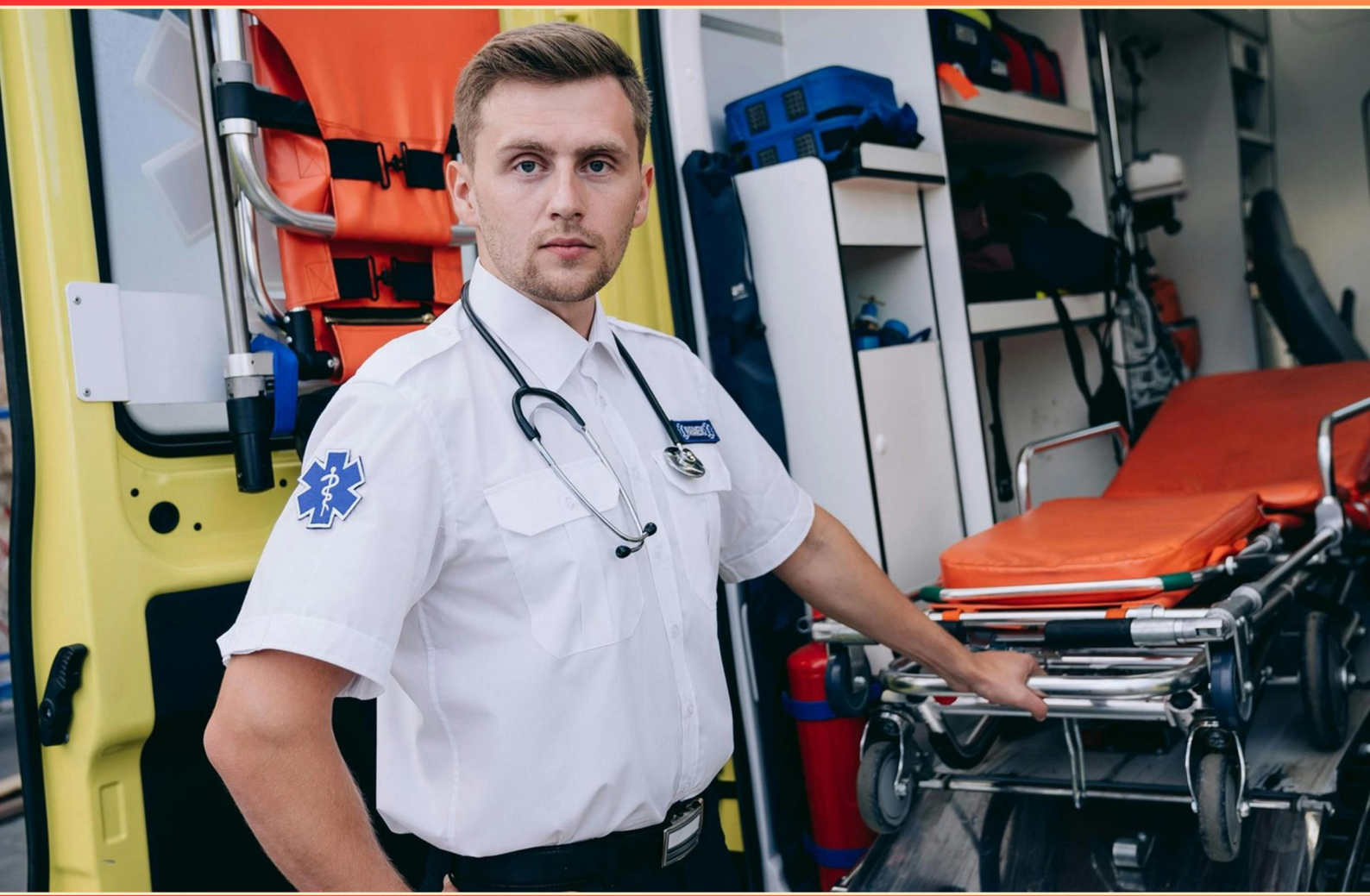
NACE FOUNDATIONS OF NURSING PRACTICE TEST (SAMPLE)

STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

VISIT US ONLINE FOR THE FULL VERSION STUDY GUIDE

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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 critical thinking in nursing refer to?

A. The ability to analyze information and make informed decisions based on evidence

B. Relying on standard protocols to guide patient care

C. Following instructions from senior staff without question

D. Using intuition to guide patient assessments

2. Which aspect is essential when managing a patient's anxiety associated with an acute medical condition?

A. Offering distractions

B. Providing clear information

C. Ignoring the symptoms

D. Encouraging inactivity

3. What does patient advocacy in nursing involve?

A. Supporting and promoting the best interests and welfare of the patient

B. Informing patients about health insurance options

C. Managing healthcare staff schedules

D. Collecting patient feedback for hospital administration

4. What should the night shift nurse report to the surgeon for a patient having a procedure in the morning?

A. "NPO since 2300."

B. "No allergies to medications."

C. "Allergy to shellfish."

D. "History of hypertension."

5. If a patient is diaphoretic and tachycardic when walking, which additional symptom might be expected?

A. Increased appetite

B. Orthostatic hypotension noted with dangling

C. Chest pain

D. Dizziness only upon standing

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6. Which of the following are common signs of respiratory distress in a patient?

A. Shortness of breath, increased respiratory rate, use of accessory muscles

B. Fever, bradycardia, cyanosis

C. Hypotension, dizziness, malaise

D. General fatigue, headache, decreased appetite

7. What does OS indicate in term of eye prescriptions?

A. Right eye

B. Left eye

C. Both eyes

D. Neither eye

8. When documenting drainage from a wound, what is the most accurate description?

A. Outer dressing is dry and intact

B. Moderate drainage noted underneath dressing

C. Two 4x4 gauze pads saturated with blood

D. Drainage present with no signs of infection

9. What is one of the primary roles of a Licensed Practical Nurse (LPN)?

A. To perform complex surgical procedures

B. To conduct independent nursing research

C. To provide basic nursing care under supervision

D. To diagnose medical conditions independently

10. What does AD stand for in medical terminology?

A. Auris dextra (right ear)

B. Auris sinister (left ear)

C. Oculus dextra (right eye)

D. Oculus sinister (left eye)

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Answers

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

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Explanations

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1. What does critical thinking in nursing refer to?

A. The ability to analyze information and make informed decisions based on evidence

B. Relying on standard protocols to guide patient care

C. Following instructions from senior staff without question

D. Using intuition to guide patient assessments

Critical thinking in nursing is fundamentally about the ability to analyze information and make informed decisions based on evidence. This skill is essential for nurses as it enables them to assess complex situations, consider different perspectives, and integrate clinical knowledge with patient preferences and needs. By utilizing critical thinking, nurses can evaluate patient data, recognize patterns, and develop effective care plans that are tailored to individual circumstances. It empowers nurses to question assumptions, think creatively, and justify their decisions, ultimately leading to improved patient outcomes. In contrast, relying solely on standard protocols may not allow for the flexibility necessary in unique patient situations, and following instructions without question can hinder a nurse's ability to advocate for their patients or to apply evidence-based practice critically. Similarly, while intuition can play a role in assessments, it should be complemented by critical thinking to ensure that care decisions are comprehensive and grounded in the best available evidence. This makes critical thinking an essential component of proficient nursing practice.

2. Which aspect is essential when managing a patient's anxiety associated with an acute medical condition?

A. Offering distractions

B. Providing clear information

C. Ignoring the symptoms

D. Encouraging inactivity

Providing clear information is essential when managing a patient's anxiety associated with an acute medical condition because it helps to reduce uncertainty and fear. Anxiety often stems from a lack of understanding about what is happening, the treatments involved, and the potential outcomes. By presenting clear, accurate, and timely information, nurses and healthcare providers can enable patients to make sense of their situation, understand the care they are receiving, and foster a sense of control. Clear communication can also help to establish trusting relationships between healthcare providers and patients, providing emotional support and reassurance. When patients feel informed, they are more likely to engage in their care and express their concerns, which can further alleviate anxiety. In contrast, the other options may not effectively address the root of the patient's anxiety, as distractions do not provide understanding, ignoring symptoms may worsen anxiety, and encouraging inactivity could lead to increased feelings of helplessness.

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3. What does patient advocacy in nursing involve?

A. Supporting and promoting the best interests and welfare of the patient

B. Informing patients about health insurance options

C. Managing healthcare staff schedules

D. Collecting patient feedback for hospital administration

Patient advocacy in nursing fundamentally involves supporting and promoting the best interests and welfare of the patient. This encompasses a range of responsibilities, including ensuring that patients have access to the information they need to make informed decisions about their care, representing the patient's views and needs within the healthcare system, and safeguarding their rights and dignity. Effective patient advocacy requires nurses to listen to their patients, understand their needs, and communicate those needs to other healthcare professionals. This may involve intervening on behalf of the patient to ensure they receive appropriate treatment, understanding their wishes regarding care options, or helping them navigate complex healthcare systems. By acting as an advocate, nurses play a vital role in enhancing patient safety and quality of care, contributing to better health outcomes and overall patient satisfaction. While informing patients about health insurance options, managing healthcare staff schedules, and collecting patient feedback may be parts of a nurse's broader responsibilities, they do not encapsulate the essence of patient advocacy. Advocacy specifically focuses on the relational and supportive aspects of ensuring a patient's voice is heard and their rights are upheld in the context of their healthcare experience.

4. What should the night shift nurse report to the surgeon for a patient having a procedure in the morning?

A. "NPO since 2300."

B. "No allergies to medications."

C. "Allergy to shellfish."

D. "History of hypertension."

The most critical piece of information to report to the surgeon is the patient's allergy to shellfish. This detail is essential because it impacts the choice of anesthesia and medications that may be used during the procedure, as well as any potential for allergic reactions. Allergies can lead to serious complications if the patient is exposed to allergens, so it is imperative for the surgical team to be aware of them ahead of time. While the other options contain important information— such as fasting status, medication allergies in general, and medical history— they do not pose the immediate risk that a known allergy does. For example, being NPO (nothing by mouth) since a specific time is relevant to surgical preparation, but it does not directly affect patient safety as much as an allergy. Similarly, while a history of hypertension is important for postoperative care and monitoring, it does not have the same urgency as a documented allergy. Therefore, communicating the shellfish allergy is crucial for ensuring the patient's safety during the surgery.

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5. If a patient is diaphoretic and tachycardic when walking, which additional symptom might be expected?

A. Increased appetite

B. Orthostatic hypotension noted with dangling

C. Chest pain

D. Dizziness only upon standing

In the scenario where a patient is diaphoretic (excessively sweating) and tachycardic (having an elevated heart rate) while walking, the additional symptom that might be expected is orthostatic hypotension noted with dangling. This symptom indicates that the patient's blood pressure may drop when changing positions, particularly from sitting to standing. The physiological stress of walking, combined with sweating and an increased heart rate, can contribute to insufficient blood flow to the brain upon standing, leading to symptoms like dizziness or faintness. Orthostatic hypotension occurs due to a failure of the body's normal mechanisms to regulate blood pressure during position changes, which can be more pronounced in patients experiencing distress or exertion. In this context, it highlights the cardiovascular system's response to physical activity and stress, suggesting that further monitoring of the patient's vitals and responses to positional changes is warranted. The other symptoms listed do not directly correlate with the combination of sweating and increased heart rate during walking in the same way. For instance, increased appetite is not typically associated with such distress signals, while chest pain could indicate a more serious underlying condition warranting immediate attention, and dizziness only upon standing is a less comprehensive statement about the patient's potential symptoms compared to orthost

6. Which of the following are common signs of respiratory distress in a patient?

A. Shortness of breath, increased respiratory rate, use of accessory muscles

B. Fever, bradycardia, cyanosis

C. Hypotension, dizziness, malaise

D. General fatigue, headache, decreased appetite

The correct choice identifies common signs of respiratory distress, which are critical for nurses and healthcare professionals to recognize quickly. Shortness of breath, an increased respiratory rate, and the use of accessory muscles are hallmark indicators of a patient struggling to breathe effectively. Shortness of breath signifies that the body is not receiving enough oxygen, prompting the person to alter their breathing pattern. An increased respiratory rate occurs as the body attempts to compensate for lower oxygen levels or higher carbon dioxide levels in the blood. The use of accessory muscles, such as those in the neck and shoulders, indicates that the patient is employing additional muscles to assist in the breathing process, which is often a response to increased work of breathing or airway obstruction. Recognizing these signs is vital in assessing a patient's respiratory status and initiating prompt interventions to ensure oxygenation and respiratory function are maintained. Other options present signs that may indicate different medical issues not specifically related to respiratory distress.

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7. What does OS indicate in term of eye prescriptions?

A. Right eye

B. Left eye

C. Both eyes

D. Neither eye

In the context of eye prescriptions, "OS" stands for "oculus sinister," which is Latin for "left eye." This terminology is used by eye care professionals to denote which eye is being referred to in a prescription for corrective lenses or other visual aids. Understanding the acronyms used in eye prescriptions is essential for both healthcare providers and patients, as it helps prevent confusion regarding which eye needs specific treatment or correction. In contrast, "OD" refers to the right eye ("oculus dexter"), and "OU" refers to both eyes ("oculus uterque"). This precise language ensures clarity in communication about patients' visual needs.

8. When documenting drainage from a wound, what is the most accurate description?

A. Outer dressing is dry and intact

B. Moderate drainage noted underneath dressing

C. Two 4x4 gauze pads saturated with blood

D. Drainage present with no signs of infection

The choice stating "Moderate drainage noted underneath dressing" provides a clear and objective assessment of the wound's status. It effectively communicates the extent of drainage associated with the wound, which is crucial for ongoing treatment and monitoring. This level of detail indicates not just the presence of drainage, but also its volume, which can influence clinical decisions regarding care, such as whether to change the dressing more frequently or assess for complications. The description of moderate drainage is specific enough to inform the healthcare team without being overly subjective. This type of documentation helps in tracking the healing process and any potential changes in the wound condition, which are important in nursing practice. Other options, while they provide some relevant information, do not convey the same degree of clinical detail. For instance, stating that "Outer dressing is dry and intact" provides information but does not indicate any drainage and could be misleading regarding the wound's condition. Similarly, "Two 4x4 gauze pads saturated with blood" specifies drainage volume but lacks context regarding its severity or ongoing changes in the wound. The option "Drainage present with no signs of infection" does not quantify the drainage, making it less informative for monitoring purposes.

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9. What is one of the primary roles of a Licensed Practical Nurse (LPN)?

A. To perform complex surgical procedures

B. To conduct independent nursing research

C. To provide basic nursing care under supervision

D. To diagnose medical conditions independently

One of the primary roles of a Licensed Practical Nurse (LPN) is to provide basic nursing care under supervision. LPNs are trained to perform a variety of patient care tasks, such as taking vital signs, administering medications, assisting with activities of daily living, and providing comfort measures. Their scope of practice allows them to work closely with registered nurses (RNs) and physicians, while adhering to the established healthcare plans. In practice, LPNs often operate in a supportive role, where they demonstrate their skills in providing direct patient care while under the guidance and supervision of RNs or other healthcare providers. This collaboration ensures that patients receive comprehensive and safe care. The other roles mentioned, such as performing complex surgical procedures, conducting independent nursing research, and diagnosing medical conditions independently, fall outside the scope of practice for LPNs and are generally reserved for RNs or other advanced practitioners. This distinction highlights the LPN's focus on providing essential care within a structured healthcare team, rather than engaging in more advanced or independent practices.

10. What does AD stand for in medical terminology?

A. Auris dextra (right ear)

B. Auris sinister (left ear)

C. Oculus dextra (right eye)

D. Oculus sinister (left eye)

In medical terminology, AD stands for Auris dextra, which translates to "right ear" in Latin. This abbreviation is commonly used in clinical settings to specify which ear is being referenced, particularly when documenting patient information such as hearing assessments or administration of medications. Understanding these abbreviations is essential in ensuring clear communication and accurate documentation in healthcare. Each term in the other options refers to different anatomical structures or sides: Auris sinister means "left ear," Oculus dextra refers to "right eye," and Oculus sinister stands for "left eye," but only Auris dextra specifically indicates the right ear, thereby making it the correct answer in this context.

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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://nacefoundofnursing.examzify.com

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

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