DELEGATION HEALTH MANAGEMENT PRACTICE EXAM (SAMPLE)

STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

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Introduction

Preparing for a certification exam can feel overwhelming, but with the right tools, it becomes an opportunity to build confidence, sharpen your skills, and move one step closer to your goals. At Examzify, we believe that effective exam preparation isn't just about memorization, it's about understanding the material, identifying knowledge gaps, and building the test-taking strategies that lead to success.

This guide was designed to help you do exactly that.

Whether you're preparing for a licensing exam, professional certification, or entry-level qualification, this book offers structured practice to reinforce key concepts. You'll find a wide range of multiple-choice questions, each followed by clear explanations to help you understand not just the right answer, but why it's correct.

The content in this guide is based on real-world exam objectives and aligned with the types of questions and topics commonly found on official tests. It's ideal for learners who want to:

- Practice answering questions under realistic conditions,
- Improve accuracy and speed,
- Review explanations to strengthen weak areas, and
- Approach the exam with greater confidence.

We recommend using this book not as a stand-alone study tool, but alongside other resources like flashcards, textbooks, or hands-on training. For best results, we recommend working through each question, reflecting on the explanation provided, and revisiting the topics that challenge you most.

Remember: successful test preparation isn't about getting every question right the first time, it's about learning from your mistakes and improving over time. Stay focused, trust the process, and know that every page you turn brings you closer to success.

Let's begin.

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How to Use This Guide

This guide is designed to help you study more effectively and approach your exam with confidence. Whether you're reviewing for the first time or doing a final refresh, here's how to get the most out of your Examzify study guide:

1. Start with a Diagnostic Review

Skim through the questions to get a sense of what you know and what you need to focus on. Your goal is to identify knowledge gaps early.

2. Study in Short, Focused Sessions

Break your study time into manageable blocks (e.g. 30 – 45 minutes). Review a handful of questions, reflect on the explanations.

3. Learn from the Explanations

After answering a question, always read the explanation, even if you got it right. It reinforces key points, corrects misunderstandings, and teaches subtle distinctions between similar answers.

4. Track Your Progress

Use bookmarks or notes (if reading digitally) to mark difficult questions. Revisit these regularly and track improvements over time.

5. Simulate the Real Exam

Once you're comfortable, try taking a full set of questions without pausing. Set a timer and simulate test-day conditions to build confidence and time management skills.

6. Repeat and Review

Don't just study once, repetition builds retention. Re-attempt questions after a few days and revisit explanations to reinforce learning. Pair this guide with other Examzify tools like flashcards, and digital practice tests to strengthen your preparation across formats.

There's no single right way to study, but consistent, thoughtful effort always wins. Use this guide flexibly, adapt the tips above to fit your pace and learning style. You've got this!

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Questions

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1. A client has a respiratory rate of 4 breaths/min. What should the nurse prioritize in assessments?

A. Arterial blood gas (ABG) and breath sounds.

B. Level of consciousness and a pulse oximetry value.

C. Breath sounds and reflexes.

D. Pulse oximetry value and heart sounds.

2. If an emergency client shows respiratory distress after a burn, what is the primary goal of care?

A. Providing pain relief.

B. Maintaining airway patency.

C. Assessing the burn extent.

D. Collecting a detailed history.

3. In which condition should the nurse be vigilant with oxygen therapy during labor for the client?

A. preterm labor

B. gestational diabetes

C. sickle cell anemia

D. preeclampsia

4. In the event of a building collapse, which victim should the nurse care for first?

A. A victim with an open fracture of the left lower extremity

B. A victim who is crying hysterically and complaining of pain in the right ankle

C. A victim who is unresponsive and not breathing with a fixed and dilated left pupil

D. A victim with an apparent chest wall defect and asymmetrical chest wall movement

5. In the case of a client with upper GI bleeding, what is the priority nursing action?

A. Obtain vital signs.

B. Ask the client about preceding events.

C. Complete an abdominal physical assessment.

D. Insert a nasogastric (NG) tube.

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6. What is the priority assessment during the fourth stage of labor?

A. Assessing the uterine fundus and lochia

B. Checking the mother's temperature

C. Encouraging food and fluid intake

D. Providing privacy for the parents and their newborn infant

7. What should a nurse do upon observing ecchymosis in various stages of healing on a 75-year-old client?

A. Notify the nursing supervisor.

B. Notify the health care provider.

C. Inquire how these bruises occurred.

D. Document the findings.

8. What is contraindicated during a seizure to maintain the client's airway?

A. Loosening clothing

B. Forcing the jaw open

C. Ensuring the environment is clear

D. Turning the client on their side

9. For which client should the nurse instruct the assistive personnel (AP) to use an electric razor for shaving?

A. The client with hypokalemia related to diuretic therapy

B. The client with an elevated white blood cell count related to infection

C. The client with severe pain related to osteoporosis

D. The client with thrombocytopenia related to chemotherapy

10. Which personnel is most suitable for tasks requiring advanced patient assessments?

A. Assistive personnel.

B. Licensed practical nurses.

C. Registered nurses.

D. Nurse assistants.

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Answers

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1. B
2. B
3. C
4. D
5. A
6. A
7. C
8. B
9. C
10. C

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Explanations

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1. A client has a respiratory rate of 4 breaths/min. What should the nurse prioritize in assessments?

A. Arterial blood gas (ABG) and breath sounds.

B. Level of consciousness and a pulse oximetry value.

C. Breath sounds and reflexes.

D. Pulse oximetry value and heart sounds.

In the context of a respiratory rate as low as 4 breaths per minute, the most critical priority assessments should include the level of consciousness and a pulse oximetry value. A respiratory rate this low signifies severe respiratory distress and potential hypoventilation, which can lead to inadequate oxygenation of the body and a buildup of carbon dioxide. The level of consciousness is crucial to assess because a decreased consciousness level can indicate hypoxia or hypercapnia (elevated carbon dioxide levels), which can further compromise the individual's condition. Assessing the level of consciousness allows the nurse to gauge how well the brain is being supplied with oxygen and to detect signs of respiratory failure early. Pulse oximetry is also essential because it provides immediate, non-invasive information about the client's oxygen saturation levels. This measurement directly reflects the efficacy of the client's respiratory function and indicates whether the client is experiencing hypoxemia (low blood oxygen levels). Timely monitoring through pulse oximetry can help guide further interventions, such as administering supplemental oxygen or preparing for more advanced respiratory support. Thus, prioritizing these two assessments helps the nurse quickly identify life-threatening conditions and intervene appropriately to stabilize the client.

2. If an emergency client shows respiratory distress after a burn, what is the primary goal of care?

A. Providing pain relief.

B. Maintaining airway patency.

C. Assessing the burn extent.

D. Collecting a detailed history.

In emergency situations involving a client who is showing respiratory distress after a burn, the primary goal of care is to maintain airway patency. This is critical because burns, especially those involving the face or the airway, can lead to swelling and obstruction. Ensuring that the airway remains open is essential for adequate oxygenation and ventilation, which can be life-saving. Addressing respiratory distress directly impacts the patient's ability to breathe and maintain adequate oxygen levels in the blood. If the airway is compromised, no other interventions can effectively safeguard the patient's health; thus, this becomes the top priority. While providing pain relief, assessing the burn extent, and collecting a detailed history are also important components of care, they are secondary to ensuring that the airway remains unobstructed. Pain management can alleviate suffering but does not address the immediate risk to life posed by compromised airways. Similarly, knowing the extent of the burn and collecting patient history are necessary for therapeutics and long-term management but should follow the stabilization of the airway.

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3. In which condition should the nurse be vigilant with oxygen therapy during labor for the client?

A. preterm labor

B. gestational diabetes

C. sickle cell anemia

D. preeclampsia

Oxygen therapy during labor is particularly crucial for clients with sickle cell anemia due to the underlying pathophysiology of the condition. Sickle cell anemia can lead to vaso-occlusive crises, where sickled red blood cells obstruct blood vessels, resulting in significant pain and compromised oxygen delivery to tissues. During labor, the body's oxygen demand increases, and any compromise in oxygen supply can exacerbate the situation for a client with this condition. The risk of hypoxia is heightened during labor, as the stress of contractions and potential maternal hypovolemia can further reduce oxygenation. Therefore, maintaining adequate oxygen levels is critical to prevent complications such as maternal or fetal distress. Administering supplemental oxygen can help mitigate these risks and ensure that both the mother and fetus receive sufficient oxygen, supporting optimal outcomes during labor. While the other conditions mentioned may require monitoring and care, they do not present the same immediate risks related to oxygenation that sickle cell anemia poses during labor.

4. In the event of a building collapse, which victim should the nurse care for first?

A. A victim with an open fracture of the left lower extremity

B. A victim who is crying hysterically and complaining of pain in the right ankle

C. A victim who is unresponsive and not breathing with a fixed and dilated left pupil

D. A victim with an apparent chest wall defect and asymmetrical chest wall movement

The choice of caring for the victim with an apparent chest wall defect and asymmetrical chest wall movement first is rooted in the principles of triage and prioritizing life-threatening conditions. This scenario is indicative of a potential compromise to the victim's respiratory system, possibly due to a pneumothorax or severe chest trauma, which can quickly lead to respiratory failure and death if not addressed immediately. In disaster situations, healthcare providers are trained to assess patients based on the severity of their injuries and the immediacy of medical intervention required. Victims with airway or breathing issues, such as those with chest wall defects, have the highest priority because their condition can deteriorate rapidly, making timely intervention critical to improve their chances of survival. While the other victims may have significant injuries or distress, they do not present with an immediate life threat status that compromises breathing as clearly as the victim with the chest wall defect does. Therefore, the urgency associated with managing the airway and breathing compels the nurse to prioritize this victim.

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5. In the case of a client with upper GI bleeding, what is the priority nursing action?

A. Obtain vital signs.

B. Ask the client about preceding events.

C. Complete an abdominal physical assessment.

D. Insert a nasogastric (NG) tube.

In the case of a client presenting with upper GI bleeding, the priority nursing action is to obtain vital signs. This is crucial for several reasons. First, vital signs provide immediate insights into the client's hemodynamic stability. In cases of upper GI bleeding, the client may be at risk for hypovolemic shock due to blood loss. Monitoring vital signs, including heart rate, blood pressure, and respiratory rate, allows the nurse to assess the severity of the bleeding and to determine if the client is experiencing symptoms of shock, such as tachycardia or hypotension. Gathering this information promptly helps guide subsequent interventions, such as fluid resuscitation or notifying the healthcare provider of a critical status. Once vital signs are assessed, the nurse can then prioritize other actions, such as evaluating the client's history or completing a physical assessment, but immediate evaluation of vital signs is essential to ensure the client's safety in a potentially life-threatening situation.

6. What is the priority assessment during the fourth stage of labor?

A. Assessing the uterine fundus and lochia

B. Checking the mother's temperature

C. Encouraging food and fluid intake

D. Providing privacy for the parents and their newborn infant

During the fourth stage of labor, which lasts approximately the first one to two hours postpartum, the priority assessment involves evaluating the uterine fundus and lochia. This stage is critical for closely monitoring the mother's condition after the delivery of the placenta, as it is a time when postpartum hemorrhage can occur. Assessing the uterine fundus helps determine whether it is firm and contracted, which is essential for preventing excessive bleeding. A firm fundus indicates that the uterus is effectively constricting blood vessels that were previously connected to the placenta. If the fundus is boggy or soft, it raises concern for potential hemorrhage, necessitating immediate interventions such as uterine massage or medications like oxytocin to promote uterine contraction. Monitoring lochia provides insight into the mother's bleeding pattern. Normal lochia is expected after delivery, but a sudden increase or change in color or smell can indicate complications. While checking the mother's temperature, encouraging food and fluid intake, and ensuring privacy are certainly important components of postpartum care, they are secondary to the immediate need for assessing the uterine fundus and lochia during this critical recovery phase. This priority assessment directly addresses the most significant risks present right after childbirth.

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7. What should a nurse do upon observing ecchymosis in various stages of healing on a 75-year-old client?

A. Notify the nursing supervisor.

B. Notify the health care provider.

C. Inquire how these bruises occurred.

D. Document the findings.

Inquiring how the bruises occurred is a crucial step in the nursing process when observing ecchymosis, especially in an older adult. This approach allows the nurse to gather vital information about the patient's condition, which can lead to a better understanding of potential causes. Ecchymosis in multiple stages of healing can suggest various underlying factors, including trauma, coagulopathy, or risks related to falls—common concerns in elderly patients. By asking about the circumstances surrounding the bruises, the nurse can assess for any potential risk factors or incidents that may require further investigation or intervention. Understanding the cause can aid in planning appropriate care and determining if additional evaluations or referrals are necessary to ensure the patient's safety and well-being. Documentation, notifying supervisors or healthcare providers, while important, doesn't directly engage with the immediate need to assess the situation at hand. Gathering contextual information enhances the holistic approach to patient management, ensuring that all aspects of the client's health are considered and addressed promptly.

8. What is contraindicated during a seizure to maintain the client's airway?

A. Loosening clothing

B. Forcing the jaw open

C. Ensuring the environment is clear

D. Turning the client on their side

Forcing the jaw open during a seizure is contraindicated as it poses significant risks to both the individual experiencing the seizure and the person attempting to assist. This action can lead to injury, such as broken teeth, jaw dislocation, or harm to the person providing assistance. Moreover, it does not effectively maintain the airway and may introduce other hazards, such as accidental choking if the person bites down. In contrast, loosening clothing helps provide comfort and ensure that the person has room to breathe more easily. Ensuring the environment is clear is also important to prevent injury from nearby objects. Turning the client on their side is a key practice during a seizure, as it prevents aspiration and facilitates easier breathing by allowing any fluids to drain from the mouth. Hence, avoiding actions that can lead to injury or complication is crucial during a seizure event, especially concerning airway management.

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9. For which client should the nurse instruct the assistive personnel (AP) to use an electric razor for shaving?

A. The client with hypokalemia related to diuretic therapy

B. The client with an elevated white blood cell count related to infection

C. The client with severe pain related to osteoporosis

D. The client with thrombocytopenia related to chemotherapy

The most appropriate choice for instructing the assistive personnel to use an electric razor for shaving is the client with thrombocytopenia related to chemotherapy. This client has a reduced platelet count, which raises the risk of bleeding due to even minor cuts or nicks during shaving. Electric razors are safer for this situation because they reduce the likelihood of cutting the skin compared to traditional razors. Using an electric razor minimizes the risk of injury, aligning with the nursing responsibility to ensure client safety. This is particularly important in clients who have conditions that can lead to increased bleeding or delayed healing. Comparatively, the other clients may have different needs or considerations that do not necessitate the use of an electric razor. While hypokalemia, elevated white blood cell counts, and severe pain may require careful management, they do not present the same immediate risks associated with shaving as thrombocytopenia does. Therefore, the recommendation to use an electric razor is specifically tailored to the safety needs of the individual with a reduced platelet count.

10. Which personnel is most suitable for tasks requiring advanced patient assessments?

A. Assistive personnel.

B. Licensed practical nurses.

C. Registered nurses.

D. Nurse assistants.

Registered nurses are the most suitable personnel for tasks requiring advanced patient assessments due to their extensive education and training. They hold a minimum of an associate degree in nursing, though many have a bachelor's degree, which encompasses a comprehensive curriculum that includes anatomy, physiology, pharmacology, and a range of clinical skills. This education equips them with the critical thinking and clinical judgment necessary to perform in-depth assessments of patients, interpret complex data, and formulate care plans. Moreover, registered nurses are licensed professionals, which allows them to take on a multitude of responsibilities, including making independent decisions regarding patient care. Their role often involves collaborating with physicians and other healthcare providers, as well as educating patients about their health conditions and care plans, all of which require a solid foundation in patient assessments. In contrast, personnel such as assistive personnel, licensed practical nurses, and nurse assistants have varying levels of training and scope of practice that typically do not cover advanced patient assessment. While they play essential roles in patient care, their duties are usually more limited and focused on fundamental support tasks, rather than comprehensive evaluations of patient health status. This distinction clearly highlights why registered nurses are the appropriate choice for advanced assessment tasks.

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Next Steps

Congratulations on reaching the final section of this guide. You've taken a meaningful step toward passing your certification exam and advancing your career.

As you continue preparing, remember that consistent practice, review, and self-reflection are key to success. Make time to revisit difficult topics, simulate exam conditions, and track your progress along the way.

If you need help, have suggestions, or want to share feedback, we'd love to hear from you. Reach out to our team at hello@examzify.com.

Or visit your dedicated course page for more study tools and resources:

https://delegationhealthmgmt.examzify.com

We wish you the very best on your exam journey. You've got this!

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