

NCLEX Readiness Practice Test (Sample)

Study Guide



Everything you need from our exam experts!

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SAMPLE

Questions

SAMPLE

- 1. When developing a care plan for a client with cirrhosis, what action is appropriate to prioritize first?**
 - A. Apply oxygen to the client**
 - B. Evaluate laboratory results**
 - C. Assess the client's level of consciousness**
 - D. Obtain a dietary history**
- 2. A nurse must closely monitor which laboratory value for a client on heparin therapy for DVT?**
 - A. Platelet count**
 - B. Clotting time**
 - C. Bleeding time**
 - D. Activated PTT**
- 3. What nursing intervention is most effective in helping a withdrawn client develop relationship skills?**
 - A. Initiate client interactions with one or two other clients**
 - B. Assist the client to analyze the meaning of behaviors**
 - C. Offer the client frequent opportunities to interact with the nurse**
 - D. Remind the client frequently to interact with other clients**
- 4. What is the appropriate intervention when a nurse aspirates 180 mL of undigested feeding from a client with ALS?**
 - A. Reinsert the residual and then flush with sterile water**
 - B. Reinsert the residual and hold the next feeding**
 - C. Discard the residual and hold the next feeding**
 - D. Discard the residual and administer the feeding**
- 5. What is the recommended action when a client is found to have a high serum potassium level?**
 - A. Instruct the client to increase potassium intake**
 - B. Notify the healthcare provider**
 - C. Encourage oral hydration**
 - D. Initiate a high-protein diet**

- 6. A 9-year-old with terminal cancer is asking about dying. What should the nurse do first?**
- A. Encourage the child to ask the parents these questions**
 - B. Notify the health care provider about the child's questions**
 - C. Reassure the child that everyone is trying to help get better**
 - D. Tell the parents about the child's questions**
- 7. What is a common side effect of opioid pain medication that nursing staff need to monitor closely?**
- A. Hypertension**
 - B. Bradycardia**
 - C. Constipation**
 - D. Insomnia**
- 8. Which dinner selection is the most appropriate to promote nutrition for a client in an acute manic episode of bipolar disorder?**
- A. Baked sweet potato, kale, yeast roll, water**
 - B. Cheeseburger, apple, vanilla milkshake**
 - C. Spaghetti with meatballs, fruit salad, milk**
 - D. Vegetable soup, salad, dinner roll, iced tea**
- 9. When assessing a newborn's fontanel, what should the nurse expect to find as normal?**
- A. A bulging anterior fontanel**
 - B. A depressed anterior fontanel**
 - C. A soft and flat anterior fontanel**
 - D. A triangular-shaped anterior fontanel**
- 10. What should the nurse include in the admission report for a client taking phenytoin?**
- A. Report of unsteady gait, rash, and diplopia**
 - B. Serum phenytoin levels**
 - C. Report of any seizure activity**
 - D. All of the above**

Answers

SAMPLE

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

SAMPLE

Explanations

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1. When developing a care plan for a client with cirrhosis, what action is appropriate to prioritize first?

- A. Apply oxygen to the client**
- B. Evaluate laboratory results**
- C. Assess the client's level of consciousness**
- D. Obtain a dietary history**

Prioritizing the assessment of the client's level of consciousness is crucial in the context of cirrhosis due to the potential for hepatic encephalopathy. Cirrhosis can lead to the accumulation of ammonia and other toxins in the bloodstream because the liver is unable to effectively filter them out. This buildup can significantly affect neurological function and consciousness. By assessing the level of consciousness, the healthcare provider can identify any changes or deterioration in the client's mental status that could indicate the onset of hepatic encephalopathy or other complications associated with liver failure. Early identification of changes in consciousness allows for timely interventions, which can be critical in managing the client's condition and preventing further complications. While evaluating laboratory results and obtaining a dietary history are important components of care for a client with cirrhosis, they do not directly address immediate changes in the client's neurological status. Applying oxygen may be necessary if the client shows signs of respiratory distress, but it would not be the first priority in the absence of such symptoms. Therefore, assessing the level of consciousness takes precedence to ensure safe and adequate monitoring of the client's condition.

2. A nurse must closely monitor which laboratory value for a client on heparin therapy for DVT?

- A. Platelet count**
- B. Clotting time**
- C. Bleeding time**
- D. Activated PTT**

The most critical laboratory value to monitor for a client on heparin therapy for deep vein thrombosis (DVT) is the activated partial thromboplastin time (aPTT). Heparin is an anticoagulant that works by inhibiting various factors in the intrinsic pathway of the coagulation cascade, which affects the aPTT. This test specifically assesses the effectiveness of heparin and helps ensure that the client remains within a safe therapeutic range to prevent clotting too much or experiencing complications such as bleeding. Monitoring the aPTT is essential because it provides real-time information on the anticoagulant effect of heparin. Generally, the aPTT should be maintained at a specific target range depending on the reason for anticoagulation therapy. This allows for the adjustment of heparin dosage based on the results, helping to minimize the risk of adverse effects associated with improper heparin use. Monitoring other values, like platelet count, are also important in the context of heparin therapy to assess the risk of heparin-induced thrombocytopenia (HIT), and while clotting time and bleeding time are relevant in broader contexts of coagulation status, aPTT is the key indicator for continuous heparin therapy.

3. What nursing intervention is most effective in helping a withdrawn client develop relationship skills?

- A. Initiate client interactions with one or two other clients**
- B. Assist the client to analyze the meaning of behaviors**
- C. Offer the client frequent opportunities to interact with the nurse**
- D. Remind the client frequently to interact with other clients**

Offering the client frequent opportunities to interact with the nurse is effective because it creates a supportive and safe environment for the client to practice relationship skills. This approach allows the nurse to model appropriate interaction techniques and provides real-time feedback that is crucial for skill development. Regular interaction with the nurse can help build the client's confidence in social situations, as the nurse acts as a stable and understanding figure. Additionally, these frequent interactions can help the client feel less isolated and more encouraged to express themselves, which is an essential part of developing social skills. This intervention also fosters a trusting relationship between the nurse and the client, reinforcing the therapeutic relationship that can motivate the client to engage with others more broadly outside of these interactions. In contrast, the other options might not adequately support the client in developing relationship skills. For instance, initiating interactions with other clients may overwhelm the withdrawn client, while discussing behaviors may feel too abstract without practical application. Reminding the client to interact with others may come across as directive instead of supportive, potentially increasing feelings of pressure or inadequacy. Therefore, consistent interaction with the nurse represents the most effective intervention for fostering relationship skill development in a withdrawn client.

4. What is the appropriate intervention when a nurse aspirates 180 mL of undigested feeding from a client with ALS?

- A. Reinsert the residual and then flush with sterile water**
- B. Reinsert the residual and hold the next feeding**
- C. Discard the residual and hold the next feeding**
- D. Discard the residual and administer the feeding**

In the scenario where a nurse aspirates 180 mL of undigested feeding from a client with amyotrophic lateral sclerosis (ALS), the most appropriate intervention is to reinsert the residual and hold the next feeding. This approach is critical because the presence of a significant amount of undigested feeding (in this case, 180 mL) indicates that the client's gastrointestinal tract may not be effectively processing the current feeding. By reintroducing the aspirated residual back into the stomach, the nurse is preventing unnecessary loss of nutrition that may still be usable by the client. The decision to hold the next feeding allows for the assessment of the client's tolerance and prevents further complications, such as aspiration, discomfort, or gastrointestinal overload. Monitoring how the client responds after this intervention is essential, as it provides important insights into their nutritional needs and gastrointestinal function. If similar issues continue, a reassessment of the feeding regimen, including the rate, type of formula, or an evaluation for potential gastrointestinal issues, may be warranted.

5. What is the recommended action when a client is found to have a high serum potassium level?

- A. Instruct the client to increase potassium intake**
- B. Notify the healthcare provider**
- C. Encourage oral hydration**
- D. Initiate a high-protein diet**

Notifying the healthcare provider is the recommended action when a client has a high serum potassium level because hyperkalemia can lead to serious complications, such as cardiac arrhythmias or even cardiac arrest. The healthcare provider can then assess the situation, determine the severity of the hyperkalemia, and initiate appropriate interventions, which may include medications, dietary changes, or other therapeutic measures to lower the potassium level safely. In cases of elevated potassium, timely medical intervention is crucial to prevent potential life-threatening outcomes. While oral hydration may be beneficial in certain contexts, it is not the primary or immediate response when addressing high potassium levels. Increased potassium intake or a high-protein diet could exacerbate the issue, and therefore, these actions are contraindicated. Thus, the correct intervention emphasizes the importance of professional oversight in managing such electrolyte imbalances.

6. A 9-year-old with terminal cancer is asking about dying. What should the nurse do first?

- A. Encourage the child to ask the parents these questions**
- B. Notify the health care provider about the child's questions**
- C. Reassure the child that everyone is trying to help get better**
- D. Tell the parents about the child's questions**

The most appropriate initial action when a 9-year-old with terminal cancer expresses concerns about dying is to tell the parents about the child's questions. This approach respects the child's emotional state and acknowledges the importance of parental support during such a sensitive time. Open communication with the parents can help ensure that they are aware of the child's concerns and can engage in discussions that are appropriate for the child's developmental level. By informing the parents, the nurse can facilitate a supportive environment where they can answer the child's questions with love and guidance. This reinforces the role of the family in providing comfort and understanding, which is particularly crucial in palliative care situations. Engaging the parents also allows for the possibility of aligning responses to the child's inquiries, ensuring that the child feels supported and understood, while also potentially addressing any fears or misconceptions the child may have about dying. Moreover, parents might require support and guidance on how to handle such conversations effectively, which the nurse can also facilitate.

7. What is a common side effect of opioid pain medication that nursing staff need to monitor closely?

- A. Hypertension**
- B. Bradycardia**
- C. Constipation**
- D. Insomnia**

Constipation is a well-documented side effect of opioid pain medications that nursing staff need to monitor closely. Opioids work by binding to opioid receptors in the brain, spinal cord, and gastrointestinal tract, which can lead to a reduction in gastrointestinal motility. This slowing of bowel function results in decreased peristalsis and prolonged transit time in the intestines, leading to hardness of stool and difficulty in passing it. Many patients receiving opioids for pain management may not experience constipation until several days into treatment, and it can often persist unless actively managed. This makes it crucial for healthcare providers to assess bowel habits regularly and consider preventative measures such as prescribing laxatives and encouraging increased fluid intake and dietary fiber when appropriate, even before constipation becomes problematic. Managing this side effect is essential not only for comfort but also for overall patient compliance and wellbeing.

8. Which dinner selection is the most appropriate to promote nutrition for a client in an acute manic episode of bipolar disorder?

- A. Baked sweet potato, kale, yeast roll, water**
- B. Cheeseburger, apple, vanilla milkshake**
- C. Spaghetti with meatballs, fruit salad, milk**
- D. Vegetable soup, salad, dinner roll, iced tea**

In promoting nutrition for a client experiencing an acute manic episode of bipolar disorder, it's essential to consider options that provide balanced nutrients, energy, and stability to assist with physical health during a time of heightened mood and activity levels. In this scenario, the cheeseburger, apple, and vanilla milkshake combination provides a robust source of protein, carbohydrates, and fat. Protein is crucial for neurotransmitter synthesis, which may help stabilize mood, while carbohydrates provide a quick source of energy that could be beneficial during periods of mania. The apple offers fiber and vitamins, contributing to overall nutritional intake, and the milkshake adds additional calories and calcium. This meal stands out as a more complete and energy-dense option, which is particularly important for clients experiencing an acute manic episode, as they may have heightened energy needs and decreased appetite regulation. Additionally, the familiar comfort food aspect of a cheeseburger may appeal to the client, promoting ingestion despite potential appetite challenges. In contrast, other options may not offer the same balance of macronutrients or caloric density that can support the energy levels during manic episodes, which might lead to inadequate nutrition and hinder recovery.

9. When assessing a newborn's fontanel, what should the nurse expect to find as normal?

- A. A bulging anterior fontanel**
- B. A depressed anterior fontanel**
- C. A soft and flat anterior fontanel**
- D. A triangular-shaped anterior fontanel**

In a normal assessment of a newborn's fontanel, particularly the anterior fontanel, the nurse should expect it to be soft and flat. The anterior fontanel, which is located at the top of the skull where the frontal and parietal bones meet, typically remains open for several months after birth to allow for brain growth and skull expansion. A soft and flat fontanel indicates that there is no increased intracranial pressure and that the hydration status of the infant is stable. A bulging fontanel could suggest increased intracranial pressure, which is not a normal finding. Similarly, a depressed fontanel may indicate dehydration or a low intracranial pressure state, both of which are concerning situations. The shape of a fontanel is also important; while the anterior fontanel is expected to be diamond-shaped rather than triangular, a triangular-shaped fontanel would not be a typical finding. Overall, soft and flat is an indication of a healthy state in a newborn's fontanel assessment, aligning with expected norms in neonatal care.

10. What should the nurse include in the admission report for a client taking phenytoin?

- A. Report of unsteady gait, rash, and diplopia**
- B. Serum phenytoin levels**
- C. Report of any seizure activity**
- D. All of the above**

In the admission report for a client taking phenytoin, it is essential to include a comprehensive overview that highlights various significant aspects of the client's health status. Reporting unsteady gait, rash, and diplopia is crucial because these can be potential side effects or indications of toxicity related to phenytoin use. Each symptom reflects possible complications that necessitate further monitoring and intervention. Including serum phenytoin levels in the report is also vital, as it helps to ascertain whether the medication is within the therapeutic range. This information is critical for determining the effectiveness of the treatment and preventing toxicity, considering that phenytoin has a narrow therapeutic index. Finally, recording any seizure activity is important because it provides insight into the current management of the client's condition. Understanding how often seizures occur can help assess the efficacy of the ongoing treatment and determine whether adjustments to the medication regimen are needed. In summary, a complete admission report for a client taking phenytoin should encompass evidence of any side effects, current medication levels, and seizure activity to ensure thorough assessment and appropriate care planning. This holistic approach allows for the identification of potential complications and informs the healthcare team for optimal client management.