NCLEX-RN Practice Questions

Shared by Le on 24-08-2026

For More Free Questions and Preparation Resources

Check the Links on Last Page

Question 1

Question Type: MultipleChoice

To facilitate maximum air exchange, the nurse should position the client in:

Options:

A- High Fowler
B- Orthopneic
C- Prone
D- Flat-supine

P2P exams

Answer:

B

Explanation:

(A) The high Fowler position does increase air exchange, but not to the extent of orthopneic position. (B) The orthopneic position is a sitting position that allows maximum lung expansion. (C) The prone position places pressure on diaphragm and does not promote maximum air exchange. (D) The flat-supine position places pressure on diaphragm by abdominal organs and does not promote maximum air exchange.

Question 2

Question Type: MultipleChoice

P2P exams

A 40-year-old client has been admitted to the hospital with severe substernal chest pain radiating down his left arm. The nurse caring for the client establishes the following priority nursing diagnosis---Alteration in comfort, pain related to:

Options:

A- Increased excretion of lactic acid due to myocardial hypoxia
B- Increased blood flow through the coronary arteries
C- Decreased stimulation of the sympathetic nervous system
D- Decreased secretion of catecholamines secondary to anxiety

Answer:

A

Explanation:

(A) Anaerobic metabolism results because the decreased blood supply to the myocardium causes a release of lactic acid. Lactic acid is an irritant to the myocardial neural receptors, producing chest pain. (B) Chest pain is caused by a decrease in the O2 supply to the myocardial cells. Treatment modalities for chest pain are aimed toward increasing the blood flow through coronary arteries. (C) Chest pain causes an increase in the stimulation of the sympathetic nervous system. This stimulation increases the heart rate and blood pressure, causing an increase in myocardial workload aggravating the chest pain. (D) Chest pain and anxiety cause increased secretion of catecholamines by stimulating the sympathetic nervous system. This stimulation increases chest pain by increasing the workload of the heart.

Question 3

Question Type: MultipleChoice

The nurse begins morning assessment on a male client and notices that she is unable to palpate either of his dorsalis pedis pulses in his feet. What is the first nursing action after assessing this finding?

Options:

A- Palpate these pulses again in 15 minutes.
B- Use a Doppler to determine presence and strength of these pulses.
C- Document the finding that the pulses are not palpable.
D- Call the physician and notify the physician of this finding.

Answer:

B

Explanation:

(A) Palpating these pulses again in 15 minutes may only result in the same findings. (B) Any time during an assessment that the nurse is unable to palpate pulses, the nurse should then obtain a Doppler and assess for presence or absence of the pulse and pulse strength, if a pulse is present. (C) Pulses may be present and assessed through use of a Doppler. Absence of

palpable pulses does not indicate absence of blood flow unless pulses cannot be located with a Doppler. (D) The nurse would only call the physician after determining that the pulses are absent by both palpation and Doppler.

Question 4

Question Type: MultipleChoice

A neonate was admitted to the hospital with projectile vomiting. According to the parents, the baby had experienced vomiting episodes after feeding for the last 2 days. A medical diagnosis of hypertrophic pyloric stenosis was made. On assessment, the infant had poor skin turgor, sunken eyeballs, dry skin, and weight loss. Identify the number-one priority nursing diagnosis.

Options:

A- Fluid volume deficit
B- Altered nutrition
C- Altered bowel elimination
D- Anxiety

Answer:

A

Explanation:

(A) Fluid volume deficit is the major problem. Symptoms of dehydration are evident. The effects of fluid and electrolyte balance may be life threatening. Rehydration can be accomplished effectively through IV fluids and electrolytes. (B) Vomiting may also signal a nutritional problem. However, the nutritional problem would be secondary to fluid and electrolyte disturbances. The infant may also be placed on NPO status. (C) With vomiting, a decrease in the size and number of stools is expected. (D) The infant cannot verbalize feelings of anxiety. Anxiety would not be an appropriate diagnosis.

Question 5

Question Type: MultipleChoice

A 52-year-old client is scheduled for a small-bowel resection in the morning. In conjunction with other preoperative preparation, the nurse is teaching her diaphragmatic breathing exercises. She will teach the client to:

Options:

A- Inhale slowly and deeply through the nose until the lungs are fully expanded, hold the breath a couple of seconds, and then exhale slowly through the mouth. Repeat 2--3 more times to complete the series every 1--2 hours while awake
B- Purse the lips and take quick, short breaths approximately 18--20 times/min
C- Take a large gulp of air into the mouth, hold it for 10--15 seconds, and then expel it through the nose. Repeat 4--5 times to complete the series
D- Inhale as deeply as possible and then immediately exhale as deeply as possible at a rate of approximately 20--24 times/min

Answer:

A

Explanation:

(A) This is the correct method of teaching diaphragmatic breathing, which allows full lung expansion to increase oxygenation, prevent atelectasis, and move secretions up and out of the lungs to decrease risk of pneumonia. (B) Quick, short breaths do not allow for full lung expansion and movement of secretions up and out of the lungs. Quick, short breaths may lead to O2 depletion, hyperventilation, and hypoxia. (C) Expelling breaths through the nose does not allow for full lung expansion and the use of diaphragmatic muscles to assist in moving secretions up and out of the lungs. (D) Inhaling and exhaling at a rate of 20--24 times/min does not allow time for full lung expansion to increase oxygenation. This would most likely lead to O2 depletion and hypoxia.

Question 6

Question Type: MultipleChoice

A long-term goal for the nurse in planning care for a depressed, suicidal client would be to:

Options:

A- Provide him with a safe and structured environment.
B- Assist him to develop more effective coping mechanisms.

C- Have him sign a ''no-suicide'' contract.
D- Isolate him from stressful situations that may precipitate a depressive episode.

Answer:

B

Explanation:

(A) This statement represents a short-term goal. (B) Long-term therapy should be directed toward assisting the client to cope effectively with stress. (C) Suicide contracts represent short-term interventions. (D) This statement represents an unrealistic goal. Stressful situations cannot be avoided in reality.

Question 7

Question Type: MultipleChoice

A female client has a chest tube placed. It is accidentally pulled out of the intrapleural space when she is ambulating. The first action the nurse should take is to:

Options:

A- Instruct the client to cough deeply to re-expand her lung
B- Put on sterile gloves and replace the tube
C- Apply a petrolatum dressing over the site
D- Auscultate the lung to determine if she needs the tube replaced

Answer:

C

Explanation:

(A) This action is inappropriate. Coughing will not re-expand the lung and could result in further harm. (B) This action is a medical procedure, not a nursing procedure. (C) An occlusive dressing will prevent further air leak until the physician institutes further treatment. (D) The decision to reinsert the tube is a medical decision, not a nursing one.

Question 8

Question Type: MultipleChoice

A 3-month-old infant has had a unilateral cleft lip repair. He has resumed feedings of oral formul

a. The nurse should feed the infant with:

Options:

A- Gavage tube
B- Nipple and bottle
C- A straw and cup
D- Syringe

Answer:

D

Explanation:

(A) A gavage tube may damage suture line. It is the most invasive and should be the last measure. (B) A nipple and bottle require sucking, which may damage sutures. (C) A 3-month-old infant is not able to drink from a straw. (D) A syringe allows for the formula to be placed to the side and back of the mouth. This minimizes the amount of sucking needed.

Question 9

Question Type: MultipleChoice

A client is in active labor and has been admitted to the labor and delivery unit. The RN has just done a sterile vaginal exam and determines that the client is dilated 5 cm, effaced 85%, and the fetus's head is at 0 station. She asks if she could have a lumbar epidural now. The epidural is started, and the anesthetic agent used is bupivacaine (Marcaine). After the client has received her lumbar epidural, it is important for the RN to monitor her for which of the following side effects:

Options:

A- Hypertension

B- Hypotension
C- Hypoglycemia
D- Hyperglycemia

Answer:

B

Explanation:

(A) The medication bupivacaine will cause vasodilation in the vascular system, and this does not result in elevation of the ma-ternal blood pressure. (B) The medication bupivacaine will cause vasodilation in the vascular system, and this will result in lowering the maternal blood pressure. (C) Bupivacaine does not interfere with the functioning of the endocrine system. (D) Bupivacaine does not interfere with the functioning of the endocrine system.

Question 10

Question Type: MultipleChoice

Diabetes mellitus is a disorder that affects 3.1 out of every 1000 children younger than 20 years old. It is characterized by an absence of, or marked decrease in, circulating insulin. When teaching a newly diagnosed diabetes client, the nurse includes information on the functions of insulin:

Options:

A- Transport of glucose into body cells and storage of glycogen in the liver
B- Glycogenolysis and facilitation of glucose use for energy
C- Glycogenolysis and catabolism
D- Catabolism and hyperglycemia

Answer:

A

Explanation:

(A) Lack of insulin causes glycogenolysis, catabolism, and hyperglycemia. (B) Insulin promotes the conversion of glucose to glycogen for storage and regulates the rate at which carbohydrates are used by cells for energy. (C) Insulin is anabolic in nature. (D) Glucose stimulates protein

synthesis within the tissue and inhibits the breakdown of protein into amino acids.

Question 11

Question Type: MultipleChoice

A client who is a breast-feeding mother develops mastitis. The clinical signs and symptoms of mastitis include:

Options:

A- Marked engorgement, elevated temperature, chills, and breast pain with an area that is red and hardened
B- Marked engorgement and breast pain
C- Elevated temperature and general malaise
D- Cracked nipple with complaints of soreness

Answer:

A

Explanation:

(A) Mastitis is a bacterial inflammation of the breast tissue found primarily in breast-feeding mothers. The bacteria usually enter the breast through a cracked nipple, or the infection results from stasis of milk behind a blocked duct. (B) With breast engorgement during breast-feeding, there may be marked breast pain. This is not necessarily a sign of infection. (C) Women may become ill during breast-feeding with other bacterial or viral infections that are not related to mastitis. (D) Improper care of the nipples or improper positioning of the infant during breastfeeding may result in cracked or sore nipples.

To Get Premium Files for NCLEX-RN Visit

https://www.p2pexams.com/products/nclex-rn

For More Free Questions Visit

https://www.p2pexams.com/nclex/pdf/nclex-rn