

NCLEX Readiness 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

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- 1. 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**

- 2. What is a priority focus a nurse should check before administering a high dose potassium bolus IV?**
 - A. Oral fluid intake**
 - B. Bowel sounds**
 - C. Grip strength**
 - D. Urine output**

- 3. Before administering clozapine to a client with schizophrenia, which statement requires priority investigation?**
 - A. "I have gained a few pounds since I started this medication."**
 - B. "I have had a sore throat for 3 days and feel feverish today."**
 - C. "I have noticed increased salivation and drooling."**
 - D. "I often feel sleepy when I take this medication."**

- 4. How should a nurse respond to a client expressing beliefs that conflict with their treatment?**
 - A. Ignore the comments and continue treatment**
 - B. Encourage beliefs to remain unchanged**
 - C. Provide education about treatment rationale**
 - D. Suggest termination of treatment**

- 5. What is a key intervention for a nurse managing a patient with an increased risk of deep vein thrombosis?**
 - A. Ensure the client's mobility by encouraging ambulation**
 - B. Limit fluid intake to prevent swelling**
 - C. Implement strict bed rest at all times**
 - D. Use anti-embolism stockings as prescribed**

- 6. What action should a nurse perform first when starting an infusion of IV fluids?**
- A. Attach the distal end of the tubing to the client**
 - B. Spike the IV bag and fill the drip chamber**
 - C. Open the roller clamp and fill the tubing**
 - D. Close the roller clamp on the IV tubing**
- 7. In the context of treating anxiety, when should a nurse evaluate the effectiveness of an intervention?**
- A. At the start of treatment**
 - B. After the first week of treatment**
 - C. Every three months**
 - D. Immediately after an intervention**
- 8. What method should a nurse use to administer continuous oxygen therapy to a client with emphysema to avoid depressed ventilation?**
- A. At a low flow rate**
 - B. Through nasal cannula**
 - C. With humidification**
 - D. Cooled**
- 9. What breathing technique can help during a hot flash?**
- A. Deep breathing exercises**
 - B. Rapid breathing techniques**
 - C. Breathing through the mouth only**
 - D. Holding the breath**
- 10. What is the first assessment a nurse should complete for a child receiving succimer for lead poisoning?**
- A. Check serum potassium level**
 - B. Check complete blood count (CBC) with differential**
 - C. Check blood calcium level**
 - D. Test deep tendon reflexes**

Answers

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

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Explanations

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1. 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.

2. What is a priority focus a nurse should check before administering a high dose potassium bolus IV?

- A. Oral fluid intake**
- B. Bowel sounds**
- C. Grip strength**
- D. Urine output**

When administering a high-dose potassium bolus intravenously, the priority focus for the nurse should be urine output. Monitoring urine output is critical because potassium is primarily excreted by the kidneys. If a patient has impaired renal function or decreased urine output, there is a significant risk of hyperkalemia, which can lead to serious complications, including cardiac arrhythmias or cardiac arrest. Ensuring adequate urine output prior to the administration of potassium helps to confirm that the kidneys can effectively handle the increased potassium load. In patients with reduced urine output, administering a potassium bolus could exacerbate hyperkalemia, potentially placing the patient in danger. Therefore, checking urine output is essential to ensure patient safety and prevent adverse effects from high potassium levels.

3. Before administering clozapine to a client with schizophrenia, which statement requires priority investigation?

- A. "I have gained a few pounds since I started this medication."
- B. "I have had a sore throat for 3 days and feel feverish today."**
- C. "I have noticed increased salivation and drooling."
- D. "I often feel sleepy when I take this medication."

The statement regarding having a sore throat for three days and feeling feverish today necessitates priority investigation due to the potential risk of agranulocytosis, a serious side effect associated with clozapine. Clozapine can cause a significant decrease in white blood cells, increasing the risk of infections. Symptoms like a sore throat and fever can indicate that the client may be experiencing an infection, which could be compounded by low white blood cell counts. Close monitoring of the client's complete blood count (CBC) is crucial while they are on clozapine, especially during the first few months of treatment. Therefore, reporting these symptoms signals the need for immediate evaluation and possible blood tests to ensure the client's safety and prevent complications associated with significant immune suppression. This proactive approach is essential in nursing care to mitigate risks associated with antipsychotic medications.

4. How should a nurse respond to a client expressing beliefs that conflict with their treatment?

- A. Ignore the comments and continue treatment
- B. Encourage beliefs to remain unchanged
- C. Provide education about treatment rationale**
- D. Suggest termination of treatment

When a client expresses beliefs that conflict with their treatment, providing education about the rationale behind the treatment is an essential nursing response. This approach allows the nurse to address the client's concerns and helps to clarify misunderstandings, fostering a collaborative and respectful dialogue. By explaining the reasons for the recommended treatment, the nurse can assist the client in gaining a better understanding of the potential benefits, risks, and the importance of adherence to the treatment plan. This educational intervention can also help in building rapport, encouraging the client to share further concerns, and working together to find a path that respects their values while ensuring they receive appropriate care. Understanding the basis of treatment can empower clients, enhancing their ability to make informed decisions regarding their health. In this context, simply ignoring the client's comments would not address their concerns and could lead to further resistance to treatment. Encouraging beliefs to remain unchanged does not support the therapeutic process when those beliefs interfere with health. Suggesting termination of treatment would not be aligned with the goal of providing patient-centered care and achieving optimal health outcomes.

5. What is a key intervention for a nurse managing a patient with an increased risk of deep vein thrombosis?

- A. Ensure the client's mobility by encouraging ambulation**
- B. Limit fluid intake to prevent swelling**
- C. Implement strict bed rest at all times**
- D. Use anti-embolism stockings as prescribed**

Using anti-embolism stockings as prescribed is a key intervention for managing a patient with an increased risk of deep vein thrombosis (DVT) because these garments enhance venous return and reduce venous stasis in the lower extremities. By providing graduated compression, they help to promote circulation, prevent blood pooling, and decrease the likelihood of thrombus formation. This mechanical support is particularly important in patients who are immobile or have other risk factors for DVT. Additionally, anti-embolism stockings are non-invasive and can be used alongside other interventions, such as mobility enhancement and hydration strategies, to comprehensively address DVT risk. When prescribed, it is essential to ensure proper fit and that the patient understands how to wear them correctly to maximize their efficacy. This intervention is evidence-based and widely recognized in clinical practice guidelines as essential for prevention in at-risk populations.

6. What action should a nurse perform first when starting an infusion of IV fluids?

- A. Attach the distal end of the tubing to the client**
- B. Spike the IV bag and fill the drip chamber**
- C. Open the roller clamp and fill the tubing**
- D. Close the roller clamp on the IV tubing**

When starting an infusion of IV fluids, the first action a nurse should perform is to close the roller clamp on the IV tubing. This step is crucial as it prevents any fluid from unintentionally flowing through the tubing before the system is properly primed and ready for use. Ensuring that the roller clamp is closed also helps to maintain aseptic technique, as it minimizes the risk of contamination of the IV line before the nurse is ready to attach it to the patient or spike the IV bag. Before initiating the infusion, the nurse should ensure all necessary steps are taken to prepare the IV setup properly, such as spiking the bag and filling the drip chamber, but these actions should only follow the initial closure of the roller clamp. Thus, closing the roller clamp is an important first step to ensure safe and effective IV fluid administration.

7. In the context of treating anxiety, when should a nurse evaluate the effectiveness of an intervention?

- A. At the start of treatment**
- B. After the first week of treatment**
- C. Every three months**
- D. Immediately after an intervention**

Evaluating the effectiveness of an intervention for anxiety immediately after it is implemented is critical for several reasons. First, timely evaluation allows the nurse to assess the immediate impact of the intervention on the patient's anxiety levels. Observing changes right after the intervention can help determine if the approach is effective or if adjustments are needed. Furthermore, anxiety can be influenced by various factors that may fluctuate rapidly, so assessing the results right away ensures that the treatment plan is responsive to the patient's current state. This immediate feedback loop is essential for providing high-quality care and making informed decisions about ongoing treatment. While evaluations at other intervals, such as at the start of treatment or after several weeks or months, are important for long-term assessment, they do not provide the crucial immediate insights that can guide immediate clinical decisions and potentially enhance patient comfort and coping mechanisms. This proactive approach is particularly essential in mental health care, where timely adjustments can significantly influence patient outcomes.

8. What method should a nurse use to administer continuous oxygen therapy to a client with emphysema to avoid depressed ventilation?

- A. At a low flow rate**
- B. Through nasal cannula**
- C. With humidification**
- D. Cooled**

Administering continuous oxygen therapy to a client with emphysema should be done at a low flow rate to avoid the risk of depressing the patient's ventilation. In patients with chronic obstructive pulmonary disease (COPD) like emphysema, the respiratory drive often relies on low levels of oxygen rather than elevated levels of carbon dioxide. If high concentrations of oxygen are provided, it may suppress the client's ability to breathe effectively, leading to potential respiratory failure. Using a low flow rate ensures that oxygen is delivered in a way that increases oxygen saturation without completely eliminating the hypoxic drive that some individuals have adapted to. This careful balance is crucial to maintain adequate respiration in patients with compensatory physiologic mechanisms. While the other methods mentioned, such as using a nasal cannula, with humidification, or using cooled oxygen, may have their own benefits or applications in different contexts, the most direct approach to prevent the risk of depressed ventilation in these patients is to carefully regulate the oxygen flow rate.

9. What breathing technique can help during a hot flash?

- A. Deep breathing exercises**
- B. Rapid breathing techniques**
- C. Breathing through the mouth only**
- D. Holding the breath**

Deep breathing exercises are effective during a hot flash because they help activate the body's relaxation response, counteracting the physiological effects of stress and discomfort that accompany hot flashes. By taking slow, deep breaths, individuals can promote a sense of calm and reduce feelings of anxiety or panic that may arise during these episodes. This technique increases oxygen flow and encourages mindfulness, allowing the person to focus on their breath rather than the hot flash itself. In contrast, rapid breathing techniques may lead to increased heart rate and anxiety, which can exacerbate the symptoms of a hot flash. Breathing through the mouth can dry out the oral mucosa and is less effective for achieving a state of relaxation compared to inhaling through the nose, which helps to filter and humidify the air. Lastly, holding the breath does not provide any of the calming benefits that come with sustained, controlled breathing and could lead to increased discomfort or panic during a hot flash.

10. What is the first assessment a nurse should complete for a child receiving succimer for lead poisoning?

- A. Check serum potassium level**
- B. Check complete blood count (CBC) with differential**
- C. Check blood calcium level**
- D. Test deep tendon reflexes**

The first assessment a nurse should complete for a child receiving succimer for lead poisoning is to check the complete blood count (CBC) with differential. This is essential because succimer, as a chelating agent, can have hematological side effects, including changes in white blood cell counts. Monitoring for potential cytopenias or other abnormalities in the blood can help ensure the child's safety during treatment. The CBC helps to identify any underlying issues related to the child's overall health, especially in cases of lead poisoning, where anemia can be present due to the toxic effects of lead on bone marrow. By assessing the CBC early in the treatment process, the nurse can detect any adverse effects from the medication early, enabling timely intervention. Other assessments, such as checking serum potassium levels or blood calcium levels, while important in certain contexts, are not the immediate priority when starting treatment for lead poisoning with succimer. Testing deep tendon reflexes is also valuable for assessing neurological function but does not take precedence over monitoring blood parameters in this specific situation.

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://nclexreadiness.examzify.com>

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

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