

PLAINWORK

50 NCLEX-RN Practice Questions, Explained

Answer key with rationales

- 50 single-best-answer questions across 15 subject areas
- A rationale and a checkable reference for every answer
- Printable workbook plus a separate answer key
- Flashcard file that imports straight into Anki
- Spreadsheet of every question for your own drills

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Answers and rationales

Question 1

ADVANCED SKILLS

Verification of NG tube after initial placement is performed by which of the following methods?

- A. X-ray
- B. Testing of aspirate pH
- C. Administering air into the tube ("Whoosh test")
- D. Measuring tube length

Answer: A - X-ray

Radiographic confirmation is the gold-standard method for verifying nasogastric tube placement after initial insertion because it directly visualizes the tube tip in the stomach and prevents pulmonary misplacement.

Not B: Aspirate pH can be misleading; acidic gastric fluid may be absent or contaminated.

Not C: Air insufflation does not confirm intragastric location; it may produce sounds even if misplaced.

Not D: Length measurement only estimates insertion depth; it cannot ensure the tip is in the stomach.

Remember: X-ray sees the tip; other tests just guess.

Question adapted from Open RN, Nursing Advanced Skills, Chippewa Valley Technical College (CC BY 4.0, <https://wtcs.pressbooks.pub/nursingadvancedskills/chapter/5-7-learning-activities/>); rationale written by Plainwork.

Question 2

ADVANCED SKILLS

The nurse is providing care for a patient who has an order to include "TKO" fluid infusion. The nurse understands that TKO fluids should be infusing at the following rate:

- A. 5 mL/hr
- B. 10-20 mL/hr
- C. 50 mL/hr
- D. 100 mL/hr

Answer: B - 10-20 mL/hr

TKO (to keep open) fluids are administered at a low rate, typically 10–20 mL per hour, sufficient to maintain catheter patency without fluid overload.

Not A: 5 mL/hr is too low; line may clot.

Not C: 50 mL/hr exceeds TKO purpose; risks fluid overload.

Not D: 100 mL/hr is a therapeutic rate, not a keep-open rate.

Remember: TKO = tiny drip, 10-20 mL/hr keeps line open.

Question adapted from Open RN, Nursing Advanced Skills, Chippewa Valley Technical College (CC BY 4.0, <https://wtcs.pressbooks.pub/nursingadvancedskills/chapter/1-8-learning-activities/>); rationale written by Plainwork.

Question 3

ADVANCED SKILLS

The nurse is caring for a patient with a central venous access catheter. The nurse is repositioning the patient in bed when the CVAD extension tubing becomes tangled under the patient. As the patient is being turned, the tubing pulls the central venous catheter from the patient. What is the most appropriate first action?

- A. Cover the insertion site and apply direct manual pressure
- B. Call a Code Blue
- C. Have the patient "bear down"
- D. Attempt to reinsert the line

Answer: A - Cover the insertion site and apply direct manual pressure

When a central line is inadvertently pulled out, the first priority is to control bleeding and protect the site; covering the insertion site and applying direct manual pressure prevents hemorrhage and infection before further interventions.

Not B: The patient is not in cardiac arrest; a Code Blue is unnecessary.

Not C: Bearing down can increase intrathoracic pressure and worsen bleeding.

Not D: Reinsertion must wait until bleeding is controlled and a qualified provider acts.

Remember: First stop bleeding, then assess line.

Question adapted from Open RN, Nursing Advanced Skills, Chippewa Valley Technical College (CC BY 4.0, <https://wtcs.pressbooks.pub/nursingadvancedskills/chapter/4-8-learning-activities/>); rationale written by Plainwork.

Question 4

ADVANCED SKILLS

A nurse is caring for a patient with an infusing IV who is receiving 2 grams of Rocephin (Ancef) into their 20 gauge right forearm PIV. The nurse notes that the IV site is swelling, reddened, and fluid is leaking at the infusion site. The nurse takes which of the following actions to appropriately address the complication?

- A. Slow the infusion and elevate the extremity
- B. Attempt to reposition the cannula and re-tape the infusion site to stabilize the device
- C. Stop the infusion and remove the cannula
- D. Increase the infusion rate to finish the Ancef infusion and then discontinue the site.

Answer: C - Stop the infusion and remove the cannula

The swelling, redness, and leaking indicate infiltration. The immediate priority is to stop the medication, disconnect the line, and remove the peripheral catheter to prevent tissue damage and allow assessment.

Not A: Slowing infusion and elevating does not stop ongoing infiltration.

Not B: Repositioning a compromised catheter risks further tissue injury.

Not D: Increasing rate worsens infiltration and delays necessary intervention.

Remember: Infiltration = stop, disconnect, remove.

Question adapted from Open RN, Nursing Advanced Skills, Chippewa Valley Technical College (CC BY 4.0, <https://wtcs.pressbooks.pub/nursingadvancedskills/chapter/1-8-learning-activities/>); rationale written by Plainwork.

Question 5

ADVANCED SKILLS

A nurse receives an order to place an NG tube to decompress a patient's stomach due to ileus. The nurse correctly selects which type of tube to assist with stomach decompression?

- A. Levin
- B. Dobhoff
- C. Salem Sump
- D. Any of these tubes are appropriate

Answer: C - Salem Sump

The Salem Sump tube has a larger lumen and a distal suction port with side holes, allowing effective gastric decompression and continuous suction, which is required for an ileus.

Not A: Levin tubes are single-lumen and lack suction ports, unsuitable for decompression.

Not B: Dobhoff tubes are small-bore feeding catheters, not designed for gastric suction.

Not D: All tubes cannot decompress; only a dedicated suction tube works.

Remember: Salem Sump = suction, side holes, decompression.

Question adapted from Open RN, Nursing Advanced Skills, Chippewa Valley Technical College (CC BY 4.0, <https://wtcs.pressbooks.pub/nursingadvancedskills/chapter/5-7-learning-activities/>); rationale written by Plainwork.

Question 6

CLINICAL SKILLS

The amount of suction pressure utilized for oropharyngeal suctioning is aligned to the patient's:

- A. Weight
- B. Height
- C. Age
- D. Gender

Answer: C - Age

Suction pressure limits are determined by the patient's age to prevent mucosal damage and hypoxemia. Standard pressures range from 60-80 mmHg for neonates up to 100-150 mmHg for adults, making age the deciding factor.

Not A: Weight does not dictate airway tissue fragility or standard suction pressure ranges.

Not B: Height has no bearing on airway size, tissue fragility, or suction pressure requirements.

Not D: Gender does not influence airway mucosal sensitivity or the required suction pressure limits.

Remember: Age dictates the gauge for safe suction pressure.

Question adapted from Open RN, Nursing Skills, Chippewa Valley Technical College (CC BY 4.0, <https://wtcs.pressbooks.pub/nursingskills/chapter/22-8-learning-activities/>); rationale written by Plainwork.

Question 7

CLINICAL SKILLS

The Glasgow Coma scale measures patients according to what three categories of response:

- A. Motor, Sensory, and Verbal
- B. Motor, Cognition, and Verbal
- C. Motor, Eye Opening, and Verbal
- D. Eye Opening, Verbal, and Auditory

Answer: C - Motor, Eye Opening, and Verbal

The Glasgow Coma Scale (GCS) is a standardized tool used to assess a patient's level of consciousness by evaluating three specific categories of response: eye opening, verbal response, and motor response.

Not A: Sensory response is not a component evaluated by the Glasgow Coma Scale.

Not B: Cognition is not a distinct category assessed in the Glasgow Coma Scale.

Not D: Auditory response is not a category measured by the Glasgow Coma Scale.

Remember: Remember EVM: Eye opening, Verbal response, Motor response.

Question adapted from Open RN, Nursing Skills, Chippewa Valley Technical College (CC BY 4.0, <https://wtcs.pressbooks.pub/nursingskills/chapter/6-13-learning-activities/>); rationale written by Plainwork.

Question 8

CLINICAL SKILLS

A nurse is performing an abdominal assessment and places his/her hand on the patient's abdomen over an area with moderate pressure. The nurse then abruptly withdraws his/her hand. This assessment technique is indicated when assessing for:

- A. abdominal rigidity
- B. guarding
- C. borborygmus
- D. rebound tenderness

Answer: D - rebound tenderness

Rebound tenderness is elicited by applying gentle pressure then quickly releasing; pain on release indicates peritoneal irritation, such as appendicitis. The described abrupt hand withdrawal after moderate pressure is classic for this sign.

Not A: Abdominal rigidity is constant firmness, not assessed by sudden release.

Not B: Guarding is involuntary muscle spasm, evaluated by sustained palpation.

Not C: Borborygmus refers to bowel sounds heard with a stethoscope.

Remember: Quick release pain = rebound tenderness.

Question adapted from Open RN, Nursing Skills, Chippewa Valley Technical College (CC BY 4.0, <https://wtcs.pressbooks.pub/nursingskills/chapter/12-7-learning-activities/>); rationale written by Plainwork.

Question 9

CLINICAL SKILLS

"Are you having any issues with seeing, hearing, smelling, tasting, or feeling things?" would fall into what category of functional health assessment?

- A. Self-Perception and Self-Concept
- B. Health Perception - Health Management
- C. Cognitive and Perceptual
- D. Roles and Relationships

Answer: C - Cognitive and Perceptual

Gordon's Functional Health Patterns classify sensory functions—such as vision, hearing, taste, touch, and smell—along with cognitive abilities and pain perception, under the Cognitive and Perceptual pattern. This question directly assesses these sensory capabilities.

Not A: Focuses on self-worth, body image, and personal identity rather than physical senses.

Not B: Addresses the client's general health awareness, lifestyle choices, and adherence to treatments.

Not D: Evaluates social connections, family dynamics, and the client's responsibilities in life.

Remember: Senses and thoughts belong to the cognitive and perceptual pattern.

Question adapted from Open RN, Nursing Skills, Chippewa Valley Technical College (CC BY 4.0, <https://wtcs.pressbooks.pub/nursingskills/chapter/2-12-learning-activities/>); rationale written by Plainwork.

Question 10

DOSAGE CALCULATIONS

A nurse is preparing to administer 1 g of cefazolin in 150 mL of normal saline over 45 minutes to a preoperative patient. At what rate in mL/h should the nurse program the infusion pump?

- A. 200 mL/h
- B. 113 mL/h
- C. 150 mL/h
- D. 300 mL/h

Answer: A - 200 mL/h

The infusion volume is 150 mL to be given over 45 minutes (0.75 hour). Dividing 150 mL by 0.75 hour yields 200 mL per hour, which is the pump setting accurately.

Not B: Result of dividing 150 mL by 1.33 hours, incorrect conversion.

Not C: Uses the total volume as hourly rate, ignoring the 45-minute duration.

Not D: Doubles the correct rate, assuming 30-minute infusion instead of 45 minutes.

Remember: Volume ÷ hours = mL per hour.

Question and rationale by Plainwork. Reference: Calculate with Confidence, 8th Edition

Question 11

DOSAGE CALCULATIONS

A pediatric patient weighing 22 lb is prescribed amoxicillin 45 mg/kg/day divided into two equal doses. The oral suspension is available as 250 mg/5 mL. How many milliliters should the nurse administer per dose?

- A. 4.5 mL
- B. 5.0 mL
- C. 9.0 mL
- D. 2.3 mL

Answer: A - 4.5 mL

The child weighs 22 lb (≈ 10 kg). At 45 mg/kg/day the total daily dose is 450 mg, split into two doses of 225 mg. The suspension contains 50 mg/mL, so $225 \text{ mg} \div 50 \text{ mg/mL} = 4.5 \text{ mL}$.

Not B: Rounded dose incorrectly; 5 mL gives 250 mg, not 225 mg.

Not C: Doubled the required dose; 9 mL equals 450 mg.

Not D: Used wrong conversion; 2.3 mL provides only ~ 115 mg.

Remember: 22 lb ≈ 10 kg; 450 mg/day $\rightarrow$ 225 mg ≈ 4.5 mL

Question and rationale by Plainwork. Reference: Silvestri, Saunders Comprehensive Review for the NCLEX-RN Examination, 9th Edition

Question 12

DOSAGE CALCULATIONS

A client with deep vein thrombosis is receiving a heparin infusion. The bag contains 25,000 units in 250 mL of 0.9% sodium chloride. The infusion pump is set to 14 mL/h. How many units per hour is the client receiving?

- A. 1,200 units/h
- B. 1,000 units/h
- C. 1,400 units/h
- D. 850 units/h

Answer: C - 1,400 units/h

The bag's concentration is $25,000 \text{ units} \div 250 \text{ mL} = 100 \text{ units/mL}$. The pump delivers 14 mL each hour, so $14 \text{ mL} \times 100 \text{ units/mL} = 1,400 \text{ units per hour}$, matching option C.

Not A: Assumes 12 mL/h or 85 units/mL, not the given concentration.

Not B: Uses 10 mL/h or 100 units/mL, misreading rate.

Not D: Incorrect math; $14 \text{ mL/h} \times 100 \text{ units/mL} \neq 850$.

Remember: 100 units per mL $\times$ 14 mL = 1,400 units.

Question and rationale by Plainwork. Reference: Morris, D. G. (2021). Calculate with Confidence (8th ed.). Elsevier.

Question 13

ENDOCRINE

A client with diabetes is shaky, sweaty, and confused. Blood glucose is 52 mg/dL, and the client can swallow. What should the nurse do first?

- A. Give 15 g of fast-acting carbohydrate
- B. Give regular insulin
- C. Recheck the glucose in one hour
- D. Serve a full meal

Answer: A - Give 15 g of fast-acting carbohydrate

A blood glucose level below 70 mg/dL indicates hypoglycemia. Because the client is conscious and able to swallow safely, the immediate priority is raising blood glucose using the Rule of 15 by administering 15 grams of fast-acting carbohydrates.

Not B: Insulin lowers blood glucose further, which could cause fatal neuroglycopenia.

Not C: Rechecking in one hour delays critical care; recheck blood glucose after 15 minutes.

Not D: Full meals contain fats and proteins that delay the absorption of necessary simple sugars.

Remember: Rule of 15: Give 15 grams of fast carbs, recheck in 15.

Question and rationale by Plainwork. Reference: American Diabetes Association, Standards of Care in Diabetes, Section 6

Question 14

FUNDAMENTALS

What is the ideal position for a patient when completing a bladder scan?

- A. High fowlers
- B. Semi-fowlers
- C. Supine
- D. Prone

Answer: C - Supine

The bladder scan requires the patient to lie flat on their back so the scanner can obtain an unobstructed view of the full bladder without abdominal compression, ensuring accurate volume measurement.

Not A: Elevated torso tilts the bladder, distorting volume readings.

Not B: Partial elevation still compresses the lower abdomen, reducing accuracy.

Not D: Scanning from the front is impossible when patient lies on stomach.

Remember: Supine flat gives the clearest bladder view.

Question adapted from Open RN, Nursing Fundamentals, Chippewa Valley Technical College (CC BY 4.0, <https://wtcs.pressbooks.pub/nursingfundamentals/chapter/16-11-learning-activities/>); rationale written by Plainwork.

Question 15

FUNDAMENTALS

The mission of which of the following organizations is to "improve health care for the public by inspiring organizations to excel in providing safe, effective, and high quality health care".

- A. Centers for Medicare and Medicaid (CMS)
- B. National Institute of Health (NIH)
- C. Centers for Disease Control (CDC)
- D. Joint Commission

Answer: D - Joint Commission

The Joint Commission's mission is to improve health care for the public by inspiring organizations to excel in providing safe, effective, high-quality care, matching the wording in the stem.

Not A: CMS focuses on Medicare/Medicaid administration, not mission phrasing.

Not B: NIH's mission centers on biomedical research, not health-care quality improvement.

Not C: CDC aims to protect public health through disease control, not organizational excellence.

Remember: Joint Commission = safety-first accreditation mission.

Question adapted from Open RN, Nursing Fundamentals, Chippewa Valley Technical College (CC BY 4.0, <https://wtcs.pressbooks.pub/nursingfundamentals/chapter/1-9-learning-activities/>); rationale written by Plainwork.

Question 16

FUNDAMENTALS

Mrs. Johnson is an 84-year-old woman whose husband just passed away from complications of congestive heart failure. She is brought to the clinic by her daughter because of increasing fatigue, malaise, weakness, and loss of appetite. You begin to take her vital signs and she starts weeping saying she misses her husband. Which of the following responses is the best therapeutic response?

- A. Tell me what your relationship with your husband was like.
- B. Your husband would not want you to be sad.
- C. At least you had many years together.
- D. I know how you feel. I recently lost my good friend.

Answer: A - Tell me what your relationship with your husband was like.

Asking about her relationship invites her to explore feelings, validates grief, and uses therapeutic communication techniques such as open-ended questioning, which promotes emotional processing and rapport.

Not B: It dismisses her emotions and imposes the husband's presumed wishes.

Not C: It minimizes current pain and shifts focus away from her present grief.

Not D: Self-disclosure redirects attention to the nurse, hindering client-centered support.

Remember: Ask, don't tell—let her share her story.

Question adapted from Open RN, Nursing Fundamentals, Chippewa Valley Technical College (CC BY 4.0, <https://wtcs.pressbooks.pub/nursingfundamentals/chapter/17-8-learning-activities/>); rationale written by Plainwork.

Question 17

FUNDAMENTALS

This vitamin helps prevent fetal neural tube defects in utero.

- A. B9 (Folic Acid)
- B. B3 (Niacin)
- C. B6 (Pyridoxine)
- D. B2 (Riboflavin)

Answer: A - B9 (Folic Acid)

Folic acid (vitamin B9) is essential for DNA synthesis and cell division, and adequate maternal intake before conception and during early pregnancy reduces the risk of neural tube defects such as spina bifida.

Not B: Niacin is involved in energy metabolism, not neural tube development.

Not C: Pyridoxine supports amino-acid metabolism, but does not prevent neural tube defects.

Not D: Riboflavin is needed for redox reactions, unrelated to fetal neural tube closure.

Remember: Folate = fetal tube protection.

Question adapted from Open RN, Nursing Fundamentals, Chippewa Valley Technical College (CC BY 4.0, <https://wtcs.pressbooks.pub/nursingfundamentals/chapter/14-5-learning-activities/>); rationale written by Plainwork.

Question 18

GUIDELINES

According to the 2026 Brazilian perioperative ventilation guideline, which setting best reduces postoperative pulmonary complications?

- A. Tidal volume 10 mL/kg predicted body weight
- B. Tidal volume 6-8 mL/kg predicted body weight
- C. FiO2 100% for the entire case
- D. PEEP 0 cm H2O throughout surgery

Answer: B - Tidal volume 6-8 mL/kg predicted body weight

Using a tidal volume of 6–8 mL/kg predicted body weight provides lung-protective ventilation, limiting volutrauma and atelectasis, which the 2026 Brazilian guideline identifies as the most effective strategy to lower postoperative pulmonary complications.

Not A: Tidal volume 10 mL/kg exceeds lung-protective range, increasing volutrauma risk.

Not C: FiO2 100% promotes absorption atelectasis and oxidative injury.

Not D: Zero PEEP allows alveolar collapse, worsening oxygenation.

Remember: Low tidal volume = lung-protective, fewer post-op lung problems.

Question and rationale by Plainwork. Reference: (practice guideline, CC BY), 2026-08-18

Question 19

GUIDELINES

A nurse cares for a patient diagnosed with a peptic ulcer who has no history of NSAID use and tests negative for *Helicobacter pylori*. Which emerging etiology should the nurse recognize as an increasing cause of this condition?

- A. Non-*H. pylori* *Helicobacter* infection
- B. Chronic psychological stress
- C. Gastroesophageal reflux disease
- D. Excessive dietary spicy food intake

Answer: A - Non-*H. pylori* *Helicobacter* infection

In patients with peptic ulcer disease who are *Helicobacter pylori*-negative and do not use NSAIDs, non-*H. pylori* *Helicobacter* species (such as *Helicobacter heilmannii*) are increasingly recognized as a significant emerging cause of mucosal ulceration.

Not B: Stress can exacerbate ulcer symptoms but does not directly cause peptic ulceration.

Not C: GERD causes esophageal mucosal damage, not gastric or duodenal peptic ulcers.

Not D: Spicy foods irritate existing ulcers but do not cause new ulcer formation.

Remember: No NSAIDs, no H. pylori? Think non-H. pylori Helicobacter species.

Question and rationale by Plainwork. Reference: (practice guideline, CC BY), 2026-08-24

Question 20

GUIDELINES

A nurse is teaching a client who received botulinum toxin type A injections for cervical dystonia. Which symptom should the nurse instruct the client to report immediately?

- A. Localized flu-like symptoms
- B. Moderate neck stiffness
- C. Difficulty swallowing or breathing
- D. Mild soreness at the injection site

Answer: C - Difficulty swallowing or breathing

Botulinum toxin can spread beyond the injection site, causing life-threatening systemic effects like dysphagia and dyspnea. These symptoms indicate respiratory compromise or aspiration risk and require immediate emergency evaluation.

Not A: Flu-like symptoms are common, mild, and typically resolve without intervention.

Not B: Neck stiffness is a common, transient side effect that does not require emergency care.

Not D: Mild soreness at the injection site is an expected, self-limiting local reaction.

Remember: Botox: If they struggle to swallow or breathe, they need help immediately.

Question and rationale by Plainwork. Reference: (practice guideline, CC BY), 2026-09-02

Question 21

GUIDELINES

A female client with severe plaque psoriasis is prescribed oral acitretin. Which instruction is most important for the nurse to include in the teaching plan?

- A. Donate blood monthly to monitor blood counts.
- B. Take the medication on an empty stomach.
- C. Expect your skin to be resistant to sunburn.
- D. Avoid pregnancy during and for 3 years after therapy.

Answer: D - Avoid pregnancy during and for 3 years after therapy.

Acitretin is extremely teratogenic with a long half-life. Female clients of childbearing potential must use effective contraception and avoid pregnancy during therapy and for at least three years after discontinuing the medication to prevent severe birth defects.

Not A: Blood donation is strictly prohibited during and for three years after therapy to protect pregnant recipients.

Not B: Acitretin should be taken with food to maximize absorption.

Not C: Acitretin increases photosensitivity, making the skin more susceptible to sunburn, not resistant.

Remember: Acitretin: Avoid pregnancy for three years after the last dose.

Question and rationale by Plainwork. Reference: (practice guideline, CC BY), 2026-08-29

Question 22

HEALTH ALTERATIONS

A patient with suspected active pulmonary tuberculosis requires emergency intubation in the emergency department. Which action should the nurse prioritize to ensure safety?

- A. Position a portable fan to blow air toward the door.
- B. Move the patient to a negative-pressure room.
- C. Limit personal protective equipment to sterile gloves.
- D. Wear a standard surgical mask during the procedure.

Answer: B - Move the patient to a negative-pressure room.

Active pulmonary tuberculosis requires airborne precautions to prevent transmission. Moving the patient to a negative-pressure room is the priority, especially during aerosol-generating procedures like intubation, to contain infectious particles.

Not A: Fans disperse infectious droplets into surrounding areas, increasing transmission risk.

Not C: Intubation requires full airborne PPE, including an N95 respirator, not just gloves.

Not D: Standard surgical masks do not filter airborne TB bacilli; an N95 respirator is required.

Remember: TB in the air? Negative pressure is the first care.

Question and rationale by Plainwork. Reference: CDC Infection Prevention and Control Guidelines

Question 23

HEALTH ALTERATIONS

During the emergency insertion of a central venous catheter for a patient in septic shock, the nurse observes the physician's sterile glove touch the non-sterile bedside table. Which action should the nurse take first?

- A. Document the breach and monitor the site for infection.
- B. Assist with completing the insertion to avoid delay.
- C. Clean the contaminated glove with chlorhexidine wipes.
- D. Immediately inform the physician and provide a new glove.

Answer: D - Immediately inform the physician and provide a new glove.

Maintaining strict asepsis during central venous catheter insertion is critical to prevent bloodstream infections. The nurse must immediately advocate for patient safety by pointing out the sterile breach and providing a replacement sterile glove.

Not A: Monitoring does not prevent infection; the active breach must be corrected immediately.

Not B: Completing the insertion with contaminated gloves risks a life-threatening bloodstream infection.

Not C: Chlorhexidine wipes cannot reliably re-sterilize a contaminated glove.

Remember: See a sterile breach, speak up and replace.

Question and rationale by Plainwork. Reference: CDC Guidelines for the Prevention of Intravascular Catheter-Related Infections

Question 24

HEALTH ALTERATIONS

A nurse is caring for a mechanically ventilated patient receiving continuous enteral feedings. Which action should the nurse prioritize to prevent ventilator-associated pneumonia?

- A. Elevate the head of the bed to 30 to 45 degrees
- B. Perform deep tracheal suctioning every two hours
- C. Change the ventilator circuit tubing every 24 hours
- D. Instill sterile saline before endotracheal suctioning

Answer: A - Elevate the head of the bed to 30 to 45 degrees

Elevating the head of the bed to 30 to 45 degrees is the priority intervention to prevent aspiration of gastric contents and enteral formula, which significantly reduces the risk of ventilator-associated pneumonia.

Not B: Suctioning should be performed only when clinically indicated, not on a routine schedule.

Not C: Routine daily circuit changes increase infection risk; change only when soiled or malfunctioning.

Not D: Saline instillation dislodges bacteria into the lower airway, increasing pneumonia risk.

Remember: Keep the head high (30 to 45 degrees) to keep the lungs dry.

Question and rationale by Plainwork. Reference: Preventing ventilator-associated pneumonia: A position paper of the International Society for Infectious Diseases, 2024 update. Int J Infect Dis 2025

Question 25

HEALTH ALTERATIONS

A multi-trauma patient in the resuscitation bay requires emergency urinary catheterization. Which action by the nurse best maintains infection control and sterile technique during this urgent procedure?

- A. Obtain a new sterile kit if contamination occurs.
- B. Cleanse the perineal area using a back-to-front motion.
- C. Use clean utility gloves to expedite the insertion.
- D. Pre-test the balloon by inflating it prior to insertion.

Answer: A - Obtain a new sterile kit if contamination occurs.

Strict sterile technique is vital to prevent catheter-associated urinary tract infections. If any contamination of the sterile field or equipment occurs, the nurse must immediately discard the contaminated items and obtain a new sterile kit.

Not B: Cleansing must be front-to-back to prevent introducing rectal bacteria into the urethra.

Not C: Sterile gloves, not clean utility gloves, are required to maintain asepsis during insertion.

Not D: Pre-testing the balloon is no longer recommended as it can damage the catheter.

Remember: Contaminated kit? Start fresh to prevent CAUTI.

Question and rationale by Plainwork. Reference: CDC Guidelines for Prevention of Catheter-Associated Urinary Tract Infections

Question 26

HEALTH PROMOTION

Which of the following is a risk factor for developing febrile seizures?

- A. High levels of zinc and iron in the blood
- B. Family history of seizures
- C. Maternal diet of fruits and vegetables
- D. Delayed vaccination schedule

Answer: B - Family history of seizures

A family history of febrile or unprovoked seizures is a major risk factor for febrile seizures, indicating a strong genetic predisposition. Other risk factors include a high peak temperature, young age, and certain viral infections.

Not A: Zinc and iron deficiencies, rather than high levels, are associated with febrile seizures.

Not C: A maternal diet rich in fruits and vegetables does not cause febrile seizures.

Not D: Delayed vaccinations increase the risk of vaccine-preventable infections that cause high fevers.

Remember: Febrile seizures: Family history is the strongest spark.

Question adapted from Open RN, Nursing Health Promotion, Chippewa Valley Technical College (CC BY 4.0, <https://wtcs.pressbooks.pub/healthpromo/chapter/16-24-learning-activities/>); rationale written by Plainwork.

Question 27

HEALTH PROMOTION

You are working with a patient whose family expects all members to conform to the same religious practices and discourages any deviation. The patient expresses a desire to explore different beliefs but fears rejection from their family. What term best describes the unhealthy aspect of this family dynamic?

- A. Rigid family expectations
- B. Poor communication patterns
- C. Lack of privacy and autonomy
- D. Role inadequacy

Answer: A - Rigid family expectations

The family's insistence that all members follow identical religious practices creates inflexible, controlling expectations that suppress individual belief exploration, which is defined as rigid family expectations—a maladaptive dynamic limiting autonomy.

Not B: Communication may be limited but not the primary unhealthy factor here.

Not C: Privacy and autonomy are affected, yet the core issue is expectation rigidity.

Not D: Role inadequacy refers to mismatched responsibilities, not imposed belief conformity.

Remember: Rigid expectations choke personal belief freedom.

Question adapted from Open RN, Nursing Health Promotion, Chippewa Valley Technical College (CC BY 4.0, <https://wtcs.pressbooks.pub/healthpromo/chapter/4-9-learning-activities/>); rationale written by Plainwork.

Question 28

HEALTH PROMOTION

A nurse is educating a client newly diagnosed with primary dysmenorrhea about pain management strategies. Which statement by the client indicates a need for further teaching?

- A. "I will take ibuprofen before my period starts to help prevent pain."
- B. "A heating pad on my abdomen can help relieve discomfort."
- C. "If NSAIDs don't work, I can try hormonal therapy like birth control pills."
- D. "I should avoid exercise during my period because movement worsens the pain."

Answer: D - "I should avoid exercise during my period because movement worsens the pain."

Regular physical activity and exercise actually help alleviate primary dysmenorrhea by releasing endorphins, improving pelvic blood flow, and reducing stress. Advising a client to avoid movement during their period is incorrect and indicates a need for further teaching.

Not A: NSAIDs are first-line therapies best started before menses to block prostaglandin synthesis.

Not B: Local heat application relaxes pelvic muscles and effectively reduces cramping and discomfort.

Not C: Hormonal contraceptives suppress ovulation and thin the endometrium, successfully reducing menstrual pain.

Remember: Keep moving to beat the cramping pain.

Question adapted from Open RN, Nursing Health Promotion, Chippewa Valley Technical College (CC BY 4.0, <https://wtcs.pressbooks.pub/healthpromo/chapter/18-22-learning-activities/>); rationale written by Plainwork.

Question 29

HEALTH PROMOTION

Which stage of Kolb's Experiential Learning Cycle involves looking back on a concrete experience and analyzing it in the context of existing knowledge?

- A. Concrete Experience
- B. Reflective Observation
- C. Abstract Conceptualization
- D. Active Experimentation

Answer: B - Reflective Observation

Reflective observation requires the learner to consciously step back from a task to review and assess the experience. During this phase, individuals reflect on what occurred and consider how it aligns with their prior understanding.

Not A: Concrete experience involves actively participating in a new event rather than reflecting on it.

Not C: Abstract conceptualization focuses on developing new theories and general concepts from reflections.

Not D: Active experimentation involves testing newly formed concepts and skills in practical scenarios.

Remember: Reflective observation means looking back before building new abstract theories.

Question adapted from Open RN, Nursing Health Promotion, Chippewa Valley Technical College (CC BY 4.0, <https://wtcs.pressbooks.pub/healthpromo/chapter/1-9-learning-activities/>); rationale written by Plainwork.

Question 30

INFECTION CONTROL

A client is admitted with active pulmonary tuberculosis. Which precautions should the nurse use?

- A. Droplet precautions and a surgical mask
- B. Airborne precautions and an N95 respirator
- C. Contact precautions and a gown
- D. Standard precautions only

Answer: B - Airborne precautions and an N95 respirator

Active pulmonary TB is transmitted via aerosolized droplet nuclei that remain suspended; therefore airborne precautions are required, and the nurse must wear a fit-tested N95 respirator to filter particles $\leq 0.3 \mu\text{m}$.

Not A: TB spreads via airborne droplet nuclei; surgical mask and droplet precautions do not provide adequate protection.

Not C: TB spreads via inhaled aerosols, not direct contact; gowns and contact precautions are ineffective.

Not D: Standard precautions alone do not block airborne Mycobacterium tuberculosis; airborne isolation is mandatory.

Remember: Airborne TB = N95 respirator, negative pressure room.

Question and rationale by Plainwork. Reference: CDC, Guideline for Isolation Precautions (2007, updated)

Question 31

LAB VALUES

A client with acute kidney injury has a serum potassium level of 6.8 mEq/L. Which electrocardiogram change should the nurse expect to observe?

- A. Flattened T waves
- B. Shortened PR interval
- C. Tall, peaked T waves
- D. Prominent U waves

Answer: C - Tall, peaked T waves

Severe hyperkalemia (K^+ 6.8 mEq/L) depolarizes myocardial cells, producing characteristic tall, peaked T waves on the ECG, often the earliest sign before QRS widening or arrhythmias develop.

Not A: Flattened T waves indicate low potassium, not high.

Not B: Shortened PR interval is not associated with hyperkalemia.

Not D: Prominent U waves are a sign of hypokalemia.

Remember: Hyperkalemia shows tall, peaked T waves.

Question and rationale by Plainwork. Reference: Silvestri, Saunders Comprehensive Review for the NCLEX-RN Examination, 8th Edition

Question 32

LAB VALUES

A client with acute exacerbation of chronic obstructive pulmonary disease (COPD) is lethargic and has shallow respirations. Which arterial blood gas (ABG) result should the nurse expect?

- A. pH 7.32, $PaCO_2$ 38 mmHg, HCO_3^- 18 mEq/L
- B. pH 7.49, $PaCO_2$ 40 mmHg, HCO_3^- 30 mEq/L
- C. pH 7.48, $PaCO_2$ 30 mmHg, HCO_3^- 22 mEq/L
- D. pH 7.31, $PaCO_2$ 52 mmHg, HCO_3^- 24 mEq/L

Answer: D - pH 7.31, $PaCO_2$ 52 mmHg, HCO_3^- 24 mEq/L

During an acute COPD flare the patient retains CO_2 , producing a primary respiratory acidosis; compensation has not yet raised bicarbonate, so the ABG shows low pH, elevated $PaCO_2$, and near-normal HCO_3^- .

Not A: Low pH with low $PaCO_2$ indicates metabolic acidosis, not COPD retention.

Not B: pH alkalosis with normal $PaCO_2$ and high HCO_3^- reflects metabolic alkalosis, unrelated.

Not C: Elevated pH and low $PaCO_2$ describe respiratory alkalosis, opposite of expected.

Remember: COPD flare = CO_2 retention $\rightarrow$ acidic, high CO_2 , normal bicarb.

Question and rationale by Plainwork. Reference: Brunner & Suddarth's Textbook of Medical-Surgical Nursing, 15th Edition

Question 33

LAB VALUES

A nurse is teaching a client with type 2 diabetes about a scheduled hemoglobin A1c test. Which statement by the client indicates a correct understanding of this laboratory test?

- A. It determines if my kidneys are filtering sugar properly.
- B. It detects the amount of sugar in my urine over a week.
- C. It measures my blood sugar levels right at this moment.
- D. It shows my average blood sugar over the past three months.

Answer: D - It shows my average blood sugar over the past three months.

Hemoglobin A1c reflects the percentage of glycated hemoglobin, indicating average plasma glucose over the previous 8–12 weeks, thus providing a three-month glycemic trend. It is used to assess diabetes control.

Not A: Hemoglobin A1c does not evaluate kidney filtration.

Not B: Urine glucose testing does not reflect long-term blood glucose.

Not C: A1c is not a point-of-care glucose measurement.

Remember: A1c shows three-month average blood sugar.

Question and rationale by Plainwork. Reference: American Diabetes Association Standards of Care in Diabetes 2023

Question 34

MANAGEMENT

An unlicensed assistive personnel performs vital signs collection on a group of patients and reports the findings to the nurse providing care. Based upon the information provided, which patient should the nurse see first?

- A. RR 16
- B. O2 sat 90%
- C. BP 91/53
- D. HR 87

Answer: B - O2 sat 90%

An oxygen saturation of 90% indicates hypoxemia, which can rapidly compromise tissue oxygenation and requires immediate nursing assessment before other abnormal but less urgent findings.

Not A: Respiratory rate 16 is within normal adult range.

Not C: Blood pressure is low but not immediately life-threatening.

Not D: Heart rate 87 is normal for an adult.

Remember: Low O2 sat = act first, it's the most urgent.

Question adapted from Open RN, Nursing Management and Professional Concepts, Chippewa Valley Technical College (CC BY 4.0, <https://wtcs.pressbooks.pub/nursingmpc/chapter/2-7-learning-activities/>); rationale written by Plainwork.

Question 35

MANAGEMENT

As the RN, you review and assess the immediate needs of the clients you are assigned. Based on the client's needs, which of the following interventions should the RN delegate to the LPN?

- A. Teach the elderly client about home care of the indwelling Foley catheter.
- B. Interpret the morning labs on the client with end stage renal disease.
- C. Administer antineoplastic medications to the client diagnosed with bladder cancer.
- D. Administer an oral opioid to the client diagnosed with pyelonephritis.

Answer: D - Administer an oral opioid to the client diagnosed with pyelonephritis.

Administering routine oral medications, including opioids, to stable clients falls safely within the licensed practical nurse's scope of practice. The registered nurse must retain tasks involving complex clinical judgment, specialized administration, and primary client teaching.

Not A: Initial client education and discharge teaching require registered nurse assessment and clinical judgment.

Not B: Interpreting diagnostic laboratory values requires registered nurse-level clinical analysis and judgment.

Not C: Administering antineoplastic or chemotherapy medications requires specialized certification reserved for registered nurses.

Remember: RNs do EAT: evaluate, assess, and teach; LPNs give meds.

Question adapted from Open RN, Nursing Management and Professional Concepts, Chippewa Valley Technical College (CC BY 4.0, <https://wtcs.pressbooks.pub/nursingmpc/chapter/3-7-learning-activities/>); rationale written by Plainwork.

Question 36

MANAGEMENT

Shared governance models reflect which type of management style?

- A. Autocratic
- B. Bureaucratic
- C. Transformative
- D. Laissez-faire

Answer: C - Transformative

Shared governance is a collaborative organizational model that empowers clinical nurses to participate in decision-making. This aligns with transformative leadership, which focuses on empowerment, collaboration, shared vision, and staff development to improve outcomes.

Not A: Autocratic leadership centralizes all decision-making power in a single leader, excluding staff input.

Not B: Bureaucratic leadership relies strictly on fixed rules, hierarchy, and established policies rather than empowerment.

Not D: Laissez-faire leadership is hands-off and lacks the structured collaboration and support of shared governance.

Remember: Shared governance transforms staff by giving them a voice.

Question adapted from Open RN, Nursing Management and Professional Concepts, Chippewa Valley Technical College (CC BY 4.0, <https://wtcs.pressbooks.pub/nursingmpc/chapter/10-9-learning-activities/>); rationale written by Plainwork.

Question 37

MANAGEMENT

A nurse is caring for a post-operative coronary artery bypass graft patient who has been transferred to the ICU and is one hour post-op. Which of the following findings requires immediate intervention?

- A. Urinary output of 15 ml/hr
- B. Hgb 10.4 gm/dL
- C. BP 96/54
- D. Potassium 3.2 mmol/L

Answer: D - Potassium 3.2 mmol/L

Post-CABG patients are at high risk for arrhythmias; a potassium of 3.2 mmol/L is below the safe threshold (<3.5) and needs prompt correction to prevent life-threatening dysrhythmias.

Not A: Low output but not immediately life-threatening; assess volume status.

Not B: Mild anemia; typical post-op value, no urgent action.

Not C: Borderline low pressure; usually tolerated, treat if symptomatic.

Remember: Hypokalemia first: fix K⁺ to stop post-CABG arrhythmias.

Question adapted from Open RN, Nursing Management and Professional Concepts, Chippewa Valley Technical College (CC BY 4.0, <https://wtcs.pressbooks.pub/nursingmpc/chapter/2-7-learning-activities/>); rationale written by Plainwork.

Question 38

MENTAL HEALTH

Namita is a 12 year old student who was recently removed from her home by Child Protective Services because of neglect from her mother who suffers from alcoholism. She has no relationship with her father. At school, she has been having angry outbursts in class yelling at her teachers and bullying her friends. This behavior is characteristic of which category of PTSD symptoms?

- A. Re-experiencing
- B. Avoidance
- C. Arousal and Reactivity
- D. Cognition and Mood

Answer: C - Arousal and Reactivity

Alterations in arousal and reactivity in PTSD include irritable behavior, angry outbursts, and aggressive actions toward others. Namita's yelling at teachers and bullying peers directly demonstrate these hyperarousal and reactive symptoms following her childhood trauma.

Not A: Involves intrusive memories, flashbacks, or nightmares about the traumatic event, not externalized anger.

Not B: Involves staying away from people, places, or thoughts that remind them of the trauma.

Not D: Involves negative beliefs, distorted blame, feelings of detachment, or inability to experience positive emotions.

Remember: Angry outbursts and aggression equal hyperarousal and reactivity.

Question adapted from Open RN, Nursing: Mental Health and Community Concepts, Chippewa Valley Technical College (CC BY 4.0, <https://wtcs.pressbooks.pub/nursingmhcc/chapter/9-12-learning-activity-knowledge-check/>); rationale written by Plainwork.

Question 39

MENTAL HEALTH

Which of the following medication orders does the nurse anticipate from the provider?

- A. Sertraline 50mg orally once daily in the morning
- B. Olanzapine 5mg orally once daily in the morning
- C. Benztropine 2mg orally prn extrapyramidal symptoms
- D. Gabapentin 100mg orally daily at bedtime

Answer: A - Sertraline 50mg orally once daily in the morning

Sertraline, an SSRI, is first-line for depression in older adults; a low dose taken each morning minimizes side effects and insomnia, making it the most appropriate initial order.

Not B: Olanzapine treats psychosis, not first-line for uncomplicated depression.

Not C: Benztropine is for antipsychotic-induced EPS, not indicated for depression.

Not D: Gabapentin treats neuropathic pain, not depression, so it's inappropriate.

Remember: SSRIs first-line for senior depression, taken in morning.

Question adapted from Open RN, Nursing: Mental Health and Community Concepts, Chippewa Valley Technical College (CC BY 4.0, <https://wtcs.pressbooks.pub/nursingmhcc/chapter/4-13-learning-activity-virtual-scenario/>); rationale written by Plainwork.

Question 40

MENTAL HEALTH

Which of the following actions should a nurse undertake to promote respect and dignity when working with mental health clients?

- A. Make decisions on behalf of the individual
- B. Use technical language to explain treatment
- C. Encourage decision making in alignment with clinical preferences
- D. Provide access to decision making options

Answer: D - Provide access to decision making options

Providing access to decision-making options respects autonomy, promotes dignity, and empowers clients to participate in their own care, aligning with person-centered mental health practice and supporting recovery.

Not A: Making decisions for the client undermines autonomy and violates dignity.

Not B: Technical language can confuse clients and hinder respectful communication.

Not C: Encouraging decision making only when it matches clinical preferences limits client choice.

Remember: Offer choices, preserve dignity.

Question adapted from Open RN, Nursing: Mental Health and Community Concepts, Chippewa Valley Technical College (CC BY 4.0, <https://wtcs.pressbooks.pub/nursingmhcc/chapter/1-10-knowledge-check/>); rationale written by Plainwork.

Question 41

MENTAL HEALTH

Which of the following actions should nurses take to ensure their individual safety when providing care to mental health clients?

- A. Wear visible identification on a lanyard
- B. Ignore individual feelings and sensitivities
- C. Avoid wearing necklaces and earrings
- D. Wear long hair down

Answer: C - Avoid wearing necklaces and earrings

Nurses should avoid wearing necklaces and earrings because these items can be grabbed, used as weapons, or become entangled during a client's aggressive behavior, increasing risk of injury to both nurse and client.

Not A: Identification lanyards can be seized and used as a weapon.

Not B: Ignoring feelings compromises therapeutic rapport and safety.

Not D: Long hair down can be grabbed during agitation.

Remember: No jewelry, no hazards.

Question adapted from Open RN, Nursing: Mental Health and Community Concepts, Chippewa Valley Technical College (CC BY 4.0, <https://wtcs.pressbooks.pub/nursingmhcc/chapter/1-10-knowledge-check/>); rationale written by Plainwork.

Question 42

PHARMACOLOGY

A client taking digoxin reports nausea and seeing yellow-green halos around lights. What should the nurse do first?

- A. Give the dose with a snack
- B. Hold the dose and notify the provider
- C. Explain that these are expected side effects
- D. Give an antiemetic, then the digoxin

Answer: B - Hold the dose and notify the provider

Nausea and yellow-green halos are classic signs of digoxin toxicity. Because digoxin has a narrow therapeutic index, the nurse must immediately hold the medication and notify the healthcare provider to prevent life-threatening cardiac arrhythmias.

Not A: Giving the dose with food delays necessary intervention and worsens life-threatening toxicity.

Not C: These are signs of life-threatening toxicity, not expected or benign side effects.

Not D: Administering an antiemetic masks toxicity symptoms while giving more digoxin worsens the poisoning.

Remember: Yellow halos and nausea mean digoxin toxicity: hold the dose immediately!

Question and rationale by Plainwork. Reference: Lehne's Pharmacology for Nursing Care, 11th ed.; FDA Lanoxin (digoxin) label

Question 43

PHARMACOLOGY

A 68-year-old man receives IV unfractionated heparin for DVT. After 6 hours, his aPTT is 85 seconds (reference 25-35 s). Which action is most appropriate?

- A. Hold infusion and administer protamine sulfate.
- B. Decrease the heparin infusion rate.
- C. Continue the current infusion rate.
- D. Increase the heparin infusion rate.

Answer: B - Decrease the heparin infusion rate.

The aPTT is markedly above the therapeutic range, indicating excess anticoagulation. The safest step is to reduce the heparin infusion rate to bring the aPTT back into target, rather than stopping or reversing it.

Not A: Protamine is reserved for severe bleeding or very high aPTT, not mild excess.

Not C: Continuing the current rate maintains supratherapeutic anticoagulation and bleeding risk.

Not D: Increasing the rate would worsen the already high aPTT.

Remember: High aPTT → dial back heparin, not stop.

Question and rationale by Plainwork. Reference: American College of Chest Physicians Antithrombotic Therapy Guidelines, 2022

Question 44

PHARMACOLOGY

A 55-year-old with type 2 diabetes is started on a basal insulin that has no pronounced peak and lasts about 24 hours. Which insulin is most appropriate?

- A. Insulin lispro
- B. Insulin glargine
- C. NPH insulin
- D. Insulin aspart

Answer: B - Insulin glargine

Insulin glargine is a long-acting basal insulin that provides a relatively flat glucose-lowering profile without a marked peak and maintains activity for approximately 24 hours, matching the described requirements.

Not A: Insulin lispro is rapid-acting, peaks within an hour, not basal.

Not C: NPH insulin has a pronounced peak and shorter duration than 24 hours.

Not D: Insulin aspart is rapid-acting, unsuitable for basal coverage.

Remember: Glargine = flat, 24-hour basal insulin.

Question and rationale by Plainwork. Reference: American Diabetes Association. Standards of Care in Diabetes—2024.

Question 45

PHARMACOLOGY

A client taking lithium carbonate for bipolar disorder reports persistent bilateral coarse hand tremors and diarrhea. Which action should the nurse take first?

- A. Request a prescription for an antiparkinsonian agent.
- B. Hold the medication and prepare for a serum lithium draw.
- C. Administer the dose and encourage increased fluid intake.
- D. Instruct the client to restrict dietary sodium intake.

Answer: B - Hold the medication and prepare for a serum lithium draw.

Persistent coarse tremor and diarrhea are early signs of lithium toxicity; the priority is to stop further exposure and obtain a serum lithium level to determine if the dose is supratherapeutic before any other interventions.

Not A: Antiparkinsonian agents treat tremor but do not address potential lithium toxicity.

Not C: Continuing the dose and increasing fluids may worsen toxicity by raising lithium levels.

Not D: Sodium restriction can increase lithium reabsorption, raising serum levels and toxicity risk.

Remember: Tremor + diarrhea → stop lithium, check level.

Question and rationale by Plainwork. Reference: Halter, M. J. (2022). Varcarolis' Foundations of Psychiatric-Mental Health Nursing (9th ed.).

Question 46

PRIORITIZATION

Which client should the nurse assess first?

- A. Day 2 after appendectomy, pain 4 out of 10
- B. COPD, oxygen saturation 90%
- C. After hip surgery, new restlessness, saturation 86%
- D. Diabetes, asking for a breakfast tray

Answer: C - After hip surgery, new restlessness, saturation 86%

The client shows new restlessness and an oxygen saturation of 86%, indicating acute hypoxemia and possible pulmonary embolism, which requires immediate assessment before other less critical concerns.

Not A: Pain score 4/10 is moderate; not life-threatening.

Not B: Saturation 90% is low but stable without distress.

Not D: Breakfast request is non-urgent; vital signs are stable.

Remember: Low O₂ + restlessness = immediate assessment.

Question and rationale by Plainwork. Reference: Lewis's Medical-Surgical Nursing, 12th ed.; GOLD COPD Report (SpO₂ target 88-92%)

Question 47

PUBLIC HEALTH

A public health nurse is implementing a new syphilis screening protocol at a correctional facility intake center. Which action by the nurse best demonstrates the correct application of an opt-out screening strategy?

- A. Informing the client that the test is routine unless refused
- B. Screening only clients who present with active genital lesions
- C. Testing only clients who report high-risk sexual behaviors
- D. Requiring a signed written consent form before drawing blood

Answer: A - Informing the client that the test is routine unless refused

Opt-out screening means the test is performed routinely for everyone unless the individual explicitly declines. The nurse informs the client that testing will occur as standard intake care while preserving the client's right to refuse.

Not B: This describes diagnostic testing based on symptoms, not universal population-based screening.

Not C: This represents targeted risk-based testing rather than a universal opt-out strategy.

Not D: Mandating a separate written consent form defines an opt-in testing model.

Remember: Opt-out means tested by default, unless the patient says no.

Question and rationale by Plainwork. Reference: CDC MMWR, Thu, 17 Sep 2026

Question 48

PUBLIC HEALTH

A public health nurse is responding to a suspected Ebola outbreak. Which intervention is the highest priority to interrupt the chain of transmission in the community?

- A. Implementing immediate community-wide quarantine
- B. Rapid identification and isolation of symptomatic contacts
- C. Administering prophylactic antivirals to all close contacts
- D. Distributing broad-spectrum antibiotics to the community

Answer: B - Rapid identification and isolation of symptomatic contacts

The most effective way to break Ebola transmission is promptly identifying symptomatic individuals and isolating them, preventing contact with infectious fluids; this targeted approach stops spread faster than broad quarantine or unproven treatments.

Not A: Community-wide quarantine delays care and is impractical for Ebola control.

Not C: No approved prophylactic antivirals exist for Ebola.

Not D: Antibiotics do not affect a viral hemorrhagic fever.

Remember: Find and isolate cases before they spread.

Question and rationale by Plainwork. Reference: CDC MMWR, Tue, 15 Sep 2026.

Question 49

PUBLIC HEALTH

A public health nurse is planning child survival interventions in a region with high under-5 mortality, guided by CHAMPS surveillance data. To address the leading infectious cause of death in this age group, which intervention is most critical?

- A. Implementing mass deworming campaigns
- B. Distributing insecticide-treated bed nets
- C. Administering prophylactic zinc supplements
- D. Expanding pneumococcal conjugate vaccination

Answer: D - Expanding pneumococcal conjugate vaccination

Pneumonia, primarily due to *Streptococcus pneumoniae*, remains the top infectious killer of children under five; pneumococcal conjugate vaccine directly prevents this disease, making its expansion the most impactful intervention.

Not A: Deworming reduces helminth burden but does not target the leading cause of under-5 mortality.

Not B: Bed nets prevent malaria, which is not the top infectious death cause in most regions.

Not C: Zinc supplementation helps diarrheal outcomes but does not address the primary fatal infection.

Remember: Vaccinate kids, stop pneumonia deaths.

Question and rationale by Plainwork. Reference: CDC MMWR, Tue, 08 Sep 2026

Question 50

PUBLIC HEALTH

A nurse in a travel clinic is counseling an unvaccinated client planning a trip to Cuba. Which vaccine should the nurse recommend to prevent a common foodborne and waterborne viral infection associated with travel to this region?

- A. Hepatitis B vaccine
- B. Yellow fever vaccine
- C. Hepatitis A vaccine
- D. Meningococcal vaccine

Answer: C - Hepatitis A vaccine

Hepatitis A is a highly contagious viral liver infection transmitted primarily through the fecal-oral route via contaminated food or water. It is the most common vaccine-preventable disease in travelers visiting developing countries, including Cuba.

Not A: Hepatitis B is transmitted through blood and bodily fluids, not contaminated food or water.

Not B: Yellow fever is a mosquito-borne viral illness, not spread through food or water.

Not D: Meningococcal disease is bacterial and transmitted through respiratory droplets, not food or water.

Remember: Hep A is from food and water; Hep B is from blood.

Question and rationale by Plainwork. Reference: CDC MMWR, Thu, 24 Sep 2026

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