CPNRE Practice Test: 50 Free Questions with Answers

Original practice questions for the Canadian Practical Nurse Registration Examination (CPNRE), grouped like the 2022–2026 blueprint. Answer key and rationales start on a new page.

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Professional, ethical and legal practice 10 questions · 15–25% of the real exam

1. A caller says they are a close friend of a client and asks the LPN how the client is doing. What is the most appropriate response?

- **A.** Give a general update without the diagnosis
- **B.** Ask the caller to confirm the client's birth date
- **C.** Explain that sharing needs the client's consent
- **D.** Transfer the call so the charge nurse can answer

2. An LPN notices a mistake in an entry they made earlier in a client's paper chart. How should the LPN correct it?

- **A.** Cover the entry with correction fluid
- **B.** Draw one line through it, initial and date
- **C.** Remove the page and recopy the whole note
- **D.** Write over the entry so it is unreadable

3. An LPN realizes they gave a client a dose of metoprolol that was ordered for a different client. What should the LPN do first?

- **A.** Complete an incident report on the unit
- **B.** Tell the client's family about the error
- **C.** Give the right client their dose now
- **D.** Assess the client who received the dose

4. An RN asks an LPN to carry out a procedure the LPN has never been educated or assessed to perform. What should the LPN do?

- **A.** Decline and explain the gap in their competence
- **B.** Do the procedure while the RN watches closely
- **C.** Read the procedure online, then carry it out
- **D.** Ask a health care aide to perform it instead

5. A client who speaks limited English needs to consent to a procedure. The client's adult son offers to interpret. What is the best action?

A. Let the son interpret all of the details
B. Arrange a qualified medical interpreter
C. Explain using simple English and gestures
D. Ask the client to nod if they understand

6. During a shift, an LPN notices a colleague with slurred speech who smells of alcohol and is preparing medications. What should the LPN do?

A. Keep watching the colleague over a few shifts
B. Talk to the colleague privately after the shift
C. Report the concern to the manager right away
D. Ask other coworkers whether they noticed too

7. Which practice best protects client confidentiality on social media?

A. Post only clients' first names in stories
B. Share stories with identifying details removed
C. Keep work stories on a private account only
D. Never post any information about clients

8. When should an LPN document care they have provided?

A. As soon as possible after giving the care
B. At the end of the shift for every client
C. Before giving the care, to save time later
D. Only when something unusual has happened

9. A long-term care resident offers the LPN an expensive watch as thanks for their care. What is the most appropriate response?

A. Accept it so the resident is not offended
B. Thank the resident and politely decline it
C. Accept it and share it with the whole team
D. Accept it once the resident has moved home

10. A confused client keeps pulling at their IV line. What should the LPN try first?

A. Apply wrist restraints to protect the line
B. Request an order for a sedative medication
C. Try alternatives such as covering the IV site
D. Remove the IV until the client is calmer

Foundations of practice 33 questions · 60–70% of the real exam

11. Four hours after abdominal surgery, a client has the following findings. Which one should the LPN report immediately?

A. Incision pain rated 5 out of 10
B. Heart rate up from 84 to 124
C. Serous drainage on the dressing
D. Oral temperature of 37.6 °C

12. The parent of a 2-year-old with gastroenteritis gives the LPN an update. Which finding suggests the child is becoming dehydrated?

A. Crying with tears during diaper changes
B. Moist lips and a moist inside of the mouth
C. No wet diaper for the last eight hours
D. Eager to drink from a sippy cup when offered

13. An 84-year-old client with dementia has become much more confused and agitated since yesterday. What should the LPN do first?

A. Assess the client for signs of infection
B. Ask the family to stay with the client tonight
C. Request an order for a sedative medication
D. Apply mitts to keep the client from harm

14. Before giving a client's ordered digoxin, the LPN counts an apical pulse of 52 beats per minute. What should the LPN do?

A. Give the dose and recheck in an hour
B. Hold the dose and report the pulse
C. Give half the dose and document it
D. Recheck at the wrist and then give it

15. A client with type 1 diabetes has a blood glucose of 3.2 mmol/L. The client is alert and able to swallow. What is the LPN's first action?

A. Give the scheduled rapid-acting insulin
B. Recheck the blood glucose in one hour
C. Offer a sandwich with protein and fat
D. Give 15 g of fast-acting carbohydrate

16. A client says quietly, "I won't be a problem for anyone much longer." What is the most appropriate response by the LPN?

A. Ask the client directly about thoughts of suicide
B. Tell the client things will look better tomorrow
C. Change the subject to something more hopeful
D. Leave the client alone for some quiet time to rest

17. Two hours after a vaginal birth, the LPN finds the client's uterus soft and above the umbilicus, with heavy bleeding. What should the LPN do first?

A. Help the client walk to the bathroom
B. Increase the IV rate without an order
C. Massage the fundus until it is firm
D. Lay the client flat with both legs raised

18. A client is admitted on airborne precautions for suspected pulmonary tuberculosis. What does the LPN wear to enter the room?

A. A surgical mask with a face shield
B. A gown and gloves with no mask
C. A procedure mask tied at the back
D. A fit-tested N95 respirator mask

19. Ten minutes after a blood transfusion starts, the client reports chills and lower back pain. What is the LPN's first action?

A. Stop the transfusion immediately
B. Slow the rate and recheck it soon
C. Give acetaminophen for the chills
D. Cover the client with a blanket

20. A client with a new cast on the forearm reports pain that is getting worse despite medication, and the fingers feel cool and tingly. What should the LPN do?

A. Raise the arm and recheck it in one hour
B. Give a second dose of the ordered analgesic
C. Report the findings to the prescriber now
D. Apply ice packs over the outside of the cast

21. The order is acetaminophen 650 mg by mouth. The tablets available are 325 mg each. How many tablets does the LPN give?

A. 1 tablet
B. 1.5 tablets
C. 2 tablets
D. 3 tablets

22. The order is heparin 5,000 units subcutaneously. The vial contains 10,000 units/mL. How many millilitres does the LPN give?

A. 0.25 mL
B. 0.5 mL
C. 1 mL
D. 2 mL

23. An infusion of 1,000 mL normal saline is to run over 8 hours on a pump. At what rate does the LPN set the pump?

A. 80 mL/h
B. 100 mL/h
C. 125 mL/h
D. 150 mL/h

24. A child weighs 20 kg. Amoxicillin is ordered at 45 mg/kg/day in 3 divided doses. How much is each dose?

A. 150 mg
B. 300 mg
C. 450 mg
D. 900 mg

25. A client is taking warfarin. Which result should the LPN check before giving the next dose?

A. Check the client's INR result
B. Check the client's potassium level
C. Check the client's A1C result
D. Check the client's creatinine level

26. A client takes furosemide daily. Which finding is most important for the LPN to report?

A. A sodium of 139 mmol/L
B. A potassium of 3.1 mmol/L
C. A urine output of 60 mL/h
D. A blood pressure of 124/78

27. An hour after IV morphine, a client is very drowsy with a respiratory rate of 8 breaths per minute. What should the LPN do first?

A. Encourage the client to deep breathe and cough
B. Recheck the respiratory rate in 30 minutes
C. Stimulate the client and call for help now
D. Document the finding as an expected effect

28. An LPN is teaching a client how to use sublingual nitroglycerin for chest pain. Which instruction is correct?

A. Swallow the tablet whole with a glass of water
B. Keep the tablets in a clear daily pill organizer
C. Take up to six doses before seeking any help
D. Call 911 if pain lasts 5 minutes after a dose

29. Which type of insulin can be given intravenously?

A. Regular insulin, a short-acting insulin
B. Insulin NPH, an intermediate-acting insulin
C. Insulin glargine, a long-acting insulin
D. Insulin detemir, a long-acting insulin

30. A client with COPD is short of breath. Which position will help them breathe most easily?

A. Lying flat on the back with one pillow
B. Sitting up and leaning slightly forward
C. Side-lying with the head of the bed flat
D. Trendelenburg with the legs raised

31. An LPN is leaving the room of a client on contact and droplet precautions. In what order is personal protective equipment removed?

A. Gown, mask, gloves, eye protection
B. Mask, gloves, gown, eye protection
C. Gloves, gown, eye protection, mask
D. Eye protection, mask, gown, gloves

32. Which description matches a stage 2 pressure injury?

A. Intact skin with redness that does not blanch
B. Full-thickness loss with exposed bone or tendon
C. Full-thickness loss with visible fatty tissue
D. Partial-thickness loss with a shallow open area

33. Which action best helps prevent pressure injuries in a client who cannot move in bed?

A. Reposition the client at least every 2 hours
B. Massage red areas over the bony prominences
C. Keep the head of the bed raised to 60 degrees
D. Place a donut cushion under the client's sacrum

34. Which skill would the LPN expect a typically developing 9-month-old to have?

A. Walks alone across a large room
B. Pulls to stand holding onto furniture
C. Speaks in short two-word phrases
D. Builds a tower of six small blocks

35. A parent asks how to place their newborn's car seat. What does the LPN advise?

A. Forward-facing in the front passenger seat
B. Forward-facing in the back seat of the car
C. Rear-facing in the back seat of the car
D. Rear-facing in the front passenger seat

36. A mother asks how she will know her breastfed baby is getting enough milk. Which sign is reassuring after the first week?

A. Losing 15% of birth weight in week one
B. Feeding no more often than every 4 hours
C. Sleeping through the night at one week
D. Six or more wet diapers in each 24 hours

37. Which intervention best reduces the risk of falls for an older adult in hospital?

A. Keep the bed in its lowest position

B. Raise all four bed rails overnight

C. Offer a sleeping pill at bedtime

D. Limit fluids after the evening meal

38. A client is having a panic attack, breathing fast and saying they feel they are dying. What should the LPN do first?

A. Leave the client to rest in a quiet room

B. Stay with the client and speak calmly

C. Teach new coping skills during the attack

D. Ask the client to explain what caused it

39. A client takes lithium. Which finding suggests lithium toxicity and should be reported?

A. Gradual weight gain over several months

B. A slightly dry mouth on waking each day

C. Vomiting, diarrhea and a coarse tremor

D. Mild thirst on a very hot afternoon

40. A nasogastric tube has just been inserted for feeding. What is the most reliable way to confirm its placement before the first feed?

A. Listen over the stomach while injecting air

B. Check that the client can still speak clearly

C. Look at the colour of the fluid aspirated

D. Confirm the placement with an x-ray first

41. Which finding is most typical of left-sided heart failure?

A. Crackles heard in both lung bases

B. Swelling in both feet and ankles

C. An enlarged liver on assessment

D. Distended neck veins when upright

42. A client suddenly develops a facial droop and slurred speech. What should the LPN do?

A. Let the client rest and recheck in an hour

B. Report it at once and note when it started

C. Give acetaminophen for the client's headache

D. Offer fluids in case the client is dehydrated

43. A dying client has noisy, gurgling breathing, and the family is upset by the sound. What should the LPN do?

A. Suction the mouth deeply every 15 minutes

B. Give sips of fluid to loosen the secretions

C. Ask the family to wait outside the room

D. Reposition the client and explain the sound

Collaborative practice 7 questions · 10–20% of the real exam

44. An order reads 10 mg of a medication that the LPN knows is usually given as 1 mg. What should the LPN do?

A. Give the dose as it is written in the order
B. Give the usual dose and document the reason
C. Ask a coworker whether the dose looks right
D. Clarify the order with the prescriber first

45. Three days after a stroke, a client coughs every time they drink water. What is the most appropriate action by the LPN?

A. Hold fluids and request a swallowing assessment
B. Give fluids through a straw to slow each sip
C. Remind the client to drink more slowly each time
D. Thicken all fluids using the unit's supplies

46. An LPN calls a physician using SBAR about a client after surgery. Which statement is the "Recommendation"?

A. "His blood pressure is now 82/50."
B. "He had a hip replacement yesterday."
C. "I think he may be bleeding internally."
D. "Please come and assess him right now."

47. Which approach to shift handover best supports client safety?

A. Give report at the bedside where possible
B. Give report in the hallway to save time
C. Leave a written note and skip verbal report
D. Report only on clients whose status changed

48. Which client is most appropriate for the LPN to assign to a health care aide?

A. A client newly admitted with chest pain
B. A stable client who needs help with bathing
C. A client due for a first dose of insulin
D. A client who returned from surgery an hour ago

49. A physician speaks rudely to an LPN in front of a client. What is the most professional response?

A. Answer in the same tone to stand firm
B. Ignore it and never raise it with anyone
C. Speak with the physician privately later
D. Complain about it to the client's family

50. A client newly diagnosed with type 2 diabetes asks for detailed help planning meals. Which referral is most appropriate?

A. Refer the client to an occupational therapist

B. Refer the client to the unit pharmacist

C. Refer the client to a hospital social worker

D. Refer the client to a registered dietitian

Answer key and rationales

1. Answer: C. Health information belongs to the client, and it is shared only with the client's consent. Even a "general update" confirms the person is a patient. Knowing a birth date does not give the caller a right to information, and the charge nurse is bound by the same rule, so passing the call on does not solve the problem.

2. Answer: B. A single line keeps the original entry readable, and the initials and date show who corrected it and when. The chart is a legal record: covering, removing or obliterating an entry looks like hiding information, even when the intent is honest.

3. Answer: D. Client safety comes first. Metoprolol can lower the heart rate and blood pressure, so the client who received it is assessed, including vital signs, and the error is reported to the prescriber and the nurse in charge. The incident report and disclosure follow policy afterwards; they never come before checking on the client.

4. Answer: A. An LPN only performs activities they are educated and competent to do, whoever asks. Declining and explaining lets the team find someone who is competent and plan any learning needed. Supervision does not create competence, a quick online read is not education, and passing the task to a health care aide moves it to someone with even less preparation.

5. Answer: B. Informed consent depends on the client truly understanding, and a trained medical interpreter gives accurate, neutral interpretation. Family members may filter or soften information and may have their own interests. Simple English, gestures and nodding cannot confirm understanding of risks and alternatives.

6. Answer: C. An impaired colleague preparing medications is an immediate risk to clients, so the concern is reported to the person in charge right away. Waiting until after the shift or over several shifts leaves clients at risk, and asking coworkers spreads the concern without protecting anyone.

7. Answer: D. The safe standard is not to post client information at all. Removing names or details is not enough: a unit, a date or an unusual situation can still identify someone, and private accounts can be screenshotted and shared.

8. Answer: A. Documentation should be timely: as soon as possible after the care, while details are accurate and the record is useful to the rest of the team. End-of-shift charting invites errors and gaps, charting in advance records care that may not happen, and routine care must be documented too.

9. Answer: B. Accepting a valuable gift blurs the professional boundary and can create a sense of obligation or the appearance of exploitation. The LPN thanks the resident warmly and declines. Accepting it for the team, or later, does not remove the boundary problem.

10. Answer: C. Restraints, physical or chemical, are a last resort. The least restrictive measures come first: covering or securing the site, reorienting the client, and looking for a cause of the distress. Removing the IV interrupts ordered therapy without solving the problem.

11. Answer: B. A sharp rise in heart rate soon after surgery can be the first sign of bleeding or shock, and it needs to be reported now. Moderate incision pain is expected and is managed with the ordered analgesia. A small amount of serous drainage is normal early on, and a temperature of 37.6 °C in the first day is common and is monitored.

12. Answer: C. A marked drop in urine output, such as no wet diaper for many hours, is one of the earliest reliable signs of dehydration in a young child and should be reported. Tears, moist mucous membranes and a child who is keen to drink all point to adequate hydration.

13. Answer: A. A sudden change over a day or two is not the slow course of dementia. It suggests delirium, and infection, often urinary or respiratory, is a common cause in older adults. Assessing comes before anything else. Sedation and restraints can make delirium worse, and family support helps but does not find the cause.

14. Answer: B. Digoxin slows the heart rate, and an apical pulse below 60 in an adult is the usual threshold to hold the dose and report, unless the prescriber has set a different parameter. Giving the full dose risks worsening bradycardia, the LPN cannot change the dose on their own, and a radial pulse is less accurate than the apical count already taken.

15. Answer: D. A glucose below 4.0 mmol/L is hypoglycemia. For a conscious client who can swallow, the treatment is 15 g of fast-acting carbohydrate, such as juice or glucose tablets, then a recheck in 15 minutes. Fat and protein slow absorption, waiting an hour delays treatment, and giving insulin would lower the glucose further.

16. Answer: A. A statement like this can signal suicidal thinking. Asking directly does not plant the idea; it opens the conversation and lets the LPN assess risk and report it. False reassurance and changing the subject shut the client down, and leaving the client alone could leave them at risk.

17. Answer: C. A soft (boggy) uterus with heavy bleeding means the uterus is not contracting, the most common cause of postpartum hemorrhage. Fundal massage helps it contract and is the first action, followed by reporting. A full bladder can contribute, but walking a bleeding client is unsafe; changing an IV rate needs an order; and positioning does not stop the bleeding.

18. Answer: D. Tuberculosis spreads by tiny airborne particles that stay suspended in the air. A fit-tested N95 respirator filters them; surgical and procedure masks do not seal well enough. Gowns and gloves are for contact precautions and add nothing against airborne spread on their own.

19. Answer: A. Chills and back pain early in a transfusion can signal a hemolytic reaction, which can be life-threatening. The transfusion is stopped at once, the line kept open with normal saline as per policy, and the reaction reported. Slowing the rate still delivers incompatible blood, and treating the symptoms hides the cause.

20. Answer: C. Pain out of proportion to the injury that analgesia does not relieve, with coolness and tingling, are warning signs of compartment syndrome, a surgical emergency. They are reported immediately. Waiting an hour or giving more analgesic delays treatment, and ice does not relieve the pressure inside the cast.

21. Answer: C. Divide the dose ordered by the strength on hand: 650 mg ÷ 325 mg = 2 tablets.

22. Answer: B. Dose ordered ÷ concentration = volume: 5,000 units ÷ 10,000 units/mL = 0.5 mL. Heparin is a high-alert medication, so many settings require an independent double-check.

23. Answer: C. Total volume ÷ time = rate: 1,000 mL ÷ 8 h = 125 mL/h.

24. Answer: B. First the daily dose: 45 mg × 20 kg = 900 mg per day. Divided into 3 doses: 900 mg ÷ 3 = 300 mg per dose. 900 mg is the whole day's amount, a common error.

25. Answer: A. Warfarin's effect is monitored with the INR (international normalized ratio). A result above the ordered range raises bleeding risk and is reported before giving the dose. The other tests monitor different conditions.

26. Answer: B. Furosemide is a loop diuretic that causes potassium loss. A potassium of 3.1 mmol/L is low and raises the risk of dangerous heart rhythms. The sodium, urine output and blood pressure are within expected ranges.

27. Answer: C. Sedation with a respiratory rate of 8 signals opioid-induced respiratory depression, an emergency. The LPN tries to rouse the client, stays with them and calls for help so the team can act, which may include an ordered opioid antagonist. Waiting or documenting it as expected delays care.

28. Answer: D. Clients are taught to call 911 if chest pain is not relieved, or is getting worse, 5 minutes after the first dose, as their prescriber directs. The tablet dissolves under the tongue rather than being swallowed, and it is stored in its original dark container because light and air weaken it.

29. Answer: A. Regular (short-acting) insulin is the type used intravenously, for example in an insulin infusion. Long-acting and intermediate-acting insulins are given subcutaneously only.

30. Answer: B. Sitting upright and leaning forward lets the diaphragm move more freely and makes accessory muscles more effective. Lying flat or with the head down pushes abdominal contents against the diaphragm and makes breathing harder.

31. Answer: C. Gloves are the most contaminated, so they come off first, then the gown, with hand hygiene, then facial protection (eye protection, then mask), followed by hand hygiene again. Removing the mask or eye protection with contaminated gloves still on risks touching the face.

32. Answer: D. Stage 2 is partial-thickness skin loss with exposed dermis, often a shallow open area or an intact blister. Non-blanchable redness on intact skin is stage 1; visible fat is stage 3; exposed bone or tendon is stage 4.

33. Answer: A. Regular repositioning relieves pressure over bony areas. Massaging reddened skin can damage tissue, raising the head of the bed high increases shear on the sacrum, and donut cushions concentrate pressure around the ring.

34. Answer: B. Pulling to stand while holding furniture is typical around 9 months. Walking alone usually comes around 12 to 15 months, two-word phrases around 2 years, and a six-block tower around 2 years.

35. Answer: C. Infants ride rear-facing in the back seat, which best protects the head, neck and spine. A rear-facing seat must never go in front of an active airbag, and forward-facing is for older, larger children within the seat's limits.

36. Answer: D. Once milk is established, six or more wet diapers a day is a reassuring sign of good intake. Newborns usually feed 8 or more times in 24 hours, sleeping through the night at one week is not expected, and a loss of 15% of birth weight is too much and needs follow-up.

37. Answer: A. A low bed reduces injury if the client gets up or falls. Four raised rails can lead to climbing over them and worse falls, sedatives increase fall risk, and restricting fluids risks dehydration and confusion.

38. Answer: B. During a panic attack the priority is safety and reassurance: stay, use a calm voice and short sentences, and help slow the breathing. Leaving the client alone increases fear, and teaching or exploring causes waits until the anxiety has eased.

39. Answer: C. Vomiting, diarrhea and a coarse tremor are signs of lithium toxicity and need prompt reporting and a lithium level. Weight gain, a dry mouth and mild thirst are common side effects that are monitored but are not signs of toxicity on their own.

40. Answer: D. An x-ray is the most reliable confirmation of a newly inserted feeding tube before anything is given through it. Listening for air is unreliable, the ability to speak does not rule out airway placement, and aspirate colour alone is not conclusive.

41. Answer: A. When the left ventricle fails, blood backs up into the lungs, causing crackles and shortness of breath. Ankle swelling, an enlarged liver and distended neck veins are typical of right-sided failure, where blood backs up into the body.

42. Answer: B. Sudden facial droop and slurred speech suggest a stroke, and treatment depends on time. The LPN reports immediately and notes when symptoms started. Waiting, medicating or giving fluids by mouth delays care, and fluids risk aspiration if swallowing is affected.

43. Answer: D. Noisy breathing near death is usually from secretions the client can no longer clear, and it is rarely distressing to the client. Turning the client to the side often helps, and explaining the sound supports the family. Deep frequent suctioning causes distress, excluding the family is not person-centred, and fluids risk aspiration.

44. Answer: D. A dose ten times the usual amount may be a transcription or decimal error. The LPN is accountable for every dose given and must clarify a questionable order with the prescriber before acting. Following it blindly is unsafe, the LPN cannot change the dose on their own, and a coworker's opinion does not replace the prescriber's clarification.

45. Answer: A. Coughing with thin fluids after a stroke suggests dysphagia and a risk of aspiration. Oral fluids are held and the finding is reported so the team can arrange a swallowing assessment, usually by a speech-language pathologist, who decides the safe texture. Straws can increase aspiration risk, and thickening fluids without an assessment or order guesses at the answer.

46. Answer: D. SBAR stands for Situation, Background, Assessment and Recommendation. The blood pressure is the Situation, the surgery is the Background, the concern about bleeding is the Assessment, and asking the physician to come now is the Recommendation: the specific action the LPN is requesting.

47. Answer: A. Bedside handover lets both nurses see the client and the equipment, and lets the client correct or add information. Hallway reports risk privacy breaches, a note alone allows no questions, and leaving out stable clients means the next nurse lacks a full picture.

48. Answer: B. Health care aides can take on predictable, routine care for stable clients, such as help with bathing. New chest pain and a fresh post-operative client need ongoing nursing assessment, and medication administration stays with the nurse.

49. Answer: C. Raising the concern privately and calmly keeps the client out of the conflict and gives the working relationship a chance to improve. Responding in kind escalates it, ignoring it lets the behaviour continue, and involving the family is unprofessional. If it continues, the LPN follows the employer's policy.

50. Answer: D. Detailed meal planning is the expertise of a registered dietitian. A pharmacist advises on medications, a social worker on social and financial supports, and an occupational therapist on daily-living function.

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