

Registration Exam for Practical Nursing (REx-PN) Practice Test (Sample)

Study Guide



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SAMPLE

Questions

SAMPLE

- 1. Which client should the nurse prioritize for assessment based on their presenting symptoms?**
 - A. A client with a respiratory rate of 24 and an oxygen saturation of 94%.**
 - B. A client with diabetes mellitus who has a blood glucose of 134 mg/dL.**
 - C. A client six hours post-op from a hysterectomy reporting nausea.**
 - D. A client with a recent cast application complaining of their arm feeling "asleep."**

- 2. What side effect should the nurse monitor in a client receiving steroid therapy for cancer treatment?**
 - A. Increased muscle mass**
 - B. Weight loss**
 - C. Hyperglycemia**
 - D. Improved immune function**

- 3. Which layer of the skin is primarily affected in a second-degree burn?**
 - A. Epidermis**
 - B. Dermis**
 - C. Subcutaneous tissue**
 - D. Muscle**

- 4. During a tetralogy of Fallot spell, what is the nurse's priority action for an infant?**
 - A. Administer sodium bicarbonate**
 - B. Calm the infant**
 - C. Notify the healthcare provider**
 - D. Administer propranolol**

- 5. For a diabetic client, which diet aspect is crucial for managing their condition?**
 - A. High protein intake.**
 - B. Limited carbohydrate intake.**
 - C. Increased fat consumption for energy.**
 - D. Frequent high-calorie snacks.**

- 6. What would be an appropriate nursing action when assessing a client with severe hypothermia?**
- A. Monitor for increased heart rate.**
 - B. Assess for elevated blood pressure.**
 - C. Provide warm fluids orally.**
 - D. Determine the level of consciousness.**
- 7. When providing education on iron supplementation, which action should clients be advised to take?**
- A. Take with a meal rich in calcium**
 - B. Drink a glass of orange juice with the supplement**
 - C. Report any black stools to the physician**
 - D. Increase dietary fiber intake**
- 8. After failing a final anatomy exam, what defense mechanism is demonstrated by a student who expresses anger toward the instructor?**
- A. Acting out**
 - B. Projection**
 - C. Compensation**
 - D. Reaction-formation**
- 9. What nursing intervention is appropriate before administering medication to a child with a chronic condition?**
- A. Verify the child's allergies**
 - B. Review the medication's side effects**
 - C. Ensure the child has had a meal**
 - D. Limit physical activity prior to administration**
- 10. What gauge needle should the LPN use to administer phytonadione to an infant?**
- A. 20-gauge needle**
 - B. 25-gauge needle**
 - C. 22-gauge needle**
 - D. 21-gauge needle**

Answers

SAMPLE

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

SAMPLE

Explanations

SAMPLE

1. Which client should the nurse prioritize for assessment based on their presenting symptoms?
- A. A client with a respiratory rate of 24 and an oxygen saturation of 94%.
 - B. A client with diabetes mellitus who has a blood glucose of 134 mg/dL.
 - C. A client six hours post-op from a hysterectomy reporting nausea.
 - D. A client with a recent cast application complaining of their arm feeling "asleep."**

Prioritizing a client for assessment is crucial in nursing practice, particularly when it comes to identifying potential complications. In this scenario, the client with a recent cast application who is complaining of their arm feeling "asleep" raises significant concern. This symptom could suggest potential issues such as compromised circulation or nerve compression, which can lead to serious complications if not addressed promptly. The feeling of the arm being "asleep" may indicate reduced blood flow or nerve signaling, potentially resulting in the loss of function or tissue damage if left unassessed. The urgency stems from the need to ensure that the circulation to the limb is intact and that the cast is not too tight, which could lead to compartment syndrome—a serious condition that requires immediate intervention. While the other options present symptoms that may also warrant attention, they do not pose the same immediate risks. The client with a respiratory rate of 24 and oxygen saturation of 94% may indicate mild respiratory distress but does not necessarily require priority assessment over potential extremity compromise. The client with diabetes having a blood glucose level of 134 mg/dL is within an acceptable range and does not indicate an acute issue. The post-operative client experiencing nausea is a common occurrence and typically does not suggest an emergency condition unless coupled

2. What side effect should the nurse monitor in a client receiving steroid therapy for cancer treatment?
- A. Increased muscle mass
 - B. Weight loss
 - C. Hyperglycemia**
 - D. Improved immune function

The focus of monitoring for clients receiving steroid therapy, particularly in the context of cancer treatment, includes being vigilant for hyperglycemia. Corticosteroids, commonly used in managing cancer therapy, can induce insulin resistance and elevate blood glucose levels. This effect can be particularly concerning in clients who may already be at risk for diabetes or those who have pre-existing diabetes, as it can lead to complications such as diabetic ketoacidosis or other serious metabolic issues if not managed effectively. Clients on steroid therapy may experience other side effects such as mood changes, increased appetite, and fluid retention, but hyperglycemia is a significant metabolic effect that requires monitoring. The management of blood glucose levels is crucial to prevent potential complications and ensure safe continuity of treatment. Monitoring for hyperglycemia allows the healthcare team to provide timely interventions, such as insulin therapy or dietary modifications, to maintain glycemic control.

3. Which layer of the skin is primarily affected in a second-degree burn?

- A. Epidermis**
- B. Dermis**
- C. Subcutaneous tissue**
- D. Muscle**

A second-degree burn, also known as a partial-thickness burn, primarily affects the dermis, which is the second layer of skin located beneath the epidermis. This type of burn not only damages the outer layer (epidermis) but also penetrates into the dermis, leading to more severe symptoms such as pain, redness, swelling, and blistering. The involvement of the dermis in second-degree burns is crucial because this layer contains nerve endings, blood vessels, and connective tissue, which play significant roles in sensation and healing. The injury to the dermis is what contributes to the pain and the likelihood of complications and the healing process, as the dermal layer is essential for the skin's structural integrity and its ability to regenerate. While the epidermis is involved in second-degree burns, the hallmark of such burns is the damage extending into the dermis. The subcutaneous tissue, which lies beneath the dermis, is not affected in second-degree burns. Instead, it is commonly involved in deeper burns, like third-degree burns. Muscle tissue is also not affected in a second-degree burn, as this injury does not penetrate that deeply into the skin layers.

4. During a tetralogy of Fallot spell, what is the nurse's priority action for an infant?

- A. Administer sodium bicarbonate**
- B. Calm the infant**
- C. Notify the healthcare provider**
- D. Administer propranolol**

In the context of a tetralogy of Fallot spell, the priority action for the nurse is to calm the infant. During such spells, the infant experiences a sudden decrease in oxygenated blood flow, which can lead to hypoxia. The infant may exhibit signs of distress, such as difficulty breathing, cyanosis, and irritability. By calming the infant, the nurse can help reduce the metabolic demands on the heart and improve the infant's overall comfort, potentially alleviating some of the physiological stress associated with the spell. Calming strategies may include holding the infant in a comforting position, using soothing voices, or employing gentle touch. These approaches can help decrease the infant's anxiety and may momentarily stabilize their condition by promoting relaxation. Other interventions, while important in the overall management of the condition, may not be as immediately effective as providing comfort during an acute episode.

5. For a diabetic client, which diet aspect is crucial for managing their condition?

- A. High protein intake.**
- B. Limited carbohydrate intake.**
- C. Increased fat consumption for energy.**
- D. Frequent high-calorie snacks.**

Managing diabetes effectively involves careful control of carbohydrate intake, as carbohydrates have the most significant impact on blood glucose levels. The body breaks down carbohydrates into glucose, which enters the bloodstream and can cause fluctuations in blood sugar. Therefore, limiting carbohydrate intake helps to stabilize these levels and prevent spikes that can lead to complications. A diet low in refined sugars and carbohydrates can contribute to better glycemic control, reducing the risk of hyperglycemia and helping maintain overall health. This strategy is typically part of a comprehensive diabetic management plan that includes monitoring blood sugar levels and working with healthcare providers to design a diet that suits individual needs while promoting long-term health. In contrast, focusing primarily on high protein or fat intake may not provide the balanced nutrition necessary for overall health and could unintentionally lead to other complications. Frequent high-calorie snacks, particularly those high in sugar, can also lead to unhealthy blood glucose fluctuations, making it essential for diabetic clients to focus on their carbohydrate consumption.

6. What would be an appropriate nursing action when assessing a client with severe hypothermia?

- A. Monitor for increased heart rate.**
- B. Assess for elevated blood pressure.**
- C. Provide warm fluids orally.**
- D. Determine the level of consciousness.**

Determining the level of consciousness is an appropriate nursing action when assessing a client with severe hypothermia because hypothermia can lead to altered mental status. As the body temperature drops, the central nervous system becomes impaired, which can affect cognitive function and responsiveness. Assessing the level of consciousness helps the nurse evaluate the severity of the hypothermia and guides further interventions, such as the need for rewarming. In contrast, monitoring for increased heart rate would generally not be relevant, as heart rate may actually decrease in severe hypothermia. Similarly, elevated blood pressure is not typically associated with severe hypothermia; blood pressure may also be low or unstable in such cases. Providing warm fluids orally is not advisable in severe hypothermia because the risk of aspiration and further complications increases when a patient's level of consciousness is impaired, making it unsafe to administer fluids orally.

7. When providing education on iron supplementation, which action should clients be advised to take?

- A. Take with a meal rich in calcium**
- B. Drink a glass of orange juice with the supplement**
- C. Report any black stools to the physician**
- D. Increase dietary fiber intake**

When providing education on iron supplementation, it is important to advise clients to drink a glass of orange juice with the supplement. This recommendation is based on the role of vitamin C in enhancing the absorption of iron in the body. Iron is better absorbed in the presence of vitamin C, making orange juice an effective accompaniment. By consuming the supplement with a vitamin C-rich beverage, clients can improve the efficacy of their iron supplementation regimen. Other options can lead to less effective iron absorption or may not be relevant to the client's experience with iron supplementation. For instance, taking iron with a meal high in calcium can interfere with iron absorption, as calcium competes with iron for absorption in the digestive tract. Reporting black stools is a valid concern, as it can indicate potential gastrointestinal bleeding or be a common side effect of iron supplements; however, this does not enhance absorption. Increasing dietary fiber intake may also be advisable for overall gut health but does not directly relate to the effectiveness of iron supplementation.

8. After failing a final anatomy exam, what defense mechanism is demonstrated by a student who expresses anger toward the instructor?

- A. Acting out**
- B. Projection**
- C. Compensation**
- D. Reaction-formation**

The defense mechanism demonstrated by the student who expresses anger toward the instructor after failing the final anatomy exam is acting out. Acting out is a mechanism where individuals express their emotional distress through actions rather than communicating their feelings verbally. In this scenario, the student is likely feeling a mix of frustration, disappointment, or inadequacy and is channeling those feelings into outward expressions of anger towards the instructor, rather than addressing the underlying emotions or the failure itself. Understanding this mechanism is essential in recognizing that the student is struggling with their emotional response to failure. By acting out, the student avoids confronting their feelings of disappointment and shame associated with the exam result. This can lead to a cycle of negative feelings and behaviors if not addressed appropriately. In contrast, other mechanisms mentioned do not apply to this specific situation, as they represent different responses to emotional conflict.

9. What nursing intervention is appropriate before administering medication to a child with a chronic condition?

- A. Verify the child's allergies**
- B. Review the medication's side effects**
- C. Ensure the child has had a meal**
- D. Limit physical activity prior to administration**

Verifying the child's allergies is a crucial nursing intervention before administering medication, particularly for a child with a chronic condition. Allergies can lead to severe and potentially life-threatening reactions, such as anaphylaxis, if the child is administered a medication they are allergic to. By confirming the child's allergies, the nurse helps to ensure patient safety and prevent adverse reactions. This step is essential, especially since children with chronic conditions may already be on multiple medications, increasing the risk of interactions or allergic responses. While reviewing the medication's side effects can be important for education and monitoring purposes, ensuring the safety of the medication administration takes precedence. Ensuring the child has had a meal may be relevant for certain medications (like those that should be taken with food), but it doesn't address the fundamental safety concern of allergies. Limiting physical activity is generally not a standard practice related to medication administration unless specified by the medication or condition, and would not typically be a necessary intervention prior to giving most medications.

10. What gauge needle should the LPN use to administer phytonadione to an infant?

- A. 20-gauge needle**
- B. 25-gauge needle**
- C. 22-gauge needle**
- D. 21-gauge needle**

The appropriate choice for administering phytonadione to an infant is a 25-gauge needle. This selection is crucial because a smaller gauge needle, such as a 25-gauge, is less invasive and more suitable for the delicate veins of infants. Infants typically have smaller blood vessels and thinner skin, so a finer needle minimizes trauma and discomfort during the injection. Administering medications like phytonadione, which is often given to prevent or treat vitamin K deficiency in newborns, requires a careful approach to ensure the safety and comfort of the patient. A larger gauge needle, such as 20-gauge or 22-gauge, risks causing more pain or potential complications such as bruising or infiltration due to the increased size. The use of a 25-gauge needle strikes an appropriate balance, allowing for effective administration while also considering the infant's anatomy and comfort.