18 NCLEX-RN Practice Questions: Answers & Rationales

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Free NCLEX-RN practice questions (2026): 18 original, independently authored questions with visible answers and explanations. Review them as a learning exercise, not a statistically validated test, a secure question bank, a predictor of passing or an official NCSBN product. Specific patient-care actions must follow authorised clinical policy.

How to use these NCLEX-style practice questions

- Read each question and decide before reading its explanation.
- Identify the Client Needs category and safety cue before choosing.
- Explain why each tempting distractor is not the safest answer in that specific scenario.
- Record gaps using the study-plan error log.

All questions use fictional adult scenarios unless otherwise stated. There is no copyrighted exam content, score calculator, simulated computerized adaptive test or claim of professional clinical validation. Select-all-that-apply items below use a simple visible-answer format; official partial-credit scoring is not replicated.

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18 original NCLEX-RN practice questions with rationales

Question 1: Management of Care

A nurse receives a handoff on four adults. Which client needs assessment first?

- An alert client requesting help with routine discharge paperwork
- A stable client requesting a scheduled bath
- A client with newly worsening breathlessness and difficulty speaking in full sentences
- A client asking when lunch will arrive

Correct answer: C. Rationale: New respiratory deterioration can threaten immediate safety. Prompt assessment and escalation take priority over stable routine needs. The other requests matter but are less urgent.

Why the other options are incorrect: A: Discharge paperwork can follow assessment of the new breathing problem. B: A routine bath can be rescheduled while urgent needs are addressed. D: A meal-time question does not indicate the immediate risk described in this handoff.

Clinical-judgment takeaway: Prioritisation uses clinical cues rather than who asked first.

Question 2: Safety and Infection Prevention and Control

After removing disposable gloves used during routine patient contact, what should the nurse do?

- Perform hand hygiene at the indicated moment
- Assume the gloves fully protected the hands
- Put the same gloves on again for a second client
- Clean hands only if dirt is visible

Correct answer: A. Rationale: Gloves do not replace hand hygiene. Hand hygiene is required at applicable moments, including after glove removal according to protocol.

Why the other options are incorrect: B: Gloves can become contaminated, and removal can contaminate hands. C: Disposable gloves must not be carried from one patient's care to another. D: Hands may carry microorganisms without visible dirt.

Clinical-judgment takeaway: Equipment is one safety layer; it does not eliminate contamination pathways.

Question 3: Management of Care

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Which task is most suitable for assignment to trained assistive personnel for a stable client, subject to local scope and competency rules?

- Initial assessment of new chest discomfort
- Interpreting an unexpected ECG finding
- Changing a medication regimen independently
- Assisting with routine hygiene for a clinically stable client

Correct answer: D. Rationale: Routine hygiene for a stable client may be delegated after appropriate assessment and in accordance with local rules. Clinical assessment, interpretation and prescribing remain outside that task.

Why the other options are incorrect: A: New chest discomfort requires nursing assessment and timely escalation. B: Interpreting an ECG requires clinical judgment beyond routine personal care. C: Changing a medication regimen requires appropriate authority; it is not an assistance task.

Clinical-judgment takeaway: Consider stability, predictability, scope, training and supervision.

Question 4: Pharmacological and Parenteral Therapies

A prescription differs from the client's verified medication history. Which response best protects the client?

- Give the dose and reconcile later
- Clarify the discrepancy through the authorised medication-reconciliation process before administration
- Change the order to match the nurse's preference
- Ignore the client's reported history

Correct answer: B. Rationale: A discrepancy requires prompt verification before unsafe administration. Nurses should follow approved medication reconciliation and prescriber communication procedures.

Why the other options are incorrect: A: Giving the medicine first leaves the discrepancy unresolved at administration. C: Personal preference cannot replace a verified prescription. D: The patient's account may reveal missing information and needs checking.

Clinical-judgment takeaway: Patient safety requires verification, not guessing.

Question 5: Psychosocial Integrity

A patient says, 'I feel frightened about the procedure.' Which reply best supports therapeutic communication?

- Tell me what concerns you most about the procedure
- You have nothing to worry about
- You need to stop thinking negatively
- The team is too busy to discuss it

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Correct answer: A. Rationale: Open-ended exploration validates the client's perspective and helps identify a specific information or support need. Minimising or dismissing feelings is less therapeutic.

Why the other options are incorrect: B: Promising there is nothing to worry about dismisses the concern without exploring it. C: Telling the patient to stop thinking negatively closes the conversation. D: Dismissing the concern because staff are busy prevents identification of a support need.

Clinical-judgment takeaway: Listen before offering explanations or reassurance.

Question 6: Reduction of Risk Potential

The laboratory calls with a result designated critical under the facility's policy. What should the nurse prioritise?

- File the result for the next scheduled review
- Assume the machine is wrong without investigation
- Verify the report according to policy, assess the client and notify the appropriate responsible clinician promptly
- Change treatment without an order

Correct answer: C. Rationale: Critical results require timely verification, assessment,

communication and any authorised interventions. Delaying or independently changing therapy creates risk.

Why the other options are incorrect: A: Waiting for scheduled review ignores the critical-result reporting pathway. B: A possible specimen or analyser problem needs verification, not dismissal. D: The result alone does not authorise an independent treatment change.

Clinical-judgment takeaway: Critical is a reporting pathway as well as a potential clinical risk.

Question 7: Basic Care and Comfort

A patient with limited mobility wants help repositioning. Which approach is most appropriate?

- Use a fixed technique regardless of condition
- Assess comfort, mobility, pressure risk, equipment needs and preferred positioning before assisting
- Avoid documenting any skin concerns
- Keep the client in one position until the next shift

Correct answer: B. Rationale: Individualised mobility and skin-risk assessment supports comfort and injury prevention. Repositioning methods and schedules depend on the client and local policy.

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Why the other options are incorrect: A: One technique may not suit the patient's mobility, pain or equipment needs. C: Skin concerns need assessment and documentation so the team can respond. D: Leaving the patient in one position without assessment ignores comfort and pressure risk.

Clinical-judgment takeaway: Comfort care is assessed, individualised and reassessed.

Question 8: Health Promotion and Maintenance

After teaching a client how to follow their prescribed discharge plan, how can the nurse best assess understanding?

- Ask 'Do you understand?' and accept yes
- Provide information only to accompanying family members
- Assume understanding from polite nodding
- Ask the client to explain the plan back in their own words and clarify gaps

Correct answer: D. Rationale: Teach-back elicits what the client understood rather than asking for a yes/no response. Gaps can then be corrected respectfully with suitable accessible materials.

Why the other options are incorrect: A: A yes/no answer does not show which steps the patient can explain. B: Family support may help, but teaching must still involve the patient as appropriate. C: Nodding can reflect politeness or uncertainty; it does not

demonstrate understanding.

Clinical-judgment takeaway: Assessment of learning should test understanding, not compliance.

Question 9: Safety and Infection Prevention and Control

The nurse notices a wet floor near a client who is walking with assistance. What is the best immediate response?

- Ignore it because environmental services will arrive
- Ask the client to step over the spill
- Protect the client from the hazard and arrange safe removal or reporting of the spill
- Leave the area without notifying anyone

Correct answer: C. Rationale: The nurse should reduce an immediate environmental fall hazard and activate the local response to resolve it. Waiting without protecting the client increases risk.

Why the other options are incorrect: A: Waiting for another service leaves an immediate hazard in the patient's path. B: Stepping over a spill still exposes the patient to the hazard. D: Leaving without arranging protection or reporting leaves the risk unresolved.

Clinical-judgment takeaway: Environment matters in preventing patient harm.

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Question 10: Physiological Adaptation

A postoperative adult who was awake and conversing is now increasingly difficult to awaken. What is the priority?

- Document the change and wait for routine rounds
- Urgently assess and activate the appropriate escalation pathway
- Assume sleep is expected after surgery
- Offer oral fluids before assessing airway protection

Correct answer: B. Rationale: A new change in level of responsiveness may indicate serious deterioration. Urgent assessment and escalation are essential; no diagnosis can be assumed from this cue alone.

Why the other options are incorrect: A: Documentation is needed, but must not delay the urgent response. C: Increasing difficulty waking is a change from baseline, not a finding to dismiss. D: Oral fluid before assessing alertness and airway protection may be unsafe.

Clinical-judgment takeaway: New changes from baseline override routine tasks.

Question 11: Management of Care

During handoff, the nurse realises an important finding was not communicated. What should happen next?

- Wait until the next routine report
- Change the written record to hide the omission
- Assume another team member will notice
- Provide a clear and timely follow-up handoff to the responsible team

Correct answer: D. Rationale: Timely, accurate communication allows the receiving team to respond to safety-relevant information. Documentation must be factual and should not conceal errors.

Why the other options are incorrect: A: The receiving team may make decisions before the next routine report. B: Changing a record to conceal an omission creates further inaccurate information. C: Assuming someone else will notice does not establish that the message was received.

Clinical-judgment takeaway: Closing communication gaps is a patient safety action.

Question 12: Psychosocial Integrity

A competent adult declines a non-emergency procedure after receiving information. What is the best nursing response?

- Respect the decision, clarify understanding and follow the consent and escalation policy
- Force the procedure because it was scheduled
- Ask another person to sign without assessing authority
- Record the procedure as completed

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Correct answer: A. Rationale: Informed refusal requires respectful communication, assessment of understanding and appropriate documentation/escalation. Specific legal rules vary and emergencies require separate considerations.

Why the other options are incorrect: B: A scheduled procedure does not itself establish consent. C: A substitute signature does not resolve the informed refusal in this scenario. D: Recording an unperformed procedure as completed is inaccurate documentation.

Clinical-judgment takeaway: Autonomy and safety both require careful documentation.

Question 13: Pharmacological and Parenteral Therapies

During an IV infusion, the client reports new pain and the insertion site appears swollen. What is the best next step?

- Increase the infusion rate
- Assess immediately and stop or pause the infusion as indicated by the local protocol, then seek appropriate assistance
- Ignore the symptoms if the pump is not alarming
- Remove all vascular access without assessment or policy

Correct answer: B. Rationale: New pain and swelling may indicate an infusion complication.

Immediate assessment and appropriate interruption/management according to protocol protect the client. The precise response depends on the medication and clinical setting.

Why the other options are incorrect: A: Increasing the rate can worsen exposure if the infusion is causing harm. C: A pump can continue running despite an insertion-site problem. D: Removing every access line without assessment ignores the affected site, infused medicine and required management plan.

Clinical-judgment takeaway: Equipment alarms do not replace assessment of the patient and insertion site.

Question 14: Health Promotion and Maintenance

Which approach best supports person-centred education when a patient has difficulty hearing instructions?

- Speak rapidly and repeat the same long speech
- Direct all instructions to another person without consent
- Assume the patient lacks decision-making capacity
- Ask about preferred communication needs, reduce background noise and use accessible written or visual supports as appropriate

Correct answer: D. Rationale: Accessible education adapts communication to individual preferences and checks understanding. Hearing difficulty alone does not establish impaired decision-making capacity.

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Why the other options are incorrect: A: Rapid repetition leaves the communication barrier in place. B: Speaking only to another person can exclude the patient from their own care. C: Hearing difficulty does not, by itself, show a problem with understanding or making decisions.

Clinical-judgment takeaway: Communication accessibility is part of safe patient education.

Question 15: Reduction of Risk Potential

A patient who recently fell now reports new severe pain and cannot bear weight. What should the nurse do first?

- Assess the new findings, prevent further injury and arrange prompt clinical review
- Encourage immediate unassisted walking
- Assume the symptoms are anxiety-related
- Discharge the client without reassessment

Correct answer: A. Rationale: New pain and inability to bear weight after a fall require assessment for potential injury and appropriate escalation. Forcing mobility may worsen harm.

Why the other options are incorrect: B: Unassisted walking before assessment may worsen injury or lead to another fall. C: Anxiety must not be used to dismiss new severe pain and loss of function. D: Discharge without reassessment ignores the new findings.

Clinical-judgment takeaway: Risk assessment must respond to changes, not only initial screening.

Question 16: Physiological Adaptation

A client with a respiratory condition has worsening observed work of breathing compared with the previous hour. Which interpretation is most appropriate?

- An increase in work of breathing is always expected
- The numerical oxygen reading alone determines every intervention
- The change should prompt timely assessment and appropriate escalation rather than an automatic diagnosis
- The client should be left unobserved until the next shift

Correct answer: C. Rationale: Changes in breathing effort and condition require interpretation alongside other cues. The correct response is timely assessment and authorised escalation; the cause cannot be confirmed from one description.

Why the other options are incorrect: A: New increased breathing effort should not automatically be treated as expected. B: One oxygen reading does not describe effort, alertness or the whole clinical picture. D: Leaving the patient unobserved postpones assessment of a worsening condition.

Clinical-judgment takeaway: Trend and clinical context matter alongside measurements.

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Question 17: Select all that apply . Infection control

Which actions can support preventing healthcare-associated transmission? Select all that apply.

- Reuse the same disposable gloves for several patients
- Perform hand hygiene at applicable moments
- Clean shared equipment as required before another patient uses it
- Use task-appropriate personal protective equipment according to precautions

Correct answer: B, C and D. Rationale: Hand hygiene, appropriate PPE and shared-equipment cleaning are complementary protections. Reusing disposable gloves between patients increases cross-contamination risk.

Check each option: A: Reusing disposable gloves across patients creates a route for cross-contamination. B: Hand hygiene reduces transfer through contaminated hands. C: Cleaning shared equipment helps prevent it carrying contamination to another patient. D: PPE should match the task and applicable precautions.

Clinical-judgment takeaway: Evaluate every option; this item has three correct choices.

Question 18: Select all that apply . Clinical judgment

A stable patient develops new confusion and repeatedly attempts to get up unassisted.

Which nursing responses are appropriate? Select all that apply.

- Assess new changes in cognition and potential contributing concerns
- Assume the behaviour is intentional and stop observation
- Address immediate environmental safety and obtain appropriate help
- Communicate the change promptly to the responsible clinical team

Correct answer: A, C and D. Rationale: New confusion can indicate a clinical change and creates immediate fall risk. Appropriate responses include assessment, safety measures, timely reporting and reassessment, not dismissing the finding.

Check each option: A: A new cognitive change needs assessment against baseline. B: Attributing the behaviour to intention can delay recognition of illness. C: Immediate assistance and environmental safety address the risk of an unassisted fall. D: Prompt reporting lets the team assess the change and revise care.

Clinical-judgment takeaway: A cue can require assessment and protection simultaneously.

Unfolding case-study practice

After the mixed questions, complete our six-question Next Generation NCLEX clinical-judgment case. It follows one fictional patient's changing cues across recognising, analysing, prioritising, planning, acting and evaluating. The official 2026 NCLEX-RN test plan includes three six-item unfolding case sets in the minimum-length exam; the linked case is original independent practice.

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How to review weak topics by category

TABLE / Suggested follow-up material for missed NCLEX-style questions

Weakness	Review resource	What to test again
Prioritisation, handoff or care plans	Nursing process guide	Priority cues, measurable outcomes, evaluation
Hand hygiene or precautions	WHO five moments	Moments before/after care and glove limitations
Clinical assessment	Head-to-toe nursing assessment	Reported versus observed findings and deterioration
Response to clinical changes	Six-step NGN case	Recognise cues and update decisions as data change

Frequently asked questions

Are these actual NCLEX exam questions?

No. They are original learning examples aligned broadly to the 2026 RN test-plan topics. They have not been used on the secure examination.

Can a score on these 18 questions predict whether I will pass?

No. A small, unvalidated set is not a readiness or pass-probability measure. Use explanations to detect learning gaps, then practise with additional reliable materials.

Why are answers visible?

Showing rationales immediately supports self-directed revision and printing. Candidates should attempt each question before reading its answer. A separate scored interactive question bank would require distinct development and validation.

Clinical topics behind these questions

Review medication checks for questions 4 and 13, therapeutic communication for questions 5 and 14, and falls assessment and safe mobility for questions 9, 15 and 18. For the infection-control items, see the CDC’s core infection-prevention practices.

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Official reference and review disclosure

Content categories and clinical judgment framework referenced from the 2026 NCLEX-RN Test Plan; see NCSBN official sample items and exam preview for real interface examples. The NCLEX trademark belongs to NCSBN. Clinical accuracy review pending: these fictional educational questions and rationales have not been independently signed off by a qualified nursing clinician or educator. Not a substitute for supervised clinical training, current care protocols, or individual patient advice. My Nursing Hub is independent and not endorsed by NCSBN or Pearson VUE.

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