C

Q87. A client with major depressive disorder is started on an SSRI. Which teaching point is most important?
A. “You can stop taking this medication once you feel better.”
B. “Improvement in mood may take several weeks.”
C. “If you miss a dose, double up the next dose.”
D. “You should avoid all cheese and cured meats.”

Answer: B

Q88. A nurse is caring for a client with acute kidney injury and decreased urine output. Which finding is most concerning?
A. Weight gain of 1 kg (2.2 lb) in 24 hours
B. Serum creatinine increase from 1.0 to 1.4 mg/dL (88–124 µmol/L)
C. Blood pressure 150/88 mm Hg
D. Mild peripheral edema

Answer: A

Q89. A nurse evaluates a client learning to use a metered-dose inhaler. Which action indicates correct use?
A. Inhales quickly and forcefully after activating
B. Exhales immediately after inhaling the medication
C. Shakes the inhaler, exhales fully, then inhales slowly while pressing the canister
D. Does not shake the inhaler before use

Answer: C

Q90. A client with schizophrenia reports hearing voices saying, “You are worthless.” What is the nurse’s best response?
A. “Those voices aren’t real; ignore them.”
B. “I don’t hear the voices, but I understand they are real to you.”

C. “Why are you listening to the voices?”
D. “You must not tell anyone about these voices.”

Answer: B

Q91. A nurse prepares to administer eye drops to a client. Which step is correct?
A. Place drops directly on the cornea
B. Pull the lower eyelid down and place drops into the conjunctival sac
C. Ask the client to blink repeatedly during administration
D. Touch the tip of the bottle to the eyelid for stability

Answer: B

Q92. A client with cirrhosis and ascites is prescribed spironolactone. Which teaching point is most important?
A. “Use a salt substitute high in potassium.”
B. “Avoid foods high in potassium, such as bananas and oranges.”
C. “You may safely drink alcohol in moderation.”
D. “You will not need blood tests while taking this medication.”

Answer: B

Q93. A nurse cares for a client with a stage 3 pressure injury on the sacrum. Which intervention is most appropriate?
A. Cleanse with harsh antiseptic solution
B. Use a moist-to-dry gauze dressing changed every 2 hours
C. Cleanse with normal saline and apply prescribed moisture-retentive dressing
D. Leave the wound open to air

Answer: C

Q94. A pregnant client at 30 weeks’ gestation presents with sudden onset of painless vaginal bleeding. Which condition is most suspected?
A. Placenta previa
B. Placental abruption
C. Preterm labor
D. Uterine rupture

Answer: A

Q95. A nurse is teaching a newly diagnosed HIV-positive client about antiretroviral therapy (ART). Which statement indicates understanding?
A. “I can stop my medications when my CD4 count improves.”
B. “Taking my medications consistently can help control the virus.”
C. “I only need to take these medications when I feel sick.”
D. “I should share my medications with my partner to protect them.”

Answer: B

Q96. A client with a tracheostomy becomes distressed and is coughing vigorously, and the tracheostomy tube is expelled. What should the nurse do first?
A. Call the rapid response team
B. Insert a new sterile tracheostomy tube with obturator
C. Cover the stoma with sterile gauze
D. Provide manual ventilation via mouth-to-mouth

Answer: B

Q97. A nurse is assessing a client 2 hours after receiving spinal anesthesia. Which finding is most concerning?
A. Inability to move toes
B. Severe, throbbing headache when sitting up
C. Decreased sensation at the surgical site
D. Mild nausea

Answer: B

Q98. A client with an NG tube to low intermittent suction complains of nausea. The nurse notes no gastric output for 1 hour. Which action is priority?
A. Irrigate the NG tube with normal saline as prescribed
B. Increase the suction pressure
C. Administer PRN antiemetic
D. Clamp the NG tube for 30 minutes

Answer: A

Q99. A client is prescribed metformin for type 2 diabetes. Which condition would cause the nurse to question this prescription?
A. Hypertension
B. Chronic kidney disease with elevated creatinine
C. Osteoarthritis
D. Hyperlipidemia

Answer: B

Q100. A nurse cares for a client with neutropenia. Which visitor should be restricted?
A. Spouse who had a cold 3 weeks ago
B. Child with runny nose and low-grade fever today
C. Sibling who received influenza vaccine yesterday
D. Neighbor who has no current complaints

Answer: B

CASE STUDY 2 (Q101–Q106)

Unfolding medical-surgical case; 6 linked items.

Scenario:
Ms. Carter, a 52-year-old client, is admitted with acute abdominal pain, fever, and vomiting. She has a history of type 2 diabetes and obesity. On assessment:

- Temp: 38.8°C (101.8°F)
- HR: 110/min
- BP: 100/60 mm Hg
- RR: 24/min
- Pain: 8/10, localized in the right lower quadrant
- Abdomen: rigid with rebound tenderness; bowel sounds hypoactive

Lab results: WBC 18,500/mm³ (18.5×10^9/L).

Q101. Based on the assessment, which condition is most likely?
A. Cholecystitis
B. Appendicitis with possible perforation
C. Peptic ulcer disease
D. Irritable bowel syndrome

Answer: B

Q102. Which prescription should the nurse question for Ms. Carter?
A. NPO status
B. IV isotonic fluids
C. Opioid analgesics as needed
D. Large-volume enema to “clear the bowel”

Answer: D

Q103. Ms. Carter is scheduled for emergency surgery. Which preoperative nursing action is priority?
A. Teach postoperative incentive spirometry
B. Obtain informed consent after sedation is given
C. Ensure the client has an empty bladder
D. Shave the abdominal area with a razor

Answer: C

Q104. Postoperatively, Ms. Carter returns with NG tube to low suction and IV fluids. Which finding requires immediate intervention?
A. Small amount of serosanguineous drainage on dressing
B. Absent bowel sounds in all quadrants
C. SpO_2 90% on 2 L/min O_2, RR 28/min, shallow
D. Pain 6/10 controlled with PCA

Answer: C

Q105. Twelve hours after surgery, Ms. Carter’s NG output is 800 mL of green fluid. Which lab value is the nurse most concerned about?

A. Sodium 140 mEq/L (140 mmol/L)
B. Potassium 3.1 mEq/L (3.1 mmol/L)
C. Hemoglobin 12 g/dL (120 g/L)
D. Glucose 150 mg/dL (8.3 mmol/L)

Answer: B

Q106. Which teaching point will best reduce Ms. Carter's risk of postoperative venous thromboembolism?
A. "Limit fluid intake to reduce swelling."
B. "Perform ankle pumps and ambulate as soon as allowed."
C. "Avoid using compression stockings."
D. "Stay in bed for the first week at home."

Answer: B

(End of Case Study 2)

Q107. A nurse assesses a client with possible opioid withdrawal. Which finding is most consistent with withdrawal, not overdose?
A. Pinpoint pupils and respiratory depression
B. Hypotension and bradycardia
C. Yawning, lacrimation, and muscle aches
D. Extreme somnolence and hyporeflexia

Answer: C

Q108. A client with myasthenia gravis is receiving pyridostigmine. Which statement indicates a need for further teaching?
A. "I will take my medication about 30–60 minutes before meals."
B. "I may have increased salivation and sweating."
C. "If I miss a dose, I will double the next dose."
D. "I should notify my provider if I have increased muscle weakness."

Answer: C

Q109. A nurse is caring for an older adult with delirium. Which intervention is most appropriate?
A. Use physical restraints to prevent wandering
B. Provide frequent reorientation and a well-lit room
C. Keep the room dark and quiet at all times
D. Use complex explanations to stimulate cognition

Answer: B

Q110. A client with hyperthyroidism is scheduled for radioactive iodine therapy. Which instruction is most important?
A. “Avoid pregnancy for several months after treatment.”
B. “Expect immediate relief of symptoms after the dose.”
C. “Take this medication with high-fiber foods.”
D. “Stop all thyroid medications the day after therapy.”

Answer: A

Q111. A client receiving TPN suddenly has the infusion stopped due to pump malfunction. What is the nurse’s priority action?
A. Start 0.9% normal saline at the same rate
B. Hang 10% dextrose in water until TPN is restarted
C. Keep the line open with heparinized saline
D. Turn off the line and leave it clamped

Answer: B

Q112. An adolescent with type 1 diabetes is sick with the flu, has poor appetite, and asks what to do about insulin. Which teaching is most appropriate?
A. “Skip your insulin if you are not eating.”
B. “Continue taking insulin and check blood glucose more frequently.”
C. “Double your insulin dose to prevent high glucose from stress.”
D. “Only take long-acting insulin during illness.”

Answer: B

Q113. A nurse observes a new mother with postpartum blues. Which statement requires further evaluation for possible postpartum depression?
A. “I cry easily but feel better when my partner helps.”

B. “I sometimes wonder if my baby and family would be better off without me.”
C. “I feel overwhelmed but love my baby.”
D. “My sleep is interrupted, but I can nap when the baby sleeps.”

Answer: B

Q114. A client with peripheral arterial disease (PAD) reports pain in the calves when walking that is relieved by rest. This symptom is known as:
A. Rest pain
B. Claudication
C. Neuropathic pain
D. Referred pain

Answer: B

Q115. A nurse is teaching a client about using crutches. Which action indicates correct use of the three-point gait?
A. Bear full weight on both legs when moving crutches forward
B. Move both crutches and the affected leg forward together, then move the unaffected leg
C. Place weight on the axilla to support body weight
D. Keep crutches 2–3 inches directly in front of the feet

Answer: B

Q116. A client receiving chemotherapy reports mouth sores and difficulty eating. Which intervention is most appropriate?
A. Provide spicy foods to stimulate appetite
B. Encourage alcohol-based mouthwash after meals
C. Offer soft, bland foods and saline mouth rinses
D. Recommend brushing teeth with a stiff toothbrush

Answer: C

Q117. A nurse is reviewing lab results for a client on warfarin therapy. Which INR value indicates therapeutic anticoagulation for atrial fibrillation?
A. 0.9
B. 1.5

C. 2.5
D. 5.0

Answer: C

Q118. A client with COPD receives teaching on pursed-lip breathing. Which outcome shows the technique is effective?
A. Increased respiratory rate
B. Decreased dyspnea and improved exhalation
C. Increased use of accessory muscles
D. Decreased tidal volume

Answer: B

Q119. A nurse is caring for a client with a chest tube. The water seal chamber shows continuous bubbling. What is the most likely cause?
A. Normal function
B. Air leak in the system
C. Need for immediate removal of chest tube
D. Imminent cardiac tamponade

Answer: B

Q120. A client with Alzheimer disease becomes agitated during evening care. What is the nurse's best intervention?
A. Insist on completing all care tasks quickly
B. Use calm, simple explanations and allow breaks during care
C. Restrain the client to ensure safety
D. Turn off all lights and leave the client alone

Answer: B

CASE STUDY 3 (Q121–Q126)

Pediatric / acute care case; 6 linked items.

Scenario:
Ethan, a 4-year-old child, is brought to the emergency department with a 2-day history of fever, sore throat, and difficulty swallowing. On assessment:

- Temp: 39.4°C (103°F)
- HR: 130/min
- RR: 28/min
- SpO_2: 94% on room air
- Child is sitting up, leaning forward, drooling, and refusing to lie down.

The parents report Ethan has not received any vaccinations since birth.

Q121. Which condition is the nurse most concerned about?
A. Viral pharyngitis
B. Epiglottitis
C. Otitis media
D. Croup (laryngotracheobronchitis)

Answer: B

Q122. Which action is priority for Ethan?
A. Obtain a throat culture using a swab
B. Attempt to visualize the throat with a tongue depressor
C. Keep the child calm and avoid invasive procedures until airway equipment is available
D. Force the child to lie supine for a full assessment

Answer: C

Q123. Which collaborative intervention does the nurse anticipate for Ethan?
A. Immediate IM epinephrine for anaphylaxis
B. Preparation for possible emergent intubation
C. IV thrombolytics
D. Oral antibiotics at home

Answer: B

Q124. Ethan's parent asks why he suddenly got so sick. Which explanation is best?
A. "This condition is most likely due to a food allergy."
B. "The tissue at the back of his throat is inflamed and can quickly block his airway."
C. "He has a chronic disease that will recur frequently."
D. "His airway is blocked because he swallowed a foreign object."

Answer: B

Q125. Which is the priority nursing outcome for Ethan during initial treatment?
A. Normal white blood cell count
B. Resolution of sore throat
C. Patent airway with adequate oxygenation
D. Afebrile temperature

Answer: C

Q126. Before discharge, which teaching point is most important for Ethan's parents?
A. "Give over-the-counter cough medicine for future sore throats."
B. "Avoid all antibiotics unless prescribed for life-threatening illness."
C. "Discuss an up-to-date immunization plan with the pediatrician."
D. "Use home remedies instead of bringing him to the hospital."

Answer: C

(End of Case Study 3)

Q127. A client with gout is prescribed allopurinol. Which teaching is most important?
A. "You can stop the medication when the pain is gone."
B. "Take the medication with a large dose of vitamin C."
C. "Increase your fluid intake to at least 2–3 liters per day."
D. "Eat more organ meats for protein."

Answer: C

Q128. A nurse cares for a client with suspected meningitis. Which action is priority?
A. Place the client on droplet precautions
B. Start a high-protein diet
C. Encourage frequent visitors
D. Delay antibiotics until lumbar puncture results return

Answer: A

Q129. A client with COPD is receiving instructions on energy conservation. Which statement indicates understanding?
A. “I will rush through my morning routine to get it over with.”
B. “I will sit while performing activities such as bathing.”
C. “I will avoid resting and stay active all day.”
D. “I should hold my breath when lifting objects.”

Answer: B

Q130. A client with chronic heart failure is prescribed a fluid restriction of 1.5 L/day. Which statement shows correct understanding?
A. “I will not count soup or ice cream as fluids.”
B. “I will drink most of my fluids in the evening.”
C. “I can use small cups to help track the amount I drink.”
D. “The restriction does not include coffee or tea.”

Answer: C

Q131. A nurse notes that a client receiving IV vancomycin has redness, warmth, and tenderness along the vein. What is the priority action?
A. Slow the infusion rate
B. Stop the infusion and remove the IV catheter
C. Apply cold compresses and continue infusion
D. Elevate the limb and document findings only

Answer: B

Q132. A client with suspected tuberculosis (TB) asks how TB is transmitted. Which response is most accurate?
A. “TB spreads through contact with contaminated surfaces.”

B. “TB spreads through airborne droplets when an infected person coughs or sneezes.”
C. “TB is only transmitted through sexual contact.”
D. “TB spreads only through blood exposure.”

Answer: B

Q133. A nurse is preparing to administer insulin glargine and regular insulin. Which action is correct?
A. Draw both insulins into the same syringe
B. Give glargine and regular insulin in separate syringes
C. Mix glargine with NPH but not regular
D. Hold glargine if regular insulin is given

Answer: B

Q134. A client receiving an IV infusion of potassium chloride complains of burning at the IV site. What is the nurse’s first action?
A. Stop the infusion and assess the site
B. Increase the infusion rate to complete it faster
C. Flush the site with heparin
D. Reassure the client that burning is normal and continue

Answer: A

Q135. A client with bipolar disorder in the manic phase refuses to eat. Which intervention is most appropriate?
A. Offer high-calorie finger foods and drinks that can be eaten while moving
B. Insist the client sit at the table for three full meals daily
C. Remove the client from group activities until eating improves
D. Schedule family members to bring in meals

Answer: A

Q136. A nurse assessing an older adult notes a new onset of confusion, restlessness, and decreased urine output. Which finding should the nurse investigate first?
A. Recent medication changes
B. Evidence of urinary retention or infection

C. Sleep disturbances
D. Social isolation

Answer: B

Q137. A client is prescribed a transdermal fentanyl patch for chronic pain. Which teaching is most important?
A. “You may apply heat over the patch to increase absorption.”
B. “Dispose of used patches by flushing them down the toilet.”
C. “Do not cut the patch and keep it away from children.”
D. “Change the patch every day regardless of pain level.”

Answer: C

Q138. A nurse cares for a client with left-sided stroke. Which nursing action is a priority for promoting safe mobility?
A. Place the call bell on the affected side
B. Stand on the client’s affected side when ambulating
C. Avoid using gait belts
D. Encourage the client to walk alone as soon as possible

Answer: B

Q139. A client with insomnia is receiving nonpharmacologic sleep hygiene teaching. Which statement indicates understanding?
A. “I will drink coffee only in the evening.”
B. “I will use my bedroom only for sleep and intimacy.”
C. “I will nap frequently during the day.”
D. “I will watch television in bed until I fall asleep.”

Answer: B

Q140. A nurse is assessing a pregnant client at 38 weeks’ gestation who reports a sudden gush of fluid from the vagina. Which question is most important to ask first?
A. “What color was the fluid?”
B. “Have you felt the baby move?”
C. “Did you eat recently?”
D. “Do you have a headache?”

Answer: A

Q141. A client with chronic liver disease is at risk for hepatic encephalopathy. Which dietary change is most helpful in preventing this complication?
A. High-protein diet
B. High-sodium diet
C. Moderate protein, increased carbohydrates, reduced animal protein as prescribed
D. High-fat diet

Answer: C

Q142. A nurse is preparing to insert a urinary catheter into a female client. Which action is most important to maintain sterility?
A. Place the catheter kit on the client's bed without a barrier
B. Clean the perineal area from front to back
C. Inflate the balloon before insertion
D. Use nonsterile gloves when handling the catheter

Answer: B

Q143. A client taking isoniazid (INH) for tuberculosis reports numbness and tingling in the hands and feet. What is the nurse's best action?
A. Reassure the client this is a normal side effect
B. Suggest reducing the dose without consulting the provider
C. Report possible peripheral neuropathy; anticipate vitamin B_6 supplementation
D. Advise the client to stop the medication abruptly

Answer: C

Q144. A nurse is caring for a client with nasogastric tube feeding who is at risk for aspiration. Which action best reduces this risk?
A. Elevate the head of the bed to at least 30–45° during and after feeding
B. Clamp the tube after feeding and place the client supine
C. Instill all formula as a single bolus
D. Turn off residual checks

Answer: A

Q145. A client presents to the emergency department after a sexual assault. Which nursing action is priority?
A. Ask detailed questions about the assault in a crowded triage area
B. Encourage the client to shower before the exam
C. Provide a safe, private environment and assess for physical injuries
D. Delay care until law enforcement arrives

Answer: C

Q146. A nurse caring for four clients must respond to which call light first?
A. Client with COPD requesting help to the bathroom
B. Postoperative client reporting incision pain rated 8/10
C. Client with diabetes reporting feeling “shaky and sweaty”
D. Client asking what time dinner will be served

Answer: C

Q147. A client with an implanted pacemaker reports dizziness and near-syncope. Which assessment is priority?
A. Check the apical pulse and compare with the pacemaker setting
B. Ask about recent exercise
C. Determine last bowel movement
D. Assess for ankle swelling

Answer: A

Q148. A nurse teaching a client about colonoscopy preparation explains the purpose of the bowel prep. Which statement indicates understanding?
A. “The bowel prep will help prevent dehydration.”
B. “The bowel prep cleans out my colon so the doctor can see clearly.”
C. “The bowel prep is to test my kidneys.”
D. “The bowel prep will prevent me from having constipation later.”

Answer: B

Q149. A client in the emergency department reports sudden severe chest pain and dyspnea. The nurse notes tracheal deviation to the left and absent breath sounds on the right. Which condition is most likely?

A. Pulmonary embolism
B. Tension pneumothorax
C. Myocardial infarction
D. Pleural effusion

Answer: B

Q150. A nurse is counseling a client who states, “I feel overwhelmed caring for my spouse who has advanced dementia.” What is the nurse’s best response?

A. “You should not feel that way; at least your spouse is still here.”
B. “Let’s talk about support services and respite care that may help you.”
C. “You need to be stronger for your spouse.”
D. “Try not to think about it so much.”

Answer: B

NCLEX-RN Practice Questions Set-2

Q1. A nurse is reviewing morning lab results. Which client should the nurse assess first?
A. Client on warfarin with INR 2.4
B. Client with pneumonia with WBC 14,000/mm³ (14 × 10⁹/L)
C. Client with chest pain and troponin newly elevated above reference range
D. Client with chronic kidney disease with creatinine 2.0 mg/dL (177 µmol/L)

Answer: C

Q2. A client with heart failure is prescribed furosemide. Which assessment best evaluates the medication's effectiveness?
A. Daily weight
B. Appetite
C. Bowel sounds
D. Pupillary response

Answer: A

Q3. A nurse teaches a client with newly diagnosed hypertension about lifestyle changes. Which statement indicates effective learning?
A. "I will limit my alcohol intake to one drink per day."
B. "I will stop taking medication when my blood pressure is normal."
C. "I will avoid exercise to keep my heart from working too hard."
D. "I will use salt substitutes high in potassium without asking my provider."

Answer: A

Q4. A client with chronic kidney disease reports persistent nausea and a metallic taste. Which lab result is most likely elevated?
A. Hemoglobin
B. Blood urea nitrogen (BUN)
C. Serum calcium
D. Serum glucose

Answer: B

Q5. A nurse is providing preoperative teaching to a client who will receive a spinal anesthetic. Which statement requires further teaching?
A. “I might feel numbness in my legs after surgery.”
B. “I should call if I have a severe headache when I sit up.”
C. “I will be completely asleep during the procedure.”
D. “I may need help turning in bed at first.”

Answer: C

Q6. A client with asthma is prescribed fluticasone inhaler. Which instruction is most important?
A. “Use this medication to relieve sudden wheezing.”
B. “Rinse your mouth after each use to prevent infection.”
C. “Use the inhaler only on days when you feel symptoms.”
D. “Take this medication before using your rescue inhaler.”

Answer: B

Q7. A nurse cares for a client with a nasogastric tube for continuous feeding. The client’s respirations suddenly increase and oxygen saturation falls. What is the priority action?
A. Increase the feeding rate
B. Check residual volume
C. Stop the feeding and assess lung sounds
D. Flush the tube with additional water

Answer: C

Q8. A client taking lisinopril reports a new dry, hacking cough. Which is the nurse’s best response?
A. “This is expected; no action is needed.”
B. “Stop the medication immediately on your own.”
C. “Contact your provider; a different medication may be needed.”
D. “Take an over-the-counter cough suppressant daily.”

Answer: C

Q9. A nurse in a long-term care facility observes a UAP moving a client from bed to chair without using a gait belt. The client is unsteady. What is the nurse’s first action?
A. Report the UAP to the administrator

B. Immediately intervene to assist and ensure the client's safety
C. Document the incident without intervening
D. Ignore the situation unless the client falls

Answer: B

Q10. A client receiving IV morphine postoperatively states, "My pain is still an 8 out of 10." The nurse's priority action is to:
A. Tell the client pain is expected after surgery
B. Assess the client's vital signs and surgical site
C. Refuse additional medication due to risk of addiction
D. Ask the client to wait until the next scheduled dose

Answer: B

Q11. A nurse is assessing a newborn 1 hour after birth. Which finding requires immediate intervention?
A. Acrocyanosis of hands and feet
B. Respiratory rate 64/min with nasal flaring and grunting
C. Irregular respirations
D. Heart rate 140/min

Answer: B

Q12. A client with rheumatoid arthritis is prescribed methotrexate. Which teaching point is most important?
A. "Avoid pregnancy while taking this medication."
B. "Limit fluid intake to prevent swelling."
C. "Take an extra dose when pain is severe."
D. "Stop all vaccinations while on this medication."

Answer: A

Q13. A client with a history of alcohol use disorder is admitted with confusion and ataxia. Which vitamin deficiency is most likely?
A. Vitamin A
B. Vitamin B_1 (thiamine)

C. Vitamin C
D. Vitamin D

Answer: B

Q14. A nurse teaches testicular self-examination to a 20-year-old client. Which statement indicates understanding?
A. “I should examine my testicles once a year.”
B. “I will perform the exam monthly in a warm shower.”
C. “Pain is normal when I feel my testicles.”
D. “I should not be concerned about any lumps.”

Answer: B

Q15. A nurse is preparing to administer an intramuscular injection in the ventrogluteal site to an adult. Which land-marking technique is correct?
A. Use the deltoid muscle
B. Place the heel of the hand on the greater trochanter and point thumb toward the groin
C. Locate the vastus lateralis by dividing the thigh into thirds
D. Inject into the dorsogluteal upper outer quadrant

Answer: B

Q16. A client with a history of angina reports chest discomfort while walking. After resting, pain resolves in 5 minutes. Which type of angina is this?
A. Unstable angina
B. Variant (Prinzmetal) angina
C. Stable exertional angina
D. Silent ischemia

Answer: C

Q17. A nurse is evaluating teaching about seizure precautions. Which client statement requires further instruction?
A. “I will avoid swimming alone.”
B. “I can still drive as long as I feel fine.”
C. “I will wear a medical alert bracelet.”
D. “My family knows not to put anything in my mouth during a seizure.”

Answer: B

Q18. A client with chronic anemia reports fatigue. Which diet selection best supports improved hemoglobin?
A. Toast with jam and coffee
B. Scrambled eggs, spinach, and orange juice
C. Yogurt with fruit
D. White rice and boiled chicken

Answer: B

Q19. A client with type 2 diabetes takes glyburide. Which finding is most concerning?
A. Fasting glucose 130 mg/dL (7.2 mmol/L)
B. Mild weight gain
C. Episodes of shakiness and sweating between meals
D. Hemoglobin A1c 6.8%

Answer: C

Q20. A client is prescribed nitroglycerin patch for chronic angina. Which instruction is most important?
A. “Apply the patch to the same site daily.”
B. “If a headache occurs, remove the patch permanently.”
C. “Remove the patch at night for 10–12 hours as directed.”
D. “Cut the patch if you feel dizzy.”

Answer: C

Q21. A nurse evaluates a 10-month-old infant’s development. Which finding requires further evaluation?
A. Pulls to stand
B. Crawls on hands and knees
C. Says “mama” and “dada” nonspecifically
D. Has not yet begun to sit without support

Answer: D

Q22. A client taking sertraline reports new-onset insomnia and decreased libido. Which is the best response by the nurse?
A. “These side effects may occur; talk to your provider about possible adjustments.”
B. “Stop the medication for a week to see if symptoms improve.”
C. “Double your dose to get better symptom control.”
D. “These side effects mean the medication is not working at all.”

Answer: A

Q23. A nurse is caring for a client on contact precautions. Which action is most important to prevent pathogen spread?
A. Wearing a surgical mask
B. Using a dedicated blood pressure cuff in the room
C. Keeping the door closed at all times
D. Limiting visitors to family only

Answer: B

Q24. A client is receiving a unit of packed red blood cells. Fifteen minutes after starting the transfusion, the client reports itching and hives. What is the nurse’s first action?
A. Slow the transfusion and give acetaminophen
B. Stop the transfusion and maintain IV access with normal saline
C. Administer diphenhydramine and continue transfusion
D. Document and finish transfusion quickly

Answer: B

Q25. A nurse performs a safety assessment in the home of an older adult using a walker. Which finding requires intervention?
A. Grab bars installed in the bathroom
B. Bright lighting in hallways
C. Scatter rugs on hardwood floors
D. Shoes with nonskid soles

Answer: C

Q26. A postpartum client who is breastfeeding asks about contraception. Which method is most appropriate?

A. Estrogen-containing combined oral contraceptive
B. Progestin-only pill as prescribed
C. No contraception; breastfeeding prevents pregnancy
D. Doubling prenatal vitamins

Answer: B

Q27. A nurse caring for a client with schizophrenia hears the client say, “The television is sending me messages.” What is the best response?
A. “The television can’t send messages; that isn’t real.”
B. “What kind of messages do you think you are receiving?”
C. “Ignore the television and focus on something else.”
D. “You shouldn’t talk about that with anyone.”

Answer: B

Q28. A client is admitted with suspected stroke. Which diagnostic test should the nurse anticipate as priority?
A. MRI with contrast
B. Non-contrast CT scan of the head
C. EEG
D. Carotid ultrasound

Answer: B

Q29. A school nurse is teaching adolescents about vaping. Which statement by a student shows correct understanding?
A. “Vaping is safer than cigarettes because there is no nicotine.”
B. “Vaping can still damage lungs and may contain nicotine.”
C. “Vaping is safe if done only on weekends.”
D. “Vaping only causes bad breath but no serious problems.”

Answer: B

Q30. A client with heart failure is prescribed digoxin. Which assessment finding suggests digoxin toxicity?
A. Heart rate 84/min
B. Nausea and blurred yellow vision

C. Increased urine output
D. Improved appetite

Answer: B

Q31. A nurse is teaching a client about home oxygen use. Which statement indicates a need for further teaching?
A. “I will keep the oxygen tank away from heat sources.”
B. “I will not use petroleum jelly near my nose while using oxygen.”
C. “I can smoke as long as the oxygen is turned off.”
D. “I will secure the tanks in an upright position.”

Answer: C

Q32. A client with newly diagnosed HIV is anxious about disclosure at work. What is the nurse’s best response?
A. “You are legally required to tell your employer.”
B. “Let’s talk about your concerns and discuss your rights to privacy.”
C. “You should not be working with other people now.”
D. “You must notify all coworkers individually.”

Answer: B

Q33. A nurse prepares to administer 0.5 mL of a vaccine intramuscularly to a healthy 3-year-old. Which site is most appropriate?
A. Deltoid muscle
B. Dorsogluteal muscle
C. Vastus lateralis
D. Abdomen

Answer: A

Q34. A client with cirrhosis and ascites is scheduled for paracentesis. Which preprocedure action is a priority?
A. Ensure the client has an empty bladder
B. Start NPO status for 12 hours
C. Administer diuretics immediately before procedure
D. Place the client in Trendelenburg position

Answer: A

Q35. The nurse is assessing a client after thyroidectomy. Which finding requires immediate intervention?
A. Hoarseness when speaking
B. Difficulty swallowing and high-pitched stridor
C. Mild neck discomfort at the incision
D. Heart rate 96/min

Answer: B

Q36. A nurse is teaching parents about injury prevention for their 2-year-old child. Which statement indicates correct understanding?
A. “We will use a forward-facing car seat in the back seat.”
B. “We should store cleaning supplies in a locked cabinet.”
C. “We can leave our toddler alone in the bathtub for a few minutes.”
D. “We will give adult-strength medications in smaller doses.”

Answer: B

Q37. A client with COPD is receiving nebulized bronchodilator treatments. Which finding indicates the treatment is effective?
A. Increased wheezing
B. Decreased anxiety and improved air entry
C. Respiratory rate increases from 20/min to 30/min
D. Oxygen saturation decreases from 93% to 88%

Answer: B

Q38. A client in the emergency department states, “I have taken 30 tablets of acetaminophen in the last 4 hours.” What is the nurse’s priority action?
A. Obtain a serum acetaminophen level and anticipate N-acetylcysteine
B. Give aspirin to counteract effects
C. Encourage oral fluids
D. Wait 24 hours and recheck labs

Answer: A

Q39. A nurse teaches a client with GERD about lifestyle changes. Which statement indicates understanding?
A. “I will lie flat after meals to help digestion.”
B. “I will avoid large, high-fat meals close to bedtime.”
C. “I should drink peppermint tea to soothe my stomach.”
D. “I’ll wear tight belts to support my abdomen.”

Answer: B

Q40. A client with depression has not attended group therapy for 3 days and remains in bed. What is the nurse’s best initial intervention?
A. State, “You must go to group or you can’t stay here.”
B. Sit quietly with the client and offer simple activities
C. Ignore the behavior to avoid reinforcing it
D. Immediately discharge the client for noncompliance

Answer: B

CASE STUDY 1 – Diabetic Ketoacidosis (Q41–Q46)

Scenario:
Jordan, a 17-year-old with type 1 diabetes, is brought to the emergency department with abdominal pain, nausea, and increased urination. He has missed several insulin doses.

Assessment:

- Temp: 37.6°C (99.7°F)
- HR: 120/min
- RR: 30/min, deep and rapid
- BP: 98/60 mm Hg
- Breath has fruity odor
- Capillary glucose: “HI” on meter (>400 mg/dL / >22.2 mmol/L)

Q41. Which manifestation indicates Jordan is likely in diabetic ketoacidosis (DKA)?
A. Bradycardia and shallow respirations
B. Fruity breath and Kussmaul respirations
C. Peripheral edema and weight gain
D. Hypotension with bradypnea

Answer: B

Q42. Which provider prescription should the nurse implement first?
A. Start IV insulin infusion
B. Administer 0.9% normal saline bolus
C. Begin potassium replacement
D. Obtain urine ketone sample

Answer: B

Q43. Jordan's potassium level is 5.5 mEq/L (5.5 mmol/L) on admission. What is the best nursing action?
A. Hold potassium replacement initially but monitor closely
B. Administer potassium chloride immediately
C. Restrict all potassium in IV fluids and diet permanently
D. Ignore the value; it is within reference range

Answer: A

Q44. As treatment progresses, Jordan's blood glucose is 230 mg/dL (12.8 mmol/L), and IV insulin is continuing. Which fluid change does the nurse anticipate?
A. Change to dextrose-containing IV solution
B. Change to pure water IV infusion
C. Stop IV fluids entirely
D. Switch to hypertonic saline

Answer: A

Q45. Which nursing assessment best evaluates Jordan's response to fluid resuscitation?
A. Daily weight once at discharge

B. Serial blood pressures and heart rates
C. Number of insulin units given
D. Pain rating scale

Answer: B

Q46. Which discharge teaching is most important to help prevent future DKA episodes?
A. “Skip insulin if you do not feel like eating.”
B. “Double your insulin dose when exercising.”
C. “Check blood glucose more frequently when you are ill and never omit insulin without guidance.”
D. “Stop all sugary drinks only when glucose is normal.”

Answer: C

Q47. A nurse is assessing a client with suspected deep vein thrombosis (DVT) in the right leg. Which finding supports this diagnosis?
A. Cool, pale right leg
B. Bilateral leg swelling
C. Warmth, redness, and tenderness in right calf
D. Decreased hair growth on both legs

Answer: C

Q48. A pregnant client at 10 weeks’ gestation experiences morning sickness. Which intervention is appropriate?
A. Eat a large breakfast with high fat
B. Take prenatal vitamins on an empty stomach
C. Eat dry crackers before getting out of bed
D. Drink a large glass of water before sleep

Answer: C

Q49. A client with chronic heart failure is prescribed a 2-gram sodium diet. Which food selection is appropriate?
A. Canned soup and salted crackers

B. Fresh grilled fish with steamed vegetables
C. Fast-food burger and fries
D. Ham sandwich with pickles

Answer: B

Q50. A nurse is preparing to administer 3 units of packed red blood cells to a client with severe anemia. Which action is essential before starting the first unit?
A. Verify client identification and blood product with another licensed nurse
B. Obtain consent after starting the transfusion
C. Run blood with 5% dextrose
D. Use standard peripheral IV tubing without a filter

Answer: A

Q51. While receiving IV vancomycin, a client develops flushing of the neck and upper chest, with mild hypotension. This is most consistent with:
A. Anaphylactic reaction
B. Red man syndrome from rapid infusion
C. Fluid overload
D. Local phlebitis

Answer: B

Q52. A nurse cares for a client with nephrotic syndrome. Which assessment finding is expected?
A. Severe proteinuria and edema
B. Polycythemia
C. Hyperglycemia
D. Increased urine output

Answer: A

Q53. A client prescribed haloperidol becomes rigid, febrile, and confused. What is the priority action?
A. Give PRN lorazepam
B. Suspect neuroleptic malignant syndrome and notify provider urgently

C. Increase the haloperidol dose
D. Provide warm blankets and continue medication

Answer: B

Q54. A nurse is planning care for a client with Parkinson disease. Which goal is priority?
A. Maintain head of bed flat at all times
B. Promote safe mobility and prevent falls
C. Restrict all fluid intake
D. Encourage long periods of immobility

Answer: B

Q55. A client in labor is receiving oxytocin infusion. The nurse observes contractions every 1 minute, lasting 90 seconds, with late decelerations. What is the priority action?
A. Increase oxytocin rate
B. Discontinue oxytocin infusion
C. Encourage the client to bear down
D. Place the client supine

Answer: B

Q56. A client with chronic obstructive pulmonary disease is prescribed tiotropium via inhaler. Which instruction is correct?
A. “Use this medication for quick relief during an acute attack.”
B. “This is a long-acting medication; use it every day as prescribed.”
C. “Take this medication only if wheezing becomes severe.”
D. “Use it immediately before albuterol every time.”

Answer: B

Q57. A nurse assesses a client 3 hours after right total hip replacement. Which finding requires immediate intervention?
A. Pain level 7/10 at surgical site
B. Right leg externally rotated and shortened
C. Serosanguineous drainage on dressing
D. Mild temperature elevation

Answer: B

Q58. A client with myasthenia gravis is scheduled to receive pyridostigmine at 0800. Breakfast is served at 0830. What is the best nursing action?
A. Give the medication at 0730
B. Give the medication at 0800
C. Hold the medication until after breakfast
D. Give the medication at noon

Answer: B

Q59. A nurse is teaching about home care for a child with celiac disease. Which food is appropriate?
A. Wheat toast
B. Barley soup
C. Rice noodles
D. Malted cereal

Answer: C

Q60. A client is prescribed isosorbide mononitrate for chronic angina. Which side effect is most common?
A. Constipation
B. Headache
C. Bradycardia
D. Hyperglycemia

Answer: B

Q61. A client with chronic schizophrenia takes clozapine. Which assessment finding is most concerning?
A. Weight gain of 2 kg (4.4 lb)
B. Sore throat and fever
C. Increased appetite
D. Mild sedation

Answer: B

Q62. A client in the emergency department has partial-thickness burns on both arms after a kitchen fire. What is the priority nursing action?
A. Apply ice directly to the burns
B. Cover the burns with clean, dry cloth
C. Break blisters to relieve pressure
D. Apply butter to soothe pain

Answer: B

Q63. A nurse caring for a client with heart failure notes a new S3 heart sound. This finding suggests:
A. Normal age-related change
B. Volume overload and decreased ventricular compliance
C. Valvular stenosis
D. Pericardial friction rub

Answer: B

Q64. A client is prescribed levothyroxine for hypothyroidism. Which teaching is correct?
A. “Take this medication with food for better absorption.”
B. “You will feel effects fully within 2–3 days.”
C. “Take the medication in the morning on an empty stomach.”
D. “Stop the medication once symptoms improve.”

Answer: C

Q65. A nurse assesses a 3-year-old with suspected epiglottitis. Which action is contraindicated?
A. Keeping the child calm
B. Providing humidified oxygen
C. Attempting to visualize the throat with a tongue depressor
D. Having emergency airway equipment ready

Answer: C

Q66. A client with chronic liver disease has a serum ammonia level above reference range and shows confusion. Which medication does the nurse anticipate?

A. Furosemide
B. Lactulose
C. Warfarin
D. Omeprazole

Answer: B

Q67. A client who is Muslim is scheduled for surgery during Ramadan and is fasting. What is the nurse's best action?
A. Insist the client break the fast for safety
B. Notify the provider and explore options with the client respecting religious practices
C. Cancel the surgery without discussion
D. Ignore the fasting and proceed as usual

Answer: B

Q68. A nurse in the emergency department cares for a victim of a motor vehicle collision with noisy breathing and facial trauma. What is the priority?
A. Obtain vital signs
B. Stabilize the cervical spine and airway
C. Insert a nasogastric tube
D. Assess for extremity fractures

Answer: B

Q69. A client with a history of peptic ulcer disease reports sudden severe abdominal pain and rigid abdomen. What is the nurse's priority action?
A. Give prescribed antacid
B. Place the client in high Fowler's position
C. Notify the provider of suspected perforation
D. Encourage oral fluids

Answer: C

Q70. A nurse educates a client about using an incentive spirometer postoperatively. Which statement indicates correct understanding?
A. "I will exhale quickly into the device."
B. "I should use it every hour while awake."

C. “I should only use it if I feel short of breath.”
D. “I will lie flat when using it.”

Answer: B

Q71. A nurse is assessing a client 4 hours after a cast was applied to the left leg. Which finding requires immediate intervention?
A. Mild swelling around the cast
B. Inability to move toes and increasing pain unrelieved by analgesics
C. Warm toes with brisk capillary refill
D. Slight tingling that is improving

Answer: B

Q72. A client with chronic kidney disease has an order to restrict dietary phosphorus. Which food should be limited?
A. Apple slices
B. Chicken breast
C. Cola soft drinks
D. White rice

Answer: C

Q73. A nurse cares for an anxious client before surgery. Which statement demonstrates use of therapeutic communication?
A. “There’s nothing to worry about; you’ll be fine.”
B. “Tell me what concerns you most about the surgery.”
C. “You should calm down before we proceed.”
D. “Try not to think about it.”

Answer: B

Q74. A client with tuberculosis asks how long they will need to take medications. The best response is:
A. “Until your symptoms disappear.”
B. “Until one month after your sputum is negative.”
C. “Typically for 6–9 months, as prescribed.”
D. “Only while you’re in the hospital.”

Answer: C

Q75. A client is prescribed a heparin infusion. The nurse should monitor which laboratory value to evaluate therapeutic effect?
A. PT/INR
B. aPTT
C. Hematocrit
D. Platelets

Answer: B

CASE STUDY 2 – Postpartum Complication (Q81–Q86)

Scenario:
Maria, a 27-year-old G1P1, delivered vaginally 2 hours ago. She suddenly reports feeling "dizzy and weak."

Assessment:

- BP: 80/50 mm Hg
- HR: 130/min
- RR: 22/min
- Fundus: boggy, above umbilicus and deviated to the right
- Perineal pad: saturated with bright red blood and large clots

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Q81. What is the nurse's priority action?
A. Assess the newborn
B. Call the provider and wait for instructions
C. Massage the uterine fundus and assess for bladder distention
D. Start a broad-spectrum antibiotic

Answer: C

Q82. After fundal massage, the uterus firms but remains high and deviated to the right. What is the best nursing action?
A. Insert an indwelling urinary catheter
B. Apply ice to the perineum
C. Give a stool softener
D. Discontinue IV fluids

Answer: A

Q83. The provider orders oxytocin infusion. Which assessment best evaluates oxytocin's effectiveness?
A. Decreased fundal height and firmness
B. Reduced lochia and firm, midline uterus
C. Increased bowel sounds
D. Increased urine output only

Answer: B

Q84. Which vital sign trend suggests Maria's condition is improving?
A. BP 76/40, HR 142/min
B. BP 90/60, HR 98/min
C. BP 82/48, HR 128/min
D. BP 88/54, HR 136/min

Answer: B

Q85. Maria asks, "Why did this bleeding happen?" Which explanation is best?
A. "You have an infection causing bleeding."
B. "Your uterus did not contract well after delivery, causing heavy bleeding."
C. "You pushed too long during labor."
D. "You were given too much IV fluid."

Answer: B

Q86. Which discharge teaching is most important for Maria regarding postpartum hemorrhage risk in the future?
A. "You cannot have more children."
B. "Always have a cesarean section."

C. “Inform future providers that you had postpartum hemorrhage.”
D. “Avoid breastfeeding with future pregnancies.”

Answer: C

Q87. A client with a history of depression is started on bupropion SR. Which teaching point is most important?
A. “Take this medication at bedtime only.”
B. “Swallow the pill whole; do not crush or chew.”
C. “Expect significant weight gain.”
D. “Stop the medication if you feel more energetic.”

Answer: B

Q88. A client with chronic atrial fibrillation is prescribed dabigatran. Which statement indicates correct understanding?
A. “I will avoid taking this with food.”
B. “I do not need blood tests as often as with warfarin.”
C. “I may double the dose if I miss one.”
D. “I will take aspirin daily with this medication.”

Answer: B

Q89. A nurse is assessing a 5-year-old at a well-child visit. Which finding requires further evaluation?
A. Can tie shoelaces
B. Speaks in complete sentences
C. Has imaginary friends
D. Cannot hop on one foot

Answer: D

Q90. A client with chronic kidney disease has pruritus. Which nursing intervention is most appropriate?
A. Use hot showers to relieve itching
B. Encourage frequent scratching

C. Use mild soap and moisturizers; pat skin dry
D. Avoid all lotions or creams

Answer: C

Q91. A client with a tracheostomy is receiving care. Which action by the nurse is correct?
A. Suction routinely every hour
B. Hyperoxygenate before and after suctioning
C. Use sterile water to clean the inner cannula and reuse suction catheters
D. Inflate the cuff to maximum pressure

Answer: B

Q92. A nurse cares for four clients. Which client should be seen first?
A. Client with pneumonia whose temperature is 38.3°C (101°F)
B. Client 1 day postoperative complaining of incisional pain 7/10
C. Client with asthma whose wheezing suddenly stops and appears lethargic
D. Client with chronic back pain asking for scheduled medication

Answer: C

Q93. A client with deep partial-thickness burns reports severe pain during dressing changes. Which intervention is most appropriate?
A. Administer prescribed opioid analgesic 30 minutes before the procedure
B. Change the dressing quickly without pain medication
C. Encourage the client to “tough it out”
D. Use heat packs to relieve pain

Answer: A

Q94. A client with an indwelling urinary catheter develops cloudy urine and low-grade fever. Which step helps prevent future catheter-associated infections?
A. Disconnecting the drainage bag when ambulating
B. Keeping the collection bag below bladder level
C. Flushing the catheter with antiseptic daily
D. Changing the catheter system every day

Answer: B

Q95. A nurse is teaching about emergency contraception (EC). Which statement is correct?
A. “EC must be taken within 72–120 hours after intercourse, depending on the product.”
B. “EC provides protection from pregnancy for the entire month.”
C. “EC also protects against sexually transmitted infections.”
D. “EC is only effective if taken before ovulation.”

Answer: A

Q96. A client with ulcerative colitis reports 12 bloody stools in 24 hours, dizziness, and palpitations. Which assessment is priority?
A. Skin turgor
B. Bowel sounds
C. Orthostatic blood pressures
D. Appetite

Answer: C

Q97. A nurse evaluates a new graduate’s knowledge of sterile field principles. Which action breaks sterility?
A. Keeping hands above waist level
B. Turning back briefly to grab supplies
C. Opening the sterile package away from the body first
D. Placing sterile items within 1 inch of the field border

Answer: B

Q98. A client with a history of long-term corticosteroid use is scheduled for minor surgery. Which potential complication is the greatest concern?
A. Hypoglycemia
B. Poor wound healing and infection risk
C. Hypotension
D. Hyperkalemia

Answer: B

Q99. A nurse teaches a client with chronic venous insufficiency about leg care. Which statement indicates understanding?
A. “I will elevate my legs when sitting.”
B. “I should cross my legs frequently.”
C. “I will avoid compression stockings.”
D. “I should walk as little as possible.”

Answer: A

Q100. A client with sickle cell disease reports severe generalized pain. The priority intervention is:
A. Apply cold compresses
B. Restrict fluids to prevent overload
C. Administer prescribed opioid analgesic and encourage hydration
D. Encourage ambulation to promote circulation

Answer: C

Q101. A nurse is administering ear drops to an adult. Which technique is correct?
A. Pull the pinna down and back
B. Pull the pinna up and back
C. Insert dropper tip into the ear canal
D. Have the client lie prone

Answer: B

Q102. A client with suspected appendicitis is NPO. The provider prescribes morphine for pain. The nurse should:
A. Withhold the medication until after surgery
B. Administer the medication as prescribed
C. Offer oral acetaminophen instead
D. Wait for ultrasound results

Answer: B

Q103. A client taking tamoxifen for breast cancer reports calf pain and swelling. What is the priority action?
A. Encourage increased walking

B. Suspect deep vein thrombosis and notify provider
C. Apply heat to the calf
D. Reassure the client this is an expected effect

Answer: B

Q104. A nurse is teaching parents of a child with asthma about using a spacer with a metered-dose inhaler. Which outcome indicates the spacer is effective?
A. Medication deposits mainly in the mouth
B. More medication reaches the lungs with less need for coordination
C. The child can use fewer inhalations
D. Spacer eliminates the need to rinse the mouth

Answer: B

Q105. An older adult is admitted after a fall at home. Which finding increases risk for future falls?
A. Wearing sturdy shoes
B. Using grab bars in the bathroom
C. Taking multiple sedating medications
D. Having family support nearby

Answer: C

Q106. A client with chronic kidney disease has low hemoglobin due to decreased erythropoietin production. Which medication does the nurse anticipate?
A. Ferrous sulfate
B. Epoetin alfa
C. Vitamin K
D. Filgrastim

Answer: B

Q107. A client is prescribed linezolid for MRSA pneumonia. Which concurrent medication requires caution?
A. Acetaminophen
B. Multivitamin

C. SSRIs such as sertraline
D. Calcium supplement

Answer: C

Q108. A nurse is assessing a client with suspected meningitis. Which finding requires immediate intervention?
A. Photophobia
B. Nuchal rigidity
C. Seizure activity
D. Headache

Answer: C

Q109. A client with anorexia nervosa is admitted with severe malnutrition. Which is the priority nursing diagnosis?
A. Disturbed body image
B. Risk for infection
C. Imbalanced nutrition: less than body requirements
D. Social isolation

Answer: C

Q110. A nurse administers 10 units of rapid-acting insulin lispro at 0730. The nurse should monitor for hypoglycemia at which time?
A. Around 0800–0930
B. Around 1200–1400
C. Late evening
D. No special monitoring is needed

Answer: A

CASE STUDY 3 – COPD Exacerbation (Q111–Q116)

Scenario:
Mr. Harris, a 65-year-old with long-standing COPD, is admitted with increased shortness of breath and productive cough.

Assessment on arrival:

- RR: 28/min, use of accessory muscles
- SpO_2: 86% on room air
- HR: 110/min
- BP: 138/86 mm Hg
- Barrel-shaped chest, diminished breath sounds with expiratory wheezes

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Q111. Which initial nursing action is priority?
A. Place the client flat in bed
B. Apply oxygen and position in high Fowler's
C. Encourage vigorous coughing without oxygen
D. Restrict fluids

Answer: B

Q112. The provider orders oxygen to maintain SpO_2 88–92%. Why is this range appropriate?
A. Higher oxygen always worsens COPD
B. Excessively high oxygen can reduce respiratory drive in some COPD clients
C. Low oxygen prevents CO_2 retention
D. It prevents dehydration

Answer: B

Q113. Mr. Harris receives albuterol nebulizer treatment. Which finding indicates therapeutic response?
A. Increased anxiety and tremors
B. Decreased wheezing and easier breathing
C. Decreased heart rate to 50/min
D. SpO_2 decreases to 82%

Answer: B

Q114. The nurse teaches Mr. Harris about pursed-lip breathing. Which explanation is most accurate?
A. “It helps trap air in the lungs.”
B. “It helps you exhale more slowly and keep airways open.”
C. “It increases your respiratory rate.”
D. “It is only used during exercise stress tests.”

Answer: B

Q115. Which dietary teaching is most appropriate for Mr. Harris?
A. “Eat large, high-calorie meals three times a day.”
B. “Eat small, frequent meals high in calories and protein.”
C. “Avoid all fats in your diet.”
D. “Limit fluids to 500 mL per day.”

Answer: B

Q116. Before discharge, which statement by Mr. Harris indicates the need for further teaching?
A. “I will get my flu shot every year.”
B. “I’ll avoid people who are sick when I can.”
C. “I don’t need to stop smoking as long as I use my inhalers.”
D. “I will call my provider if my sputum changes color or amount.”

Answer: C

Q117. A client with suspected Guillain-Barré syndrome is being assessed. Which finding is most characteristic?
A. Ascending muscle weakness and areflexia
B. Sudden unilateral facial droop
C. Fluctuating consciousness and tremors
D. Seizure activity

Answer: A

Q118. A nurse teaches a client with osteoporosis about fall prevention. Which home modification is appropriate?

A. Install adequate lighting in hallways
B. Use soft, loose slippers at home
C. Remove grab bars from shower
D. Add more scatter rugs for comfort

Answer: A

Q119. A client with hyperemesis gravidarum has severe vomiting. Which finding requires immediate intervention?
A. Ketonuria and weight loss
B. Blood pressure 110/70 mm Hg
C. Pulse 92/min
D. Mild dizziness on standing

Answer: A

Q120. A nurse is preparing to give potassium chloride IV. Which guideline is correct?
A. Give undiluted by IV push
B. Use infusion pump and never exceed prescribed rate
C. Administer via IM injection
D. Mix with dextrose solution only

Answer: B

Q121. A client on a psychiatric unit says, “The others are plotting to hurt me.” This is best described as:
A. Delusion of reference
B. Auditory hallucination
C. Paranoid delusion
D. Thought blocking

Answer: C

Q122. A client is prescribed atorvastatin. Which side effect should be reported immediately?
A. Mild headache
B. Muscle pain or weakness
C. Occasional constipation
D. Slight nasal congestion

Answer: B

Q123. A client with gastroenteritis is receiving IV lactated Ringer's solution. Which finding best indicates improvement in hydration status?
A. Urine output 35 mL/hr
B. Dry mucous membranes
C. Poor skin turgor
D. Confusion

Answer: A

Q124. A nurse is teaching a client with benign prostatic hyperplasia about tamsulosin. Which statement indicates understanding?
A. "This medication will shrink my prostate immediately."
B. "I should change positions slowly to prevent dizziness."
C. "I can stop taking it once my symptoms improve."
D. "It will cure the condition permanently."

Answer: B

Q125. A client with newly inserted central venous catheter c/o sudden shortness of breath. The nurse notes tachycardia and hypotension. Which complication is suspected?
A. Catheter occlusion
B. Air embolism
C. Phlebitis
D. Infection

Answer: B

Q126. A nurse is reinforcing foot care teaching for an older client with peripheral neuropathy. Which statement requires further teaching?
A. "I'll check my feet every day."
B. "I'll go barefoot inside the house to keep my feet cool."
C. "I'll wear cotton socks and closed-toe shoes."
D. "I'll call my provider if I see any sores."

Answer: B

Q127. A toddler presents with barking cough, inspiratory stridor, and low-grade fever. Which condition is most likely?
A. Epiglottitis
B. Bronchiolitis
C. Croup (laryngotracheobronchitis)
D. Asthma attack

Answer: C

Q128. A nurse prepares to discharge a client after total knee replacement. Which instruction is appropriate?
A. “Avoid flexing the knee and stay in bed for a week.”
B. “Use prescribed exercises and early ambulation to prevent stiffness and clots.”
C. “Do not use assistive devices.”
D. “You can drive yourself home.”

Answer: B

Q129. A client with cirrhosis is prescribed propranolol. The nurse understands this is used primarily to:
A. Treat ascites directly
B. Reduce portal hypertension and risk of variceal bleeding
C. Improve liver regeneration
D. Increase appetite

Answer: B

Q130. A nurse is caring for a client receiving IV chemotherapy. Which PPE is most appropriate when handling the medication?
A. Gloves only
B. Gloves and gown
C. Gloves, gown, and mask
D. No PPE needed

Answer: B

Q131. A client with depression reports starting St. John's wort without informing the provider while also taking an SSRI. The nurse's priority is to:
A. Encourage continuing both for stronger effect
B. Warn of risk for serotonin syndrome and notify provider
C. Suggest doubling the SSRI dose
D. Reassure that herbal products are always safe

Answer: B

Q132. A nurse is teaching a client with nephrolithiasis (kidney stones) about prevention. Which advice is most appropriate for calcium oxalate stones?
A. Increase fluid intake
B. Restrict all calcium-rich foods completely
C. Avoid all fruits
D. Restrict fluid intake to prevent stone movement

Answer: A

Q133. A client with heart failure is prescribed spironolactone. Which lab result should the nurse monitor closely?
A. Platelets
B. Potassium
C. Hemoglobin
D. Amylase

Answer: B

Q134. A nurse suspects elder abuse in a dependent older adult. What is the priority nursing action?
A. Confront the suspected abuser directly
B. Ensure the client's safety and follow mandatory reporting laws
C. Ignore the suspicion until proof is obtained
D. Transfer the client to another unit without reporting

Answer: B

Q135. A client with a history of IV drug use is admitted with fever and new heart murmur. Which complication is most likely?

A. Endocarditis
B. Pericarditis
C. Myocardial infarction
D. Cardiomyopathy

Answer: A

Q136. A nurse teaches a client with GERD about nighttime symptom control. Which instruction is best?
A. “Eat a large snack before bed.”
B. “Elevate the head of your bed 6 to 8 inches.”
C. “Lie flat on your back after meals.”
D. “Drink peppermint tea at bedtime.”

Answer: B

Q137. A client with advanced COPD is discussing hospice care. Which statement indicates understanding?
A. “Hospice means I won’t get any medications.”
B. “Hospice focuses on comfort and quality of life.”
C. “Hospice will cure my disease.”
D. “Hospice is only for people in a coma.”

Answer: B

Q138. A client receiving total parenteral nutrition starts to complain of shortness of breath and chest pain. What is the nurse’s first action?
A. Slow the TPN rate
B. Stop TPN, clamp line, and place client on left side with head down
C. Change the TPN tubing
D. Flush line with normal saline

Answer: B

Q139. A nurse teaches a client with chronic migraines about trigger management. Which statement indicates effective learning?
A. “I will keep a headache diary to identify possible triggers.”
B. “I’ll take pain medicine only after the pain becomes severe.”

C. “I must stop all physical activity.”
D. “I should drink more caffeinated drinks.”

Answer: A

Q140. A client is admitted for alcohol withdrawal. Which medication should the nurse anticipate to prevent complications of withdrawal?
A. Haloperidol
B. Lorazepam
C. Morphine
D. Phenytoin

Answer: B

CASE STUDY 4 – Elderly Hip Fracture (Q141–Q146)

Scenario:
Mrs. Nguyen, an 82-year-old woman, fell at home and is admitted with a left hip fracture. Surgery is scheduled for the morning.

Assessment:

- BP: 146/82 mm Hg
- HR: 96/min
- RR: 18/min
- Reports severe left hip pain with movement
- Left leg is shortened and externally rotated
- Lives alone and is unsteady when walking

Q141. What is the nurse’s priority preoperative concern?
A. Risk for infection
B. Risk for impaired skin integrity and further injury from immobility

C. Risk for constipation
D. Risk for impaired verbal communication

Answer: B

Q142. Which intervention best reduces Mrs. Nguyen's risk of pressure injuries before surgery?
A. Avoid repositioning due to pain
B. Reposition at least every 2 hours using pillows and foam pads
C. Place her directly on the affected hip
D. Use only a standard thin mattress

Answer: B

Q143. Mrs. Nguyen is worried about going home alone after surgery. What is the nurse's best response?
A. "You should not worry; your family will handle it."
B. "Let's involve the case manager to explore rehab or home health options."
C. "We can't plan anything until after you leave the hospital."
D. "You must hire a private nurse."

Answer: B

Q144. Postoperatively, which finding requires immediate intervention?
A. Pain controlled with prescribed analgesics
B. Inability to dorsiflex the left foot and numbness in toes
C. Serosanguineous drainage on dressing
D. Mild temperature elevation to 37.9°C (100.2°F)

Answer: B

Q145. Which teaching is most important to prevent future falls at home?
A. "Turn off lights when walking at night."
B. "Remove clutter and loose rugs from walkways."
C. "Wear socks only on hardwood floors."
D. "Avoid using assistive devices."

Answer: B

Q146. Mrs. Nguyen is prescribed low-molecular-weight heparin after surgery. The primary purpose is to:
A. Control postoperative pain
B. Prevent deep vein thrombosis and pulmonary embolism
C. Treat anemia
D. Improve appetite

Answer: B

Q147. A nurse prepares to administer sublingual nitroglycerin to a client with chest pain. Which assessment finding would cause the nurse to hold the medication and notify the provider?
A. Blood pressure 88/54 mm Hg
B. Pain reported as 7/10
C. Heart rate 96/min
D. SpO_2 94% on room air

Answer: A

Q148. A client asks about colon cancer screening. Which advice is most appropriate for average-risk adults?
A. “Begin regular screening at about age 45–50 as recommended by your provider.”
B. “Start screening at age 25.”
C. “Screening is only needed if you have symptoms.”
D. “You should only have screening once in a lifetime.”

Answer: A

Q149. A nurse is evaluating a client’s understanding of insulin storage. Which statement indicates correct knowledge?
A. “I’ll keep unopened insulin in the refrigerator.”
B. “I’ll freeze extra insulin so it lasts longer.”
C. “I’ll store all insulin in direct sunlight to prevent contamination.”
D. “I’ll discard insulin in use after 6 months regardless of instructions.”

Answer: A

Q150. A client experiencing grief after the death of a spouse says, “I feel guilty that I’m still alive.” What is the nurse’s best response?

A. “You shouldn’t feel guilty; that’s not helpful.”
B. “Tell me more about why you feel guilty.”
C. “You need to be strong and move on.”
D. “Try not to think about it.”

Answer: B