PLAINWORK

NCLEX-RN Mock Exam App: 400 Practice Questions with Rationales

Free sample: 10 of 400 questions

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Sample

1. A client admitted with suspected appendicitis rated right lower abdominal pain 9 out of 10. Thirty minutes later the client says the pain is 'much better,' but the nurse finds a rigid abdomen, a temperature of 102.2 °F (39 °C) and a rising heart rate. What should the nurse do first?

A. A. Apply a heating pad to the abdomen for comfort
B. B. Notify the provider immediately about possible perforation
C. C. Document the improvement in pain and recheck in four hours
D. D. Offer clear liquids because the pain has eased

B. Notify the provider immediately about possible perforation — Abrupt relief of appendiceal pain can mean the appendix has ruptured and the pressure is released, but rigid abdomen, fever and tachycardia indicate peritonitis. This is an emergency that needs immediate reporting.

Question and rationale by Plainwork. Reference: Brunner & Suddarth's Textbook of Medical-Surgical Nursing; Lewis, Medical-Surgical Nursing

2. A nurse suspects urinary retention in a client who has not voided for nine hours and has lower abdominal fullness. When percussing above the symphysis pubis, which sound supports a full bladder?

A. A. Hyperresonance
B. B. Resonance
C. C. Tympany
D. D. Dullness

D. Dullness — Percussion over fluid-filled or solid structures produces a dull sound. A bladder full of urine lies just above the pubic bone and sounds dull, while gas-filled bowel is tympanic.

Question and rationale by Plainwork. Reference: Jarvis, Physical Examination and Health Assessment

3. A client at 20 weeks of gestation comes for a prenatal visit with her partner. The partner answers every question for her and will not leave her side. The nurse sees bruises of different colors on the client's upper arms and abdomen. Which action should the nurse take first?

A. A. Ask the client, in front of her partner, how she got the bruises
B. B. Find a routine reason to see the client alone, and then ask her directly whether she is being hurt
C. C. Tell the partner that abuse is suspected and the police will be called
D. D. Give the client a leaflet about domestic violence to take home

B. Find a routine reason to see the client alone, and then ask her directly whether she is being hurt — Screening for intimate partner violence is done in private with direct, nonjudgmental questions. Asking in the abuser's presence, confronting the abuser, or sending written material home can increase the danger to the client and the fetus; violence often begins or worsens in pregnancy.

Question and rationale by Plainwork. Reference: USPSTF, Screening for Intimate Partner Violence (2025); ACOG Committee Opinion No. 518, Intimate Partner Violence

4. A 4-month-old infant is brought to the emergency department with bruises on the trunk and one ear. The father says the infant rolled off the couch. Which action is the nurse required to take?

A. A. Ask the mother in private whether the father has hurt the infant and report only if she confirms it.
B. B. Report the suspected abuse to child protective services according to state law and agency policy.
C. C. Ask the father to repeat the account and point out that it does not fit the injuries.
D. D. Document the findings and wait until imaging confirms abuse before reporting.

B. Report the suspected abuse to child protective services according to state law and agency policy. — Nurses are mandated reporters: reasonable suspicion of child abuse must be reported; proof is not required. Bruising in an infant who is not yet mobile, on the trunk or ears, with a history that does not fit the developmental stage, is a strong warning sign.

Question and rationale by Plainwork. Reference: State mandatory reporting laws (US Child Abuse Prevention and Treatment Act framework); Standard pediatric nursing texts (Hockenberry, Wong's)

5. A woman comes to the emergency department with a bruised cheek and a wrist sprain and says she fell. Her partner answers the nurse's questions for her and will not leave her side. Which action should the nurse take first?

A. A. Arrange to see the client alone, for example by escorting her to a test, and then ask about her safety.
B. B. Ask the client, with the partner present, whether anyone has hurt her.
C. C. Call the police to report the partner.
D. D. Hand the client a domestic violence hotline card while the partner is in the room.

A. Arrange to see the client alone, for example by escorting her to a test, and then ask about her safety. — Screening for intimate partner violence is done in private. Asking in front of a possible abuser prevents an honest answer and can increase the danger to the client afterward.

Question and rationale by Plainwork. Reference: USPSTF, screening for intimate partner violence, elder abuse and abuse of vulnerable adults; Standard psychiatric-mental health nursing texts (Videbeck; Townsend and Morgan; Halter/Varcarolis)

6. In a private interview a client confirms that her partner has hit her several times. She says, 'I am not ready to leave him.' Which action by the nurse is most appropriate?

A. A. Help her make a safety plan, including a packed bag, important documents and a hotline number.
B. B. Offer to bring the partner in so that the couple can talk about it together.
C. C. Tell her that little can be done until she decides to leave.
D. D. Tell her that she must leave tonight because the violence will get worse.

A. Help her make a safety plan, including a packed bag, important documents and a hotline number. — A competent adult has the right to decide whether to stay. The nurse respects the decision, avoids judgment and helps her prepare for a quick, safe exit: a bag with money, keys, documents and medicines, a place to go, a signal for help and emergency numbers.

Question and rationale by Plainwork. Reference: Standard psychiatric-mental health nursing texts (Videbeck; Townsend and Morgan; Halter/Varcarolis); USPSTF, screening for intimate partner violence, elder abuse and abuse of vulnerable adults

7. A home health nurse visits an 82-year-old widow who lives alone. In two months she has lost 6 kg, her clothing is soiled, mail is piled by the door and the refrigerator holds spoiled food. She is alert and oriented and says, 'I manage just fine.' Which action is most appropriate?

A. A. Accept her statement, because she is alert and oriented, lives independently and is entitled to decide how she wants to live her life at home
B. B. Arrange with her relatives to move her into a nursing home as soon as possible
C. C. Assess her cognition, mood, nutrition and function, and report to the provider and Adult Protective Services as the state requires
D. D. Leave a pamphlet about community meal programs and revisit in three months

C. Assess her cognition, mood, nutrition and function, and report to the provider and Adult Protective Services as the state requires — These findings describe self-neglect, which is a form of elder neglect and is reportable to Adult Protective Services in many states. A competent adult may refuse help, but the nurse must still look for treatable causes such as depression, dementia, illness or medication effects and let the right agency evaluate safety. Alertness alone does not show that she is safe.

Question and rationale by Plainwork. Reference: National Adult Protective Services Association, self-neglect resources; Touhy and Jett, Ebersole and Hess' Gerontological Nursing and Healthy Aging

8. A school nurse examines an 8-year-old who has patterned bruises on the back and says she is afraid to go home. The nurse suspects physical abuse. To whom is the nurse legally required to make a report?

A. A. The state or local child protective services agency
B. B. The child's parents, so they can explain the injuries first
C. C. Only the school principal, who then decides whether to report
D. D. The child's pediatrician, with a note in the school record

A. The state or local child protective services agency — Nurses are mandated reporters. When they have reasonable suspicion of child abuse or neglect, they must report to the child protective services agency or, depending on state law, law enforcement. Proof is not required, and the report cannot be delegated to a supervisor or delayed to confront the family.

Question and rationale by Plainwork. Reference: Child Welfare Information Gateway, Mandatory Reporters of Child Abuse and Neglect; ANA Code of Ethics for Nurses; CDC, Preventing Child Abuse and Neglect

9. During a home visit, a nurse sees unexplained bruising on an older adult's arms. The caregiver answers all questions for the client, and the client flinches when the caregiver moves near. What should the nurse do?

A. A. Wait until the next visit to see whether more evidence of mistreatment appears
B. B. Ask the client to sign a statement that the bruises came from a fall and then close the matter
C. C. Report the suspicion to Adult Protective Services and document the objective findings
D. D. Confront the caregiver about the bruises and ask whether the caregiver is hurting the client

C. Report the suspicion to Adult Protective Services and document the objective findings — Nurses are mandated or expected reporters of suspected elder abuse in most states. A reasonable suspicion is enough, and the report goes to Adult Protective Services with objective documentation.

Question and rationale by Plainwork. Reference: National Center on Elder Abuse, Administration for Community Living; American Nurses Association, Code of Ethics for Nurses with Interpretive Statements

10. 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.
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> Question and rationale by Plainwork. Reference: Standard gerontological nursing texts

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