LICENSED PRACTICAL NURSE (LPN) EXIT PRACTICE EXAM (SAMPLE)

STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

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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.

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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!

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Questions

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1. **When administering nystatin suspension to an infant's gums for a candida infection, what approach should the practical nurse (PN) take?**

   A. Use a medication cup to allow the infant to sip it

   B. Draw up the medication in a syringe that the infant can suck

   C. Soak a cotton swab in the solution and apply

   D. Administer the medication as a nasal spray

2. **What intervention is required for a postpartum client who experiences uncontrolled shaking?**

   A. Administer medications

   B. Apply cold packs

   C. Reassure with light, warm blankets

   D. Position for comfort

3. **What action should the nurse take if a client with benign prostatic hypertrophy has a postvoid residual volume exceeding 100 mL?**

   A. Increase the client's fluid intake significantly

   B. Administer a diuretic as prescribed

   C. Catheterize with an indwelling catheter and inflate the balloon if the residual volume is greater than 100 mL

   D. Encourage the client to void more frequently

4. **When assessing a client with stomatitis who is undergoing chemotherapy, what key information should the practical nurse (PN) gather?**

   A. Frequency of nausea and vomiting

   B. Ability to swallow

   C. Presence of oral lesions

   D. Dietary preferences

5. **What should the nurse monitor for when caring for a client receiving dexamethasone?**

   A. Increased levels of calcium in the blood

   B. Signs of infection due to immunosuppression

   C. Changes in heart rate and blood pressure

   D. Improvements in respiratory function

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6. What is the most effective way for a nurse to assess a patient's understanding of their health education?

A. Asking the patient to repeat the information back

B. Observing the patient's body language

C. Assuming the patient understands

D. Checking the patient's vital signs

7. What should the nurse do if resistance is met while removing a Foley catheter?

A. Stop the procedure and call a healthcare provider

B. Force the catheter out gently

C. Attempt to withdraw additional fluid from the balloon

D. Reinsert the catheter until resistance decreases

8. What is the most critical assessment for a practical nurse (PN) to perform after a client receives sedation for a procedure?

A. Assess for signs of infection

B. Evaluate breathing and consciousness

C. Monitor blood pressure and heart rate

D. Check for any signs of allergic reaction

9. What is the first action the practical nurse (PN) should take when obtaining a capillary blood sample for glucose measurement?

A. Determine which finger was used previously

B. Clean the puncture site with alcohol

C. Warm the finger before puncturing

D. Ensure the patient is fasting for at least 8 hours

10. How should the practical nurse (PN) respond when a client reports the pill he has been taking at home is a different color and size than the one being dispensed?

A. Tell the client to disregard the difference

B. Confirm the pill is correct and administer it

C. Tell the client that the PN will verify that the dispensed medication is the valid prescription

D. Suggest the client take the medication regardless of the difference

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Answers

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

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Explanations

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1. When administering nystatin suspension to an infant's gums for a candida infection, what approach should the practical nurse (PN) take?

A. Use a medication cup to allow the infant to sip it

B. Draw up the medication in a syringe that the infant can suck

C. Soak a cotton swab in the solution and apply

D. Administer the medication as a nasal spray

The correct method for administering nystatin suspension to an infant's gums involves drawing up the medication in a syringe that the infant can suck. This approach is effective because it ensures that the medication is delivered directly to the specific area where the infection is present—in this case, the gums. Using a syringe allows for precise dosing and helps keep the medication in contact with the affected area longer, increasing its effectiveness in treating the candida infection. Administering medication in a way that allows the infant to suck is particularly beneficial since it can entice them to take the medication more easily. Infants often accept liquid medications more willingly when they can suck on a syringe, as this mimics feeding behavior and can create a more comfortable experience for the child. Additionally, this method minimizes the risk of aspiration and ensures that the medication is administered safely. Alternative methods, such as using a medication cup or soaking a cotton swab, may not be as efficient since they do not allow for as targeted or controlled an application of the antifungal agent. Using a nasal spray is entirely inappropriate in this context as it does not address the oral thrush where nystatin is indicated, and could pose risks related to misadministration. This context illustrates why using a syringe that the

2. What intervention is required for a postpartum client who experiences uncontrolled shaking?

A. Administer medications

B. Apply cold packs

C. Reassure with light, warm blankets

D. Position for comfort

The correct intervention for a postpartum client experiencing uncontrolled shaking is to reassure the client and provide light, warm blankets. This shaking, often described as postpartum chills, can be a normal physiological response following childbirth. It may be triggered by changes in hormone levels, a release of tension, or the body attempting to adjust to a sudden drop in body temperature. By reassuring the client and using light, warm blankets, you help to create a sense of comfort and security, which can assist in alleviating anxiety and promoting relaxation. The warmth of the blankets can also help stabilize body temperature, thus reducing the shaking. While administering medications might seem relevant in other scenarios, it is typically not needed for postpartum chills unless there is an underlying medical condition that requires treatment. Similarly, applying cold packs could exacerbate the situation by causing further discomfort or chills, and simply positioning for comfort does not address the underlying issue of the shaking. The focus should be on providing warmth and emotional support in this context.

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3. What action should the nurse take if a client with benign prostatic hypertrophy has a postvoid residual volume exceeding 100 mL?

A. Increase the client's fluid intake significantly

B. Administer a diuretic as prescribed

C. Catheterize with an indwelling catheter and inflate the balloon if the residual volume is greater than 100 mL

D. Encourage the client to void more frequently

When a client with benign prostatic hypertrophy (BPH) has a postvoid residual volume exceeding 100 mL, the appropriate action is to catheterize with an indwelling catheter if the residual volume is significantly high. This procedure helps relieve urinary retention caused by the enlarged prostate, which can obstruct the normal flow of urine. By inserting an indwelling catheter, the nurse ensures that the bladder is drained effectively, preventing complications such as bladder distention, infections, and discomfort for the client. Indwelling catheterization provides a means to assess bladder function and keep the bladder appropriately emptied until further management can be determined. For clients with BPH, this approach is often necessary, especially in cases of significant retention, to prevent further complications. In contrast, increasing fluid intake significantly may exacerbate the problem by leading to an even greater volume of urine that the client cannot adequately void. Administering a diuretic would also increase urine production, which is inappropriate in a situation where the client is already unable to void effectively. Encouraging more frequent voiding does not address the underlying issue of urinary retention and may not be effective for someone with a significant postvoid residual volume due to the obstruction caused by BPH. Thus, catheterization provides

4. When assessing a client with stomatitis who is undergoing chemotherapy, what key information should the practical nurse (PN) gather?

A. Frequency of nausea and vomiting

B. Ability to swallow

C. Presence of oral lesions

D. Dietary preferences

Gathering information about the client's ability to swallow is crucial in the assessment of a client with stomatitis undergoing chemotherapy. Stomatitis, an inflammation of the mucous membranes in the mouth, can result in pain, swelling, and difficulty swallowing. Understanding the client's swallowing capability is essential for ensuring adequate nutrition and preventing complications such as aspiration. Additionally, this information directly impacts how the nurse can manage the client's dietary intake and provide appropriate interventions to ease their discomfort. While the other options may provide useful information regarding the client's overall condition and comfort, they do not address the immediate implications of stomatitis as directly as swallowing ability does. For instance, frequency of nausea and vomiting might give insights into the client's response to chemotherapy, but it does not relate directly to the complications caused by stomatitis. The presence of oral lesions is also significant for diagnosis and treatment, but again, it is more indirect regarding the client's immediate challenges. Dietary preferences may help tailor nutrition support but do not inform the nurse about the functional ability to eat and drink, which is paramount in managing a client with swallowing difficulties due to stomatitis.

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5. What should the nurse monitor for when caring for a client receiving dexamethasone?

A. Increased levels of calcium in the blood

B. Signs of infection due to immunosuppression

C. Changes in heart rate and blood pressure

D. Improvements in respiratory function

When caring for a client receiving dexamethasone, it is crucial to monitor for signs of infection due to immunosuppression. Dexamethasone is a corticosteroid that suppresses the immune response, which can make the patient more susceptible to infections. This happens because corticosteroids inhibit the activity of white blood cells that are essential for fighting infections, leading to an increased risk of both bacterial and viral infections. Nurses should observe the patient for any signs and symptoms indicating an infection, such as fever, chills, increased heart rate, or localized signs of inflammation. Early recognition of these symptoms is vital for prompt treatment, as untreated infections can lead to more serious complications, especially in immunocompromised patients. While monitoring for increased calcium levels, changes in heart rate and blood pressure, and improvements in respiratory function are relevant considerations for overall patient care, they are not as directly linked to the immediate effects of dexamethasone therapy or its associated risks. Dexamethasone primarily poses a risk of immunosuppression, making observation for infection a top priority in these patients.

6. What is the most effective way for a nurse to assess a patient's understanding of their health education?

A. Asking the patient to repeat the information back

B. Observing the patient's body language

C. Assuming the patient understands

D. Checking the patient's vital signs

The most effective way for a nurse to assess a patient's understanding of their health education is by asking the patient to repeat the information back to them. This technique, often referred to as "teach-back," allows the nurse to evaluate whether the patient has grasped the key concepts conveyed during the education session. When patients articulate the information in their own words, it not only confirms their understanding but also highlights any areas that may need further clarification. This method actively engages the patient, reinforcing their learning and promoting better retention of critical health information. It transforms the assessment of understanding into an interactive dialogue rather than a passive exchange, enhancing the overall educational experience for the patient. Other options, while they may provide some value, do not directly measure comprehension in the same clear and effective manner.

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7. What should the nurse do if resistance is met while removing a Foley catheter?

A. Stop the procedure and call a healthcare provider

B. Force the catheter out gently

C. Attempt to withdraw additional fluid from the balloon

D. Reinsert the catheter until resistance decreases

When resistance is encountered while removing a Foley catheter, the appropriate action involves addressing the inflated balloon that keeps the catheter in place. Attempting to withdraw additional fluid from the balloon is a critical step because the balloon may not have been fully deflated, which can cause resistance during removal. By using a syringe to withdraw fluid, the nurse can ensure that the balloon is completely deflated, allowing for easier and painless removal of the catheter. This approach minimizes the risk of injury to the urethra or bladder and ensures patient comfort. Other options, such as stopping the procedure to contact a healthcare provider or forcing the catheter out, do not address the potential issue of the balloon's inflation. Reintroducing the catheter is also unnecessary and may complicate the situation. Thus, withdrawing additional fluid from the balloon provides a safe and effective solution to the problem of resistance during catheter removal.

8. What is the most critical assessment for a practical nurse (PN) to perform after a client receives sedation for a procedure?

A. Assess for signs of infection

B. Evaluate breathing and consciousness

C. Monitor blood pressure and heart rate

D. Check for any signs of allergic reaction

Evaluating breathing and consciousness is paramount after a client receives sedation. Sedation can significantly affect a patient's respiratory drive and level of consciousness, which are crucial for maintaining safety and preventing complications. After sedation, clients may experience decreased levels of responsiveness and altered breathing patterns, increasing the risk of airway obstruction or respiratory depression. Monitoring these vital signs ensures that if any issues arise—such as hypoventilation or changes in consciousness—the healthcare provider can intervene promptly. This assessment directly addresses the immediate, life-threatening risks associated with sedation, making it the most critical focus during the recovery period. While monitoring blood pressure, heart rate, signs of infection, and allergic reactions are important, they are secondary to ensuring that the patient is breathing adequately and remains alert enough to maintain airway protection.

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9. What is the first action the practical nurse (PN) should take when obtaining a capillary blood sample for glucose measurement?

A. Determine which finger was used previously

B. Clean the puncture site with alcohol

C. Warm the finger before puncturing

D. Ensure the patient is fasting for at least 8 hours

The first action a practical nurse should take when obtaining a capillary blood sample for glucose measurement is to determine which finger was used previously. This is essential because repeated punctures on the same finger can lead to localized tissue damage, discomfort, and inaccurate blood glucose readings due to variations in blood flow. By identifying a finger that hasn't been used recently, the nurse ensures that the new puncture will yield a fresh sample without causing unnecessary trauma to the tissue. While cleaning the puncture site with alcohol or warming the finger are important steps in preparing for the blood sample collection, such actions typically follow the determination of the site to be used. Ensuring the patient has fasted for at least 8 hours is also relevant for specific glucose testing protocols, but it is not a direct initial action related to the process of collecting a capillary blood sample; that aspect primarily concerns the timing of the test rather than the procedural steps involved in sample collection.

10. How should the practical nurse (PN) respond when a client reports the pill he has been taking at home is a different color and size than the one being dispensed?

A. Tell the client to disregard the difference

B. Confirm the pill is correct and administer it

C. Tell the client that the PN will verify that the dispensed medication is the valid prescription

D. Suggest the client take the medication regardless of the difference

When a client expresses concern about a medication being a different color and size, it is essential for the practical nurse to respond in a way that prioritizes patient safety and trust. Confirming that the dispensed medication aligns with the valid prescription reflects a commitment to providing safe and accurate care. This approach not only validates the client's observation but also fosters an atmosphere of open communication between the nurse and the client. By taking the time to verify the medication, the nurse can ensure that the client receives the correct treatment without any unnecessary risks. There could be various reasons for the discrepancy, such as different manufacturers, generic versions, or even potential medication errors. Therefore, the practical nurse's responsibility includes clarifying these concerns before proceeding with the administration of the medication. This response empowers the client and encourages them to engage actively in their healthcare, which is a fundamental aspect of nursing practice. It also adheres to best practices in medication administration, which involve confirming the identity and correctness of the medication before it is given to the client.

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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://lpnexit.examzify.com

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

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