

LICENSED PRACTICAL NURSE (LPN) EXIT PRACTICE EXAM (SAMPLE)

STUDY GUIDE



**SAMPLE STUDY GUIDE
WITH LIMITED QUESTIONS**

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THE FULL VERSION STUDY GUIDE**

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Introduction

Preparing for a certification exam can feel overwhelming, but with the right tools, it becomes an opportunity to build confidence, sharpen your skills, and move one step closer to your goals. At Examzify, we believe that effective exam preparation isn't just about memorization, it's about understanding the material, identifying knowledge gaps, and building the test-taking strategies that lead to success.

This guide was designed to help you do exactly that.

Whether you're preparing for a licensing exam, professional certification, or entry-level qualification, this book offers structured practice to reinforce key concepts. You'll find a wide range of multiple-choice questions, each followed by clear explanations to help you understand not just the right answer, but why it's correct.

The content in this guide is based on real-world exam objectives and aligned with the types of questions and topics commonly found on official tests. It's ideal for learners who want to:

- Practice answering questions under realistic conditions,
- Improve accuracy and speed,
- Review explanations to strengthen weak areas, and
- Approach the exam with greater confidence.

We recommend using this book not as a stand-alone study tool, but alongside other resources like flashcards, textbooks, or hands-on training. For best results, we recommend working through each question, reflecting on the explanation provided, and revisiting the topics that challenge you most.

Remember: successful test preparation isn't about getting every question right the first time, it's about learning from your mistakes and improving over time. Stay focused, trust the process, and know that every page you turn brings you closer to success.

Let's begin.

How to Use This Guide

This guide is designed to help you study more effectively and approach your exam with confidence. Whether you're reviewing for the first time or doing a final refresh, here's how to get the most out of your Examzify study guide:

1. Start with a Diagnostic Review

Skim through the questions to get a sense of what you know and what you need to focus on. Your goal is to identify knowledge gaps early.

2. Study in Short, Focused Sessions

Break your study time into manageable blocks (e.g. 30 – 45 minutes). Review a handful of questions, reflect on the explanations.

3. Learn from the Explanations

After answering a question, always read the explanation, even if you got it right. It reinforces key points, corrects misunderstandings, and teaches subtle distinctions between similar answers.

4. Track Your Progress

Use bookmarks or notes (if reading digitally) to mark difficult questions. Revisit these regularly and track improvements over time.

5. Simulate the Real Exam

Once you're comfortable, try taking a full set of questions without pausing. Set a timer and simulate test-day conditions to build confidence and time management skills.

6. Repeat and Review

Don't just study once, repetition builds retention. Re-attempt questions after a few days and revisit explanations to reinforce learning. Pair this guide with other Examzify tools like flashcards, and digital practice tests to strengthen your preparation across formats.

There's no single right way to study, but consistent, thoughtful effort always wins. Use this guide flexibly, adapt the tips above to fit your pace and learning style. You've got this!

Questions

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- 1. What is the primary focus when implementing client-centered care?**
 - A. Meeting the needs of the institution efficiently
 - B. Ensuring patient safety and comfort
 - C. Fostering client autonomy and participation in their care
 - D. Following strict clinical protocols without deviation
- 2. Which fetal heart rate should the practical nurse (PN) report immediately to the registered nurse (RN)?**
 - A. 120 beats per minute
 - B. 150 beats per minute
 - C. 160 beats per minute
 - D. 180 beats per minute
- 3. What is the main goal of infection control practices?**
 - A. To minimize the risk of infection transmission
 - B. To increase patient movement
 - C. To track medication side effects
 - D. To provide psychological support
- 4. How should the nurse assess a client's urine in the drainage tubing of a Foley catheter?**
 - A. By observing the color and clarity of the urine
 - B. By measuring the output every hour
 - C. By palpating the abdomen for distention
 - D. By asking the client about their comfort level
- 5. When observing a male client's urinary catheter drainage setup, what is the most appropriate action for the nurse?**
 - A. Change the drainage tubing immediately
 - B. Secure the tubing to the bed frame more tightly
 - C. Observe the appearance of the urine in the drainage tubing
 - D. Inform the client about his catheter

- 6. Which action is most essential when providing oral care to an unconscious mouthbreather client?**
- A. Use mouthwash to freshen breath
 - B. Position the client on their side
 - C. Use an oral suction catheter in the buccal cavity
 - D. Apply a moisturizer to the lips
- 7. What is the appropriate nursing intervention when a client expresses grief after a spontaneous abortion?**
- A. Encourage the client to talk about their feelings
 - B. Dismiss the client's tears to focus on recovery
 - C. Express sorrow for the client's grief and offer to sit with her
 - D. Suggest the client join a support group immediately
- 8. What should the practical nurse (PN) include in the care plan for a client taking ibuprofen for arthritic pain?**
- A. Encourage the client to increase their physical activity
 - B. Observe for signs of gastrointestinal bleeding
 - C. Ensure the client takes ibuprofen with food
 - D. Advise the client to stop taking the medication if pain worsens
- 9. Why is it important for nurses to practice cultural competence?**
- A. To ensure conformity to standardized treatment protocols
 - B. To provide care that respects diverse patient backgrounds and beliefs
 - C. To avoid legal repercussions from discrimination
 - D. To improve overall efficiency in healthcare settings
- 10. Why is proper patient positioning crucial in nursing care?**
- A. It promotes independence
 - B. It allows for easier medication administration
 - C. It prevents complications like pressure ulcers
 - D. It encourages family involvement

Answers

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

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Explanations

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1. What is the primary focus when implementing client-centered care?

- A. Meeting the needs of the institution efficiently
- B. Ensuring patient safety and comfort
- C. Fostering client autonomy and participation in their care**
- D. Following strict clinical protocols without deviation

The primary focus of implementing client-centered care is to foster client autonomy and encourage participation in their own care. This approach recognizes that each client is a unique individual with their own preferences, values, and needs. By prioritizing autonomy, healthcare providers empower clients to take an active role in decision-making regarding their treatment options. This leads to increased satisfaction, improved adherence to care plans, and enhanced health outcomes because clients feel respected and valued in the healthcare process. This emphasis on autonomy also helps to build a therapeutic relationship between clients and healthcare providers. By engaging clients in discussions about their care, providers can better understand their concerns and expectations, leading to more personalized and effective care strategies. Consequently, client-centered care not only improves individual experiences but also supports holistic practices, where physical, emotional, and social aspects of care are taken into account. While ensuring patient safety and comfort is vital in any healthcare setting, it does not encapsulate the breadth of client involvement and empowerment inherent in client-centered care. Focusing solely on meeting the needs of the institution efficiently or adhering strictly to clinical protocols may overlook the significance of the client's voice and preferences, which are crucial elements in delivering high-quality, patient-focused care.

2. Which fetal heart rate should the practical nurse (PN) report immediately to the registered nurse (RN)?

- A. 120 beats per minute
- B. 150 beats per minute
- C. 160 beats per minute
- D. 180 beats per minute**

A fetal heart rate of 180 beats per minute indicates tachycardia, which is a concerning sign that requires immediate attention. Normal fetal heart rates typically range from 110 to 160 beats per minute. When the fetal heart rate exceeds this range, especially at such a high level, it can indicate potential complications that the healthcare team must assess further. Possible causes of fetal tachycardia include maternal fever, infection, fetal distress, or complications related to the pregnancy itself. In this context, a heart rate of 120 beats per minute, 150 beats per minute, and 160 beats per minute are all considered within normal limits and do not typically warrant immediate intervention. Therefore, the significantly elevated rate of 180 beats per minute stands out as abnormal and necessitates prompt evaluation by the registered nurse to determine the underlying cause and initiate appropriate interventions. Recognizing and responding to such changes in fetal heart patterns is critical for ensuring the health and safety of both the fetus and the mother.

3. What is the main goal of infection control practices?

- A. To minimize the risk of infection transmission
- B. To increase patient movement
- C. To track medication side effects
- D. To provide psychological support

The main goal of infection control practices is to minimize the risk of infection transmission. This is crucial in healthcare settings to protect both patients and healthcare workers. Infection control strategies include hand hygiene, the use of personal protective equipment (PPE), sterilization and disinfection of instruments, and the implementation of protocols to manage outbreaks. By adhering to these practices, healthcare facilities can significantly reduce the spread of infections, which is essential for maintaining patient safety and improving health outcomes. The other options, while important in their own contexts, do not align with the primary purpose of infection control. For example, increasing patient movement is more related to physical therapy and mobility, tracking medication side effects pertains to pharmacovigilance, and providing psychological support focuses on mental health. Therefore, the core objective remains firmly focused on infection prevention and control.

4. How should the nurse assess a client's urine in the drainage tubing of a Foley catheter?

- A. By observing the color and clarity of the urine
- B. By measuring the output every hour
- C. By palpating the abdomen for distention
- D. By asking the client about their comfort level

Observing the color and clarity of the urine is a vital component of assessing a client's urine in the drainage tubing of a Foley catheter. This observation provides critical information about the client's hydration status, potential infection, and the presence of any abnormalities. For instance, clear urine typically indicates good hydration, while dark, cloudy, or bloody urine may suggest dehydration, infection, or other medical concerns that need further evaluation. Measuring urine output every hour is also important, but it focuses more on the volume aspect rather than the characteristics of the urine itself. Palpating the abdomen for distention is a physical assessment technique that can indicate other issues, such as urinary retention or other abdominal problems, but it does not provide direct information about the urine in the catheter. Asking the client about their comfort level can yield valuable subjective data regarding their overall condition, but it does not directly assess the urine drainage and its characteristics. Hence, observing the color and clarity is the most direct and informative assessment method regarding the urine in drainage tubing.

5. When observing a male client's urinary catheter drainage setup, what is the most appropriate action for the nurse?

- A. Change the drainage tubing immediately
- B. Secure the tubing to the bed frame more tightly
- C. Observe the appearance of the urine in the drainage tubing**
- D. Inform the client about his catheter

Observing the appearance of the urine in the drainage tubing is crucial for assessing the client's urinary output and detecting any potential complications. The urine's color, clarity, and any presence of sediment or unusual odors can provide important information about the client's hydration status and kidney function, as well as indicate possible infections or obstruction within the urinary tract. Monitoring the characteristics of the urine is an essential nursing responsibility, as it helps establish a baseline for urinary function and can assist in early identification of issues that may require medical intervention. This approach ensures that the nurse is actively engaging in patient monitoring, which is fundamental to providing quality care. Looking at the other options, while securing the tubing or informing the client may seem helpful, they do not directly address the immediate need for assessment and monitoring of the client's urinary health. Changing the drainage tubing without a clear indication of a problem may not be necessary, and could pose unnecessary risks, such as introducing infection. Engaging in a thorough evaluation of the urine in the drainage tubing is the most appropriate initial action in this scenario.

6. Which action is most essential when providing oral care to an unconscious mouthbreather client?

- A. Use mouthwash to freshen breath
- B. Position the client on their side
- C. Use an oral suction catheter in the buccal cavity**
- D. Apply a moisturizer to the lips

When providing oral care to an unconscious mouthbreather client, the most essential action is to use an oral suction catheter in the buccal cavity. This is crucial because patients who are unconscious cannot manage their secretions, leading to a risk of aspiration, choking, or infection. The oral suction catheter is specifically designed to remove accumulated saliva, debris, and any other substances that could obstruct the airway or lead to aspiration pneumonia, which is especially important for a mouthbreather who may have dryness and increased secretions. While using mouthwash to freshen breath can improve comfort, it does not address the underlying health and safety concerns associated with an unconscious patient. Positioning the client on their side is beneficial to a degree, but without suctioning, there remains a risk of secretions pooling in the mouth, which can lead to aspiration if the patient were to begin regurgitating. Applying moisturizer to the lips may provide comfort but does not significantly contribute to the client's overall oral health and safety. Hence, the focus must be on maintaining a clear oral cavity and preventing potential complications, making the use of an oral suction catheter the most critical action in this nursing scenario.

7. What is the appropriate nursing intervention when a client expresses grief after a spontaneous abortion?

- A. Encourage the client to talk about their feelings
- B. Dismiss the client's tears to focus on recovery
- C. Express sorrow for the client's grief and offer to sit with her**
- D. Suggest the client join a support group immediately

The most appropriate nursing intervention when a client expresses grief after a spontaneous abortion is to express sorrow for the client's grief and offer to sit with her. This response acknowledges the client's emotional pain and provides a supportive presence, which is crucial for someone experiencing such a significant loss. When someone goes through the experience of a spontaneous abortion, they may feel a range of emotions including sadness, guilt, and isolation. By expressing sorrow, the nurse validates the client's feelings, showing empathy and understanding. Offering to sit with her not only conveys compassion but also creates a safe space for the client to express her feelings at her own pace, which can be healing. This approach fosters therapeutic communication and can help the client process her grief in a supportive environment. In contrast, encouraging the client to talk about her feelings is also supportive but may put pressure on her to articulate emotions she might not be ready to discuss. Dismissing the client's tears undermines her grief and could make her feel unsupported, while suggesting immediate participation in a support group may not be appropriate until the client has had time to process her emotions and assess her readiness to engage with others.

8. What should the practical nurse (PN) include in the care plan for a client taking ibuprofen for arthritic pain?

- A. Encourage the client to increase their physical activity
- B. Observe for signs of gastrointestinal bleeding**
- C. Ensure the client takes ibuprofen with food
- D. Advise the client to stop taking the medication if pain worsens

The inclusion of monitoring for signs of gastrointestinal bleeding in the care plan for a client taking ibuprofen is essential due to the known side effects of nonsteroidal anti-inflammatory drugs (NSAIDs), like ibuprofen. This class of medication can irritate the gastrointestinal (GI) lining, leading to potential complications such as ulcers or bleeding. Given that ibuprofen is often used for managing pain and inflammation, especially in conditions like arthritis, the nurse must be vigilant about the client's gastrointestinal status. Signs of gastrointestinal bleeding may include symptoms like abdominal pain, black or tarry stools, or vomiting blood. By observing these symptoms, the practical nurse can intervene early, which is critical for preventing more serious health issues. This approach is a proactive measure in client care, aligning with the role of the practical nurse in assessing and monitoring the effects of prescribed medication. The emphasis on gastrointestinal health is particularly pertinent for clients who may be at higher risk due to age, concurrent medications, or a history of GI issues.

9. Why is it important for nurses to practice cultural competence?

- A. To ensure conformity to standardized treatment protocols
- B. To provide care that respects diverse patient backgrounds and beliefs**
- C. To avoid legal repercussions from discrimination
- D. To improve overall efficiency in healthcare settings

Practicing cultural competence is essential for nurses because it enables them to provide care that is respectful of, and tailored to, the diverse backgrounds, beliefs, and values of patients. This understanding fosters a therapeutic relationship based on trust and empathy, which can lead to improved health outcomes. Recognizing and valuing cultural differences allows nurses to communicate more effectively, provide appropriate interventions, and address specific health practices or preferences of patients. Effective cultural competence also involves being aware of potential biases and understanding how cultural factors can impact health behaviors and attitudes towards healthcare. When nurses embrace and practice cultural competence, they not only enhance patient satisfaction but also empower patients to engage more actively in their own care, which is critical for achieving positive health results. In essence, an emphasis on culturally competent care leads to a more inclusive healthcare environment where all patients feel understood and valued.

10. Why is proper patient positioning crucial in nursing care?

- A. It promotes independence
- B. It allows for easier medication administration
- C. It prevents complications like pressure ulcers**
- D. It encourages family involvement

Proper patient positioning is crucial in nursing care primarily because it prevents complications such as pressure ulcers. When patients are not positioned correctly, especially those with limited mobility, they are at a higher risk for developing pressure sores. These sores occur due to prolonged pressure on specific areas of the body, typically over bony prominences, which can restrict blood flow and cause tissue damage. In addition to preventing pressure ulcers, proper positioning also facilitates other aspects of patient care. For instance, it can enhance comfort, improve respiratory function, and aid in digestion. However, the key focus of positioning is to avoid complications that can lead to more serious health issues, particularly in vulnerable populations. The other options, while relevant to different aspects of care, do not directly address the primary reason for the importance of proper positioning. Promoting independence and encouraging family involvement are critical components of holistic patient care but are not the main focus of positioning. Similarly, while correct positioning might make medication administration easier in some situations, it is not the primary reason for positioning practices. The overarching goal remains to safeguard patients from avoidable adverse effects, such as pressure ulcers.

Next Steps

Congratulations on reaching the final section of this guide. You've taken a meaningful step toward passing your certification exam and advancing your career.

As you continue preparing, remember that consistent practice, review, and self-reflection are key to success. Make time to revisit difficult topics, simulate exam conditions, and track your progress along the way.

If you need help, have suggestions, or want to share feedback, we'd love to hear from you. Reach out to our team at hello@examzify.com.

Or visit your dedicated course page for more study tools and resources:

<https://lpnexit.examzify.com>

We wish you the very best on your exam journey. You've got this!

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