



Master Your NCLEX: 25 Practice Questions

Welcome to your comprehensive NCLEX review session! This presentation includes 25 carefully selected multiple-choice questions complete with answers and detailed rationales to help you prepare for success.

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Question 1: Congestive Heart Failure

A patient with congestive heart failure is admitted with shortness of breath. Which intervention is most important initially?

- A) Insert a Foley catheter
- B) Place in high Fowler's position
- C) Administer sodium polystyrene sulfonate
- D) Encourage high-protein diet

Answer: B) Place in high Fowler's position

Rationale

High Fowler's position (sitting upright at 60-90° angle) maximizes lung expansion and reduces dyspnea by decreasing pressure on the diaphragm from abdominal organs and fluid-filled lungs. This positioning is the priority intervention for acute shortness of breath in CHF patients.





Question 2: Insulin Administration



Question

A nurse prepares to administer insulin. Which step is essential?

- A) Shake the insulin vial vigorously
- B) Verify medication with another nurse
- C) Aspirate before injection
- D) Mix NPH and regular insulin in the same syringe



Answer & Rationale

Answer: D) Mix NPH and regular insulin in the same syringe

NPH (intermediate-acting) and regular (short-acting) insulin can be safely mixed in the same syringe to provide both immediate and sustained glucose control, reducing the number of injections needed. This is standard practice for patients requiring both types of insulin.

Question 3: Therapeutic Communication



The best response to a patient fearful before surgery is:

- A) "Don't worry, everything will be fine."
- B) "Why are you scared?"
- C) "It's normal to be anxious, let's talk about your concerns."
- D) "Just relax."

Answer: C) "It's normal to be anxious, let's talk about your concerns."

Rationale: This response acknowledges the patient's feelings as valid, normalizes the anxiety, and encourages expression of specific concerns. It demonstrates therapeutic communication by opening dialogue rather than dismissing feelings or asking closed questions.

Question 4: Warfarin Therapy



Question

A client on warfarin therapy reports dark stools. Which is the appropriate action?

- A) Document and reassess
- B) Tell the client this is expected
- C) Notify the healthcare provider
- D) Encourage fluids



Answer

C) Notify the healthcare provider



Rationale

Dark stools (melena) in a patient on warfarin may indicate gastrointestinal bleeding, a serious complication of anticoagulant therapy. This requires immediate provider notification as it could signal dangerous internal bleeding requiring intervention.

Question 5: Nutrition Knowledge

Which food is highest in potassium?

- A) Rice
- B) Bananas
- C) Egg whites
- D) Apple juice

Answer: B) Bananas

Rationale: Bananas contain approximately 422mg of potassium per medium fruit, significantly higher than the other options listed. Potassium knowledge is crucial when caring for patients on diuretics or with kidney disease who require careful potassium monitoring.





Question 6: Fracture with Respiratory Distress

1 Question

Priority action for a client with a fractured femur and respiratory distress:

- A) Call the provider
- B) Prepare for surgery
- C) Administer oxygen
- D) Obtain blood cultures

2 Answer

C) Administer oxygen

3 Rationale

Oxygen administration meets the immediate physiological need when respiratory distress is present. Following the ABCs (Airway, Breathing, Circulation), breathing support must be addressed before other interventions. Femur fractures can cause fat emboli that lead to respiratory distress, making oxygen crucial.

Question 7: Hypoglycemia Management



A patient with diabetes is pale and sweaty, blood sugar 45 mg/dL.
What do you do first?

- A) Give 15g glucose orally
- B) Call the provider
- C) Start IV fluids
- D) Document findings

Answer: A) Give 15g glucose orally

Rationale: For a conscious patient with hypoglycemia (BG < 70 mg/dL), the 15-15 rule applies - give 15g of fast-acting carbohydrates orally, then recheck in 15 minutes. This rapidly raises blood glucose to prevent neurological complications. Other actions follow after addressing this immediate need.

Question 8: Antihypertensive Side Effects

1

Question

The nurse assesses for which side effect when starting a new antihypertensive?

- A) Hyperglycemia
- B) Hypokalemia
- C) Dizziness
- D) Insomnia

C

Answer

Dizziness is the correct answer

!

Rationale

Many antihypertensives cause orthostatic hypotension, especially when therapy is initiated. This manifests as dizziness when changing positions. Patient safety requires close monitoring for this common side effect to prevent falls.

Question 9: Tracheostomy Care

Which is a priority care aspect for a client with a new tracheostomy?

- A) Elevate foot of bed
- B) Frequent mouth care
- C) Monitor airway patency
- D) Suction only as needed

Answer: C) Monitor airway patency

Rationale: Maintaining airway patency is the highest priority with a new tracheostomy. Obstruction from secretions, blood, or swelling can quickly lead to respiratory distress and hypoxia. Continuous assessment ensures the artificial airway remains clear and functional.



Question 10: Post-Operative Assessment



Question

A post-op client suddenly becomes confused.
The priority assessment is:

- A) Temperature
- B) Oxygen saturation
- C) Blood pressure
- D) Urine output



Answer

B) Oxygen saturation



Rationale

Sudden confusion in a post-operative patient often indicates hypoxia, which requires immediate intervention. While other vital signs are important, oxygen status directly affects brain function and should be assessed first to prevent neurological damage.

Question 11: Tuberculosis Precautions



Which PPE is needed for caring for a patient with tuberculosis?

- A) Surgical mask
- B) Gown and gloves only
- C) N95 respirator
- D) None

Answer: C) N95 respirator

Rationale: Tuberculosis is transmitted via airborne route through droplet nuclei. Standard surgical masks cannot filter these small particles. N95 respirators are specifically designed to filter 95% of airborne particles and are required for TB care according to CDC airborne precaution guidelines.



Question 12: Seizure Management

Question

First intervention for a client having a tonic-clonic seizure:

- A) Restrain the patient
- B) Place object in mouth
- C) Turn the client to side
- D) Suction airway immediately

Answer

C) Turn the client to side

Rationale

Turning the patient to a side-lying position (recovery position) prevents aspiration of secretions during a seizure. Never restrain a seizing patient or force objects into their mouth as this can cause injury. Airway protection is the priority action.

Question 13: Diuretic Therapy

A client is prescribed furosemide. Monitor for:

- A) Hypernatremia
- B) Hypokalemia
- C) Hyperglycemia
- D) Hypocalcemia

Answer: B) Hypokalemia

Rationale: Furosemide (Lasix) is a loop diuretic that increases sodium, potassium, and water excretion. Potassium loss is a significant side effect that can lead to cardiac arrhythmias. Regular monitoring of potassium levels and possible supplementation is essential during furosemide therapy.

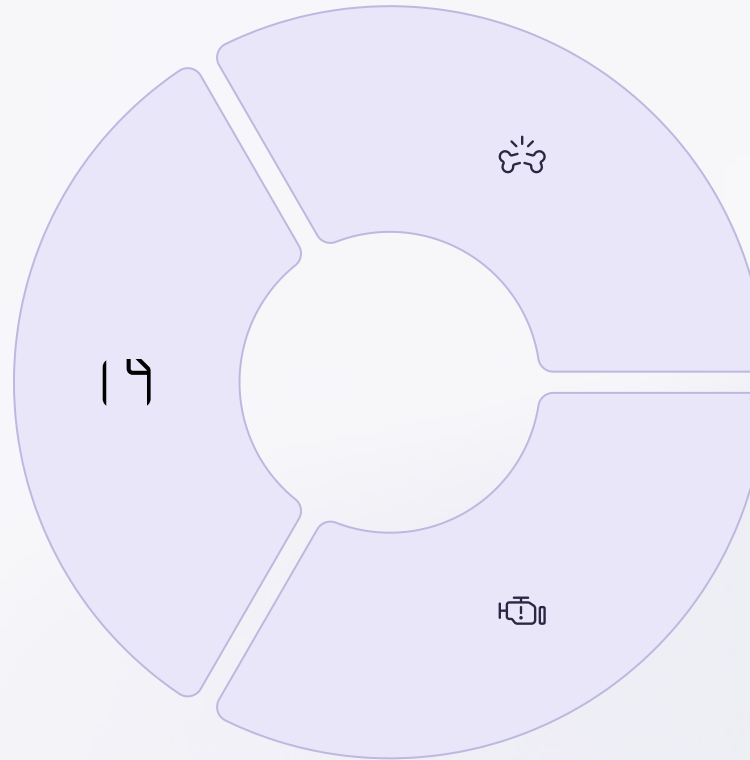


Question 14: Post-Thyroidectomy Complications

Question

Which symptom is most concerning after thyroidectomy?

- A) Hoarse voice
- B) Sore throat
- C) Tingling fingers
- D) Difficulty swallowing



Answer

C) Tingling fingers

Rationale

Tingling in the fingers, lips, or toes indicates hypocalcemia from accidental removal or damage to the parathyroid glands during thyroidectomy. This is a medical emergency requiring immediate calcium replacement to prevent tetany and laryngospasm.

Question 15: Morphine Administration



Which assessment is priority when giving morphine IV?

- A) Pain level
- B) Respiratory rate
- C) Heart rate
- D) Skin color

Answer: B) Respiratory rate

Rationale: Morphine and other opioids can cause respiratory depression, a potentially life-threatening side effect. Monitoring respiratory rate, depth, and pattern is the priority assessment to detect this complication early. Assessment should occur before, during, and after administration.

Question 16: Infection Control Measures

Question

A patient on contact precautions should have:

- A) N95 mask
- B) Private room
- C) Sterile gloves
- D) Eye protection always

Answer

B) Private room

Rationale

Contact precautions require a private room or cohorting with patients with the same organism to prevent transmission. This, along with gloves and gowns (clean, not sterile), helps contain infections spread by direct or indirect contact. N95 masks are for airborne precautions.



Question 17: IV Flow Rate Calculation

Calculating IV flow rate: Order is 1 L NS over 8 hours. Tubing: 20 drops/mL. How many drops/min?

- A) 20
- B) 42
- C) 60
- D) 30

Answer: B) 42

$$\text{Flow Rate} = \frac{\text{Volume (mL)} \times \text{Drop Factor (drops/mL)}}{\text{Time (min)}}$$

Rationale:

Step 1: Convert to mL/hr: $1000 \text{ mL} \div 8 \text{ hr} = 125 \text{ mL/hr}$

Step 2: Convert to drops/min: $(125 \text{ mL/hr} \times 20 \text{ drops/mL}) \div 60 \text{ min} = 41.7 \approx 42 \text{ drops/min}$



Question 18: Chest Tube Management



Question

Priority finding after chest tube insertion:

- A) Serous drainage
- B) Continuous bubbling in water seal
- C) No drainage for 2 hours
- D) Fluctuation with respirations



Answer & Rationale

Answer: B) Continuous bubbling in water seal

Continuous bubbling in the water seal chamber indicates an air leak, which could be from the patient's lung or a system problem. This requires immediate evaluation as it may indicate disconnection, improper placement, or a bronchopleural fistula. Normal functioning shows intermittent bubbling or fluctuation with breathing, not continuous bubbling.



Question 19: Post-Stroke Care



Which is appropriate for a client with right-sided weakness post-stroke?

- A) Place objects on the left
- B) Encourage use of right hand
- C) Place objects on the right
- D) Insert indwelling catheter

Answer: A) Place objects on the left

Rationale: Placing objects on the patient's unaffected (left) side promotes independence and successful completion of activities. This strategy compensates for right-sided weakness while encouraging functional use of the unaffected side, supporting rehabilitation principles of maximizing remaining abilities.

Question 20: Heparin Therapy Monitoring



75%



50%



25%

Question

Which lab result is most concerning for a client receiving heparin?

- A) INR 1.1
- B) Platelets 40,000
- C) Hemoglobin 15
- D) WBC 9,000

Answer

B) Platelets 40,000

Rationale

A platelet count below 50,000 in a patient receiving heparin may indicate heparin-induced thrombocytopenia (HIT), a serious immune-mediated complication. HIT paradoxically increases clotting risk despite low platelets and requires immediate discontinuation of heparin and alternative anticoagulation.

Question 21: Cardiac Arrest Assessment

Best site to check for pulse in a cardiac arrest:

- A) Radial
- B) Brachial
- C) Carotid
- D) Femoral

Answer: C) Carotid

Rationale: The carotid pulse is the most reliable pulse to check during cardiac arrest as it remains palpable even when peripheral pulses disappear due to hypotension. It's easily accessible in the neck and reflects central circulation status better than peripheral pulses.



Question 22: Crutch Walking Technique

?

Question

Which statement indicates understanding of crutch walking?

- A) "I will look at my feet while walking."
- B) "I will bear weight on my armpits."
- C) "I will place my crutches about 6 inches in front of me."
- D) "I will move both crutches with my sore leg at the same time."

✓

Answer

C) "I will place my crutches about 6 inches in front of me."



Rationale

Proper crutch placement about 6 inches in front and to the side provides a stable base of support. Weight should be borne on the hands, not armpits, to prevent nerve damage. Looking ahead (not down) maintains balance, and the correct sequence is to move crutches forward, then the affected leg.

Question 23: Central Line Care



What is the nurse's first action if central line dressing is loose?

- A) Reinforce the dressing
- B) Replace dressing using sterile technique
- C) Call the provider
- D) Tape over the area

Answer: B) Replace dressing using sterile technique

Rationale: A loose central line dressing compromises the sterile barrier and increases infection risk. Per CDC guidelines, the entire dressing must be replaced using full sterile technique, not merely reinforced or taped. This prevents central line-associated bloodstream infections (CLABSI).

Question 24: Fall Prevention



Non-skid Footwear

Provides traction and reduces risk of slipping on smooth hospital floors



Bed Rails

Can increase fall risk by creating a higher fall distance if patient attempts to climb over



Restraints

Can increase agitation and are used only as a last resort after alternatives fail

Question: Best strategy to prevent falls in hospitalized elderly clients:

- A) Raise all bed rails
- B) Provide non-skid footwear
- C) Use restraints
- D) Turn off lights at night

Answer: B) Provide non-skid footwear

Rationale: Non-skid shoes/socks significantly reduce the risk of slips and falls while maintaining patient dignity and mobility. Evidence shows raising all rails can increase fall severity, restraints are a last resort, and nighttime lighting should be maintained for safety.

Question 25: Hypovolemic Shock Risk

Question

Which patient is most at risk for hypovolemic shock?

- A) Recent surgery with 200 mL bleeding
- B) Child with fever
- C) Trauma victim with visible hemorrhage
- D) Client with hypertension



Answer

C) Trauma victim with visible hemorrhage

Rationale

Active bleeding following trauma presents the highest risk for rapid volume loss leading to hypovolemic shock. Visible hemorrhage indicates significant external blood loss that can quickly deplete intravascular volume, requiring immediate intervention to prevent cardiovascular collapse.

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