EAQ FUNDAMENTALS OF NURSING LEVEL 2 PRACTICE TEST (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. What does surgical asepsis aim to accomplish during a dressing change?

A. Confines microorganisms to the surgical site.

B. Keeps the area free of microorganisms.

C. Protects self from microorganisms in the wound.

D. Reduces risk for growing opportunistic microorganisms.

2. How should medication errors be reported in a healthcare setting?

A. By discussing them directly with the patients

B. According to organizational policy and procedures

C. Through a public announcement

D. By ignoring them if they seem minor

3. What is a critical care intervention for a patient with respiratory difficulties?

A. Encouraging them to eat solid foods immediately

B. Restricting their movement

C. Providing supplemental oxygen as needed

D. Discouraging fluid intake

4. Which medication should not be administered as an IV bolus due to the risk of cardiac arrest?

A. Saline flush

B. Naloxone (Narcan)

C. Adenosine (Adenocard)

D. Potassium chloride

5. What should be monitored in a patient taking beta-blockers?

A. Fluid intake and output

B. Heart rate and blood pressure

C. Respiratory rate

D. Serum electrolyte levels

6. What is a common sign of dehydration in an elderly patient?

A. Increased appetite

B. Decreased urine output

C. Bright, clear skin

D. Enhanced cognitive function

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7. When is it important to start rehabilitation planning for a patient?

A. After surgery

B. At the time of discharge

C. During initial assessment

D. Upon admission to the hospital

8. What is the normal range for adult blood glucose levels?

A. 60-80 mg/dL fasting

B. 70-100 mg/dL fasting

C. 100-120 mg/dL fasting

D. 120-140 mg/dL fasting

9. What nursing intervention should occur during a transfer to prevent risks to the client?

A. Hold the client upright throughout the process.

B. Monitor the client's anxiety throughout the transfer.

C. Use a gait belt for support and safety.

D. Explain each step to the client before starting.

10. What is the correct method to wash hands effectively?

A. Wash with hot water only

B. Use hand sanitizer only

C. Wash with soap and water for at least 20 seconds

D. Wipe hands with a sterile cloth

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Answers

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

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Explanations

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1. What does surgical asepsis aim to accomplish during a dressing change?

A. Confines microorganisms to the surgical site.

B. Keeps the area free of microorganisms.

C. Protects self from microorganisms in the wound.

D. Reduces risk for growing opportunistic microorganisms.

Surgical asepsis, also known as sterile technique, is a critical practice in nursing that is specifically designed to keep an area completely free of microorganisms. When performing a dressing change, maintaining this sterile environment is essential to prevent infections, particularly in open wounds or surgical sites where the potential for pathogen introduction is highest. By ensuring that the area remains free of all microorganisms, the risk of contamination is minimized, which is vital for patient safety and effective healing. The focus of surgical asepsis extends beyond merely reducing the number of microorganisms. It seeks to eliminate them entirely from the environment where the procedure is conducted. This rigorous approach involves using sterile equipment, maintaining a sterile field, and following strict hand hygiene practices, all of which contribute to the primary goal of keeping the area around the wound free of any harmful pathogens. This comprehensive strategy is crucial for preventing surgical site infections and promoting optimal recovery outcomes for patients.

2. How should medication errors be reported in a healthcare setting?

A. By discussing them directly with the patients

B. According to organizational policy and procedures

C. Through a public announcement

D. By ignoring them if they seem minor

Reporting medication errors according to organizational policy and procedures is essential for several reasons. This approach ensures that all incidents are documented consistently and accurately, enabling the healthcare facility to track, analyze, and improve its medication administration processes. Organizational policies often outline specific steps to be followed when a medication error occurs, which helps standardize responses and ensures that all team members understand their responsibilities. Additionally, following established policies promotes transparency and accountability within the healthcare system. It provides a structured method for investigating errors, identifying contributing factors, and implementing corrective actions to prevent future occurrences. These procedures are typically designed to protect patient safety and improve overall care quality. In contrast, discussing errors directly with patients can lead to confusion and anxiety, especially if not handled professionally. Public announcements could breach patient confidentiality and may not contribute to improving safety practices. Ignoring minor errors undermines the commitment to patient safety and quality care, as even minor errors can have significant consequences. Therefore, adherence to organizational policies is crucial to fostering a culture of safety and continuous improvement in healthcare settings.

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3. What is a critical care intervention for a patient with respiratory difficulties?

A. Encouraging them to eat solid foods immediately

B. Restricting their movement

C. Providing supplemental oxygen as needed

D. Discouraging fluid intake

Providing supplemental oxygen as needed is a critical care intervention for a patient experiencing respiratory difficulties. This intervention directly addresses the patient's need for improved oxygenation, which is essential for maintaining adequate tissue perfusion and overall physiological function. Oxygen therapy helps alleviate hypoxemia, allowing the patient to breathe more easily and reducing the work of breathing. It is a standard practice in critical care settings for patients who exhibit low oxygen saturation levels or display signs of respiratory distress. In contrast, the other options may not effectively meet the immediate needs of a patient in respiratory distress. For instance, encouraging solid foods may lead to further complications because eating can increase oxygen demand and exacerbate difficulty breathing. Restricting movement could hinder the patient's ability to reposition themselves, which can be vital for enhancing lung expansion and alleviating respiratory symptoms. Discouraging fluid intake is not typically indicated for respiratory issues unless there are specific concerns about fluid overload; on the contrary, adequate hydration can be important for mucus clearance and overall respiratory health.

4. Which medication should not be administered as an IV bolus due to the risk of cardiac arrest?

A. Saline flush

B. Naloxone (Narcan)

C. Adenosine (Adenocard)

D. Potassium chloride

Potassium chloride is the correct answer because it carries a significant risk of causing cardiac arrest when administered as an intravenous (IV) bolus. High levels of potassium in the bloodstream can lead to hyperkalemia, which can disrupt the electrical conduction in the heart and result in arrhythmias or even cardiac arrest. Administering potassium chloride rapidly in a bolus form can increase these risks dramatically, making it crucial to use this medication only as a slow intravenous infusion and under careful monitoring of serum potassium levels. In contrast, medications like saline flush, naloxone, and adenosine have different safety profiles. Saline is typically used for maintaining venous access and does not pose a risk of serious adverse cardiac events. Naloxone is an opioid antagonist administered to reverse opioid overdose, and while it can lead to withdrawal symptoms, it does not carry the same risk of cardiac complications when given as an IV bolus. Adenosine is utilized to treat certain types of tachycardia and is typically administered as a rapid IV push; though it has some cardiovascular effects, they are generally well-monitored and managed in a clinical setting.

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5. What should be monitored in a patient taking beta-blockers?

A. Fluid intake and output

B. Heart rate and blood pressure

C. Respiratory rate

D. Serum electrolyte levels

Monitoring heart rate and blood pressure in a patient taking beta-blockers is essential because these medications work primarily by blocking the effects of epinephrine on beta-adrenergic receptors in the heart and blood vessels. This action leads to a decrease in heart rate and myocardial contractility, ultimately reducing blood pressure. When managing a patient on beta-blockers, regular assessment of heart rate is important to ensure it remains within a safe range. If the heart rate drops too low, it may place the patient at risk for bradycardia, which can result in inadequate perfusion and other complications. Additionally, monitoring blood pressure is critical, as beta-blockers can significantly lower blood pressure, especially if the patient is also on other antihypertensive medications. By observing these vital signs, healthcare providers can adjust the medication dosage or make other therapeutic decisions that ensure the patient remains stable and that the desired therapeutic effects are achieved without causing harm.

6. What is a common sign of dehydration in an elderly patient?

A. Increased appetite

B. Decreased urine output

C. Bright, clear skin

D. Enhanced cognitive function

Decreased urine output is a common sign of dehydration in elderly patients due to the body's reduced ability to conserve water and balance fluids effectively as it ages. When a person is dehydrated, the kidneys conserve as much water as possible, leading to a noticeable reduction in urine production. This is particularly significant in older adults, who may not feel thirsty even when their bodies require fluids. In addition, elderly individuals may have other factors impacting hydration, such as chronic illnesses or medications that can further exacerbate dehydration. Recognizing decreased urine output can prompt timely interventions to replenish fluids and prevent serious complications associated with dehydration, such as kidney damage or confusion. In contrast, increased appetite, bright clear skin, and enhanced cognitive function do not align with the typical signs and symptoms of dehydration. These options would generally suggest good hydration and overall health, which is contrary to what you would expect in a dehydrated individual.

7. When is it important to start rehabilitation planning for a patient?

A. After surgery

B. At the time of discharge

C. During initial assessment

D. Upon admission to the hospital

Starting rehabilitation planning upon admission to the hospital is crucial for several reasons. This approach allows healthcare professionals to assess the patient's individual needs, capabilities, and goals early in the healthcare process. By doing so, the care team can develop a tailored rehabilitation plan that addresses specific factors such as the patient's medical condition, mobility level, and any potential barriers to recovery. Early planning ensures that all necessary resources, including physical therapy, occupational therapy, and any required home modifications, can be arranged ahead of time, leading to a smoother transition through the care continuum. Furthermore, it promotes patient engagement by involving them in their care from the outset, which can enhance motivation and adherence to the rehabilitation program. This proactive approach contrasts with waiting until after surgery or discharge, which may result in missed opportunities for intervention, continuity of care, and a more effective recovery process.

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8. What is the normal range for adult blood glucose levels?

A. 60-80 mg/dL fasting

B. 70-100 mg/dL fasting

C. 100-120 mg/dL fasting

D. 120-140 mg/dL fasting

The normal range for adult fasting blood glucose levels is 70-100 mg/dL. This range is established based on guidelines from reputable health organizations and reflects the optimal functioning of glucose metabolism in healthy adults. Maintaining blood glucose within this range is crucial for overall health, as levels too low (hypoglycemia) or too high (hyperglycemia) can indicate underlying health issues, such as diabetes or insulin resistance. In individuals who exhibit blood glucose levels within this range, it is typically indicative of effective insulin action and the proper storage and use of glucose by the body's cells. Regular monitoring of blood glucose levels is particularly important for individuals at risk for metabolic diseases, as maintaining levels within this normal range is essential for preventing complications associated with chronic conditions.

9. What nursing intervention should occur during a transfer to prevent risks to the client?

A. Hold the client upright throughout the process.

B. Monitor the client's anxiety throughout the transfer.

C. Use a gait belt for support and safety.

D. Explain each step to the client before starting.

The most effective intervention during a transfer to ensure the client's safety and well-being is to use a gait belt for support and safety. This tool provides secure support to clients during transfer, reducing the risk of falls and injuries for both the client and caregiver. Gait belts are designed to be used effectively by healthcare providers to assist clients who may have unsteady balance or require additional support, helping to facilitate a safe and smooth transfer. By using a gait belt, the caregiver can have a secure grip on the client, making it easier to stabilize or reposition them as needed. This intervention is particularly crucial for clients with mobility issues, as it helps maintain their safety and promotes confidence during movement. Other interventions, while important in their own right, do not primarily focus on the physical safety aspect of transferring. For example, monitoring anxiety is important, but it does not provide the necessary physical support that a gait belt offers. Similarly, explaining each step to the client can help alleviate fear and confusion, yet it does not address the immediate safety needs. Holding the client upright is not practical during a transfer and may not ensure the most safe or comfortable position for the client. Thus, the use of a gait belt stands out as the most crucial intervention during a transfer.

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10. What is the correct method to wash hands effectively?

A. Wash with hot water only

B. Use hand sanitizer only

C. Wash with soap and water for at least 20 seconds

D. Wipe hands with a sterile cloth

Washing hands with soap and water for at least 20 seconds is recognized as the most effective method for removing germs and preventing the spread of infection. This practice is essential because the friction created by rubbing your hands together, in combination with the cleansing properties of soap, helps to dislodge dirt, grease, and pathogens. The duration of 20 seconds is important to ensure that all areas of the hands are thoroughly cleaned, including between the fingers, under the nails, and up to the wrists. Handwashing is particularly critical before eating, after using the restroom, and after contact with surfaces that may harbor germs. While hand sanitizers can be effective in certain situations, they do not eliminate all types of germs and are not a suitable substitute for handwashing when hands are visibly dirty or greasy. Additionally, wiping hands with a sterile cloth may not adequately remove pathogens and could leave germs on the hands rather than effectively cleaning them. Thus, thorough handwashing is the recommended standard for maintaining hand hygiene.

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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://eaqfundofnursinglvl2.examzify.com

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

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