PLAINWORK

NCLEX-RN Management, Safety and Prioritization Practice App

Free sample: 10 of 269 questions

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Sample

1. A resident with age-related macular degeneration has lost central vision but keeps some side vision. Which approach best promotes safety and independence?

A. A. Dim the lighting to cut glare and serve food on pale dishes
B. B. Rearrange furniture often to keep the room stimulating
C. C. Use bright, glare-free lighting and high-contrast items, and describe where items are on the meal tray
D. D. Speak loudly and slowly because sight loss affects understanding

C. Use bright, glare-free lighting and high-contrast items, and describe where items are on the meal tray — Macular degeneration impairs central vision. Good glare-free lighting, high contrast, magnification and a consistent room arrangement help. Describing where food is on the tray, for example by clock positions, supports independence.

Question and rationale by Plainwork. Reference: Standard gerontological nursing texts

2. At the start of the shift, a nurse in a clinic finds the vaccine refrigerator thermometer above the recommended range after an overnight power failure. What should the nurse do?

A. A. Discard every vaccine in the refrigerator immediately, without contacting the manufacturer or the health department
B. B. Give the vaccines scheduled for today because they are not frozen
C. C. Move the vaccines to the freezer to cool them quickly
D. D. Mark them do not use, store them correctly, and ask the manufacturer if they are viable

D. Mark them do not use, store them correctly, and ask the manufacturer if they are viable — Vaccines lose potency when stored outside the recommended temperature range, and the loss cannot be seen. They are set aside labeled do not use, stored at the correct temperature, and the manufacturer or immunization program is asked whether they are still usable. Giving compromised vaccine may leave clients unprotected.

Question and rationale by Plainwork. Reference: CDC Vaccine Storage and Handling Toolkit; CDC Pink Book

3. Five minutes after receiving an injection of a vaccine, a client develops hives, wheezing, a swollen tongue and a falling blood pressure. What is the nurse's first action?

A. A. Ask the client to lie still and recheck vital signs in 15 minutes
B. B. Give an inhaled bronchodilator for the wheezing
C. C. Give diphenhydramine intravenously
D. D. Give epinephrine intramuscularly and call for emergency help

D. Give epinephrine intramuscularly and call for emergency help — These are signs of anaphylaxis, which involves airway and circulation. Intramuscular epinephrine is the first-line treatment and is given right away, with emergency services called. Antihistamines and bronchodilators are adjuncts and do not replace it.

Question and rationale by Plainwork. Reference: CDC General Best Practice Guidelines for Immunization (ACIP); Resuscitation Council / AHA anaphylaxis guidance

4. An 81-year-old client recovering from pneumonia has fallen twice at night while hurrying to the bathroom. The client has urinary urgency and takes a diuretic in the morning. Which intervention most directly addresses the cause of these falls?

A. A. Place a bed-exit alarm and respond as soon as it sounds
B. B. Remind the client to call for help only when the urge becomes strong
C. C. Restrict all oral fluids after the evening meal
D. D. Offer assisted toileting at set times, including once during the night

D. Offer assisted toileting at set times, including once during the night — The night falls come from an unmet toileting need: urgency sends the client walking alone and in a hurry. Assisted toileting on a schedule meets the need before urgency builds, so the client no longer has a reason to get up alone. An alarm only reacts after the client is already moving, and limiting fluids leaves the urgency in place.

Question and rationale by Plainwork. Reference: AHRQ, Preventing Falls in Hospitals: A Toolkit for Improving Quality of Care; Potter & Perry, Fundamentals of Nursing

5. A nurse sees a puddle of clear liquid on the hallway floor outside a client's room. A client using a walker is slowly approaching the area. Which action should the nurse take first?

A. A. Walk away to find a wet-floor sign and cleaning supplies, leaving the puddle
B. B. Keep the client back and stay by the spill until it is marked or cleaned
C. C. Help the client walk around the puddle and mention it at the end of the shift
D. D. Page environmental services, then return to the medication cart to continue the round

B. Keep the client back and stay by the spill until it is marked or cleaned — A hazard on a walking surface must be guarded until it is removed or clearly marked. Keeping the client back and staying at the spill prevents a fall in the next few seconds; the nurse can then have the spill marked and cleaned or ask another staff member to do so. Every staff member is responsible for hazards that are found.

Question and rationale by Plainwork. Reference: AHRQ, Preventing Falls in Hospitals: A Toolkit for Improving Quality of Care; Potter & Perry, Fundamentals of Nursing

6. A nurse has rescued a client from a room, activated the alarm and closed the door to the room with a small fire in a wastebasket. The nurse picks up a portable fire extinguisher to fight the fire. Which step does the nurse perform first in using it?

A. A. Squeeze the handle to release the agent
B. B. Sweep the nozzle from side to side across the base of the fire
C. C. Pull the pin
D. D. Aim the nozzle at the base of the flames

C. Pull the pin — The steps for using a portable extinguisher are remembered as PASS: pull the pin, aim at the base of the fire, squeeze the handle, and sweep from side to side. The pin locks the handle, so nothing else can be done until it is pulled.

Question and rationale by Plainwork. Reference: NFPA 10, Standard for Portable Fire Extinguishers; OSHA, Portable fire extinguishers

7. A nurse is about to give a client a scheduled tablet. The client says, 'That is not the pill I usually take. Mine is white and round.' The label on the package matches the medication administration record. What should the nurse do?

A. A. Give the tablet because the label matches the administration record
B. B. Explain that generic products can look different and give the tablet
C. C. Hold the dose and verify the order and tablet with the pharmacy
D. D. Record that the client refused and notify the provider

C. Hold the dose and verify the order and tablet with the pharmacy — A client's comment that a medication looks different is a safety cue, and clients often catch errors. A match between label and record does not exclude a wrong product, strength or packaging mix-up, and generic products really can differ in appearance. The nurse holds the dose and verifies it before giving it.

Question and rationale by Plainwork. Reference: ISMP, Guidelines for Safe Medication Use in Acute Care; Joint Commission, National Patient Safety Goals on medication safety

8. Two clients on a medical unit have the same last name and similar first names, and their rooms are next to each other. Which action best reduces the risk of a wrong-client error?

A. A. Print each name in larger letters on the door signs of both rooms
B. B. Rely on each client to speak up whenever staff call the wrong name
C. C. Confirm identity by the room number each time, because the names are so alike
D. D. Add name alerts to both records and assign different nurses when possible

D. Add name alerts to both records and assign different nurses when possible — A name alert warns every caregiver that a similar name is on the unit, and separate nurses reduce the chance that one person mixes up two clients. Staff still confirm identity with two identifiers each time. The room number is not an identifier, and clients cannot be relied on to catch errors.

Question and rationale by Plainwork. Reference: Joint Commission, National Patient Safety Goal on identifying patients correctly; ISMP, Guidelines for Safe Medication Use in Acute Care

9. A nurse is collecting a urine specimen for culture from a client. When should the nurse label the specimen container?

A. A. Before entering the room, to save time at the bedside
B. B. By the laboratory staff when the container is delivered
C. C. At the bedside, immediately after collecting the specimen
D. D. At the nurses' station from the requisition after the specimen is collected

C. At the bedside, immediately after collecting the specimen — Specimens are labeled at the bedside, in front of the client, immediately after collection, using the client's identifiers checked against the wristband. This prevents a specimen from being matched to the wrong client. Labeling in advance or away from the client is a common source of mislabeling.

Question and rationale by Plainwork. Reference: Joint Commission, National Patient Safety Goal on identifying patients correctly; Perry, Potter & Ostendorf, Clinical Nursing Skills and Techniques

10. A client admitted with pneumonia tells the nurse, 'I get a rash and swelling from sulfa drugs.' The admission record lists no allergies, and a provider has just prescribed trimethoprim-sulfamethoxazole. Which action should the nurse take first?

A. A. Give the first dose as ordered and watch the client closely for a rash
B. B. Give half of the ordered dose first and observe for any reaction
C. C. Ask a family member to confirm the allergy before taking any other action
D. D. Hold the dose and notify the prescriber of the reported allergy

> **D.** Hold the dose and notify the prescriber of the reported allergy — A reported reaction with swelling suggests a true allergy, and a sulfonamide antibiotic could cause anaphylaxis. The nurse holds the dose, records the allergy and reaction in the chart and armband according to policy, and tells the prescriber so an alternative can be ordered.
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> Question and rationale by Plainwork. Reference: ISMP, Guidelines for Safe Medication Use in Acute Care; Joint Commission, National Patient Safety Goals on medication safety

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