

ASSOCIATE DEGREE IN NURSING (ADN) LEVEL 3 PRACTICE EXAM (SAMPLE)

STUDY GUIDE



Prepare with structure. Pass with confidence



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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.

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

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- 1. What does the Glasgow Coma Scale assess?**
 - A. A patient's pain level
 - B. A patient's level of consciousness
 - C. A patient's mobility status
 - D. A patient's reaction to stimuli

- 2. 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.

- 3. What is the primary action of anticoagulants?**
 - A. To promote blood cell production
 - B. To increase blood pressure
 - C. To prevent the formation of blood clots
 - D. To enhance oxygen delivery to tissues

- 4. What fundamental principle is emphasized in informed consent regarding the client's rights?**
 - A. Helps the client to make a living will regarding future health care
 - B. Protects the client's right to self-determination in health care decision making
 - C. Helps the client refuse treatment they do not wish to undergo
 - D. Provides the client with comprehensive knowledge about treatment options

- 5. What should a nurse instruct the parent of a teenager who experienced a hard tackle in football?**
 - A. If he seems fine now, it probably was not a concussion.
 - B. Take him immediately to the emergency department.
 - C. Watch him closely and call back if there are changes.
 - D. He cannot return to play until evaluated by a health provider.

- 6. What is the first action the nurse should take after noting a systolic murmur during a head-to-toe assessment?**
- A. Notify the HCP about the new cardiac complication
 - B. Document the finding in the client's chart and tell the charge nurse
 - C. Check the chart to determine whether this is the first time a murmur has been identified
 - D. Ask the client whether she has ever been told she has an abnormal heartbeat
- 7. Which is a common sign observed in clients with a significant neurological event?**
- A. Reflexive movement
 - B. Loss of consciousness
 - C. Uninterrupted conscious awareness
 - D. Consistent heart rhythms
- 8. What does a high BUN level indicate?**
- A. Increased liver function
 - B. Possible kidney dysfunction or dehydration
 - C. Hypercalcemia
 - D. Low blood glucose levels
- 9. What does a nurse assess when checking for peripheral pulses?**
- A. Heart rate
 - B. Circulation and blood flow to the extremities
 - C. Skin temperature
 - D. Capillary refill time
- 10. During triage, what condition should be prioritized for a patient with respiratory difficulty?**
- A. Updated medical history
 - B. Oxygen saturation evaluation
 - C. Immediate airway access
 - D. Detailed physical examination

Answers

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

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Explanations

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1. What does the Glasgow Coma Scale assess?

- A. A patient's pain level
- B. A patient's level of consciousness**
- C. A patient's mobility status
- D. A patient's reaction to stimuli

The Glasgow Coma Scale (GCS) is specifically designed to assess a patient's level of consciousness following a head injury or in situations where consciousness may be impaired. It evaluates three components: Eye Opening, Verbal Response, and Motor Response, providing a standardized way to quantify the level of alertness and responsiveness of a patient. By measuring these responses, healthcare providers can effectively gauge the severity of a patient's neurological condition and determine appropriate interventions. The higher the total GCS score, which ranges from 3 to 15, the better the patient's level of consciousness. This tool is critical in emergency medicine and neurology for monitoring changes over time and in response to treatment. Other options focus on aspects that are not the primary purpose of the GCS. While the scale might indirectly reflect reactions to stimuli and pain levels, it does not directly measure pain or mobility status.

2. 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.

3. What is the primary action of anticoagulants?

- A. To promote blood cell production
- B. To increase blood pressure
- C. To prevent the formation of blood clots**
- D. To enhance oxygen delivery to tissues

The primary action of anticoagulants is to prevent the formation of blood clots. These medications work by inhibiting various components of the coagulation cascade, which is essential for the blood clotting process. By reducing the ability of blood to clot, anticoagulants are effective in preventing conditions such as deep vein thrombosis, pulmonary embolism, and arterial thromboembolism. This action is crucial in managing patients at risk of thrombotic events, allowing for improved blood flow and a reduced likelihood of complications related to excessive clot formation. Understanding the mechanism of anticoagulants helps healthcare professionals make informed decisions about their use in a clinical setting, ensuring patient safety and optimizing therapeutic outcomes. These drugs do not influence blood cell production, blood pressure, or oxygen delivery, which distinguishes their specific role in vascular health and disease management.

4. What fundamental principle is emphasized in informed consent regarding the client's rights?

- A. Helps the client to make a living will regarding future health care
- B. Protects the client's right to self-determination in health care decision making**
- C. Helps the client refuse treatment they do not wish to undergo
- D. Provides the client with comprehensive knowledge about treatment options

The fundamental principle emphasized in informed consent is centered around the client's right to self-determination in health care decision making. Informed consent ensures that clients have the autonomy to make their own decisions regarding their medical treatment based on a clear understanding of the information presented to them. This includes the risks, benefits, and alternatives associated with a proposed treatment or intervention. By respecting a client's right to self-determination, healthcare providers empower individuals to take an active role in their care. This principle is critical in fostering trust in the nurse-client relationship, as clients feel respected and valued when their choices are honored. While helping clients make advance directives such as living wills, refusing treatment, or providing comprehensive information about treatment options are important aspects of patient education and advocacy, they do not encapsulate the core essence of self-determination. The emphasis on self-determination aligns with ethical practices within healthcare, reinforcing the importance of autonomy in individual health care choices.

5. What should a nurse instruct the parent of a teenager who experienced a hard tackle in football?

- A. If he seems fine now, it probably was not a concussion.
- B. Take him immediately to the emergency department.
- C. Watch him closely and call back if there are changes.
- D. He cannot return to play until evaluated by a health provider.**

The correct response emphasizes the importance of ensuring the safety of the teenager following a potentially traumatic event such as a hard tackle in football. A concussion is a serious brain injury that may not present immediate symptoms but can have significant consequences if overlooked. It is crucial for the athlete not to return to play until they have been evaluated by a healthcare provider, as this helps prevent further injury that might occur if a concussion is present but not recognized. By requiring an evaluation before allowing the teenager to resume sports activities, the nurse is adhering to concussion management guidelines that prioritize the health and safety of the individual. This practice is supported by recommendations from organizations such as the CDC and the American Academy of Pediatrics, which advocate for proper assessment and management of head injuries. While the other options may contain elements of truth, they do not adequately prioritize the necessary precautions to protect the teenager's health. Thus, the emphasis on evaluation by a health provider ensures a careful and informed approach to returning to physical activity.

6. What is the first action the nurse should take after noting a systolic murmur during a head-to-toe assessment?

- A. Notify the HCP about the new cardiac complication
- B. Document the finding in the client's chart and tell the charge nurse
- C. Check the chart to determine whether this is the first time a murmur has been identified**
- D. Ask the client whether she has ever been told she has an abnormal heartbeat

Determining whether the systolic murmur is a new finding is crucial for assessing the client's cardiac status effectively. By checking the chart for any previous documentation of a murmur, the nurse can discern whether this is a new development or a known condition. This knowledge helps guide subsequent actions, such as whether immediate care or monitoring is necessary. If the murmur is indeed new, it may indicate an evolving cardiac condition that requires prompt attention and potentially notifying the healthcare provider. Conversely, if it's an existing finding with documentation, the nurse can take appropriate steps to continue monitoring without immediate alarm. This foundational information is essential for establishing a comprehensive plan of care and ensuring the client's safety. Taking this initial step aids in organizing the nursing intervention, providing a clearer picture of the patient's history, and facilitating communication with the healthcare team.

7. Which is a common sign observed in clients with a significant neurological event?

- A. Reflexive movement
- B. Loss of consciousness**
- C. Uninterrupted conscious awareness
- D. Consistent heart rhythms

Loss of consciousness is a significant indicator often observed in clients experiencing a neurological event such as a stroke, seizure, or traumatic brain injury. This symptom can indicate that the brain's normal functions are disrupted, potentially affecting the areas that control consciousness. When there is an interruption in the blood flow to the brain or significant injury, it can lead to alterations in awareness and responsiveness, prompting a loss of consciousness. The presence of this symptom plays a critical role in a clinician's assessment and can help guide immediate interventions and further evaluation. Early recognition of loss of consciousness can lead to timely medical treatment, which is essential in managing neurological emergencies effectively.

8. What does a high BUN level indicate?

- A. Increased liver function
- B. Possible kidney dysfunction or dehydration**
- C. Hypercalcemia
- D. Low blood glucose levels

A high BUN (Blood Urea Nitrogen) level is primarily associated with possible kidney dysfunction or dehydration. BUN is a waste product formed in the liver after the body breaks down protein, and it is typically eliminated through the kidneys. When kidney function is impaired, BUN levels can rise. Additionally, dehydration can lead to an increase in BUN due to a decreased fluid volume in the body, which concentrates the waste products in the blood. The other options do not directly relate to the implications of elevated BUN levels. Increased liver function would more likely affect other liver enzyme levels rather than BUN. Hypercalcemia pertains to elevated calcium levels and does not affect nitrogen levels directly. Low blood glucose levels would not be indicated by BUN levels either, as they pertain to entirely different metabolic processes. Understanding the significance of BUN in relation to kidney health underscores its importance in assessing kidney function and hydration status in patients.

9. What does a nurse assess when checking for peripheral pulses?

- A. Heart rate
- B. Circulation and blood flow to the extremities**
- C. Skin temperature
- D. Capillary refill time

When a nurse assesses peripheral pulses, the primary focus is on circulation and blood flow to the extremities. Peripheral pulses are the pulsations of arteries in the limbs, and their strength, rhythm, and quality provide crucial information regarding the vascular status of the extremities. By palpating these pulses, the nurse can determine if there is adequate blood flow reaching the arms and legs, which is essential for tissue perfusion. Monitoring peripheral pulses helps identify conditions such as peripheral artery disease, blood clots, or vascular occlusion, which can compromise circulation. Observations of the pulse's characteristics, combined with other assessments, can indicate the overall effectiveness of the cardiovascular system. Although heart rate can be indirectly inferred from peripheral pulse assessment, its main purpose is to assess the adequacy of circulation rather than solely measuring how fast the heart beats. Similarly, skin temperature and capillary refill time are useful peripheral circulation assessments but are separate evaluations that can complement the overall understanding of circulation status.

10. During triage, what condition should be prioritized for a patient with respiratory difficulty?

- A. Updated medical history
- B. Oxygen saturation evaluation
- C. Immediate airway access**
- D. Detailed physical examination

In the context of triage, prioritizing immediate airway access is critical for a patient experiencing respiratory difficulty. The airway is a fundamental component of respiration, and any compromise can result in severe hypoxia or respiratory failure. Establishing clear and patent airway access can be life-saving, as it allows for the delivery of oxygen and other necessary interventions. Addressing airway issues as a priority ensures that any obstructive conditions or complications can be managed effectively and promptly. Other evaluations, such as assessing oxygen saturation or thorough medical histories, are important but take a secondary role to ensuring that the airway is secure. If the airway is compromised, no other interventions will be effective until it is addressed. Therefore, in a triage scenario, the immediate and effective management of the airway takes precedence over other assessments.

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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://adultnursinglvl3.examzify.com>

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

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