

Licensed Practical Nurse (LPN) Exit Practice Exam (Sample)

Study Guide



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SAMPLE

Questions

SAMPLE

- 1. For a client who has difficulty swallowing tablets, what is the best nursing action when administering a sublingual tablet?**
 - A. Crush the tablet and mix it with applesauce**
 - B. Place the tablet under the client's tongue**
 - C. Administer the tablet with a spoonful of water**
 - D. Chew the tablet before swallowing**
- 2. Which laboratory values should the PN monitor to evaluate the effectiveness of an antibiotic in a client with a respiratory tract infection?**
 - A. Hemoglobin and hematocrit levels**
 - B. Sputum culture and white blood cell count**
 - C. Liver enzymes and renal function tests**
 - D. Blood glucose and electrolyte levels**
- 3. Which symptom should the nurse associate with Cushingoid effects of dexamethasone?**
 - A. Fatigue and dizziness**
 - B. Moon face, slow wound healing, and muscle wasting**
 - C. Weight loss and increased appetite**
 - D. Joint pain and swelling**
- 4. What is the primary objective of patient education in nursing?**
 - A. To make healthcare providers' jobs easier**
 - B. To ensure patients understand their treatment and health**
 - C. To reduce patient visits to hospitals**
 - D. To prepare patients for surgical procedures**
- 5. What vital sign is typically assessed first when entering a patient's room?**
 - A. Blood pressure**
 - B. Heart rate**
 - C. Respiratory rate**
 - D. Temperature**

- 6. A decrease in hemoglobin levels may indicate what condition?**
- A. Infection**
 - B. Pneumonia**
 - C. Potential anemia or blood loss**
 - D. Dehydration**
- 7. What would you consider when planning care for a diabetic patient?**
- A. Blood glucose monitoring, diet, and medication adherence**
 - B. Strict bed rest and isolation**
 - C. Focusing only on diet**
 - D. Only monitoring physical exercise**
- 8. What is a common symptom of dehydration?**
- A. Dry mucous membranes**
 - B. Increased urine output**
 - C. Swollen ankles**
 - D. Bradycardia**
- 9. What should an LPN do if they notice a significant change in a patient's condition?**
- A. Document the change in the patient's file**
 - B. Notify the supervising RN or physician immediately**
 - C. Wait for the scheduled check-up**
 - D. Consult with a fellow LPN on the matter**
- 10. Which intervention is considered within the scope of practice for a practical nurse?**
- A. Assisting with surgical procedures**
 - B. Demonstrating deep breathing and coughing to a postoperative client**
 - C. Administering IV medications**
 - D. Making independent nursing diagnosis**

Answers

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- 1. B**
- 2. B**
- 3. B**
- 4. B**
- 5. C**
- 6. C**
- 7. A**
- 8. A**
- 9. B**
- 10. B**

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Explanations

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1. For a client who has difficulty swallowing tablets, what is the best nursing action when administering a sublingual tablet?

- A. Crush the tablet and mix it with applesauce**
- B. Place the tablet under the client's tongue**
- C. Administer the tablet with a spoonful of water**
- D. Chew the tablet before swallowing**

When administering a sublingual tablet, placing the tablet under the client's tongue is the most appropriate action. Sublingual tablets are specifically designed to dissolve quickly and be absorbed through the mucous membranes in the mouth, providing rapid systemic effects. By placing the tablet under the tongue, the medication can bypass the digestive system and liver metabolism, allowing for faster onset of action. Crushing the tablet, as suggested in one of the options, can alter its intended absorption and efficacy. Many sublingual tablets have a coating that protects the active ingredients and influences their dissolution; therefore, crushing them can lead to a reduced effect and potentially unwanted side effects. Administering the tablet with water or instructing the client to chew the tablet before swallowing can hinder the medication's proper absorption. These methods can result in the medication being processed too slowly or being rendered ineffective, as the sublingual route relies on direct contact with the sublingual mucosa for absorption. Therefore, placing the tablet under the client's tongue optimally fulfills the requirements for sublingual administration, ensuring quick and effective therapeutic action.

2. Which laboratory values should the PN monitor to evaluate the effectiveness of an antibiotic in a client with a respiratory tract infection?

- A. Hemoglobin and hematocrit levels**
- B. Sputum culture and white blood cell count**
- C. Liver enzymes and renal function tests**
- D. Blood glucose and electrolyte levels**

Monitoring sputum culture and white blood cell count is essential in evaluating the effectiveness of an antibiotic for a client with a respiratory tract infection. The sputum culture provides direct evidence of which bacteria are present in the respiratory system and allows for the identification of specific pathogens. This is crucial because the choice of antibiotic therapy often depends on the sensitivity of the bacteria to certain antibiotics. A follow-up culture can show whether the targeted organism has been eliminated or whether treatment needs to be adjusted due to resistance. Additionally, the white blood cell count is a valuable indicator of infection. An elevated white blood cell count typically indicates the presence of an infection, and as the antibiotic takes effect, one would expect to see a decrease in this count as the body responds positively to the treatment and the infection subsides. These two laboratory values together provide a comprehensive picture of both the causative agent of the infection and the body's response to the antibiotic therapy, making them key indicators in assessing treatment efficacy.

3. Which symptom should the nurse associate with Cushingoid effects of dexamethasone?

- A. Fatigue and dizziness
- B. Moon face, slow wound healing, and muscle wasting**
- C. Weight loss and increased appetite
- D. Joint pain and swelling

The symptoms associated with Cushingoid effects of dexamethasone include moon face, slow wound healing, and muscle wasting. Dexamethasone is a corticosteroid that can lead to a condition known as Cushing's syndrome when used long-term or in high doses. Moon face is characterized by a rounded facial appearance that occurs due to fat redistribution, which is a common symptom in patients with Cushing's syndrome. Slow wound healing is another hallmark effect as corticosteroids can suppress the inflammatory response and impair tissue regeneration, impacting the healing process. Muscle wasting occurs because of the catabolic effects of glucocorticoids, leading to the breakdown of protein in muscle tissue. In contrast, fatigue and dizziness are more general symptoms and may not specifically indicate Cushingoid effects. Weight loss and increased appetite contradict the effects of Cushing syndrome, which typically leads to weight gain and increased appetite due to metabolic alterations. Joint pain and swelling do not specifically signal Cushingoid effects directly related to dexamethasone use. Thus, the association of specific symptoms such as moon face, slow wound healing, and muscle wasting accurately reflects the unique presentations linked to the use of dexamethasone resulting in Cushingoid features.

4. What is the primary objective of patient education in nursing?

- A. To make healthcare providers' jobs easier
- B. To ensure patients understand their treatment and health**
- C. To reduce patient visits to hospitals
- D. To prepare patients for surgical procedures

The primary objective of patient education in nursing is to ensure that patients understand their treatment and health. This understanding is crucial as it empowers patients to take an active role in their own care and make informed decisions regarding their health. Effective patient education allows individuals to comprehend their diagnoses, treatment plans, and the importance of adherence to medications or lifestyle changes. By focusing on understanding, patients are more likely to engage in self-monitoring and recognize when to seek additional help or clarification. This leads to improved health outcomes, increased safety, and can result in better overall patient satisfaction with their healthcare experience. While other answers mention aspects that may be related to patient education, such as reducing hospital visits or preparing for surgery, they do not encompass the fundamental goal of patient education, which centers on understanding and engagement in personal health management.

5. What vital sign is typically assessed first when entering a patient's room?

- A. Blood pressure**
- B. Heart rate**
- C. Respiratory rate**
- D. Temperature**

The respiratory rate is typically assessed first when entering a patient's room because it provides immediate insight into the patient's respiratory function and overall stability. Observing the respiratory rate can reveal potential issues such as respiratory distress or abnormalities that may require urgent attention. This vital sign is often reflective of the patient's current health status, especially in emergency situations where respiratory compromise can quickly lead to serious complications. By starting with the respiratory rate, the healthcare provider can establish a baseline for the patient's ventilatory status and decide if further interventions or assessments are needed. After the respiratory rate is assessed, other vital signs like heart rate, blood pressure, and temperature can be measured in sequence to form a complete picture of the patient's condition.

6. A decrease in hemoglobin levels may indicate what condition?

- A. Infection**
- B. Pneumonia**
- C. Potential anemia or blood loss**
- D. Dehydration**

A decrease in hemoglobin levels is directly associated with conditions that affect the blood's ability to carry oxygen, and one of the most common implications of low hemoglobin is the potential for anemia or blood loss. Anemia can arise from various causes, such as nutritional deficiencies (like iron deficiency), chronic disease, or bone marrow problems. Blood loss can occur from gastrointestinal bleeding, heavy menstrual periods, or trauma, leading to reduced hemoglobin levels. Conditions like infection, pneumonia, or dehydration might not necessarily lead to a decrease in hemoglobin levels. Infections can cause an increase in white blood cells rather than direct changes to hemoglobin. Pneumonia is primarily a respiratory condition and might not directly impact the hemoglobin levels unless significantly severe or prolonged, which might lead to hypoxia and subsequent anemia. Dehydration often causes hemoconcentration, which might falsely elevate hemoglobin levels or keep them stable rather than decrease them. Thus, the correct choice indicating a decrease in hemoglobin levels pointing to anemia or blood loss provides a clear understanding of potential underlying health concerns.

7. What would you consider when planning care for a diabetic patient?

- A. Blood glucose monitoring, diet, and medication adherence**
- B. Strict bed rest and isolation**
- C. Focusing only on diet**
- D. Only monitoring physical exercise**

When planning care for a diabetic patient, it is essential to consider a comprehensive approach that includes blood glucose monitoring, diet, and medication adherence. Blood glucose monitoring is vital in managing diabetes, allowing for timely adjustments in treatment and lifestyle to maintain optimal glucose levels. Proper dietary management is crucial as it helps in controlling blood sugar levels, encourages healthy eating habits, and supports overall metabolic health. Additionally, medication adherence is important because it ensures that the patient is taking prescribed medications correctly, which is critical for managing blood sugar levels and preventing complications. The other options lack the necessary breadth and depth required in diabetic care. Strict bed rest and isolation are not appropriate for managing diabetes, as activity can play an important role in blood sugar control. Focusing only on diet neglects other essential factors, such as medication and monitoring, which are key components of diabetes management. Lastly, only monitoring physical exercise ignores the significance of diet and medication, which together create a well-rounded care plan to effectively manage diabetes. Thus, the selected answer encapsulates a holistic approach to caring for diabetic patients.

8. What is a common symptom of dehydration?

- A. Dry mucous membranes**
- B. Increased urine output**
- C. Swollen ankles**
- D. Bradycardia**

A common symptom of dehydration is dry mucous membranes. When the body is dehydrated, it lacks the necessary fluids to maintain normal bodily functions, which can lead to various signs. The mucous membranes, found in areas such as the mouth and nasal passages, rely on adequate hydration to remain moist. When fluid levels drop, these membranes become dry and brittle, making this a clear indicator of dehydration. Increased urine output, while indicative of other conditions or excessive fluid intake, does not align with dehydration, as the body typically decreases urine output in an attempt to conserve water during dehydration. Swollen ankles are generally associated with fluid retention or various health issues, rather than dehydration. Bradycardia, or a slow heart rate, is not a direct symptom of dehydration and can arise from a multitude of other factors such as medications or underlying health conditions.

9. What should an LPN do if they notice a significant change in a patient's condition?

- A. Document the change in the patient's file**
- B. Notify the supervising RN or physician immediately**
- C. Wait for the scheduled check-up**
- D. Consult with a fellow LPN on the matter**

When a Licensed Practical Nurse (LPN) observes a significant change in a patient's condition, notifying the supervising RN or physician immediately is the most appropriate action. This is critical because significant changes could indicate a serious and potentially life-threatening situation that requires immediate intervention. Quick communication with nursing or medical management ensures that appropriate assessments, treatments, or interventions can be initiated without delay, which is crucial for patient safety and health outcomes. Timely reporting allows for a higher level of clinical evaluation that an LPN may not be authorized to perform independently. This collaboration is essential as it ensures a coordinated approach to patient care, allowing the healthcare team to respond effectively and efficiently. While documenting the change is valuable, it should not replace the immediate responsibility of notifying the supervising nurse or physician. Waiting for a scheduled check-up or consulting with a fellow LPN may delay necessary action, which could compromise the patient's well-being. Therefore, the priority is to relay the information quickly to those who can manage the patient's care appropriately.

10. Which intervention is considered within the scope of practice for a practical nurse?

- A. Assisting with surgical procedures**
- B. Demonstrating deep breathing and coughing to a postoperative client**
- C. Administering IV medications**
- D. Making independent nursing diagnosis**

Demonstrating deep breathing and coughing techniques to a postoperative client is an intervention that aligns well with the scope of practice for a practical nurse. This task is essential for patient education and recovery, especially after surgery, where respiratory function can be compromised. By engaging patients in deep breathing and coughing exercises, the practical nurse helps reduce the risk of postoperative complications such as pneumonia, aids in lung expansion, and promotes effective ventilation. This intervention does not require advanced nursing assessment skills or complex decision-making, making it a fitting responsibility for a licensed practical nurse. Practical nurses are trained to provide direct patient care and education, which fits within their role, particularly in a postoperative setting where monitoring and supporting recovery is crucial.