NCLEX-Style Practice Questions with Rationales

Q1. A nurse is caring for a client experiencing a panic attack. Which action is the **priority**?
A. Encourage the patient to talk about their feelings.
B. Leave the patient alone to calm down.
C. Stay with the patient and reduce external stimuli.
D. Offer the patient food and fluids.

Answer: C
Rationale: Clients in a panic attack need immediate support. Staying with them and reducing stimuli helps decrease anxiety and prevents escalation. Leaving them alone (B) increases risk. Talking (A) may come later, once the patient is calmer.

Q2. A client newly prescribed an SSRI reports increased energy after one week but continues to have suicidal thoughts. What is the nurse's best action?
A. Reassure the client this is normal.
B. Increase the client's activity level.
C. Closely monitor the client for suicidal behavior.
D. Stop the SSRI immediately.

Answer: C
Rationale: SSRIs can initially increase energy before mood improves, which can raise suicide risk. The nurse must monitor closely for suicidal behavior during the first weeks.

Q3. A patient with bulimia nervosa is admitted to the unit. Which nursing intervention is most appropriate?
A. Allow the patient to eat alone to reduce embarrassment.
B. Monitor the patient for 1 hour after meals.
C. Provide the patient with a high-fat diet.
D. Encourage the patient to exercise after meals.

Answer: B
Rationale: Clients with bulimia often purge after eating. Monitoring for 1-hour post-meal helps prevent vomiting or laxative abuse. Allowing them to eat alone (A) increases purging risk.

Q4. Which finding should the nurse report immediately for a patient taking clozapine?
A. Mild weight gain
B. Increased appetite
C. Fever and sore throat
D. Constipation

Answer: C
Rationale: Clozapine can cause agranulocytosis. Fever and sore throat are signs of infection and

must be reported immediately. Weight gain and constipation are common but less urgent side effects.

Q5. A client with bipolar disorder in the manic phase is most at risk for which problem?
A. Excessive sleep
B. Social isolation
C. Injury to self or others
D. Weight gain

Answer: C
Rationale: Clients in mania exhibit impulsivity, poor judgment, hyperactivity, and can become violent. Safety is the top priority. They usually have **decreased sleep** and increased activity.

Q6. A nurse suspects a patient is at risk for suicide. Which question is most appropriate to ask first?
A. "Do you have a plan to harm yourself?"
B. "Why would you want to die?"
C. "Don't you know how much your family loves you?"
D. "Have you ever heard voices telling you to hurt yourself?"

Answer: A
Rationale: It's important to directly ask about suicidal thoughts, intent, and plan. This does not increase risk; instead, it helps identify the level of danger. Asking "why" (B) is judgmental, and (C) minimizes feelings

Q7. A client is undergoing ECT. Which action should the nurse take prior to the procedure?
A. Encourage the client to drink fluids.
B. Administer a large meal.
C. Ensure the client is NPO for 6–8 hours.
D. Place the client in a quiet environment.

Answer: C
Rationale: Clients must be NPO 6–8 hours prior to ECT to prevent aspiration during anesthesia. Fluids and meals before treatment are contraindicated.

Q8. Which symptom should a nurse expect in a patient experiencing **acute stress**?
A. Elevated temperature and flushed skin
B. Chest pain, GI upset, sweating, and headache
C. Euphoria and insomnia
D. Weight gain and slow heart rate

Answer: B
Rationale: Acute stress commonly presents with chest pain, GI upset, sweating, headaches, and palpitations.

Q9. Which intervention is most important when caring for a client having a **panic attack**?
A. Provide detailed explanations.
B. Stay with the client and use a calm voice.
C. Encourage physical exercise immediately.
D. Give a large meal to calm the patient.

Answer: B
Rationale: During panic attacks, the priority is safety and calming measures. Staying with the client and speaking calmly decreases fear.

Q10. A nurse is caring for a client on lithium therapy. Which finding indicates toxicity?
A. Increased urination and thirst
B. Vision changes and irregular heartbeat
C. Dry mouth and mild tremors
D. Mild weight gain

Answer: B
Rationale: Lithium toxicity signs include vision changes, irregular heartbeat, joint pain, and swelling. Mild thirst and urination are expected side effects.

Q11. Which finding requires immediate intervention in a client taking clozapine?
A. Drowsiness
B. Weight gain
C. Fever and sore throat
D. Constipation

Answer: C
Rationale: Clozapine can cause agranulocytosis. Infection symptoms like fever and sore throat require urgent reporting.

Q12. The nurse observes calluses on the knuckles of a client with normal weight. This is most consistent with:
A. Anorexia nervosa
B. Bulimia nervosa
C. Binge-eating disorder
D. Major depressive disorder

Answer: B
Rationale: Russell's sign (calluses on knuckles) occurs in bulimia due to repeated self-induced vomiting.

Q13. Which intervention is appropriate for a client with anorexia nervosa?
A. Allowing them to eat meals alone
B. Sitting with the client during meals and 1 hour after
C. Encouraging vigorous exercise after eating
D. Allowing unrestricted bathroom use after meals