NCLEX Emergency Nursing Practice Test (Sample)

Study Guide

Everything you need from our exam experts!

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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

1. **The nurse and unlicensed assistive personnel (UAP) are caring for clients in the ED. Which task would be most appropriate to delegate to the UAP?**

   A. **Tell the UAP to take the vital signs of a client with a gunshot wound to the chest.**

   B. **Instruct the UAP to flush the eyes of a client who splashed bleach in the eyes.**

   C. **Ask the UAP to use the Rule of Nines to determine the percentage body surface burned.**

   D. **Request the UAP complete the discharge teaching for the client diagnosed with scabies.**

2. **Oral penicillin is the treatment for exposure to which biological agent?**

   A. **Anthrax**

   B. **Botulism**

   C. **Plague**

   D. **Smallpox**

3. **Which situation would require the charge nurse in a long-term care facility to obtain information from a material safety data sheet (MSDS)?**

   A. **The nurse was accidentally stuck with a used insulin syringe**

   B. **The custodian spilled bleach water on the floor of the lobby.**

   C. **The family member brought the resident's dog into the building.**

   D. **The resident had a mercury thermometer that broke in the bathroom.**

4. **Which assessment data would indicate to the nurse the client is experiencing hypovolemic shock?**

   A. **The client's BP is 80/40 and apical pulse 128.**

   B. **The client's cardiac output is 5 L/min.**

   C. **The client's central venous pressure (CVP) is 8 cm H2O.**

   D. **The client is hypertensive and bradycardic.**

5. Which nurse is described as the strength of the ED and should typically serve as the relief charge nurse?

A. The orienting ED nurse

B. The RN who frequently functions as charge nurse of the ED

C. The RN who has floated between the ED and ICU

D. The RN who is interested in training for the ICU

6. The disaster triage system classifies which client as Minimal category, Priority 3, and color green?

A. The client with a sucking chest wound who is alert.

B. The client with a head injury who is unresponsive.

C. The client with an abdominal wound and stable vital signs.

D. The client with a sprained ankle that may be fractured.

7. A potential chemical spill has occurred on the medical floor. Which intervention should the charge nurse implement first?

A. Instruct the staff to evacuate the immediate area.

B. Contain the area where the chemical spill occurred.

C. Notify the hazard management team.

D. Contact the hospital shift supervisor.

8. The triage nurse receives a phone call in an outpatient clinic. Which client should be advised to come to the emergency clinic today?

A. The client who reports burning and pain upon urination.

B. The client who calls is complaining of severe chest pain.

C. The client who has had a stuffy nose and cough for 2 days.

D. The client who needs a physical examination for football.

9. Which PPE level provides the highest level of protection against hazardous exposures?

A. Level A

B. Level B

C. Level C

D. Level D

10. Which assessment data indicates a client with septic shock is responding to treatment?

A. Vital signs: T 100.4°F, P 104, R 26, BP 102/60.

B. A white blood cell count of 18,000 mm3.

C. Urinary output of 200 mL in the last 4 hours.

D. Dry, mucous membranes and tented skin turgor.

Answers

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

Explanations

1. The nurse and unlicensed assistive personnel (UAP) are caring for clients in the ED. Which task would be most appropriate to delegate to the UAP?

A. Tell the UAP to take the vital signs of a client with a gunshot wound to the chest.

B. Instruct the UAP to flush the eyes of a client who splashed bleach in the eyes.

C. Ask the UAP to use the Rule of Nines to determine the percentage body surface burned.

D. Request the UAP complete the discharge teaching for the client diagnosed with scabies.

Focusing on delegation, tasks should be ones that don't require nursing judgment or advanced clinical skills. Initiating eye irrigation after a chemical splash is a straightforward, time-critical first aid action that a UAP can perform under supervision. Copious irrigation minimizes ocular injury and is primarily an immediate safety measure, not a clinical decision, so it's appropriate for delegation while the nurse prepares further care and monitoring. The other tasks require nursing assessment, interpretation, or education. Taking vital signs for a patient with a gunshot wound to the chest involves ongoing monitoring and recognizing signs of deterioration. Using the Rule of Nines to estimate burn area requires clinical calculation and judgment. Discharge teaching for scabies involves structured patient education and assessment of understanding.

2. Oral penicillin is the treatment for exposure to which biological agent?

A. Anthrax

B. Botulism

C. Plague

D. Smallpox

Exposure to Bacillus anthracis, the bacterium that causes anthrax, is treated with antibiotics to prevent bacterial growth and toxin production. Oral penicillin can be effective against susceptible strains, making it a reasonable option for post-exposure prophylaxis or mild disease. In clinical practice, guidelines often favor ciprofloxacin or doxycycline for post-exposure prophylaxis due to broader coverage and resistance considerations, and more aggressive IV antibiotics are used for established inhalational cases, sometimes with antitoxins. Other agents listed do not fit because their primary treatments differ: botulism is managed with antitoxin and supportive care rather than antibiotics; plague is treated with other antibiotics such as streptomycin, gentamicin, or doxycycline; smallpox is addressed with vaccination and supportive care rather than antibiotics.

3. Which situation would require the charge nurse in a long-term care facility to obtain information from a material safety data sheet (MSDS)?

A. The nurse was accidentally stuck with a used insulin syringe

B. The custodian spilled bleach water on the floor of the lobby.

C. The family member brought the resident's dog into the building.

D. The resident had a mercury thermometer that broke in the bathroom.

Understanding how to use an MSDS is about knowing where to find hazard details, required protection, and exact cleanup or disposal steps for chemical substances. Mercury from a broken thermometer is a toxic chemical spill with specific containment and decontamination needs. The MSDS would guide you to isolate the area, ventilate if safe, avoid direct contact, and not use a vacuum or broom that could aerosolize mercury. Cleanup would typically involve using a mercury spill kit or damp materials to scoop up beads, placing them in a sealed container, and disposing of them as hazardous waste per local regulations, along with proper removal and decontamination of contaminated clothing and surfaces. The other scenarios involve situations where standard medical exposure protocols or routine cleaning procedures apply, rather than requiring MSDS-directed chemical spill procedures.

4. Which assessment data would indicate to the nurse the client is experiencing hypovolemic shock?

A. The client's BP is 80/40 and apical pulse 128.

B. The client's cardiac output is 5 L/min.

C. The client's central venous pressure (CVP) is 8 cm H2O.

D. The client is hypertensive and bradycardic.

When intravascular volume is severely reduced, perfusion pressure drops and the heart tries to compensate by beating faster. This creates a pattern of low blood pressure with a fast pulse, signaling shock from volume loss. The data showing a systolic pressure as low as 80 mmHg along with a rapid apical pulse of 128 beats per minute fits this picture: the body is in shock from low circulating volume, and the heart is working harder to maintain perfusion. Other data don't fit hypovolemic shock as well. A cardiac output of 5 L/min can be within the normal range, which wouldn't by itself indicate shock. A central venous pressure of 8 cm H2O suggests elevated preload, not the reduced preload seen with hypovolemia. Hypertension with bradycardia is not typical for hypovolemic shock, which usually presents with low blood pressure and tachycardia due to compensatory mechanisms.

5. Which nurse is described as the strength of the ED and should typically serve as the relief charge nurse?

A. The orienting ED nurse

B. The RN who frequently functions as charge nurse of the ED

C. The RN who has floated between the ED and ICU

D. The RN who is interested in training for the ICU

The core idea is leadership and reliability in the ED during times when the regular charge nurse isn't available. The relief charge nurse must step in and keep patient safety, throughput, and staff coordination steady, making quick, informed decisions under pressure. The RN who frequently functions as the ED charge nurse already regularly handles the responsibilities: leading the team, assigning workloads, coordinating patient flow, prioritizing needs, communicating with physicians and other departments, and upholding ED protocols. This person has proven visibility into the unit's rhythm, trauma activations, and disposition decisions, and they're trusted to maintain order and safety across shifts. That established leadership presence is exactly what a relief charge nurse needs. The orienting ED nurse is still learning the unit, which can slow decision-making and disrupt flow during a high-stress period. The RN floating between the ED and ICU may know both areas better than a pure orientee, but lack of consistent ED-specific leadership experience can undermine confidence and continuity. The RN aiming for ICU training shows interest in a different specialty and may not have the ED leadership background needed for a relief charge role. So, the nurse who frequently serves as the ED charge nurse is the best choice to serve as relief charge nurse, because demonstrated leadership, familiarity with ED workflows, and trusted decision-making under pressure are essential for that role.

6. The disaster triage system classifies which client as Minimal category, Priority 3, and color green?

A. The client with a sucking chest wound who is alert.

B. The client with a head injury who is unresponsive.

C. The client with an abdominal wound and stable vital signs.

D. The client with a sprained ankle that may be fractured.

Disaster triage aims to maximize lives saved by quickly sorting patients by how urgently they need care. Green, or Minimal, is the category for those with minor injuries who can walk and do not need immediate life-saving interventions. They can wait and be treated after more critical patients are stabilized. In these scenarios, the sprained ankle that may be fractured fits green because the person can ambulate, has no life-threatening signs, and requires only basic first aid. The other conditions indicate more serious problems requiring urgent attention: a sucking chest wound is a life-threatening injury needing immediate intervention; an unresponsive head injury carries high risk of deterioration and requires rapid evaluation and treatment; an abdominal wound with stable vitals could be yellow (delayed) but is more concerning than minimal.

7. A potential chemical spill has occurred on the medical floor. Which intervention should the charge nurse implement first?

A. Instruct the staff to evacuate the immediate area.

B. Contain the area where the chemical spill occurred.

C. Notify the hazard management team.

D. Contact the hospital shift supervisor.

Containing the area is the first action because the immediate priority in any chemical spill is to limit exposure and prevent the hazard from spreading. By isolating the spill, you establish a controlled zone, reduce the risk to nearby patients and staff, and prevent contamination from moving through hallways, doors, or ventilation. This quick containment buys critical time to assess the chemical, determine appropriate PPE, and decide on further steps safely. Evacuating people, notifying hazard management, and contacting the shift supervisor are all important parts of the overall response, but they follow containment. If the spill isn't contained, evacuation can spread contaminants or put responders at risk, and responders would be entering an uncontrolled area. Once the area is contained, you can efficiently notify HazMat or hazard management and coordinate with leadership to escalate the response.

8. The triage nurse receives a phone call in an outpatient clinic. Which client should be advised to come to the emergency clinic today?

A. The client who reports burning and pain upon urination.

B. The client who calls is complaining of severe chest pain.

C. The client who has had a stuffy nose and cough for 2 days.

D. The client who needs a physical examination for football.

When a triage nurse handles a phone call, the priority is to spot red flags that require urgent in-person assessment. Burning and pain with urination can indicate a urinary tract infection, and while many UTIs are managed as outpatients, they can progress to more serious infections such as pyelonephritis or sepsis, especially in high-risk individuals (older adults, pregnant patients, immunocompromised, or men). Because progression can be rapid and early treatment is important, directing the client to come to the emergency clinic today for evaluation, urinalysis, and possible antibiotics is prudent. The other scenarios describe common, less urgent conditions (a viral-like upper respiratory symptoms and a routine football physical) that typically do not require ED care today.

9. Which PPE level provides the highest level of protection against hazardous exposures?

A. Level A

B. Level B

C. Level C

D. Level D

The highest level of protection comes from a fully encapsulating suit paired with a self-contained breathing apparatus. This setup seals the entire body and provides its own air supply, meaning vapors, splashes, and contaminants cannot reach the skin, eyes, or respiratory tract. That complete encapsulation and independent airflow offer the greatest defense against hazardous exposures. Other levels provide strong protection but not to the same extent. A suit with splash protection and an external respirator protects the airway well but doesn't envelop the body completely, so there's still potential entry through seams or openings. Air-purifying respirators with chemical-resistant clothing protect the lungs and skin to some degree but rely on filters and don't offer the same barrier against all exposure routes. The lowest level uses basic clothing with minimal protection, suitable only for nonhazardous environments.

10. Which assessment data indicates a client with septic shock is responding to treatment?

A. Vital signs: T 100.4°F, P 104, R 26, BP 102/60.

B. A white blood cell count of 18,000 mm3.

C. Urinary output of 200 mL in the last 4 hours.

D. Dry, mucous membranes and tented skin turgor.

In septic shock, a key sign that treatment is helping is improved perfusion to vital organs, which shows up as adequate urine output. Urine output of 200 mL over 4 hours equals about 50 mL per hour, roughly 0.7 mL/kg/hr for a typical adult—above the commonly used target of at least 0.5 mL/kg/hr. This indicates the kidneys are receiving enough blood flow and that fluid resuscitation and vasopressor therapy are stabilizing circulation. Other data don't demonstrate this immediate improvement. A temperature and heart rate that remain elevated and a blood pressure that's still borderline suggest ongoing physiologic stress rather than clear stabilization. A high white blood cell count reflects the infection but not how well the patient is responding to treatment in the moment. Dry mucous membranes and tenting skin show continuing dehydration and poor perfusion, not recovery.

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://nclexemergencynursing.examzify.com

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