

Associate Degree in Nursing (ADN) Level 3 Practice Exam (Sample)

Study Guide



Everything you need from our exam experts!

Copyright © 2026 by Examzify - A Kaluba Technologies Inc. product.

ALL RIGHTS RESERVED.

No part of this book may be reproduced or transferred in any form or by any means, graphic, electronic, or mechanical, including photocopying, recording, web distribution, taping, or by any information storage retrieval system, without the written permission of the author.

Notice: Examzify makes every reasonable effort to obtain accurate, complete, and timely information about this product from reliable sources.

SAMPLE

Table of Contents

Copyright	1
Table of Contents	2
Introduction	3
How to Use This Guide	4
Questions	5
Answers	8
Explanations	10
Next Steps	16

SAMPLE

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.

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!

Questions

SAMPLE

- 1. Which nursing intervention should be emphasized for a frail older adult in a hospital setting?**
 - A. Encouragement for self-sufficiency**
 - B. Frequent sedation for comfort**
 - C. Rigorous exercise programs**
 - D. Placement in restraints for safety**
- 2. When monitoring a client with a severe stroke, what should the nurse look for alongside decerebrate posture?**
 - A. Respiratory distress**
 - B. Slurred speech**
 - C. Wrist pronation**
 - D. Flexion at the elbows**
- 3. What is a concerning sign for a newborn following a forceps delivery?**
 - A. Ecchymosis on the face**
 - B. Reduced movement in one arm**
 - C. Temporary irritability**
 - D. Normal neonatal reflexes**
- 4. Which statement identifies a difference between children and adults that could produce a life-threatening complication for a child with craniocerebral injury?**
 - A. Cerebral tissues in children are softer, thinner, and more flexible.**
 - B. Greater portions of a child's blood volume flows to the head.**
 - C. A child's skull can expand more than an adult's can.**
 - D. Hematomas in children can include subdural, epidural, and intracerebral.**
- 5. What should a nurse instruct a client taking metformin to report?**
 - A. Dizziness**
 - B. Increased hunger**
 - C. Hyperventilation**
 - D. Headache**

6. What should the nurse do before administering carbamazepine to a patient with a gastrostomy feeding tube?

- A. Cut the medication into pieces.**
- B. Contact the primary care provider to change the order.**
- C. Ask the pharmacist for an oral suspension.**
- D. Dissolve the medication in juice.**

7. What principle should guide the delegation of tasks in nursing practice?

- A. Tasks should always be delegated to the most experienced staff**
- B. Delegated tasks must match the skill level of the delegatee**
- C. All tasks must be performed by registered nurses**
- D. Delegation should only take place in emergency situations**

8. Which lab value is most indicative of kidney function?

- A. Blood urea nitrogen**
- B. Electrolyte levels**
- C. Creatinine**
- D. Complete blood count**

9. What is a primary goal of physical therapy and nursing interventions for a client with Parkinson's disease?

- A. To maintain joint flexibility.**
- B. To reduce ataxia.**
- C. To build muscle strength.**
- D. To improve muscle endurance.**

10. Which symptom should the nurse monitor closely in a pediatric patient recovering from a head injury?

- A. Persistent vomiting**
- B. Decreased appetite**
- C. Persistent sleepiness**
- D. Headaches**

Answers

SAMPLE

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

SAMPLE

Explanations

SAMPLE

1. Which nursing intervention should be emphasized for a frail older adult in a hospital setting?

- A. Encouragement for self-sufficiency**
- B. Frequent sedation for comfort**
- C. Rigorous exercise programs**
- D. Placement in restraints for safety**

Encouraging self-sufficiency in frail older adults is a crucial nursing intervention, as it promotes autonomy and dignity while also supporting their physical and emotional well-being. When older adults are given opportunities to perform tasks independently, it can enhance their self-esteem and overall quality of life. This approach respects their individuality and fosters a sense of control over their situation, which is particularly important in a hospital setting where they may feel vulnerable. By implementing this intervention, nurses can also help in maintaining or improving the physical capabilities of older adults, which is essential for their recovery and transition back to their homes. Activities might include assistance with personal hygiene, meal planning, and mobility support, all designed to maximize their functional independence within their ability. The other options do not align with best practices for promoting the well-being of frail older adults. Frequent sedation may unnecessarily limit their ability to engage with their environment, rigorous exercise could pose a risk of injury, and the use of restraints can lead to further physical and psychological issues, such as increased agitation and loss of muscle strength. Therefore, fostering self-sufficiency stands out as the most appropriate and beneficial nursing intervention for this population.

2. When monitoring a client with a severe stroke, what should the nurse look for alongside decerebrate posture?

- A. Respiratory distress**
- B. Slurred speech**
- C. Wrist pronation**
- D. Flexion at the elbows**

In the context of monitoring a client who has experienced a severe stroke, observing wrist pronation alongside decerebrate posture is significant because it indicates specific neurological changes. Decerebrate posture itself involves extension of the arms and legs, with the toes pointed downward, and it suggests severe damage to the brainstem and certain pathways within the brain. When a client exhibits decerebrate posture, there is often a lack of purposeful movement, which may also lead to additional findings such as wrist pronation. This is an abnormal motor response and reflects further involvement of the central nervous system. It's critical for nurses to assess these responses as they help gauge the extent of neurological damage and identify the need for urgent interventions. In contrast, respiratory distress, slurred speech, and flexion at the elbows either pertain to different neurological assessments or do not align well with the specific presentation of decerebrate posture. For example, respiratory distress may occur due to various reasons and is not directly linked to decerebrate movements, while slurred speech is more typically associated with strokes affecting different brain areas, particularly those related to language. Flexion at the elbows may suggest decorticate posture, which indicates a different type of brain injury. Therefore, monitoring wrist pronation alongside decerebrate posture is a key indicator of severe neurological damage.

3. What is a concerning sign for a newborn following a forceps delivery?

- A. Ecchymosis on the face**
- B. Reduced movement in one arm**
- C. Temporary irritability**
- D. Normal neonatal reflexes**

In the context of a newborn following a forceps delivery, reduced movement in one arm is a concerning sign because it may indicate an injury or trauma to the brachial plexus, a network of nerves that control arm movement. Forceps delivery often involves significant pressure on the infant's head, which can lead to stretching or injury of these nerves, also known as Erb's Palsy. Observing reduced movement specifically in one arm could suggest that the infant has sustained such an injury, warranting further evaluation and monitoring. Ecchymosis on the face, while it can indeed occur after a forceps delivery due to the pressure applied, is generally a common and expected finding that usually resolves on its own without causing lasting harm. Temporary irritability in a newborn can also be typical following a difficult delivery and does not usually indicate a serious problem. Normal neonatal reflexes suggest that the newborn's neurological development is on track, which is a positive sign in the immediate postpartum period.

4. Which statement identifies a difference between children and adults that could produce a life-threatening complication for a child with craniocerebral injury?

- A. Cerebral tissues in children are softer, thinner, and more flexible.**
- B. Greater portions of a child's blood volume flows to the head.**
- C. A child's skull can expand more than an adult's can.**
- D. Hematomas in children can include subdural, epidural, and intracerebral.**

The statement that describes a key difference between children and adults that could lead to life-threatening complications for a child with a craniocerebral injury is that greater portions of a child's blood volume flows to the head. In children, the head is proportionally larger compared to their body size, and they have a higher blood flow to the brain relative to adults. This increased blood flow is significant because it can amplify the effects of any intracranial injury. For instance, in the event of brain swelling or bleeding, a child's smaller cranial capacity and increased blood volume to the head can result in a rapid rise in intracranial pressure. This condition can lead to severe complications, including permanent neurological damage or death, as children's brains may not tolerate increased pressures as well as those of adults. This understanding underlines the importance of careful monitoring and rapid intervention in pediatric cases of head injury, as the anatomical and physiological differences can lead to more severe outcomes than might be expected based on adult standards.

5. What should a nurse instruct a client taking metformin to report?

- A. Dizziness**
- B. Increased hunger**
- C. Hyperventilation**
- D. Headache**

Instructing a client taking metformin to report hyperventilation is critical because it may be a sign of lactic acidosis, a rare but serious side effect associated with metformin.

Lactic acidosis occurs when there is an accumulation of lactic acid in the bloodstream, which can happen under conditions that lead to decreased kidney function or excessive alcohol consumption, both of which can increase the risk of this complication.

Hyperventilation could indicate metabolic acidosis as the body tries to compensate for the acidosis by increasing respiratory rate to expel carbon dioxide. While symptoms like dizziness, increased hunger, or headache can be relevant for different health issues or medication side effects, they do not indicate an urgent need for the client to seek immediate medical attention the way hyperventilation does in this context. It is important for nurses to ensure that clients understand the signs and symptoms of serious complications related to their medications, as early reporting can lead to timely interventions.

6. What should the nurse do before administering carbamazepine to a patient with a gastrostomy feeding tube?

- A. Cut the medication into pieces.**
- B. Contact the primary care provider to change the order.**
- C. Ask the pharmacist for an oral suspension.**
- D. Dissolve the medication in juice.**

Before administering carbamazepine to a patient with a gastrostomy feeding tube, it is essential to ensure the medication is safe and appropriate for administration through this type of feeding system. Carbamazepine is typically available in various formulations, including extended-release and chewable tablets, which may not be suitable for crushing or altering. The risk of altering the medication can lead to improper dosing and effectiveness, which is critical for this anticonvulsant medication. If there is uncertainty about the administration route or formulation, contacting the primary care provider is an appropriate step. This ensures that the patient receives the correct formulation that can be safely administered through the feeding tube, such as an oral suspension if available. This is particularly important for medications that require specific formulations to prevent complications like clogging the tube or altering the medication's absorption. In this scenario, the focus is on protecting patient safety and ensuring the effective delivery of the medication as prescribed. Solutions like asking for a different formulation or finding alternative ways to administer the medication align with best practices in nursing care, particularly when dealing with patients who have specialized needs such as those with a gastrostomy tube.

7. What principle should guide the delegation of tasks in nursing practice?

- A. Tasks should always be delegated to the most experienced staff**
- B. Delegated tasks must match the skill level of the delegatee**
- C. All tasks must be performed by registered nurses**
- D. Delegation should only take place in emergency situations**

The principle that guides the delegation of tasks in nursing practice is that delegated tasks must match the skill level of the delegatee. This is crucial for maintaining patient safety and ensuring quality care. When a nurse delegates a task, it is vital to consider the competencies, experience, and training of the person receiving the delegation. This ensures that the task can be performed safely and effectively, maintaining the standards of care that patients deserve. For instance, if a complex procedure is delegated to a staff member who lacks the necessary skills or training, it could lead to mistakes or adverse events. This principle aligns with the practice of promoting accountability and responsibility within the healthcare team, as each member is expected to perform tasks that fit their qualifications. Therefore, effective delegation is rooted in understanding the abilities of each team member and tailoring assignments accordingly, which helps in optimizing team performance and enhancing patient outcomes.

8. Which lab value is most indicative of kidney function?

- A. Blood urea nitrogen**
- B. Electrolyte levels**
- C. Creatinine**
- D. Complete blood count**

The most indicative lab value of kidney function is creatinine. Creatinine is a waste product that is generated from muscle metabolism and is typically produced at a relatively steady rate. It is primarily cleared from the blood by the kidneys; thus, measuring serum creatinine levels provides important insights into kidney function. Elevated levels indicate that the kidneys are not filtering waste products efficiently, which may be a sign of impaired renal function. In contrast, while blood urea nitrogen (BUN) is also used to assess kidney function, it can be influenced by factors such as hydration status, protein intake, and liver function, making it less specific to kidney impairment compared to creatinine. Electrolyte levels can reflect kidney function to some extent, but they are more indicators of metabolic processes and imbalances than direct measures of renal function. A complete blood count (CBC) primarily assesses overall health and detects a variety of disorders, such as anemia and infections, without providing specific information about kidney performance.

9. What is a primary goal of physical therapy and nursing interventions for a client with Parkinson's disease?

- A. To maintain joint flexibility.**
- B. To reduce ataxia.**
- C. To build muscle strength.**
- D. To improve muscle endurance.**

Maintaining joint flexibility is a primary goal of physical therapy and nursing interventions for clients with Parkinson's disease due to the nature of the condition, which often leads to stiffness and rigidity in the muscles and joints. Parkinson's disease can significantly impair mobility and functional independence, and preserving the range of motion is crucial to facilitate movement and prevent complications such as contractures. In physical therapy, exercises aimed at enhancing flexibility can help alleviate some of the rigidity associated with Parkinson's, making daily activities easier and improving the overall quality of life. This goal aligns with the broader objective of promoting functional mobility and maintaining as much independence as possible for individuals living with this progressive neurological disorder. Building muscle strength, improving muscle endurance, and reducing ataxia are also important aspects of the treatment plan, but they do not specifically address the immediate concern of joint flexibility, which is crucial in managing the motor symptoms of Parkinson's disease. Therefore, focusing on maintaining joint flexibility is a foundational aspect of care for these patients.

10. Which symptom should the nurse monitor closely in a pediatric patient recovering from a head injury?

- A. Persistent vomiting**
- B. Decreased appetite**
- C. Persistent sleepiness**
- D. Headaches**

Monitoring for persistent vomiting in a pediatric patient recovering from a head injury is crucial because it can indicate increased intracranial pressure or other complications such as a concussion. Vomiting, especially if it is recurrent and severe, may be a sign that the brain is experiencing abnormal pressure or irritation, which can lead to more serious conditions if left unaddressed. This symptom might also reflect a potential deterioration in the patient's neurological status. While decreased appetite, persistent sleepiness, and headaches can all be relevant symptoms to watch for in a patient recovering from a head injury, they do not specifically signal immediate risks to the patient's neurological integrity the way persistent vomiting does. Persistent sleepiness could be normal but needs to be monitored to ensure it doesn't signify worsening conditions. Headaches may also be common after a head injury but typically are less alarming than the danger posed by persistent vomiting.

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://adultnursinglvl3.examzify.com>

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

SAMPLE