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PRACTICE NCLEX-PN QUESTIONS

Free Practice Questions & Answers for the: National Council Licensure Examination – Practical Nurses

1. **Question 1:**
   Which of the following medications is classified as a non-selective beta-blocker and can lead to a potentially life-threatening hypertensive crisis when discontinued abruptly?

   A) Propranolol
   B) Metoprolol
   C) Atenolol
   D) Carvedilol

   Solution 1: A) Propranolol

   Propranolol is a non-selective beta-blocker, and abrupt discontinuation can lead to rebound hypertension and even hypertensive crisis due to unopposed alpha-adrenergic effects.

2. **Question 2:**
   A patient with heart failure is prescribed a loop diuretic. Which laboratory result should the nurse monitor most closely?

   A) Serum potassium level
   B) Serum sodium level
   C) Blood glucose level
   D) Serum calcium level

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Solution 2: A) Serum potassium level

Loop diuretics such as furosemide can lead to potassium loss, which can result in hypokalemia. Hypokalemia can be life-threatening and must be closely monitored in patients on loop diuretics.

3. **Question 3:**

Which medication should be administered as an antidote for acetaminophen (paracetamol) overdose?

A) Naloxone
B) N-acetylcysteine
C) Atropine
D) Flumazenil

Solution 3: N-acetylcysteine

N-acetylcysteine is the antidote for acetaminophen overdose and helps prevent liver damage by replenishing glutathione.

4. **Question 4:**

A patient with type 2 diabetes is prescribed metformin. What potential adverse effect should the nurse educate the patient about, which can occur rarely but is life-threatening?

A) Weight gain
B) Hypoglycemia
C) Lactic acidosis
D) Hyperkalemia

Solution 4: C) Lactic acidosis

Metformin can rarely cause lactic acidosis, which is a serious and potentially life-threatening condition. Patients should be educated to report symptoms such as weakness, muscle pain, and difficulty breathing.

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5. **Question 5:**

Which medication should the nurse administer first in the event of an opioid overdose?

A) Epinephrine
B) Naloxone
C) Albuterol
D) Atropine

Solution 5: B) Naloxone

Naloxone is the antidote for opioid overdose and should be administered first to reverse the effects of opioids and restore normal respiratory function.

6. **Question 6:**

A patient with chronic gout is prescribed allopurinol. What should the nurse monitor to assess the effectiveness of this medication?

A) Blood pressure
B) Serum uric acid levels
C) Blood glucose levels
D) Liver function tests

Solution 6: B) Serum uric acid levels

Allopurinol is used to reduce serum uric acid levels in patients with gout. Monitoring serum uric acid levels helps assess the medication's effectiveness.

7. **Question 7:**

A patient with a history of peptic ulcer disease is prescribed an NSAID for pain management. Which medication can be added to reduce the risk of NSAID-induced gastrointestinal bleeding?

A) Omeprazole
B) Aspirin
C) Clopidogrel
D) Ibuprofen

Solution 7: A) Omeprazole

Omeprazole is a proton pump inhibitor that can be added to reduce the risk of NSAID-induced gastrointestinal bleeding by reducing stomach acid production.

8. **Question 8:**

A patient with asthma is prescribed a long-acting beta-agonist (LABA). Which important instruction should the nurse provide to the patient?

A) Use the LABA as a rescue inhaler during asthma attacks.
B) Take the LABA daily for long-term asthma control.
C) Discontinue the LABA if experiencing tremors.
D) Mix the LABA with a short-acting bronchodilator for better efficacy.

Solution 8: B) Take the LABA daily for long-term asthma control.

LABAs are long-term control medications and should be taken regularly as prescribed for asthma management. They are not used as rescue inhalers.

9. **Question 9:**

A patient with hypertension is prescribed an angiotensin-converting enzyme (ACE) inhibitor. What should the nurse monitor closely in this patient?

A) Serum potassium levels
B) Serum sodium levels
C) Blood glucose levels
D) Serum calcium levels

Solution 9: A) Serum potassium levels

ACE inhibitors can lead to hyperkalemia, so monitoring serum potassium levels is crucial to prevent complications.

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10. **Question 10:**

A patient is receiving heparin therapy for deep vein thrombosis. What laboratory test should the nurse monitor to assess the therapeutic effect of heparin?

A) Prothrombin time (PT)
B) Activated partial thromboplastin time (aPTT)
C) Platelet count
D) International normalized ratio (INR)

Solution 10: B) Activated partial thromboplastin time (aPTT)

Heparin's therapeutic effect is monitored using the aPTT, with the goal of achieving a specific therapeutic range to prevent thrombosis.

11. **Question 11:**

A patient taking warfarin (Coumadin) for anticoagulation therapy complains of dark, tarry stools and fatigue. Which laboratory test should the nurse monitor to assess for potential complications?

A) Hemoglobin
B) Creatinine
C) Serum sodium
D) Liver function tests

Solution 11: A) Hemoglobin

Dark, tarry stools and fatigue may indicate gastrointestinal bleeding, so monitoring hemoglobin levels is essential to assess for potential complications of anticoagulation therapy.

12. **Question 12:**

A patient with a history of alcohol use disorder is prescribed disulfiram (Antabuse). What should the nurse educate the patient about regarding the use of disulfiram?

A) It helps with alcohol cravings.
B) It causes sedation and dizziness.

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C) It should be taken with alcohol.
D) It can cause a severe reaction if alcohol is consumed.

Solution 12: D) It can cause a severe reaction if alcohol is consumed.

Disulfiram is used to deter alcohol consumption by causing a severe reaction (disulfiram-alcohol reaction) if alcohol is ingested.

13. **Question 13:**

A patient with chronic kidney disease is prescribed a phosphate binder. Which medication is commonly used to lower serum phosphate levels in such patients?

A) Furosemide
B) Calcitriol
C) Sodium bicarbonate
D) Sevelamer

Solution 13: D) Sevelamer

Explanation: Sevelamer is a phosphate binder used to lower serum phosphate levels in patients with chronic kidney disease.

14. **Question 14:**

A patient with Parkinson's disease is prescribed levodopa-carbidopa (Sinemet). Which dietary consideration should the nurse discuss with the patient?

A) Limit intake of vitamin C-rich foods.
B) Increase intake of dairy products.
C) Take the medication with a high-protein meal.
D) Avoid foods rich in carbohydrates.

Solution 14: C) Take the medication with a high-protein meal.

Taking levodopa-carbidopa with a high-protein meal can reduce the risk of nausea and enhance its absorption.

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15. **Question 15:**
A patient with epilepsy is prescribed phenytoin (Dilantin). Which serum level should the nurse monitor to ensure therapeutic drug levels?

A) Serum sodium
B) Serum potassium
C) Serum calcium
D) Phenytoin (Dilantin)

Solution 15: D) Phenytoin (Dilantin)

Explanation: Monitoring serum phenytoin levels is crucial to ensure that therapeutic drug levels are maintained while avoiding toxicity.

16. **Question 16:**
A patient with heart failure is prescribed spironolactone. Which electrolyte imbalance should the nurse closely monitor for while the patient is on this medication?

A) Hyponatremia
B) Hypokalemia
C) Hyperkalemia
D) Hypernatremia

Solution 16: C) Hyperkalemia

Spironolactone is a potassium-sparing diuretic, and its use can lead to hyperkalemia. Close monitoring of potassium levels is essential.

17. **Question 17:**
A patient with hypertension is prescribed an angiotensin II receptor blocker (ARB). Which laboratory test should the nurse monitor to assess the medication's effectiveness?

A) Serum calcium levels
B) Serum sodium levels
C) Blood glucose levels
D) Blood pressure

Solution 17: D) Blood pressure

The effectiveness of an ARB in treating hypertension is primarily assessed by monitoring blood pressure levels.

18. **Question 18:**

A patient with rheumatoid arthritis is prescribed methotrexate. What should the nurse educate the patient about regarding methotrexate use?

A) It should be taken on an empty stomach.
B) It can be used as needed for pain.
C) It requires regular monitoring of liver function.
D) It should not be taken with folic acid supplements.

Solution 18: C) It requires regular monitoring of liver function.

Explanation: Methotrexate can have hepatotoxic effects, so regular monitoring of liver function is necessary while on this medication.

19. **Question 19:**

A patient with asthma is prescribed a leukotriene receptor antagonist. Which medication is in this drug class and is used as an adjunct therapy for asthma?

A) Albuterol
B) Montelukast
C) Prednisone
D) Ipratropium

Solution 19: B) Montelukast

Montelukast is a leukotriene receptor antagonist used as an adjunct therapy for asthma to reduce inflammation and improve symptoms.

20. **Question 20:**

A patient with depression is prescribed a selective serotonin reuptake inhibitor (SSRI). What should the nurse educate the patient about regarding SSRI use?

A) It should be taken with grapefruit juice for better absorption.
B) It may cause weight gain as a common side effect.
C) It can lead to serotonin syndrome if combined with certain medications.
D) It is safe to discontinue abruptly without tapering.

Solution 20: C) It can lead to serotonin syndrome if combined with certain medications.

SSRI use can lead to serotonin syndrome when combined with other medications that affect serotonin levels. Patients should be educated to avoid such combinations.

21. **Question 21:**

A patient with a history of hypertension presents to the emergency department with sudden chest pain and shortness of breath. The nurse suspects a myocardial infarction. Which laboratory test is most indicative of myocardial damage?

A) Troponin I
B) C-reactive protein (CRP)
C) Creatine kinase (CK)
D) Brain natriuretic peptide (BNP)

Solution 21: A) Troponin I

Troponin I is a specific marker for myocardial damage and is elevated in myocardial infarction.

22. **Question 22:**

A patient with atrial fibrillation is prescribed warfarin (Coumadin) for stroke prevention. What is the primary goal of anticoagulant therapy in this patient?

A) To lower blood pressure
B) To prevent clot formation in the atria
C) To relieve chest pain

D) To improve cardiac output

Solution 22: B) To prevent clot formation in the atria

The primary goal of anticoagulant therapy in atrial fibrillation is to prevent the formation of blood clots in the atria, which can lead to stroke.

23. **Question 23:**

A patient with heart failure is prescribed digoxin. Which parameter should the nurse monitor most closely while the patient is on this medication?

A) Serum potassium levels
B) Serum sodium levels
C) Blood glucose levels
D) Blood pressure

Solution 23: A) Serum potassium levels

Digoxin can lead to hypokalemia, which can be life-threatening. Monitoring serum potassium levels is essential.

24. **Question 24:**

A patient with aortic stenosis complains of dizziness and fainting spells. What is the most likely cause of these symptoms in this patient?

A) Hypertension
B) Bradycardia
C) Tachycardia
D) Hyperlipidemia

Solution 24: B) Bradycardia

In aortic stenosis, the heart has to work harder to pump blood, and bradycardia can lead to decreased cardiac output, causing dizziness and fainting.

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25. **Question 25:**

A patient with heart failure is prescribed an angiotensin-converting enzyme (ACE) inhibitor. What is the primary mechanism of action of ACE inhibitors in heart failure?

A) Vasodilation and reduced preload
B) Increased heart rate and contractility
C) Inhibition of platelet aggregation
D) Enhanced oxygen delivery to tissues

Solution 25: A) Vasodilation and reduced preload

ACE inhibitors reduce preload by causing vasodilation and are commonly used in heart failure to improve cardiac function.

26. **Question 26:**

A patient with a history of deep vein thrombosis (DVT) is prescribed enoxaparin. What is the primary purpose of enoxaparin in this patient?
A) To dissolve existing clots
B) To prevent further clot formation
C) To relieve pain and swelling
D) To improve blood circulation

Solution 26: B) To prevent further clot formation

Enoxaparin is a low molecular weight heparin used to prevent the formation of new clots and is commonly prescribed for DVT prophylaxis.

27. **Question 27:**

A patient with hypertension is prescribed an alpha-blocker. What is the primary mechanism of action of alpha-blockers in the management of hypertension?

A) Decreased heart rate
B) Decreased preload ''
C) Vasodilation
D) Increased myocardial contractility

Solution 27: C) Vasodilation

Alpha-blockers relax blood vessel walls, leading to vasodilation and a reduction in blood pressure.

28. **Question 28:**

A patient with coronary artery disease (CAD) is prescribed nitroglycerin. What is the primary action of nitroglycerin in the management of CAD?

A) Reducing heart rate
B) Decreasing preload
C) Dilating coronary arteries
D) Increasing blood viscosity

Solution 28: C) Dilating coronary arteries

Nitroglycerin dilates coronary arteries, improving blood flow to the heart muscle and relieving angina in patients with CAD.

29. **Question 29:**

A patient with peripheral artery disease (PAD) complains of intermittent claudication. What lifestyle modification should the nurse recommend to manage this symptom?

A) Increase sodium intake
B) Smoking cessation
C) Decrease physical activity
D) Limit fluid intake

Solution 29: B) Smoking cessation

Smoking cessation is essential in managing intermittent claudication in patients with PAD, as smoking exacerbates the condition.

30. **Question 30:**

A patient with heart failure is prescribed a beta-blocker. What is the primary benefit of beta-blockers in the management of heart failure?

A) Increased heart rate
B) Enhanced myocardial contractility
C) Decreased blood pressure
D) Improved cardiac remodeling

Solution 30: D) Improved cardiac remodeling

Beta-blockers help improve cardiac remodeling by reducing the workload of the heart and slowing down the progression of heart failure.

31. **Question 31:**

A patient with a history of hypertension and heart failure is prescribed an angiotensin receptor-neprilysin inhibitor (ARNI). Which medication is classified as an ARNI and is commonly used in the management of heart failure?

A) Losartan
B) Valsartan
C) Sacubitril/valsartan (Entresto)
D) Metoprolol

Solution 31: C) Sacubitril/valsartan (Entresto)

Sacubitril/valsartan is an ARNI used in the management of heart failure to reduce morbidity and mortality.

32. **Question 32:**

A patient is admitted with acute pericarditis. Which characteristic clinical finding is associated with pericarditis?

A) Jugular venous distention (JVD)
B) Dependent edema in the lower extremities
C) Inspiratory crackles in the lung bases
D) Wheezing on auscultation

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Solution 32: A) Jugular venous distention (JVD)

Jugular venous distention is a common clinical finding in pericarditis due to impaired venous return to the heart.

33. **Question 33:**
A patient with aortic regurgitation is evaluated by the nurse. What murmur is typically heard on auscultation in patients with aortic regurgitation?

A) Systolic ejection murmur
B) Diastolic decrescendo murmur
C) Diastolic crescendo murmur
D) Systolic crescendo murmur

Solution 33: B) Diastolic decrescendo murmur

A diastolic decrescendo murmur is a characteristic finding in patients with aortic regurgitation.

34. **Question 34:**
A patient with a suspected myocardial infarction is receiving oxygen therapy. What is the primary goal of oxygen therapy in this patient?

A) To reduce heart rate
B) To improve oxygen delivery to the tissues
C) To lower blood pressure
D) To increase myocardial contractility

Solution 34: B) To improve oxygen delivery to the tissues

Oxygen therapy is used to increase oxygen delivery to the tissues and reduce myocardial oxygen demand in patients with suspected myocardial infarction.

35. **Question 35:**
A patient with a history of atrial fibrillation is prescribed an oral anticoagulant. What is the primary purpose of anticoagulant therapy in this patient?

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A) To slow down the heart rate
B) To prevent clot formation in the atria
C) To increase cardiac output
D) To lower blood pressure

Solution 35: B) To prevent clot formation in the atria

The primary goal of anticoagulant therapy in atrial fibrillation is to prevent the formation of blood clots in the atria, which can lead to stroke.

36. **Question 36:**

A patient with chest pain is suspected of having unstable angina. What electrocardiographic (ECG) change is commonly seen in unstable angina?

A) ST-segment elevation
B) ST-segment depression
C) T-wave inversion
D) Q-wave formation

Solution 36: B) ST-segment depression

ST-segment depression is a common ECG change seen in unstable angina due to myocardial ischemia.

37. **Question 37:**

A patient with hypertension is prescribed a calcium channel blocker. What is the primary mechanism of action of calcium channel blockers in the management of hypertension?

A) Vasodilation
B) Increased heart rate
C) Reduced myocardial contractility
D) Enhanced renin release

Solution 37: A) Vasodilation

Calcium channel blockers relax blood vessel walls, leading to vasodilation and a reduction in blood pressure.

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38. **Question 38:**

A patient with heart failure is prescribed spironolactone. What electrolyte imbalance should the nurse closely monitor for while the patient is on this medication?

A) Hyponatremia
B) Hypokalemia
C) Hyperkalemia
D) Hypernatremia

Solution 38: C) Hyperkalemia

Spironolactone is a potassium-sparing diuretic, and its use can lead to hyperkalemia. Close monitoring of potassium levels is essential.

39. **Question 39:**

A patient with aortic dissection presents to the emergency department with severe chest pain radiating to the back. Which imaging study is the gold standard for diagnosing aortic dissection?

A) Electrocardiogram (ECG)
B) Chest X-ray
C) Echocardiography
D) Computed tomography angiography (CTA)

Solution 39: D) Computed tomography angiography (CTA)

Computed tomography angiography (CTA) is the gold standard for diagnosing aortic dissection due to its high sensitivity and specificity.

40. **Question 40:**

A patient with a history of hyperlipidemia is prescribed atorvastatin (Lipitor). What is the primary purpose of statin therapy in this patient?

A) To reduce blood pressure
B) To improve blood viscosity

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C) To lower serum cholesterol levels
D) To increase heart rate

Solution 40: C) To lower serum cholesterol levels

Statins are primarily used to lower serum cholesterol levels and reduce the risk of cardiovascular events in patients with hyperlipidemia.

41. **Question 41:**

A patient with chronic obstructive pulmonary disease (COPD) presents with increased dyspnea and thick, tenacious sputum. Which medication should the nurse anticipate administering to help improve airway clearance?

A) Albuterol (Proventil)
B) Montelukast (Singulair)
C) N-acetylcysteine (Mucomyst)
D) Prednisone

Solution 41: C) N-acetylcysteine (Mucomyst)

N-acetylcysteine is a mucolytic agent used to help liquefy and loosen thick, tenacious sputum in patients with COPD.

42. **Question 42:**

A patient with asthma is prescribed an inhaled corticosteroid (ICS). What is the primary action of ICS in the management of asthma?

A) Bronchodilation
B) Decreased airway inflammation
C) Increased mucus production
D) Relief of acute bronchospasm

Solution 42: B) Decreased airway inflammation

Inhaled corticosteroids (ICS) are used to reduce airway inflammation in asthma, which helps to prevent exacerbations.

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43. **Question 43:**

A patient with pneumonia is experiencing hypoxemia. Which oxygen delivery method provides the highest concentration of oxygen to the patient?

A) Nasal cannula
B) Simple face mask
C) Venturi mask
D) Non-rebreather mask

Solution 43: D) Non-rebreather mask

A non-rebreather mask provides the highest concentration of oxygen to the patient and is used for acute hypoxemia.

44. **Question 44:**

A patient with chronic bronchitis is prescribed ipratropium bromide (Atrovent). What is the primary action of ipratropium bromide in the management of chronic bronchitis?

A) Relief of acute bronchospasm
B) Decreased airway inflammation
C) Increased mucus production
D) Bronchodilation

Solution 44: D) Bronchodilation

Ipratropium bromide is an anticholinergic bronchodilator used to relieve acute bronchospasm in chronic bronchitis.

45. **Question 45:**

A patient with tuberculosis (TB) is prescribed a combination of rifampin and isoniazid. What important instruction should the nurse provide regarding this medication regimen?

A) Take the medications with food to reduce gastrointestinal side effects.

B) Avoid sunlight exposure while taking the medications.
C) Discontinue the medications if symptoms improve.
D) Avoid close contact with others to prevent transmission.

Solution 45: A) Take the medications with food to reduce gastrointestinal side effects.

Rifampin and isoniazid should be taken with food to reduce gastrointestinal side effects and improve absorption.

46. **Question 46:**

A patient with acute respiratory distress syndrome (ARDS) is receiving mechanical ventilation with positive end-expiratory pressure (PEEP). What is the primary purpose of using PEEP in ARDS?

A) To decrease oxygen concentration
B) To prevent lung overinflation
C) To improve patient comfort
D) To reduce the risk of infection

Solution 46: B) To prevent lung overinflation

PEEP is used in ARDS to prevent lung overinflation and maintain alveolar recruitment.

47. **Question 47:**

A patient with pneumonia is prescribed ceftriaxone (Rocephin). What is the primary action of ceftriaxone in the treatment of pneumonia?
A) Bronchodilation
B) Decreased airway inflammation
C) Relief of acute bronchospasm
D) Bacterial eradication

Solution 47: D) Bacterial eradication

Ceftriaxone is an antibiotic used to eradicate bacterial infections, including pneumonia.

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48. **Question 48:**

A patient with obstructive sleep apnea (OSA) is prescribed continuous positive airway pressure (CPAP) therapy. What is the primary goal of CPAP therapy in OSA?

A) To provide supplemental oxygen
B) To maintain a patent airway
C) To reduce daytime sleepiness
D) To improve lung compliance

Solution 48: B) To maintain a patent airway

CPAP therapy in OSA is used to maintain a patent airway by delivering a continuous flow of air under pressure, preventing airway collapse during sleep.

49. **Question 49:**

A patient with emphysema is prescribed home oxygen therapy. Which oxygen delivery device should the nurse recommend for long-term oxygen therapy at home?

A) Nasal cannula
B) Simple face mask
C) Venturi mask
D) Transtracheal oxygen catheter

Solution 49: A) Nasal cannula

Nasal cannulas are commonly used for long-term oxygen therapy at home due to their comfort and ease of use.

50. **Question 50:**

A patient with suspected pulmonary embolism (PE) is ordered a ventilation-perfusion (V/Q) scan. What does the V/Q scan assess in patients with suspected PE?

A) Pulmonary artery pressure

B) Pulmonary artery compliance
C) Ventilation-perfusion mismatch
D) Left ventricular ejection fraction

Solution 50: C) Ventilation-perfusion mismatch

A V/Q scan assesses the ventilation-perfusion (V/Q) mismatch in the lungs, helping to diagnose or rule out pulmonary embolism.

51. **Question 51:**

A patient with acute exacerbation of asthma is receiving a continuous albuterol nebulization treatment. What should the nurse monitor for as a potential side effect of this treatment?

A) Hypotension
B) Bradycardia
C) Tachypnea
D) Hypokalemia

Solution 51: D) Hypokalemia

Continuous albuterol nebulization can lead to hypokalemia as a side effect due to the medication's effect on potassium levels.

52. **Question 52:**

A patient with chronic bronchitis is prescribed theophylline. What should the nurse teach the patient regarding theophylline use?

A) Take it with meals for better absorption.
B) Avoid caffeine while on theophylline.
C) Discontinue the medication if experiencing coughing.
D) It is a first-line therapy for asthma.

Solution 52: B) Avoid caffeine while on theophylline.

Theophylline interacts with caffeine and can lead to increased side effects. Patients should be educated to limit caffeine intake.

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53. **Question 53:**

A patient with pneumonia is receiving oxygen therapy via a Venturi mask. What is the primary advantage of a Venturi mask in oxygen delivery?

A) It delivers the highest oxygen concentration.
B) It is the most comfortable for the patient.
C) It allows the patient to eat while receiving oxygen.
D) It provides the highest flow rate of oxygen.

Solution 53: A) It delivers the highest oxygen concentration.

A Venturi mask is designed to provide precise oxygen concentrations, making it the most suitable choice when accurate oxygen concentration is required.

54. **Question 54:**

A patient with a history of asthma is prescribed a leukotriene receptor antagonist. Which medication belongs to this drug class and is used in the treatment of asthma?

A) Albuterol (Proventil)
B) Ipratropium bromide (Atrovent)
C) Montelukast (Singulair)
D) Prednisone

Solution 54: C) Montelukast (Singulair)

Montelukast is a leukotriene receptor antagonist used in the treatment of asthma to reduce inflammation and improve symptoms.

55. **Question 55:**

A patient with pneumonia is prescribed azithromycin (Zithromax). What is the primary action of azithromycin in the treatment of pneumonia?

A) Bronchodilation

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B) Decreased airway inflammation
C) Relief of acute bronchospasm
D) Bacterial eradication

Solution 55: D) Bacterial eradication

Azithromycin is an antibiotic used to eradicate bacterial infections, including pneumonia.

56. **Question 56:**

A patient with acute respiratory distress syndrome (ARDS) is receiving mechanical ventilation with a low tidal volume strategy. What is the primary goal of using a low tidal volume in ARDS?

A) To prevent lung overinflation
B) To increase oxygen concentration
C) To reduce patient discomfort
D) To improve lung compliance

Solution 56: A) To prevent lung overinflation

Low tidal volume ventilation in ARDS is used to prevent lung overinflation and minimize ventilator-associated lung injury.

57. **Question 57:**

A patient with pulmonary fibrosis is prescribed pirfenidone (Esbriet). What is the primary action of pirfenidone in the treatment of pulmonary fibrosis?

A) Bronchodilation
B) Decreased airway inflammation
C) Relief of acute bronchospasm
D) Inhibition of fibrosis progression

Solution 57: D) Inhibition of fibrosis progression

Pirfenidone is used to slow down the progression of fibrosis in patients with pulmonary fibrosis.

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58. **Question 58:**

A patient with a tracheostomy is at risk of infection. What should the nurse emphasize as the primary measure to prevent tracheostomy-related infections?

A) Administering broad-spectrum antibiotics
B) Frequent tracheostomy tube changes
C) Proper hand hygiene and aseptic technique
D) Increasing the humidity of the room air

Solution 58: C) Proper hand hygiene and aseptic technique

Proper hand hygiene and aseptic technique are essential measures to prevent tracheostomy-related infections.

59. **Question 59:**

A patient with chronic obstructive pulmonary disease (COPD) is prescribed home oxygen therapy. What oxygen delivery device should the nurse recommend for long-term oxygen therapy at home?

A) Venturi mask
B) Non-rebreather mask
C) Nasal cannula
D) Simple face mask

Solution 59: C) Nasal cannula

Nasal cannulas are commonly used for long-term oxygen therapy at home due to their comfort and ease of use.

60. **Question 60:**

A patient with a history of pneumothorax is prescribed pleurodesis. What is the primary goal of pleurodesis in the treatment of pneumothorax?

A) To remove excess pleural fluid

B) To relieve chest pain
C) To prevent pleural effusion recurrence
D) To improve lung compliance

Solution 60: C) To prevent pleural effusion recurrence

Pleurodesis is performed to prevent the recurrence of pneumothorax or pleural effusion by causing adhesion of the pleural layers.

61. **Question 61:**

A patient diagnosed with schizophrenia experiences auditory hallucinations and paranoid delusions. What is the nurse's priority intervention when providing care for this patient?

A) Administering antipsychotic medication
B) Encouraging the patient to share their delusions
C) Allowing the patient to isolate themselves
D) Restraining the patient to prevent harm

Solution 61: A) Administering antipsychotic medication

Administering antipsychotic medication is the priority intervention to manage symptoms in a patient with schizophrenia.

62. **Question 62:**

A nurse is caring for a patient with bipolar disorder during a manic episode. What is the primary nursing goal during this phase of the disorder?

A) Promoting rest and sleep
B) Encouraging socialization
C) Enhancing communication skills
D) Ensuring adequate nutrition and hydration

Solution 62: A) Promoting rest and sleep

During a manic episode, promoting rest and sleep is a priority to help stabilize the patient's mood.

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63. **Question 63:**

A nurse is providing care to a patient who has a history of alcohol use disorder. The patient is experiencing alcohol withdrawal symptoms. What is the priority nursing intervention for this patient?

A) Administering a benzodiazepine
B) Encouraging the patient to attend group therapy
C) Providing education about the dangers of alcohol
D) Allowing the patient to self-administer alcohol in moderation

Solution 63: A) Administering a benzodiazepine

The priority intervention for a patient experiencing alcohol withdrawal is to administer a benzodiazepine to manage withdrawal symptoms and prevent complications.

64. **Question 64:**

A Practical Nurse (PN) is collecting patient data during a routine assessment. Which of the following data collection techniques involves tapping the patient's body to elicit a specific sound response that helps assess underlying structures or fluid accumulation?

A) Percussion
B) Palpation
C) Auscultation
D) Inspection

Solution 64: A) Percussion

Percussion is a data collection technique that involves tapping the patient's body to elicit specific sound responses. This technique is used to assess underlying structures and identify areas of fluid accumulation, such as in the lungs or abdomen. It can help in diagnosing conditions like pleural effusion or abdominal distension. Palpation involves using touch or pressure to assess the texture, size, consistency, and tenderness of various body parts. Auscultation involves listening

with a stethoscope to assess internal body sounds like heart and lung sounds. Inspection involves visual examination.

65. **Question 65:**

A 32-year-old female presents with symptoms of excessive fatigue, unexplained weight gain, and cold intolerance. Physical examination and laboratory tests reveal decreased levels of thyroid hormones. The nurse suspects a disorder of the endocrine system. Which endocrine gland is most likely responsible for this condition?

A) Pituitary gland
B) Adrenal gland
C) Thyroid gland
D) Pancreas

Solution 65: C) Thyroid gland

The symptoms of excessive fatigue, unexplained weight gain, and cold intolerance are indicative of hypothyroidism, which is a condition characterized by decreased levels of thyroid hormones. The thyroid gland is responsible for producing thyroid hormones (T3 and T4), which regulate metabolism and play a crucial role in energy production and temperature regulation. In hypothyroidism, the thyroid gland is not producing sufficient thyroid hormones, leading to a slowing down of metabolic processes and the associated symptoms. Therefore, the most likely endocrine gland responsible for this condition is the thyroid gland. Treatment for hypothyroidism often involves thyroid hormone replacement therapy.

66. **Question 66:**

A nurse is providing care to a patient with anorexia nervosa. The patient refuses to eat and exhibits severe malnutrition. What should the nurse do first in this situation?

A) Educate the patient about the importance of nutrition
B) Contact the patient's family to discuss the situation
C) Administer high-calorie liquid supplements forcibly
D) Assess the patient's vital signs and medical status

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Solution 66: D) Assess the patient's vital signs and medical status

The first step in caring for a patient with severe malnutrition is to assess their vital signs and medical status to determine the level of medical intervention needed.

67. **Question 67:**

A nurse is caring for a patient who is experiencing a panic attack. What is the most appropriate nursing action during a panic attack?

A) Leave the patient alone to calm down.
B) Encourage the patient to take slow, deep breaths.
C) Administer a sedative to calm the patient.
D) Restrict the patient's movements to prevent harm.

Solution 67: B) Encourage the patient to take slow, deep breaths.

Encouraging the patient to take slow, deep breaths is a helpful nursing action during a panic attack to promote relaxation and alleviate symptoms.

68. **Question 68:**

A nurse is caring for a patient with post-traumatic stress disorder (PTSD). The patient experiences flashbacks and nightmares related to a traumatic event. What nursing intervention can help the patient cope with these symptoms?

A) Avoid discussing the traumatic event with the patient.
B) Encourage the patient to avoid situations that trigger flashbacks.
C) Teach the patient relaxation techniques and grounding exercises.
D) Administer antipsychotic medications to reduce hallucinations.

Solution 68: C) Teach the patient relaxation techniques and grounding exercises.

Teaching relaxation techniques and grounding exercises can help patients with PTSD cope with flashbacks and nightmares.

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69. **Question 69:**

A nurse is caring for a patient who is experiencing delirium. What is the priority nursing intervention for a patient with delirium?

A) Providing a calm and structured environment
B) Administering an antipsychotic medication
C) Encouraging the patient to reminisce about past experiences
D) Allowing the patient to wander freely to reduce anxiety

Solution 69: A) Providing a calm and structured environment

The priority nursing intervention for a patient with delirium is to provide a calm and structured environment to minimize confusion and agitation.

70. **Question 70:**

A nurse is caring for a patient with schizophrenia who refuses to take prescribed antipsychotic medication. What is the most appropriate nursing action in this situation?

A) Administer the medication forcibly.
B) Document the patient's refusal and notify the healthcare provider.
C) Persuade the patient to take the medication by threatening consequences.
D) Leave the patient alone until they change their mind.

Solution 70: B) Document the patient's refusal and notify the healthcare provider.

When a patient refuses medication, it is important to document the refusal and notify the healthcare provider for further assessment and possible alternative interventions.

71. **Question 71:**

A nurse is caring for a patient with dementia who exhibits aggressive behavior toward other patients. What is the most appropriate nursing intervention to address this behavior?

A) Isolate the patient to prevent harm to others.
B) Administer a sedative to calm the patient.

C) Assess and address potential causes of agitation.
D) Restrict the patient's visitation rights.

Solution 71: C) Assess and address potential causes of agitation.

In patients with dementia, aggression can result from various causes, including pain, discomfort, or unmet needs. Assessing and addressing the underlying cause is the most appropriate initial intervention.

72. **Question 72:**
A nurse is caring for a patient with generalized anxiety disorder (GAD). What therapeutic communication technique should the nurse use to help the patient express their feelings?

A) Offering reassurance and solutions
B) Providing silence and active listening
C) Interrupting to redirect the conversation
D) Avoiding the topic of anxiety

Solution 72: B) Providing silence and active listening.

Providing silence and active listening allows the patient with GAD to express their feelings and thoughts without interruption.

73. **Question 73:**
A nurse is caring for a patient diagnosed with narcissistic personality disorder. What is a key characteristic of individuals with narcissistic personality disorder?

A) Avoidance of social situations
B) Fear of criticism and rejection
C) Grandiose sense of self-importance
D) Strong interpersonal relationships

Solution 73: C) Grandiose sense of self-importance.

Individuals with narcissistic personality disorder typically exhibit a grandiose sense of self-importance and a need for excessive admiration.

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74. **Question 74:**

A nurse is providing care to a patient who is experiencing delusions. What is the most appropriate nursing approach when interacting with a patient who has delusional beliefs?

A) Agreeing with the delusions to avoid conflict
B) Challenging the delusional beliefs with evidence
C) Ignoring the delusions to prevent distress
D) Distorting reality to match the delusions

Solution 74: B) Challenging the delusional beliefs with evidence.

Challenging delusional beliefs with evidence-based information can help the patient gain insight and perspective.

75. **Question 75:**

A nurse is caring for a patient with substance use disorder who is experiencing withdrawal symptoms. What is the priority nursing intervention during the withdrawal phase?

A) Providing emotional support and counseling
B) Administering a sedative to calm the patient
C) Monitoring vital signs and managing withdrawal symptoms
D) Encouraging the patient to attend social gatherings

Solution 75: C) Monitoring vital signs and managing withdrawal symptoms.

During the withdrawal phase of substance use disorder, the priority is to monitor vital signs and manage withdrawal symptoms to ensure the patient's safety.

76. **Question 76:**

A nurse is caring for a patient diagnosed with post-traumatic stress disorder (PTSD) following a traumatic event. What is a common symptom of PTSD that the nurse should be attentive to?

A) Dissociative identity disorder
B) Recurrent panic attacks

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C) Intrusive thoughts and flashbacks
D) Bipolar disorder

Solution 76: C) Intrusive thoughts and flashbacks.

Intrusive thoughts and flashbacks are common symptoms of PTSD, where the patient re-experiences the traumatic event.

77. **Question 77:**
A nurse is providing care to a patient with borderline personality disorder who exhibits self-destructive behaviors. What should be the nurse's priority when managing self-destructive behaviors?

A) Provide positive reinforcement for self-destructive actions.
B) Ignore self-destructive behaviors to avoid attention.
C) Establish clear boundaries and safety measures.
D) Isolate the patient to prevent further harm.

Solution 77: C) Establish clear boundaries and safety measures.

Establishing clear boundaries and safety measures is a priority when managing self-destructive behaviors in patients with borderline personality disorder.

78. **Question 78:**
A nurse is caring for a patient diagnosed with an eating disorder. What is the primary goal of treatment for a patient with an eating disorder?

A) Achieving a specific body weight or BMI target
B) Encouraging frequent and large meals
C) Eliminating all dietary restrictions
D) Promoting a healthy relationship with food and body

Solution 78: D) Promoting a healthy relationship with food and body.

The primary goal of treatment for patients with eating disorders is to promote a healthy relationship with food and body image.

79. **Question 79:**

A nurse is providing care to a patient diagnosed with schizophrenia who experiences disorganized thinking and delusions. What communication technique should the nurse use when interacting with this patient?

A) Asking open-ended questions to explore delusions
B) Agreeing with the patient's delusional beliefs
C) Using simple and concrete language
D) Encouraging the patient to elaborate on hallucinations

Solution 79: C) Using simple and concrete language.

Using simple and concrete language helps patients with disorganized thinking in schizophrenia understand and engage in effective communication.

80. **Question 80:**

A nurse is caring for a patient diagnosed with major depressive disorder. What assessment finding should the nurse prioritize when evaluating the patient's condition?

A) Social withdrawal and isolation
B) Grandiose delusions
C) Increased energy levels
D) Elevated mood and affect

Solution 80: A) Social withdrawal and isolation.

Social withdrawal and isolation are common symptoms of major depressive disorder and should be closely assessed for signs of worsening depression.

81. **Question 81:**

A practical nurse is caring for a patient who is receiving intravenous (IV) heparin therapy for deep vein thrombosis (DVT). What is the priority nursing intervention to monitor for potential complications of heparin therapy?

A) Monitor the patient's platelet count.
B) Assess the patient's general immune system health.

C) Check the patient's respiratory rate.
D) Evaluate the patient's nutritional intake.

Solution 81: A) Monitor the patient's platelet count.

Monitoring the patient's platelet count is essential when administering heparin therapy to detect and prevent heparin-induced thrombocytopenia (HIT), a potentially severe complication.

82. **Question 82:**

A practical nurse is caring for a postoperative patient who had abdominal surgery. What action should the nurse take to reduce the risk of postoperative deep vein thrombosis (DVT)?

A) Administer antipyretics to lower the patient's temperature.
B) Apply cold compresses to the surgical incision site.
C) Encourage early ambulation and leg exercises.
D) Administer antibiotics to prevent infection.

Solution 82: C) Encourage early ambulation and leg exercises.

Encouraging early ambulation and leg exercises helps prevent stasis and reduces the risk of postoperative DVT.

83. **Question 83:**

A nurse is caring for a patient with a history of seizures. What is the priority nursing action when providing care for this patient?

A) Administering antipyretics to reduce fever
B) Placing the patient in a supine position
C) Ensuring the patient receives adequate fluids
D) Implementing seizure precautions and safety measures

Solution 83: D) Implementing seizure precautions and safety measures.

The priority when caring for a patient with a history of seizures is to implement seizure precautions and safety measures to prevent injury during a seizure episode.

84. **Question 84:**

A nurse is caring for a patient with a central venous catheter (CVC) in place. What is the primary nursing intervention to reduce the risk of CVC-related bloodstream infections?

A) Apply a tight dressing over the CVC site.
B) Change the CVC dressing every 48 hours.
C) Perform hand hygiene and use sterile technique during CVC care.
D) Flush the CVC with normal saline every 12 hours.

Solution 84: C) Perform hand hygiene and use sterile technique during CVC care.

Using proper hand hygiene and sterile technique during CVC care is essential to reduce the risk of CVC-related bloodstream infections.

85. **Question 85:**

A nurse is caring for an elderly patient at risk for falls. What is the priority nursing intervention to reduce the risk of falls in this patient?

A) Administering sedative medications at bedtime
B) Encouraging the patient to use assistive devices independently
C) Keeping the patient's room dimly lit at night
D) Providing a safe and clutter-free environment

Solution 85: D) Providing a safe and clutter-free environment.

The priority intervention to reduce the risk of falls in an elderly patient is to provide a safe and clutter-free environment to minimize tripping hazards.

86. **Question 86:**

A nurse is caring for a patient with diabetes mellitus who is at risk for foot ulcers. What education should the nurse provide to reduce the risk of foot ulcers in this patient?

A) Soak the feet in warm water daily.
B) Trim toenails using scissors.

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C) Wear tight-fitting shoes and socks.
D) Inspect the feet daily and report any changes.

Solution 86: D) Inspect the feet daily and report any changes.

Daily foot inspection and reporting of any changes is essential to reduce the risk of foot ulcers in patients with diabetes mellitus.

87. **Question 87:**

A nurse is caring for a patient with a history of allergic reactions to medications. What is the priority nursing intervention to reduce the risk of allergic reactions in this patient?

A) Administering a prescribed medication regardless of allergies
B) Monitoring vital signs every 4 hours
C) Asking the patient about known allergies before medication administration
D) Providing the medication in a different dosage form

Solution 87: C) Asking the patient about known allergies before medication administration.

Asking the patient about known allergies before medication administration is the priority to prevent allergic reactions.

88. **Question 88:**

A nurse is caring for a patient with a nasogastric tube (NGT) in place for enteral feeding. What action should the nurse take to reduce the risk of NGT-related complications?

A) Replace the NGT every 24 hours.
B) Verify NGT placement before each feeding.
C) Encourage the patient to cough and deep breathe frequently.
D) Increase the NGT feed rate for rapid nutrition.

Solution 88: B) Verify NGT placement before each feeding

Verifying NGT placement before each feeding is essential to reduce the risk of complications, including aspiration.

89. **Question 89:**

A nurse is caring for a patient with a history of falls. What is the priority nursing intervention to reduce the risk of falls in this patient?

A) Encourage the use of assistive devices.
B) Administer sedative medications as prescribed.
C) Limit the patient's physical activity.
D) Apply physical restraints when necessary.

Solution 89: A) Encourage the use of assistive devices.

Encouraging the use of assistive devices is a priority to reduce the risk of falls in a patient with a history of falls.

90. **Question 90:**

A nurse is caring for a postoperative patient who is at risk for surgical site infection (SSI). What is the priority nursing action to reduce the risk of SSI?

A) Administer prophylactic antibiotics after surgery.
B) Change the surgical dressing daily.
C) Keep the surgical incision open to air.
D) Encourage the patient to touch the incision frequently.

Solution 90: A) Administer prophylactic antibiotics after surgery.

Administering prophylactic antibiotics after surgery is a priority to reduce the risk of surgical site infection (SSI).

91. **Question 91:**

A nurse is caring for a patient with tuberculosis (TB). What type of isolation precautions should the nurse implement to prevent the transmission of TB to others?

A) Contact precautions
B) Droplet precautions
C) Airborne precautions
D) Standard precautions

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Solution 91: C) Airborne precautions

Airborne precautions, including the use of an N95 respirator mask, are necessary to prevent the transmission of TB, which is spread through airborne droplets.

92. **Question 92:**
A nurse is caring for a patient with Clostridium difficile (C. difficile) infection. What personal protective equipment (PPE) should the nurse wear when providing care to this patient?

A) Gloves and gown
B) Surgical mask and gloves
C) Face shield and gown
D) Respirator mask and gloves

Solution 92: A) Gloves and gown

Gloves and a gown should be worn when caring for a patient with C. difficile to prevent the spread of spores through contact.

93. **Question 93:**
A nurse is assisting with a surgical procedure in the operating room. What is the primary goal of surgical asepsis during the procedure?

A) Preventing contamination of the sterile field
B) Reducing the patient's anxiety
C) Enhancing communication among the surgical team
D) Minimizing surgical costs

Solution 93: A) Preventing contamination of the sterile field

The primary goal of surgical asepsis is to prevent contamination of the sterile field during surgical procedures to reduce the risk of infection.

94. **Question 94:**

A nurse is caring for a patient with Methicillin-resistant Staphylococcus aureus (MRSA) infection. What precautionary measure should the nurse take when entering the patient's room?

A) Apply hand sanitizer upon entering and exiting the room.
B) Use contact precautions, including gloves and gown.
C) Wear a surgical mask and eye protection.
D) Increase the room temperature to neutralize the bacteria.

Solution 94: B) Use contact precautions, including gloves and gown.

Contact precautions, including the use of gloves and a gown, are necessary when caring for a patient with MRSA to prevent transmission.

95. **Question 95:**

A nurse is caring for a patient with shingles (herpes zoster). What type of isolation precautions should the nurse implement to prevent the spread of the virus?

A) Airborne precautions
B) Contact precautions
C) Droplet precautions
D) Standard precautions

Solution 95: B) Contact precautions

Contact precautions are necessary to prevent the transmission of herpes zoster (shingles) as the virus can be spread through direct contact with skin lesions.

96. **Question 96:**

Which chamber of the heart is responsible for pumping oxygenated blood to the systemic circulation?

A) Right atrium
B) Right ventricle

C) Left atrium
D) Left ventricle

Solution 96: D) Left ventricle

The left ventricle is responsible for pumping oxygenated blood to the systemic circulation, delivering oxygen to the body's tissues and organs. The right atrium receives deoxygenated blood from the body, which is then pumped into the right ventricle. The right ventricle pumps this deoxygenated blood to the lungs for oxygenation. The left atrium receives oxygenated blood from the lungs, and the left ventricle pumps it into the systemic circulation. This is a fundamental aspect of the circulatory system's functioning.

97. **Question 97:**

A nurse is providing care to a patient with an infected wound. What type of precautions should the nurse follow when caring for the wound?

A) Standard precautions
B) Airborne precautions
C) Droplet precautions
D) Contact precautions

Solution 97: A) Standard precautions

Standard precautions should be followed when caring for all patients, regardless of their infection status, to prevent the spread of infections.

98. **Question 98:**

A nurse is caring for a patient with a respiratory infection caused by a novel virus. What type of precautions should the nurse follow when caring for this patient?

A) Droplet precautions
B) Airborne precautions
C) Contact precautions
D) Standard precautions

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Solution 98: A) Droplet precautions

Droplet precautions are used to prevent the transmission of respiratory infections transmitted through respiratory droplets, such as influenza or novel viruses. In a Practical Nurse (PN)'s day-to-day practice, the implementation of droplet precautions is pivotal for preventing the transmission of respiratory infections like influenza and novel viruses. As healthcare professionals with hands-on patient care responsibilities, we actively identify and isolate patients requiring these precautions, utilize personal protective equipment (PPE) diligently, and maintain rigorous hand hygiene to reduce the risk of disease transmission. By doing so, we help protect our patients, colleagues, and ourselves from contagious respiratory illnesses, ensuring a safer healthcare environment and the well-being of our community.

99. **Question 99:**

A nurse is caring for a patient with an infected wound and performing wound care. What is the most important step in maintaining asepsis during wound care?

A) Wearing sterile gloves
B) Using a sterile drape
C) Cleaning the wound with hydrogen peroxide
D) Applying an occlusive dressing

Solution 99: A) Wearing sterile gloves

Wearing sterile gloves is essential for maintaining asepsis during wound care and preventing contamination of the wound. Wearing sterile gloves as a Practical Nurse is an indispensable practice during wound care to uphold asepsis and prevent wound contamination. In the healthcare setting, our primary responsibility is to provide safe and high-quality patient care, and sterile gloves play a critical role in fulfilling this duty. By creating a barrier between our hands and the wound, we minimize the risk of introducing harmful microorganisms that could lead to infections, which are particularly detrimental to vulnerable patients. This practice not only ensures patient safety but also aligns with stringent infection control guidelines, emphasizing the significance of adhering to best

practices. Additionally, by wearing sterile gloves and maintaining a sterile field, we contribute to an environment conducive to wound healing, ultimately promoting positive patient outcomes.

Question 100:

A nurse is caring for a patient with active tuberculosis (TB) in a healthcare facility. What should the nurse instruct the patient to do to prevent the spread of TB to others?

A) Avoid close contact with anyone for the duration of treatment.

B) Always wear a surgical mask when outside the room.

C) Cover the mouth and nose when coughing or sneezing.

D) Share eating utensils and personal items with others.

Solution 100: C) Cover the mouth and nose when coughing or sneezing.

Instructing the patient to cover the mouth and nose when coughing or sneezing is a key preventive measure to reduce the risk of TB transmission to others.

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