

NCLEX EMERGENCY NURSING PRACTICE TEST (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. In rapid sequence intubation, which safety steps ensure correct tube placement and patient safety?**
 - A. Preoxygenation; sedation and paralysis; maintain inline cervical spine protection; verify placement with capnography; secure tube and monitor.
 - B. Administer sedatives only; no ventilation; verify placement with auscultation.
 - C. Preoxygenation; avoid paralysis; proceed without capnography.
 - D. Immediate intubation without preoxygenation.
- 2. Which action is a priority when caring for a patient with corrosive ingestion?**
 - A. Administer milk to dilute the chemical
 - B. Assess the patient's breathing and airway status
 - C. Insert an NG tube to decompress the stomach
 - D. Induce vomiting to remove the chemical quickly
- 3. Which statement indicates one of the students needs more teaching concerning information about biological warfare?**
 - A. "Anthrax, smallpox, and plagues are examples of biological agents."
 - B. "Chemical agents are more apparent and problems occur more quickly than with biological agents."
 - C. "Biological weapons are less of a threat than chemical agents."
 - D. "Biological agents can be released in one city and affect cities thousands of miles away."
- 4. Which statement reflects standard ED therapy for acute asthma?**
 - A. Oral antibiotics are the primary ED therapy for acute asthma
 - B. Inhaled beta-agonists with anticholinergics, systemic steroids, and oxygen
 - C. IV magnesium sulfate is never used in asthma
 - D. Nebulized saline alone is sufficient
- 5. How is hypoglycemia managed in adults and children presenting to the ED?**
 - A. Conscious patients should receive insulin IV; unconscious patients require IV dextrose.
 - B. Conscious: oral glucose 15-20 g; unconscious or unable to swallow: IV dextrose 25-50 mL of 50% dextrose; if IV unavailable, intramuscular glucagon.
 - C. Use only fruit juice and delay treatment.
 - D. Wait for physician orders before any treatment.

6. The ED nurse is caring for a client with a head injury and decerebrate posturing in response to painful stimuli. Which data would indicate the client's condition is improving?
- A. The client has purposeful movement when the nurse rubs the sternum.
 - B. The client extends the upper and lower extremities in response to painful stimuli.
 - C. The client is flaccid when the nurse applies painful pressure to the sternum.
 - D. The client has a Glasgow Coma Scale rating of 4 on a 1–15 scale.
7. In a unresponsive patient who is not breathing after two rescue breaths, what should be done next?
- A. Check the airway obstruction.
 - B. Assess the carotid pulse.
 - C. Begin chest compressions.
 - D. Call a code via the call light.
8. How is status epilepticus defined and what is the ED treatment sequence?
- A. A seizure lasting less than 2 minutes; treat with observation.
 - B. Seizure lasting more than 5 minutes or multiple seizures without return to baseline; benzodiazepines first-line (lorazepam); then second-line antiseizure meds (phenytoin/fosphenytoin or valproate); consider intubation.
 - C. Only focal seizures require treatment; avoid benzodiazepines.
 - D. Seizures always resolve spontaneously within 1 minute.
9. Which statement accurately describes ED management for acute asthma regarding magnesium sulfate?
- A. IV magnesium sulfate is routinely used in mild asthma
 - B. Oxygen is not necessary if the patient is asymptomatic
 - C. Inhaled beta-agonists with anticholinergics, systemic steroids, and oxygen are standard; IV magnesium sulfate is reserved for severe or refractory asthma
 - D. Oral antibiotics are central to asthma management
10. In sepsis management, when should vasopressors be started after fluid resuscitation?
- A. MAP $\geq$ 65 mmHg after fluids; continue fluids.
 - B. MAP $<$ 65 mmHg after fluids; start vasopressors.
 - C. MAP $>$ 90 after fluids; start vasopressors.
 - D. MAP $<$ 50; start vasopressors immediately.

Answers

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

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Explanations

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1. In rapid sequence intubation, which safety steps ensure correct tube placement and patient safety?

- A. Preoxygenation; sedation and paralysis; maintain inline cervical spine protection; verify placement with capnography; secure tube and monitor.**
- B. Administer sedatives only; no ventilation; verify placement with auscultation.
- C. Preoxygenation; avoid paralysis; proceed without capnography.
- D. Immediate intubation without preoxygenation.

In rapid sequence intubation, safety centers on oxygenation, controlled airway placement, protection of the spine when indicated, reliable confirmation of tube location, and continuous monitoring. Preoxygenation builds an oxygen reserve to bridge the brief apnea during intubation, reducing the risk of hypoxemia. Sedation and paralysis create a smooth, rapid intubation by preventing patient movement and coughing, making placement easier and safer. Maintaining inline cervical spine protection is crucial when trauma or suspected spinal injury is possible, so airway manipulation doesn't compromise the spine. Verifying placement with capnography gives an objective, immediate indication that the tube is in the trachea, not the esophagus, and can detect misplaced tubes right away. Finally, securing the tube and ongoing monitoring prevent dislodgement and ensure continuous assessment of ventilation and oxygenation. Without preoxygenation, desaturation is likely; auscultation alone cannot reliably confirm tube placement; skipping capnography misses a critical safety check; and neglecting airway protection for possible cervical spine injury or relying on anesthesia without paralysis can increase risk during the procedure.

2. Which action is a priority when caring for a patient with corrosive ingestion?

- A. Administer milk to dilute the chemical
- B. Assess the patient's breathing and airway status**
- C. Insert an NG tube to decompress the stomach
- D. Induce vomiting to remove the chemical quickly

Assessing and protecting the airway is the priority because caustic ingestions can rapidly cause airway edema and obstruction, making breathing status the most immediate and life-saving concern. Early signs like drooling, hoarseness, coughing, stridor, or respiratory distress mean the patient may need urgent airway support, and securing the airway (often by intubation) can prevent impending failure. Giving milk to dilute the chemical isn't recommended because it can trigger vomiting and aspiration and doesn't prevent tissue damage. Inserting an NG tube to decompress the stomach risks perforation and further injury in a damaged esophagus and is avoided until airway and injury assessment are complete. Inducing vomiting is contraindicated since it re-exposes and spreads the caustic agent to the esophagus and airway. Prioritizing airway assessment sets the stage for safe further management and reduces the risk of fatal complications.

3. Which statement indicates one of the students needs more teaching concerning information about biological warfare?

- A. "Anthrax, smallpox, and plagues are examples of biological agents."
- B. "Chemical agents are more apparent and problems occur more quickly than with biological agents."
- C. "Biological weapons are less of a threat than chemical agents."**
- D. "Biological agents can be released in one city and affect cities thousands of miles away."

Biological warfare can pose a serious and often subtle threat because many biological agents have incubation periods and can spread between people, leading to a large and delayed outbreak even if initial symptoms seem mild. This makes rapid recognition, isolation, and coordinated public health response essential, so assuming that biological weapons are less threatening misses how these agents behave in real outbreaks. The statement that biological weapons are less of a threat than chemical ones reflects a gap in understanding of how quickly and widely a biological exposure can unfold, which is why it indicates a need for more teaching. The other points touch on factual aspects—anthrax, smallpox, and plague are classic biological agents, and some chemical exposures do act immediately—so they don't demonstrate the same fundamental misconception about the danger posed by biological threats.

4. Which statement reflects standard ED therapy for acute asthma?

- A. Oral antibiotics are the primary ED therapy for acute asthma
- B. Inhaled beta-agonists with anticholinergics, systemic steroids, and oxygen**
- C. IV magnesium sulfate is never used in asthma
- D. Nebulized saline alone is sufficient

Managing acute asthma in the ED centers on rapid bronchodilation and reducing airway inflammation while ensuring adequate oxygenation. The standard approach combines inhaled bronchodilators with an anticholinergic, systemic corticosteroids, and supplemental oxygen. Inhaled beta-agonists such as albuterol quickly relax bronchial smooth muscle, providing prompt relief from wheeze and shortness of breath. Adding an anticholinergic agent like ipratropium enhances bronchodilation, especially in moderate to severe episodes. Systemic steroids—taken orally or IV—address the inflammatory component, shorten recovery time, and reduce the chance of relapse after discharge. Oxygen is used to correct or prevent hypoxemia, with targets to keep the patient's saturation in a safe range. In more severe cases, intravenous magnesium sulfate may be considered if the initial therapy doesn't yield adequate improvement. Antibiotics are not part of standard ED therapy for an acute asthma attack unless there's a concurrent bacterial infection, and nebulized saline alone does not provide enough bronchodilation to treat an acute flare.

5. How is hypoglycemia managed in adults and children presenting to the ED?

- A. Conscious patients should receive insulin IV; unconscious patients require IV dextrose.
- B. Conscious: oral glucose 15-20 g; unconscious or unable to swallow: IV dextrose 25-50 mL of 50% dextrose; if IV unavailable, intramuscular glucagon.**
- C. Use only fruit juice and delay treatment.
- D. Wait for physician orders before any treatment.

Prompt correction of hypoglycemia relies on how the patient presents. If the patient is conscious and able to swallow, give a rapid-acting carbohydrate totaling about 15-20 g (for example, glucose tablets or gel, fruit juice, or regular soda), then recheck blood glucose in about 15 minutes and repeat if still low. After it normalizes, provide a snack or meal to prevent recurrence and identify the cause. If the patient is unconscious or cannot swallow, secure IV access and give a rapid IV bolus of 25-50 mL of 50% dextrose to raise the glucose quickly. If IV access isn't possible, administer intramuscular glucagon; typical dosing is 1 mg for adults and for children above roughly 20–25 kg, with 0.5 mg for very small children. Always monitor the patient, reassess glucose after treatment, and investigate underlying causes while ensuring airway protection and ongoing evaluation. Delaying treatment, administering insulin, or waiting for physician orders before acting are inappropriate in these acute situations.

6. The ED nurse is caring for a client with a head injury and decerebrate posturing in response to painful stimuli. Which data would indicate the client's condition is improving?

- A. The client has purposeful movement when the nurse rubs the sternum.**
- B. The client extends the upper and lower extremities in response to painful stimuli.
- C. The client is flaccid when the nurse applies painful pressure to the sternum.
- D. The client has a Glasgow Coma Scale rating of 4 on a 1–15 scale.

Emergence of purposeful movement in response to a painful stimulus shows that the brain can initiate goal-directed motor activity, indicating improvement in neurological function. Decerebrate posturing reflects severe brainstem injury with rigid extension; finding purposeful movement suggests that the patient has regained some cortical or brainstem connectivity and arousal, which is a positive change in status. Continuing extensor posturing (arms and legs extended) in response to pain still indicates a severe, non-improving motor pattern and sustained brain injury. Flaccidity in response to pain means a lack of motor tone and response, which does not demonstrate active recovery at this moment. A Glasgow Coma Scale score as low as 4 reflects profound coma and poor prognosis; improvement would be seen as an increase in the GCS score, not a static 4.

7. In a unresponsive patient who is not breathing after two rescue breaths, what should be done next?

- A. Check the airway obstruction.
- B. Assess the carotid pulse.
- C. Begin chest compressions.
- D. Call a code via the call light.**

Activating emergency help right away is the next essential step. When an unresponsive patient isn't breathing, you need rapid access to a code team with advanced airway support, meds, and a defibrillator. Calling a code via the call light ensures trained personnel arrive promptly to guide and lead the resuscitation. While the code is being summoned, you would assess pulse and proceed with high-quality CPR as indicated—start chest compressions if there is no pulse, or continue ventilation and monitor if a pulse is present. The main idea is to minimize delays in getting advanced assistance so the patient can receive coordinated, life-saving care as quickly as possible.

8. How is status epilepticus defined and what is the ED treatment sequence?

- A. A seizure lasting less than 2 minutes; treat with observation.
- B. Seizure lasting more than 5 minutes or multiple seizures without return to baseline; benzodiazepines first-line (lorazepam); then second-line antiseizure meds (phenytoin/fosphenytoin or valproate); consider intubation.**
- C. Only focal seizures require treatment; avoid benzodiazepines.
- D. Seizures always resolve spontaneously within 1 minute.

The main concept is recognizing the emergency management sequence for status epilepticus, defined as a seizure lasting more than 5 minutes or two or more seizures without returning to baseline between them. In the ED, treatment begins with a benzodiazepine to stop the seizure quickly (for example, lorazepam given IV, with alternatives like midazolam or other routes if IV isn't available). If seizures persist, a second-line antiseizure medication is given to prevent recurrence, such as phenytoin or fosphenytoin or valproate (or levetiracetam). Airway and ventilation are a priority, so intubation should be considered if the patient cannot protect their airway or if they require sedation for ongoing seizure control. If seizures remain refractory after these steps, escalation to sedating infusions and ICU-level care with continuous EEG monitoring may be necessary. This aligns with what defines status epilepticus and why the treatment sequence starts with rapid seizure control with a benzodiazepine, followed by additional antiseizure therapy and airway protection. The other statements don't fit because seizures shorter than a few minutes do not define status epilepticus, observation is not appropriate in this emergency, focal seizures still require treatment, and seizures do not always resolve within a minute.

9. Which statement accurately describes ED management for acute asthma regarding magnesium sulfate?

- A. IV magnesium sulfate is routinely used in mild asthma
- B. Oxygen is not necessary if the patient is asymptomatic
- C. Inhaled beta-agonists with anticholinergics, systemic steroids, and oxygen are standard; IV magnesium sulfate is reserved for severe or refractory asthma**
- D. Oral antibiotics are central to asthma management

In acute asthma managed in the ED, the aim is rapid bronchodilation and reducing airway inflammation while ensuring adequate oxygenation. The standard approach is inhaled short-acting beta-agonists (often given with ipratropium), plus systemic corticosteroids, with supplemental oxygen to maintain a target oxygen saturation (typically above about 92–94%). Intravenous magnesium sulfate is not used routinely; it is reserved as an adjunct for severe or refractory asthma when the patient does not respond adequately to initial bronchodilator therapy. The evidence indicates it can help in those extreme cases, but it's not a first-line treatment for mild or uncomplicated attacks due to potential side effects and limited benefit in less severe episodes. Oral antibiotics are not a central part of acute asthma management, since asthma is not an infectious process unless a separate infection is present.

10. In sepsis management, when should vasopressors be started after fluid resuscitation?

- A. MAP $\geq$ 65 mmHg after fluids; continue fluids.
- B. MAP < 65 mmHg after fluids; start vasopressors.**
- C. MAP > 90 after fluids; start vasopressors.
- D. MAP < 50; start vasopressors immediately.

In septic shock, you first give a fluid bolus to restore circulating volume, then you aim to achieve a perfusion target pressure. The key moment to add vasopressors is when, after that adequate fluid resuscitation, the mean arterial pressure remains below the target (about 65 mmHg). At that point, vasopressor therapy is started to constrict vessels and improve organ blood flow, rather than pushing fluids further with diminishing returns and risk of overload. This approach keeps perfusion pressure up without relying on increasingly large fluid volumes. If the MAP is already at or above the target after fluids, vasopressors aren't needed. In practice, norepinephrine is the typical first-line agent when vasopressors are indicated.

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:

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

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