

NCLEX-RN Foundations Foundation Worksheet

8 original questions, working space and separate answer explanations. Version 2026-10-27.

Scope

Selected entry-level RN reasoning and clinical-safety foundations under the 2026 test-plan framework.

This is an untimed foundation study sample, not an official examination or complete mock test. Author-reviewed learning materials; independent educator review and learner calibration remain pending.

How to use this worksheet

Work through the questions before opening the answer section. Write your calculation or the reason for your choice. After checking the explanation, return to the linked lesson for any unfamiliar distinction.

<https://openexam.site/exams/nclex-rn/worksheets/>

QUESTION 1 / Management of care: responsibility and judgment

A trained assistive worker can collect routine intake data for a stable client, but a new symptom has also been reported. Which nursing response best fits the stated findings and professional responsibility?

- A. Delegate the assessment of the new symptom because the worker is already collecting routine client measurements.
- B. Choose an available worker without confirming competence because the client's routine task is usually predictable.
- C. Verify the task and worker's competence, give clear directions, and retain nursing assessment, supervision and follow-up.
- D. Assign the task without follow-up because the trained worker accepts responsibility for reporting any serious problem.

Working / reasoning:

Item nclex-rn-delegation-stability-1 | Lesson: <https://openexam.site/exams/nclex-rn/learn/management-judgment/>

QUESTION 2 / Precautions across care transitions

An RN changes from a conversation to a procedure with splash risk. Which nursing response best fits the stated findings and professional responsibility?

- A. Use Standard Precautions for the task's anticipated exposure, adding indicated transmission-based measures.
- B. Use no basic precautions until a laboratory result confirms an infection requiring specific additional isolation measures.
- C. Begin the procedure first and select protective barriers only if blood or body fluid becomes visibly apparent.
- D. Select the same barriers for every procedure without considering what exposure or transmission risk the task creates.

Working / reasoning:

Item nclex-rn-standard-precautions-2 | Lesson: <https://openexam.site/exams/nclex-rn/learn/infection-care/>

QUESTION 3 / Prevention teaching that can be used

A client has difficulty accessing an agreed follow-up service. Which nursing response best fits the stated findings and professional responsibility?

- A. Give all clients an identical plan without checking personal history, resources or the ability to follow its instructions.
- B. Assess personal needs and barriers, then use current applicable guidance to agree on a feasible prevention plan.
- C. Select a universal screening interval from memory without checking whether current applicable guidance supports that interval.
- D. Treat handing over a pamphlet as completed education without checking the client's understanding or practical barriers.

Working / reasoning:

Item nclex-rn-prevention-plan-3 | Lesson: <https://openexam.site/exams/nclex-rn/learn/health-promotion/>

QUESTION 4 / Listen, de-escalate and support participation

A client says they feel unheard during a care discussion. Which nursing response best fits the stated findings and professional responsibility?

- A. Change the subject immediately so the client does not dwell on feelings the nurse cannot resolve quickly.
- B. Guarantee that everything will be fine before asking what the client fears about the situation or plan.
- C. Describe the feeling as irrational before hearing the client's account of the concern or its meaning.
- D. Acknowledge the expressed feeling and invite the client to explain the concern in their own words.

Working / reasoning:

Item nclex-rn-therapeutic-listening-4 | Lesson: <https://openexam.site/exams/nclex-rn/learn/psychosocial/>

QUESTION 5 / Individualized basic care and comfort

A client's current transfer plan requires help that is not yet available. Which nursing response best fits the stated findings and professional responsibility?

- A. Use visibly damaged mobility equipment temporarily because replacement would delay the planned activity or transfer.
- B. Follow yesterday's assistance level despite a new change in function and no review of current transfer needs.
- C. Attempt the transfer without the required assistance because the distance is short and the client wants to move now.
- D. Use the current assessed assistance level and obtain the required personnel and equipment before mobilizing.

Working / reasoning:

QUESTION 6 / Medication preparation and discrepancies

The sterility of an injection container is uncertain after handling. Which nursing response best fits the stated findings and professional responsibility?

- A. Clean the outside of the vial and assume the known contamination of its contents has thereby been reversed.
- B. Save the compromised supply for a less vulnerable patient rather than obtaining medication with verified appropriate sterility.
- C. Discard the compromised vial using the required procedure and obtain an appropriate uncontaminated medication supply.
- D. Use the contents because the solution is still clear and no contamination can be seen through the vial.

Working / reasoning:

QUESTION 7 / Risk: trends, results and preparation

A device reading conflicts with the client's visible condition. Which nursing response best fits the stated findings and professional responsibility?

- A. Ignore a worsening trend and new symptoms because one reading remains inside the laboratory's stated reference range.
- B. Use a single number as a complete diagnosis without considering measurement quality, baseline or current clinical findings.
- C. Compare the trend with baseline and symptoms, verify measurement quality, and escalate a concerning change.
- D. Substitute the typical baseline for the unusual result so that the record no longer shows a concerning trend.

Working / reasoning:

QUESTION 8 / Recognize deterioration and evaluate response

A client with an infection develops severe respiratory distress. Which nursing response best fits the stated findings and professional responsibility?

- A. Offer oral food or drink before obtaining help because comfort measures should precede evaluation of respiratory distress.
- B. Immediately assess the new breathing difficulty and activate urgent support using the authorized emergency pathway.
- C. Complete routine charting before assessing the new severe breathing difficulty because the earlier observations were stable.
- D. Provide reassurance without reassessment because the client was breathing comfortably earlier in the shift.

Working / reasoning:

Item nclex-rn-acute-breathing-4 | Lesson: <https://openexam.site/exams/nclex-rn/learn/physiological/>

NCLEX-RN Foundations: Answers & Explanations

Compare the method or rule as well as the final answer. These explanations are study aids, not official scoring guidance.

QUESTION 1 / nclex-rn-delegation-stability-1

Answer: Verify the task and worker's competence, give clear directions, and retain nursing assessment, supervision and follow-up.

1. Identify the current cue and relevant uncertainty: A trained assistive worker can collect routine intake data for a stable client, but a new symptom has also been reported.
2. A stable predictable task may be delegated when allowed by jurisdiction, facility policy and demonstrated competence. The RN evaluates the situation, gives clear directions and follows up; assessment and clinical decisions are not automatically transferred with the task.
3. Select the response that addresses that cue without an unsupported assumption: Verify the task and worker's competence, give clear directions, and retain nursing assessment, supervision and follow-up.

QUESTION 2 / nclex-rn-standard-precautions-2

Answer: Use Standard Precautions for the task's anticipated exposure, adding indicated transmission-based measures.

1. Identify the current cue and relevant uncertainty: An RN changes from a conversation to a procedure with splash risk.
2. Standard Precautions are the minimum approach across care settings. Assess the procedure's likely exposure and add transmission-based measures when indicated; the absence of a diagnosis does not establish absence of risk.
3. Select the response that addresses that cue without an unsupported assumption: Use Standard Precautions for the task's anticipated exposure, adding indicated transmission-based measures.

QUESTION 3 / nclex-rn-prevention-plan-3

Answer: Assess personal needs and barriers, then use current applicable guidance to agree on a feasible prevention plan.

1. Identify the current cue and relevant uncertainty: A client has difficulty accessing an agreed follow-up service.
2. Health promotion connects current evidence to the person's circumstances. Identify knowledge, access and preference barriers before agreeing on specific steps and checking understanding.

3. Select the response that addresses that cue without an unsupported assumption: Assess personal needs and barriers, then use current applicable guidance to agree on a feasible prevention plan.

QUESTION 4 / nclex-rn-therapeutic-listening-4

Answer: Acknowledge the expressed feeling and invite the client to explain the concern in their own words.

1. Identify the current cue and relevant uncertainty: A client says they feel unheard during a care discussion.
2. Therapeutic communication explores the person's experience without false reassurance or premature advice. Listening provides information for assessment and collaborative planning.
3. Select the response that addresses that cue without an unsupported assumption: Acknowledge the expressed feeling and invite the client to explain the concern in their own words.

QUESTION 5 / nclex-rn-mobility-assessment-1

Answer: Use the current assessed assistance level and obtain the required personnel and equipment before mobilizing.

1. Identify the current cue and relevant uncertainty: A client's current transfer plan requires help that is not yet available.
2. Safe mobility depends on the client's current ability, equipment and required assistance. Reassess a new limitation and obtain appropriate help rather than relying on routine alone.
3. Select the response that addresses that cue without an unsupported assumption: Use the current assessed assistance level and obtain the required personnel and equipment before mobilizing.

QUESTION 6 / nclex-rn-vial-contamination-2

Answer: Discard the compromised vial using the required procedure and obtain an appropriate uncontaminated medication supply.

1. Identify the current cue and relevant uncertainty: The sterility of an injection container is uncertain after handling.
2. A medication container with questionable sterility is not used. Follow the relevant pharmacy and infection-prevention procedure rather than trying to visually certify sterility.
3. Select the response that addresses that cue without an unsupported assumption: Discard the compromised vial using the required procedure and obtain an appropriate uncontaminated medication supply.

QUESTION 7 / nclex-rn-trend-context-3

Answer: Compare the trend with baseline and symptoms, verify measurement quality, and escalate a concerning change.

1. Identify the current cue and relevant uncertainty: A device reading conflicts with the client's visible condition.
2. Risk recognition uses current symptoms, measurement quality, baseline and direction of change. A single reassuring detail does not erase a concerning pattern.
3. Select the response that addresses that cue without an unsupported assumption: Compare the trend with baseline and symptoms, verify measurement quality, and escalate a concerning change.

QUESTION 8 / nclex-rn-acute-breathing-4

Answer: Immediately assess the new breathing difficulty and activate urgent support using the authorized emergency pathway.

1. Identify the current cue and relevant uncertainty: A client with an infection develops severe respiratory distress.
2. A new severe breathing problem requires prompt assessment and the facility emergency process. Follow training and authorized protocols while obtaining qualified help; routine work does not take priority.
3. Select the response that addresses that cue without an unsupported assumption: Immediately assess the new breathing difficulty and activate urgent support using the authorized emergency pathway.

References and scope notes

The questions and teaching explanations are original catalog materials. References support the selected concepts; they are not endorsements or a reproduced official examination bank.

NCLEX current test plans and 2026 RN plan

<https://www.nclex.com/test-plans>

CDC core infection prevention practices

<https://www.cdc.gov/infection-control/hcp/core-practices/index.html>

CDC safe injection practices

<https://www.cdc.gov/injection-safety/hcp/clinical-safety/index.html>

CDC sepsis overview

<https://www.cdc.gov/sepsis/about/index.html>

Federal care-assistance curriculum reference

<https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-483/subpart-D/section-483.152>

Partial RN foundations aligned to the 2026 plan effective April 2026–March 2029; not complete clinical or pharmacology coverage.

200 learning items comprise 184 contextual MCQs in 46 reasoning families and 16 exact fictional calculations in 4 families.

No NGN interaction fidelity, official partial-credit scoring, unfolding case simulation, CAT or official score prediction.

Calculations use supplied hypothetical quantities and are not real medication recommendations.

Clinical educator review, clinical protocol validation and learner calibration remain pending.

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