HURST READINESS 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. **Which of the following is NOT a recommended ergonomic principle for nurses?**

   A. Maintain a wide base of support

   B. Use back muscles for heavy lifting

   C. Ask for assistance when needed

   D. Keep the center of gravity low

2. **What intervention should be emphasized to the family of a client with suicidal ideations?**

   A. Family members are responsible for preventing future attempts.

   B. When the client stops talking about suicide, the risk has increased.

   C. Warning signs are generally absent before a suicide attempt.

   D. Report sudden behavioral changes.

3. **What is the nursing priority when a client exhibits signs of respiratory depression after opioid administration?**

   A. Provide oxygen therapy

   B. Start a new IV line

   C. Administer naloxone

   D. Call the healthcare provider

4. **Which finding should a nurse report to the primary healthcare provider for a client receiving IV normal saline for dehydration?**

   A. Blood pressure of 136/84

   B. Report of nausea

   C. Client exhibiting anxiety

   D. Urinary output of 50 mL/hour

5. **What is the recommended method for removing excessive body hair before surgery?**

   A. Shaving with a razor

   B. Using hair clippers

   C. Using soap and water prior to shaving

   D. Using a depilatory cream

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6. What would be the most therapeutic response from the nurse to a client with schizophrenia who expresses fears about their doctor?

A. Are you feeling afraid now?

B. I am here with you.

C. Let's discuss something else.

D. You know that is not true.

7. What happens if a postpartum client receives the MMR vaccine?

A. Client can conceive immediately

B. Client should not become pregnant for at least 1 month

C. Client will require additional vaccinations

D. Client's breastfeeding will be impacted

8. Which symptom would indicate an acute kidney rejection that a renal transplant client should report?

A. Increased urine output.

B. High fever.

C. Severe headache.

D. Complaints of weight loss.

9. What should be monitored in a client receiving blood transfusions who has a history of mild heart failure?

A. Fluid volume overload

B. Infection risk

C. Electrolyte balance

D. Oxygen saturation

10. The nurse observes a fire in a trash can. What is the correct order of steps to take?

A. Close the door, activate the alarm, remove the client, obtain the extinguisher, extinguish the fire

B. Activate the alarm, remove the client, close the door, extinguish the fire, obtain the extinguisher

C. Remove the client, activate the alarm, close the door, obtain the extinguisher, extinguish the fire

D. Obtain the extinguisher, close the door, remove the client, activate the alarm, extinguish the fire

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Answers

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

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Explanations

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1. Which of the following is NOT a recommended ergonomic principle for nurses?

A. Maintain a wide base of support

B. Use back muscles for heavy lifting

C. Ask for assistance when needed

D. Keep the center of gravity low

Using back muscles for heavy lifting is not a recommended ergonomic principle for nurses. Instead, the emphasis is on using the legs and body weight to assist with lifting to prevent strain and injury. This approach not only reduces the risk of back injuries, which are common in nursing due to the physical nature of the job, but also promotes safe lifting techniques. Maintaining a wide base of support, asking for assistance when needed, and keeping the center of gravity low are all principles designed to enhance stability and balance while performing tasks. A wide base of support increases stability, which is crucial when moving or lifting patients. Asking for help ensures that lifting burdens are properly managed, minimizing the risk of injury. Keeping the center of gravity low helps maintain better control and stability, especially during dynamic movements. Overall, proper technique and ergonomics are essential in healthcare settings to protect the health of nurses and improve patient care.

2. What intervention should be emphasized to the family of a client with suicidal ideations?

A. Family members are responsible for preventing future attempts.

B. When the client stops talking about suicide, the risk has increased.

C. Warning signs are generally absent before a suicide attempt.

D. Report sudden behavioral changes.

Emphasizing the reporting of sudden behavioral changes is crucial for families of clients with suicidal ideations because these changes can often signal an increased risk of suicide. When someone is in distress or is contemplating suicide, they may exhibit dramatic shifts in mood, behavior, or daily functioning. Families are typically the first to notice these shifts and can play a pivotal role in seeking help or intervention at a critical time. By encouraging families to be vigilant and report any sudden changes, healthcare providers can ensure that the client receives timely support and necessary interventions. It fosters an environment where concerns can be communicated effectively, increasing the chances of preventing a potential crisis. Educating families about the importance of these behavioral changes in the context of suicide risk makes them active participants in the client's care, which can be both empowering for the family and protective for the client. The other options do not convey accurate or helpful approaches. The belief that family members are solely responsible for preventing further attempts places an unfair burden on them. Stating that when the client stops talking about suicide the risk increases can lead to misunderstanding, as open communication is vital. Lastly, the idea that warning signs are generally absent contradicts common knowledge about the presence of warning signs, which can include specific behaviors or statements before a

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3. What is the nursing priority when a client exhibits signs of respiratory depression after opioid administration?

A. Provide oxygen therapy

B. Start a new IV line

C. Administer naloxone

D. Call the healthcare provider

When a client exhibits signs of respiratory depression after opioid administration, the nursing priority is to administer naloxone. This medication is an opioid antagonist that can quickly reverse the effects of opioids, including respiratory depression, by displacing opioids from the receptors in the brain. The prompt action of administering naloxone can be life-saving, as respiratory depression can lead to hypoxia and potential brain damage or death if not addressed immediately. Providing oxygen therapy may support the client's breathing, but it does not address the underlying cause of respiratory depression, which is the opioid's effect on the central nervous system. Starting a new IV line may be necessary for future medication administration but does not directly resolve the current respiratory issue. Calling the healthcare provider is also important, but the immediate need is to reverse the respiratory depression as quickly as possible to prevent further complications. Therefore, administering naloxone is the most critical and timely intervention to prioritize.

4. Which finding should a nurse report to the primary healthcare provider for a client receiving IV normal saline for dehydration?

A. Blood pressure of 136/84

B. Report of nausea

C. Client exhibiting anxiety

D. Urinary output of 50 mL/hour

In this scenario, the most critical finding to report to the primary healthcare provider is the client's anxiety. While all the listed options may warrant attention, anxiety can be indicative of an underlying physiological issue, such as fluid overload, electrolyte imbalances, or an exacerbation of the client's dehydration, which may require prompt medical evaluation and intervention. Anxiety in a client receiving IV fluids can signal distress that might not be immediately observable through vital signs or lab results. It's essential for the healthcare provider to assess the client further, as anxiety can escalate quickly and affect treatment outcomes. Addressing the underlying cause of the anxiety may lead to a more effective management plan and ensure the client's safety. Monitoring physiological parameters like blood pressure or urinary output is also crucial, but in the context of potential complications related to IV fluid administration, the psychological and emotional state of the client can provide significant insights into their overall condition and may require immediate attention.

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5. What is the recommended method for removing excessive body hair before surgery?

A. Shaving with a razor

B. Using hair clippers

C. Using soap and water prior to shaving

D. Using a depilatory cream

The recommended method for removing excessive body hair before surgery is using hair clippers. This approach is preferred because it minimizes the risk of skin irritation, micro-abrasions, and potential infections that can occur with other methods such as shaving with a razor. Hair clippers effectively reduce the hair length without compromising the integrity of the skin, which is crucial in a surgical environment where maintaining a sterile field is essential. Furthermore, using clippers allows for faster preparation while ensuring that the skin barrier remains intact, reducing the likelihood of post-operative complications. Other methods, such as shaving with a razor or utilizing depilatory creams, can sometimes lead to skin damage or allergic reactions, which are undesirable in a surgical setting.

6. What would be the most therapeutic response from the nurse to a client with schizophrenia who expresses fears about their doctor?

A. Are you feeling afraid now?

B. I am here with you.

C. Let's discuss something else.

D. You know that is not true.

The most therapeutic response in this scenario is to express empathy and acknowledge the client's feelings. When a client with schizophrenia voices fears about their doctor, it's crucial to validate those feelings rather than dismiss them or change the subject. By asking if they are feeling afraid in that moment, the nurse opens up a conversation that can allow the client to elaborate on their fears. This approach demonstrates active listening and encourages the client to share more about their feelings and experiences, which can be pivotal for therapeutic rapport and understanding. Engaging in a dialogue about their fears also provides an opportunity for the nurse to address any misconceptions or provide reassurance regarding their care. This technique not only supports the client emotionally but also fosters a safe space for communication, which is vital for clients facing the challenges of schizophrenia. Other responses may not effectively address the client's needs. Simply stating that "I am here with you," while supportive, does not directly engage with the client's expressed fears. Changing the subject or denying the validity of the client's feelings can lead to further distress and a lack of trust. Therefore, the selected response facilitates a deeper connection and exploration of the client's concerns, making it the most therapeutic choice.

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7. What happens if a postpartum client receives the MMR vaccine?

A. Client can conceive immediately

B. Client should not become pregnant for at least 1 month

C. Client will require additional vaccinations

D. Client's breastfeeding will be impacted

Receiving the MMR (measles, mumps, and rubella) vaccine postpartum carries specific guidelines regarding future pregnancies. It is recommended that a postpartum client should avoid becoming pregnant for at least one month after receiving the vaccine. This precaution is due to the live attenuated viruses in the vaccine, as they can potentially pose a risk to a developing fetus. Waiting for at least a month ensures that the vaccine has had time to effectively immunize the client without risking any potential effects on a subsequent pregnancy. In contrast, the other options do not accurately reflect the correct guidance surrounding the MMR vaccine. There is no immediate conception contraindicated with the vaccine, as it is specifically the period following administration that requires caution. While additional vaccinations may be necessary for some individuals, the MMR vaccine is usually given as a single series; therefore, it is not accurate to state that the client will require additional vaccinations immediately following this vaccine. Furthermore, the MMR vaccine does not adversely impact breastfeeding; lactation is safe and can continue without concern following vaccination.

8. Which symptom would indicate an acute kidney rejection that a renal transplant client should report?

A. Increased urine output.

B. High fever.

C. Severe headache.

D. Complaints of weight loss.

High fever is a significant symptom that should prompt immediate attention in a renal transplant recipient, as it can indicate an acute rejection of the transplanted kidney. An increase in body temperature often signals an immune response, which may occur when the body recognizes the transplanted organ as foreign. This reaction is critical to monitor, as it can lead to serious complications if not addressed promptly. In this context, other symptoms can arise; for instance, increased urine output may be a normal or healthy sign, particularly in the early stages following a transplant when kidney function is assessed. Severe headaches might be associated with various factors unrelated to kidney rejection, and complaints of weight loss could result from multiple issues, including side effects of medications or changes in appetite. Therefore, the presence of a high fever specifically aligns with the body's immunologic response to an acute kidney rejection, making it the symptom that should be prioritized and reported by the client.

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9. What should be monitored in a client receiving blood transfusions who has a history of mild heart failure?

A. Fluid volume overload

B. Infection risk

C. Electrolyte balance

D. Oxygen saturation

Monitoring for fluid volume overload is crucial in a client receiving blood transfusions, particularly when there is a history of mild heart failure. This condition makes the client more susceptible to complications associated with increased fluid volume due to impaired cardiac function. The transfusion of blood products can lead to an increase in circulating volume, putting additional strain on the heart and potentially exacerbating heart failure symptoms. Signs of fluid overload include shortness of breath, swelling in the extremities, and elevated blood pressure. Careful assessment of the patient's fluid status during and after the transfusion helps ensure that the heart is not overwhelmed by excessive volume. While infection risk and electrolyte balance are important considerations in transfusion medicine, they do not address the immediate concern related to the client's heart condition. Oxygen saturation is also an important parameter to monitor but does not specifically relate to fluid overload, which is most pertinent for this situation. Given the patient's background, focusing on fluid volume overload is essential for safe management during and after the transfusion process.

10. The nurse observes a fire in a trash can. What is the correct order of steps to take?

A. Close the door, activate the alarm, remove the client, obtain the extinguisher, extinguish the fire

B. Activate the alarm, remove the client, close the door, extinguish the fire, obtain the extinguisher

C. Remove the client, activate the alarm, close the door, obtain the extinguisher, extinguish the fire

D. Obtain the extinguisher, close the door, remove the client, activate the alarm, extinguish the fire

The correct approach to this situation involves prioritizing the safety of individuals before addressing the fire itself. In the order provided, the first step is to remove the client from immediate danger, ensuring their safety is the primary concern, particularly in a healthcare setting where patients may have limited mobility or awareness of the situation. Following the removal of the client, activating the alarm ensures that the fire is reported promptly to the appropriate response team, allowing for a coordinated effort to handle the emergency. Closing the door helps to contain the fire, reducing the risk of it spreading to other areas, thus providing a safer environment for both the client and other individuals present. Once these steps are taken, obtaining the extinguisher can then be addressed if it's safe to do so, allowing the nurse to attempt to extinguish the fire. This sequence underscores the importance of patient safety, communication, and proper response to the threat before engaging with the fire itself. By adhering to this order, the situation effectively mitigates risk to life while addressing the fire hazard, aligning with established safety protocols in emergency response.

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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://hurstreadiness.examzify.com

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

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