

NCLEX PRACTICE TEST (SAMPLE)

STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

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Table of Contents

Copyright	1
Table of Contents	2
Introduction	3
How to Use This Guide	4
Questions	5
Answers	9
Explanations	11
Next Steps	17

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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. What is the primary focus of nursing care for a patient in shock?**
 - A. Managing pain
 - B. Ensuring adequate perfusion
 - C. Preventing infection
 - D. Providing education
- 2. What symptom may indicate an acute allergic reaction?**
 - A. Nausea
 - B. Rash
 - C. Fatigue
 - D. Headache
- 3. To minimize dyspnea in a terminally ill client, which intervention could be done by the nurse apart from administering low-flow oxygen?**
 - A. Administering prescribed morphine PRN
 - B. Encouraging frequent ambulation
 - C. Providing high-flow oxygen via nonrebreather mask
 - D. Using a cooling fan in the room
- 4. What is the purpose of the nursing process?**
 - A. To promote hospital policies
 - B. To provide structured patient care
 - C. To expedite patient discharge
 - D. To manage nursing staff schedules
- 5. What is the appropriate nursing action for a client with unstable angina who reports a new dull, throbbing headache after 5 minutes on a nitroglycerin IV infusion?**
 - A. Decrease the infusion rate and reassess the client's report of pain
 - B. Document the finding and administer prescribed acetaminophen
 - C. Notify the health care provider and request a CT scan of the head
 - D. Stop the infusion immediately and notify the health care provider

- 6. What vital sign is most closely monitored in a patient receiving opioid therapy?**
- A. Blood pressure
 - B. Temperature
 - C. Respiratory rate
 - D. Pulse
- 7. One of the FIRST signs of retroperitoneal hemorrhage after a PCI includes:**
- A. Flank ecchymosis
 - B. Increased urine output
 - C. Swelling in the limbs
 - D. Tachypnea
- 8. What interventions are appropriate to promote safety for an older adult client with advanced dementia, confusion, and a history of falls? Select all that apply.**
- A. Activate the bed alarm before leaving the room
 - B. Keep the lights dim to create a calm environment
 - C. Place a bedside commode next to the bed
 - D. Place the client in a room close to the nurses' station
 - E. Request a prescription for a vest or belt restraint
- 9. Which client should the nurse assess first in a cardiac intensive care unit?**
- A. Client 2 months post heart transplant with sustained sinus tachycardia of 110/min at rest
 - B. Client 3 hours post coronary artery stent placement with severe back pain
 - C. Client receiving IV antibiotics for infective endocarditis with a temperature of 101.5 F (38.6 C)
 - D. Client who had coronary bypass graft surgery 3 days ago with swelling in the leg used for the donor graft

10. A nurse is teaching an inservice regarding prevention of venous thromboembolism. Which nursing interventions should be included in the teaching? Select all that apply.

- A. Administer scheduled anticoagulants
- B. Apply sequential compression devices
- C. Elevate the legs with pillows behind the knees
- D. Have clients ambulate regularly as tolerated
- E. Instruct clients to point and flex the feet in bed

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Answers

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

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Explanations

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1. What is the primary focus of nursing care for a patient in shock?

- A. Managing pain
- B. Ensuring adequate perfusion**
- C. Preventing infection
- D. Providing education

The primary focus of nursing care for a patient in shock is ensuring adequate perfusion. Shock is a life-threatening condition characterized by inadequate blood flow to the body's tissues, leading to cellular dysfunction and potentially organ failure. The main objective in managing a patient in shock is to restore and maintain effective circulation, which is crucial for delivering oxygen and nutrients to cells and for removing metabolic waste products. Maintaining adequate perfusion involves monitoring vital signs, administering fluids, and possibly medications to improve blood flow and stabilize the patient's hemodynamic status. Interventions may also include positioning the patient, assessing for signs of shock, and preparing for potential advanced interventions. While managing pain, preventing infection, and providing education are important aspects of overall patient care, they are secondary to the immediate need to restore adequate perfusion in a patient experiencing shock. Addressing perfusion issues directly impacts the patient's chances of survival and recovery, making it the priority in nursing care for these patients.

2. What symptom may indicate an acute allergic reaction?

- A. Nausea
- B. Rash**
- C. Fatigue
- D. Headache

A rash is a classic symptom of an acute allergic reaction. Allergic reactions occur when the immune system responds to a substance (allergen) as if it were a harmful pathogen, leading to the release of chemicals like histamine. This response can cause various symptoms, and a rash often presents as hives, redness, or welting on the skin. The appearance of a rash, especially if it develops suddenly and is accompanied by other signs such as itching, swelling, or difficulty breathing, can indicate a more serious allergic reaction known as anaphylaxis, which requires immediate medical attention. Other symptoms like nausea, fatigue, and headache, while they can occur in various medical conditions, are not specific indicators of an acute allergic reaction and may arise from other causes. Therefore, a rash is a significant and recognizable symptom that points towards an allergic response.

3. To minimize dyspnea in a terminally ill client, which intervention could be done by the nurse apart from administering low-flow oxygen?

- A. Administering prescribed morphine PRN**
- B. Encouraging frequent ambulation
- C. Providing high-flow oxygen via nonrebreather mask
- D. Using a cooling fan in the room

Administering prescribed morphine PRN is the correct answer because, in terminally ill clients experiencing dyspnea, morphine can help relieve the sensation of shortness of breath by reducing anxiety, pain, and work of breathing. Morphine is a common medication used in palliative care to manage dyspnea effectively. Encouraging frequent ambulation, providing high-flow oxygen via a nonrebreather mask, and using a cooling fan in the room are not the most appropriate interventions for minimizing dyspnea in terminally ill clients.

4. What is the purpose of the nursing process?

- A. To promote hospital policies
- B. To provide structured patient care**
- C. To expedite patient discharge
- D. To manage nursing staff schedules

The purpose of the nursing process is to provide structured patient care. This systematic approach enables nurses to assess patient needs, diagnose health problems, plan individualized care, implement interventions, and evaluate the outcomes of the care provided. By following this framework, nurses are able to ensure that patient care is thorough, organized, and tailored to meet each patient's unique needs. The nursing process is foundational to effective nursing practice, as it fosters critical thinking, enhances problem-solving abilities, and promotes the delivery of high-quality care. This emphasis on a structured approach is essential for achieving optimal patient outcomes and ensuring that care is safe and effective. Focused on patient care means that while other aspects of healthcare, such as hospital policies, discharge processes, or staff scheduling, are important, they are not the primary focus of the nursing process itself. This process is all about the patient's well-being and ensuring that their needs are systematically addressed through ongoing assessment and tailored interventions.

5. What is the appropriate nursing action for a client with unstable angina who reports a new dull, throbbing headache after 5 minutes on a nitroglycerin IV infusion?

- A. Decrease the infusion rate and reassess the client's report of pain**
- B. Document the finding and administer prescribed acetaminophen
- C. Notify the health care provider and request a CT scan of the head
- D. Stop the infusion immediately and notify the health care provider

The appropriate nursing action for a client experiencing a new dull, throbbing headache after the initiation of a nitroglycerin IV infusion is to decrease the infusion rate and reassess the client's report of pain. Nitroglycerin is a vasodilator commonly used to relieve angina by reducing myocardial oxygen demand. However, a common side effect of nitroglycerin can include headaches due to the dilation of cerebral blood vessels. By reducing the infusion rate, the nurse can mitigate the side effect while still providing the necessary treatment for unstable angina. Reassessing the headache after the adjustment allows for continued monitoring of the client's symptoms and effectiveness of pain control. This gradual approach helps in managing potential side effects without abruptly stopping the treatment, which might compromise the management of the angina. Other choices could involve immediate actions that may not be the best first step given the context of nitroglycerin's known side effects.

6. What vital sign is most closely monitored in a patient receiving opioid therapy?

- A. Blood pressure
- B. Temperature
- C. Respiratory rate**
- D. Pulse

In patients receiving opioid therapy, the vital sign that is most closely monitored is the respiratory rate. Opioids are known for their analgesic effects, but they can also significantly depress the central nervous system, leading to respiratory depression. This can result in reduced oxygen levels and an increased risk of complications such as hypoxia and respiratory failure. Monitoring the respiratory rate allows healthcare providers to detect any changes in a patient's respiratory status promptly. A decrease in respiratory rate can signal impending respiratory distress, necessitating immediate intervention. While blood pressure, temperature, and pulse are important vital signs to monitor in any patient, they are not as directly impacted by opioid administration as the respiratory rate. Opioids may lead to variations in blood pressure and heart rate depending on the individual response, but the primary concern is the potential for life-threatening respiratory depression. Therefore, monitoring the respiratory rate is critical in ensuring patient safety during opioid therapy.

7. One of the FIRST signs of retroperitoneal hemorrhage after a PCI includes:

- A. Flank ecchymosis**
- B. Increased urine output
- C. Swelling in the limbs
- D. Tachypnea

Flank ecchymosis is considered one of the first signs of retroperitoneal hemorrhage after a PCI because it is a classic indicator of bleeding into the retroperitoneal space. The retroperitoneum is an area behind the peritoneum that contains major blood vessels and organs. When there is bleeding in this space, blood may track down and cause bruising around the flank area. Increased urine output (choice B) is not typically associated with retroperitoneal hemorrhage after a PCI. Swelling in the limbs (choice C) and tachypnea (choice D) are also not commonly seen as early signs of this complication.

8. What interventions are appropriate to promote safety for an older adult client with advanced dementia, confusion, and a history of falls? Select all that apply.

- A. Activate the bed alarm before leaving the room**
- B. Keep the lights dim to create a calm environment
- C. Place a bedside commode next to the bed
- D. Place the client in a room close to the nurses' station
- E. Request a prescription for a vest or belt restraint

Placing a bedside commode next to the bed and keeping the lights dim may actually increase the risk of falls for an older adult with advanced dementia and confusion as it may be difficult for them to navigate in a dimly lit environment and to recognize the commode as a toilet. Additionally, restraining an older adult with dementia is not recommended as it can cause further confusion and agitation. Requesting a prescription for a vest or belt restraint should also be avoided due to the potential for physical and psychological harm. Placing the client in a room close to the nurses' station may not be feasible in all healthcare settings and may not necessarily prevent falls. Activating the bed alarm before leaving the room would be the most appropriate and least restrictive intervention to promote safety for an older adult with advanced dementia, confusion, and a history of falls as it alerts healthcare staff if the client attempts to get out of bed.

9. Which client should the nurse assess first in a cardiac intensive care unit?

- A. Client 2 months post heart transplant with sustained sinus tachycardia of 110/min at rest
- B. Client 3 hours post coronary artery stent placement with severe back pain**
- C. Client receiving IV antibiotics for infective endocarditis with a temperature of 101.5 F (38.6 C)
- D. Client who had coronary bypass graft surgery 3 days ago with swelling in the leg used for the donor graft

In a cardiac intensive care unit, the priority for assessment generally involves any signs or symptoms that could indicate a life-threatening complication. The client who is three hours post coronary artery stent placement with severe back pain requires immediate attention due to the risk of complications such as hematoma formation, arterial occlusion, or vascular injury, which can lead to serious outcomes if not promptly addressed. Severe back pain in this context may also suggest cardiac complications or a vascular issue related to the procedure, making it critical for the nurse to evaluate this client first. This prioritization considers not only the timing of the procedure but also the severity of the symptom being reported. The acute nature of the severe back pain raises immediate concerns that could compromise the client's well-being, warranting swift assessment and intervention.

10. A nurse is teaching an inservice regarding prevention of venous thromboembolism. Which nursing interventions should be included in the teaching? Select all that apply.

- A. Administer scheduled anticoagulants**
- B. Apply sequential compression devices**
- C. Elevate the legs with pillows behind the knees**
- D. Have clients ambulate regularly as tolerated**
- E. Instruct clients to point and flex the feet in bed**

Administering scheduled anticoagulants is important in preventing venous thromboembolism because these medications help to prevent blood clots from forming. However, while elevating the legs with pillows behind the knees can improve circulation and minimize the risk of blood clots, it may not be enough to prevent venous thromboembolism on its own. Likewise, while applying sequential compression devices and instructing clients to point and flex their feet in bed may also improve circulation, these interventions are not recommended as standalone preventative measures. Additionally, although regular ambulation is important in promoting circulation and preventing venous thromboembolism, it may not be possible for all clients to ambulate regularly as tolerated. Therefore, while all of these interventions may contribute to the prevention of venous thromboembolism, administering scheduled anticoagulants is the most important and necessary intervention to include in the teaching.

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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://nclex.examzify.com>

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

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