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Question: 13

Which of the following is not considered one of the five rights of medication administration?

- A. client**
- B. drug**
- C. dose**
- D. routine**

Answer: D

Explanation:

Dose, client, drug, route and time are considered the five rights of medication.

Question: 14

When giving an intramuscular injection to an infant. Which of the following sites is preferred?

- A. Ventrogluteal region**
- B. Deltoid**
- C. Vastus lateralis**
- D. Dorsogluteal region**

Answer: C

Explanation:

Vastus lateralis is the ideal choice for infants.

Question: 15

When choosing a needle gauge for an intramuscular injection in a 12 year old boy. Which of the following gauges would you choose?

- A. 27 gauge**
- B. 25 gauge**
- C. 22 gauge**
- D. 20 gauge**

Answer: C

Explanation:

22 gauge is recommended for school age children, toddlers, and adolescents while 23-25 gauge is recommended for infants.

Question: 16

Which of the following is not considered one of the main mechanisms of Type II Diabetes treatment?

- A. Medications**
- B. Nutrition**
- C. Increased activity**
- D. Continuous Insulin**

Answer: D

Explanation:

Insulin is not required in continuous treatment for every Type II diabetic.

Question: 17

A nurse is caring for a retired MD. The MD asks the question, "What type of cells create exocrine secretions?" The correct answer is:

- A. alpha cells**
- B. beta cells**
- C. acinar cells**
- D. plasma cells**

Answer: C

Explanation:

Acinar cells create exocrine secretions.

Question: 18

A nurse is caring for a patient who has experienced burns to the right lower extremity. According to the Rule of Nines which of the following percents most accurately describes the severity of the injury?

- A. 36%**
- B. 27%**
- C. 18%**
- D. 9%**

Answer: C

Explanation:

Each lower extremity is scored as 18% according to the Rule of Nines.

Question: 19

A patient has experienced a severe third degree burn to the trunk in the last 36 hours. Which phase of burn management is the patient in?

- A. Shock phase**
- B. Emergent phase**
- C. Healing phase**
- D. Wound proliferation phase**

Answer: A

Explanation:

The shock phase is considered the first 24-48 hours in wound management.

Question: 20

A patient has fallen off a bicycle and fractured the head of the proximal fibula. A cast was placed on the patient's lower extremity. Which of the following is the most probable result of the fall?

- A. Peroneal nerve injury**
- B. Tibial nerve injury**
- C. Sciatic nerve injury**
- D. Femoral nerve injury**

Answer: A

Explanation:

The head of the proximal fibula is in close proximity to the peroneal nerve.

Question: 21

A nurse has been ordered to set-up Buck's traction on a patient's lower extremity due to a femur fracture. Which

of the following applies to Buck's traction?

- A. A weight greater than 10 lbs. should be used.**
- B. The line of pull is upward at an angle.**
- C. The line of pull is straight**
- D. A weight greater than 20 lbs. should be used.**

Answer: C

Explanation:

A straight line of pull is indicated with Buck's traction.

Question: 22

Which of the following motions is identified with the corresponding action? (Action- Turning palm of hand over to face in the anterior direction, dorsum of the hand is pointed downward toward the floor.)

- A. Pronation**
- B. Supination**
- C. Abduction**
- D. Adduction**

Answer: B

Explanation:

Supination- "Holding a bowl of soup in your hand."

Question: 23

A nurse is caring for a retired MD. The MD asks the question, "What type of cells secrete insulin?" The correct answer is:

- A. alpha cells**
- B. beta cells**
- C. CD4 cells**
- D. helper cells**

Answer: B

Explanation:

Beta cells secrete insulin.

Question: 24

A nurse is reviewing a patient's current Lithium levels. Which of the following values is outside the therapeutic range?

- A. 1.0 mEq/L**
- B. 1.1 mEq/L**
- C. 1.2 mEq/L**
- D. 1.3 mEq/L**

Answer: D

Explanation:

1.0-1.2 mEq/L is considered standard therapeutic range for patient care.

Question: 25

A client is going to have an endoscopy performed. Which of the following is not a probable reason for an endoscopy procedure?

Question: 1657

Nurse's Note:

0900: 70-year-old male client with a history of hypertension and diabetes presents to the emergency department with severe chest pain radiating to the left arm. The client reports associated shortness of breath and diaphoresis.

Vital Signs:

Temp: 98.6°F (37°C)

P: 115

RR: 22

BP: 180/110

O2: sat 94% on room air

The nurse suspects the client may be experiencing a myocardial infarction. Which finding supports this suspicion? (Select all that apply.)

- A. Diaphoresis.
- B. Chest pain radiating to the left arm.
- C. Elevated heart rate.
- D. Increased blood pressure.
- E. Oxygen saturation of 94%.
- F. History of diabetes.

Answer: A, B, C, D

Explanation: Diaphoresis, chest pain radiating to the left arm, elevated heart rate, and increased blood pressure are all classic signs of myocardial infarction, indicating the need for immediate intervention.

Question: 1658

Client History:

70-year-old male client with a history of heart failure presents with increased shortness of breath and a productive cough. The client reports feeling more fatigued than usual.

Vital Signs:

BP: 130/80

HR: 98

Temp: 99°F (37.2°C)

RR: 30

SpO2: 89% on 2L O2/NC

Identify the priority nursing interventions for this client. (Select All That Apply)

- A. Administer diuretics as prescribed
- B. Assess lung sounds frequently
- C. Educate the client on daily weight monitoring
- D. Initiate oxygen therapy
- E. Monitor for signs of fluid overload

Answer: A, B, D, E

Explanation: Administering diuretics helps relieve fluid overload. Assessing lung sounds frequently is critical to evaluate respiratory status. Initiating oxygen therapy addresses hypoxia, and monitoring for signs of fluid overload ensures timely intervention.

Question: 1659

A client with heart failure is prescribed furosemide. What laboratory value should the nurse monitor closely? (Select All That Apply)

- A. Potassium levels
- B. Sodium levels
- C. BUN and creatinine
- D. Calcium levels

Answer: A, B, C

Explanation: Furosemide can cause electrolyte imbalances, particularly hypokalemia and hyponatremia, and may affect renal function, necessitating monitoring of BUN and creatinine levels.

Question: 1660

Nurse's Note:

1500: 82-year-old female client with a history of dementia presents with increased agitation and refusal to eat. The family reports a sudden change in her behavior.

Vital Signs:

Temp: 98.5°F (36.9°C)

P: 80

RR: 16

BP: 120/80

O2: sat 95% on room air

Which 4 findings from the nurse's notes are most important to address immediately?

- A. Increased agitation.
- B. Refusal to eat.
- C. Sudden change in behavior.
- D. Normal vital signs.
- E. History of dementia.
- F. Family concerns.

Answer: A, B, C, F

Explanation: Increased agitation and refusal to eat are concerning as they may indicate underlying medical issues or acute changes in the client's condition. A sudden change in behavior necessitates further evaluation to identify possible causes.

Question: 1661

Nurse's Note:

1600: 49-year-old male client with a history of asthma presents with severe wheezing and shortness of breath after exposure to allergens. The client reports increased use of his rescue inhaler.

Vital Signs:

Temp: 98.4°F (36.9°C)

P: 100

RR: 28

BP: 125/80

O2: sat 87% on 3L O2 via nasal cannula

Which 4 findings from the nurse's notes are most critical to address immediately?

- A. Severe wheezing.
- B. Shortness of breath.
- C. Increased use of rescue inhaler.
- D. Oxygen saturation of 87%.
- E. Normal blood pressure.
- F. Elevated pulse rate.

Answer: A, B, D, C

Explanation: Severe wheezing and shortness of breath indicate an acute asthma exacerbation requiring immediate treatment. An oxygen saturation of 87% suggests hypoxia, necessitating urgent intervention.

Question: 1662

Nurse's Note:

2600: 65-year-old male client with a history of chronic heart failure presents with increased edema and shortness of breath. The client reports a rapid weight gain of 5 pounds over the past week.

Vital Signs:

Temp: 98.7°F (37.1°C)

P: 90

RR: 24

BP: 135/85

O2: sat 90% on 3L O2 via nasal cannula

Which findings from the nurse's notes require immediate attention? (Select all that apply.)

- A. Increased edema.
- B. Shortness of breath.
- C. Rapid weight gain.
- D. Oxygen saturation of 90%.
- E. Elevated blood pressure.
- F. History of heart failure.

Answer: A, B, D, C

Explanation: Increased edema and shortness of breath are indicative of fluid overload that requires urgent intervention. An oxygen saturation of 90% suggests hypoxia that needs to be addressed immediately.

Question: 1663

A nurse is preparing to administer a blood transfusion. Which of the following assessments should be performed before starting the transfusion? (Select All That Apply)

- A. Check the patient's vital signs
- B. Confirm the blood type and Rh factor with another nurse
- C. Assess for any history of allergic reactions to blood products
- D. Obtain a signed consent form

Answer: A, B, C, D

Explanation: It is essential to check vital signs to establish a baseline, confirm blood type for compatibility, assess for allergic history to prevent reactions, and ensure that informed consent is obtained before any transfusion.

Question: 1664

Client History:

65-year-old female client with a history of hypertension presents with severe headache and visual disturbances. The client reports a sudden onset of symptoms and has a family history of stroke.

Nurse's Note:

Vital signs reveal elevated blood pressure, and the client is diaphoretic. Neurological assessment shows weakness on the right side.

Determine the priority nursing actions for this client. (Select All That Apply)

- A. Administer antihypertensive medication
- B. Initiate a stroke protocol
- C. Monitor neurological status frequently
- D. Prepare for a CT scan
- E. Provide education on stroke prevention

Answer: B, C, D

Explanation: Initiating a stroke protocol is crucial for rapid assessment and intervention. Monitoring neurological status helps detect changes in condition. Preparing for a CT scan is essential to rule out hemorrhagic stroke.

Question: 1665

A nurse is assessing a client with pneumonia. Which of the following findings would indicate the need for immediate intervention? (Select All That Apply)

- A. Respiratory rate of 28 breaths per minute
- B. Oxygen saturation of 90%
- C. Productive cough with green sputum
- D. Chest pain with inspiration

Answer: A, B, D

Explanation: Increased respiratory rate, low oxygen saturation, and chest pain during inspiration indicate potential respiratory distress and warrant immediate intervention.

Question: 1666

Nurse's Note:

1500: 65-year-old male client with a history of coronary artery disease presents with chest pain described as "pressure" and shortness of breath. The client is on aspirin and a beta-blocker.

Vital Signs:

Temp: 98.6°F (37°C)

P: 112

RR: 24

BP: 160/100

O2: sat 94% on room air

What findings from the nurse's notes require immediate intervention? (Select all that apply.)

- A. Chest pain described as "pressure."
- B. Shortness of breath.
- C. Elevated heart rate.
- D. Elevated blood pressure.
- E. History of coronary artery disease.
- F. Oxygen saturation of 94%.

Answer: A, B, D, C

Explanation: Chest pain and shortness of breath in the context of coronary artery disease are critical signs that require urgent assessment. Elevated heart rate and blood pressure may indicate increased myocardial oxygen demand, necessitating immediate intervention.

Question: 1667

Client History:

45-year-old client diagnosed with type 1 diabetes presents with severe abdominal pain, nausea, and vomiting. The client has been experiencing increased thirst and urination. Laboratory results reveal a blood glucose level of 450 mg/dL and metabolic acidosis.

Nurse's Note:

The client appears lethargic and dehydrated. The respiratory rate is rapid, and breath has a fruity odor. The renal function tests indicate elevated creatinine levels.

Determine the priority nursing diagnosis for this client. (Select All That Apply)

- A. Risk for fluid volume deficit
- B. Ineffective airway clearance
- C. Impaired glucose metabolism
- D. Risk for impaired skin integrity

E. Acute pain related to abdominal distention

Answer: A, C

Explanation: The client presents with hyperglycemia and signs of diabetic ketoacidosis (DKA), indicating impaired glucose metabolism. Risk for fluid volume deficit is significant due to dehydration from osmotic diuresis. Addressing these issues is critical for the client's stabilization.

Question: 1668

Client History:

67-year-old female client with a history of chronic kidney disease presents with fatigue, pruritus, and confusion. The family reports increased forgetfulness.

Vital Signs:

BP: 120/70

HR: 85

Temp: 98.9°F (37.2°C)

RR: 20

SpO₂: 96% on room air

Identify the priority nursing interventions for this client. (Select All That Apply)

- A. Administer phosphate binders as prescribed
- B. Educate the client on fluid restrictions
- C. Monitor laboratory values for renal function
- D. Assess skin integrity regularly
- E. Implement a low-protein diet

Answer: A, C, E

Explanation: Administering phosphate binders helps manage hyperphosphatemia. Monitoring laboratory values is essential for tracking renal function, and implementing a low-protein diet is critical to reduce the workload on the kidneys.

Question: 1669

A nurse is reviewing a client's lab results. Which result would indicate a need for further investigation in a patient undergoing treatment for cancer?

- A. Elevated white blood cell count
- B. Low hemoglobin level

- C. Elevated liver enzymes
- D. Normal platelet count

Answer: C

Explanation: Elevated liver enzymes could indicate liver metastasis or toxicity from chemotherapy, requiring further investigation.

Question: 1670

Client History:

79-year-old female client with a history of heart failure presents with sudden onset of shortness of breath and chest pain. The family reports increased fatigue over the past week.

Nurse's Note:

The client appears anxious, and lung auscultation reveals bilateral crackles. Vital signs indicate tachycardia and hypotension.

Vital Signs:

BP: 90/60

HR: 110

Temp: 98.6°F (37°C)

RR: 30

SpO2: 92% on 3L O2/NC

Identify the priority nursing interventions for this client. (Select All That Apply)

- A. Administer diuretics as prescribed
- B. Prepare for possible intubation
- C. Assess for signs of fluid overload
- D. Monitor vital signs frequently
- E. Educate the family on heart failure management

Answer: A, B, C, D

Explanation: Administering diuretics helps relieve fluid overload. Preparing for intubation may be necessary if the respiratory distress worsens. Assessing for signs of fluid overload is critical, and monitoring vital signs frequently ensures timely interventions.

Question: 1671

A patient has been diagnosed with chronic obstructive pulmonary disease (COPD) and is experiencing an exacerbation. What is the most critical nursing intervention?

- A. Encourage deep breathing exercises
- B. Administer bronchodilators as ordered
- C. Provide supplemental oxygen
- D. Monitor respiratory rate

Answer: B

Explanation: Administering bronchodilators is critical for relieving bronchospasm and improving airflow during an exacerbation.

Question: 1672

Nurse's Note:

Report: A 50-year-old client with a history of liver cirrhosis is admitted with gastrointestinal bleeding. The client reports vomiting bright red blood and has dark, tarry stools.

Vital Signs:

Temp 97°F (36.1°C), HR 130, BP 85/50, RR 24.

Lab Results:

Hgb 8.0 g/dL, Hct 25%, Platelets 90,000/mm³, INR 2.5.

Identify the critical factors for the nurse to consider in this case. (Select all that apply.)

- A. Bright red blood in vomit
- B. Dark, tarry stools
- C. Low hemoglobin and hematocrit levels
- D. Elevated INR
- E. History of liver cirrhosis

Answer: A, B, C, D, E

Explanation: Each option presents vital information regarding the severity of the client's condition, indicating significant hemorrhage and potential liver dysfunction requiring immediate nursing action.



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