

# Certified Medical-Surgical Registered Nurse Practice Test (Sample)

## Study Guide



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**SAMPLE**

## **Questions**

- 1. The nurse is teaching infection control measures. What is the first line of intervention for preventing the spread of infection?**
  - A. Wearing gloves**
  - B. Administering antibiotics**
  - C. Hand hygiene**
  - D. Assigning private rooms for patients**
- 2. What vital sign parameter is critical when monitoring patients with cardiac issues?**
  - A. Blood pressure and skin temperature**
  - B. Heart rate and rhythm**
  - C. Respiratory rate and oxygen saturation**
  - D. Body temperature and weight**
- 3. When should a nurse assess a patient's IV site?**
  - A. Only after administering medication**
  - B. At least once every shift and after any medication is given**
  - C. Only if the patient reports pain at the site**
  - D. Prior to patient discharge only**
- 4. Which intervention is beneficial for preventing respiratory complications in post-operative patients?**
  - A. Encouraging bed rest**
  - B. Encouraging deep breathing exercises**
  - C. Limiting fluid intake**
  - D. Restricting movements for 24 hours**
- 5. Which action occurs primarily during the evaluation phase of the nursing process?**
  - A. Data collection**
  - B. Decision-making and judgment**
  - C. Priority-setting and expected outcomes**
  - D. Reassessment and audit**

- 6. What is the purpose of patient teaching about deep vein thrombosis (DVT) prevention?**
- A. To teach patients about medication administration**
  - B. To reduce the risk of complications related to immobility**
  - C. To encourage more fluid intake**
  - D. To ensure proper wound care**
- 7. Which assessment tool is most effective for determining pain levels?**
- A. The visual analog scale**
  - B. The numeric pain rating scale (0-10)**
  - C. The 5-point Likert scale**
  - D. The faces pain scale**
- 8. What would be an appropriate response by the nurse when a patient's wife expresses concern that her husband might have had a stroke?**
- A. It's really too early to be concerned about that. Let's wait until the test results come back.**
  - B. If it is a stroke, your husband is in the right hospital for treatment.**
  - C. Yes, he does have symptoms of a stroke. That's what the tests will help us find out.**
  - D. I'm going to get you some information to read about strokes and their treatment.**
- 9. Which outcome is most expected from proper wound care management?**
- A. Full recovery in all patients**
  - B. Minimal pain during dressing changes**
  - C. Decreased chance of infection**
  - D. Aesthetic improvement of surgical sites**

**10. A patient with an arterial ulcer over the left lateral malleolus complains of pain at the ulcer site. The pain is most commonly caused by:**

- A. Edema**
- B. Exudate**
- C. Infection**
- D. Ischemia**

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## **Answers**

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

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## **Explanations**

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**1. The nurse is teaching infection control measures. What is the first line of intervention for preventing the spread of infection?**

**A. Wearing gloves**

**B. Administering antibiotics**

**C. Hand hygiene**

**D. Assigning private rooms for patients**

Hand hygiene is the first line of intervention for preventing the spread of infection because clean hands are crucial in reducing the transmission of pathogens from one person to another. By performing hand hygiene, such as washing hands with soap and water or using hand sanitizer, healthcare providers can effectively remove and kill germs that could potentially cause infections. This simple act is considered the most important measure in infection control practices. While wearing gloves, administering antibiotics, and assigning private rooms for patients are all important in infection control, none of these measures are as fundamental as proper hand hygiene in preventing the spread of infections.

**2. What vital sign parameter is critical when monitoring patients with cardiac issues?**

**A. Blood pressure and skin temperature**

**B. Heart rate and rhythm**

**C. Respiratory rate and oxygen saturation**

**D. Body temperature and weight**

Monitoring heart rate and rhythm is crucial for patients with cardiac issues because these parameters provide essential information about the heart's electrical activity and overall function. Abnormalities in heart rate can indicate underlying problems such as arrhythmias, which can lead to severe complications if not addressed promptly. Changes in heart rhythm can signal changes in clinical status that may require immediate intervention. Additionally, heart rate can reflect how well the heart is pumping blood throughout the body and how the body is responding to various stresses, including physical activity or medication. For patients with conditions such as heart failure, myocardial infarction, or arrhythmias, continuous assessment of heart rate and rhythm is vital to ensure that any deviations from normal can be acted upon quickly to prevent further deterioration. This focus on cardiac-specific vital signs allows healthcare providers to manage and adjust treatment plans effectively, ensuring the best possible outcomes for these patients.

### 3. When should a nurse assess a patient's IV site?

- A. Only after administering medication
- B. At least once every shift and after any medication is given**
- C. Only if the patient reports pain at the site
- D. Prior to patient discharge only

Assessing a patient's IV site is a critical component of nursing care to ensure patient safety and the proper functioning of the IV. Regular assessment of the IV site helps identify potential complications such as phlebitis, infiltration, or infection, which can lead to serious patient issues if not addressed promptly. Conducting an assessment at least once every shift ensures ongoing monitoring and facilitates early detection of any problems that may arise. This proactive approach is essential for maintaining the integrity of the IV access and ensuring that the patient is receiving their prescribed therapies without interruption. Additionally, assessing the IV site after administering medication allows the nurse to evaluate the site for any immediate reactions or complications following the medication administration. The other options do not address the need for regular monitoring. Limiting assessment to only after administering medication or solely when the patient reports pain could lead to delayed recognition of complications, which can compromise patient safety and treatment efficacy. Similarly, assessing only prior to discharge would not allow for timely intervention in the case of developing problems with the IV site during the hospitalization.

### 4. Which intervention is beneficial for preventing respiratory complications in post-operative patients?

- A. Encouraging bed rest
- B. Encouraging deep breathing exercises**
- C. Limiting fluid intake
- D. Restricting movements for 24 hours

Encouraging deep breathing exercises is critical in preventing respiratory complications in post-operative patients. After surgery, particularly when patients are under anesthesia, they can experience a decrease in lung capacity and an increased risk of atelectasis, which is the collapse of part or all of a lung. Deep breathing exercises help to expand the lungs, promote ventilation, and facilitate the clearance of lung secretions. This action is particularly important in enhancing oxygenation and preventing complications such as pneumonia, which can occur due to shallow breathing and reduced mobility post-surgery. In contrast, encouraging bed rest may lead to further respiratory decline as patients may not be mobilizing enough to promote effective lung function. Limiting fluid intake can actually worsen respiratory status by leading to thicker secretions and a higher likelihood of obstruction. Similarly, restricting movements for 24 hours can inhibit the patient's ability to take deep breaths and cough effectively, contributing to poor respiratory outcomes. Thus, deep breathing exercises stand out as a proactive intervention to maintain lung function and prevent respiratory complications in post-operative care.

**5. Which action occurs primarily during the evaluation phase of the nursing process?**

- A. Data collection**
- B. Decision-making and judgment**
- C. Priority-setting and expected outcomes**
- D. Reassessment and audit**

During the evaluation phase of the nursing process, reassessment and audit occur primarily. This phase involves comparing the patient's actual outcomes to the expected outcomes set during the planning phase. Reassessment involves gathering data to determine the patient's current status and progress, while audit involves evaluating the effectiveness of the nursing care provided. This phase helps in determining whether the nursing interventions were successful in achieving the desired outcomes for the patient.

**6. What is the purpose of patient teaching about deep vein thrombosis (DVT) prevention?**

- A. To teach patients about medication administration**
- B. To reduce the risk of complications related to immobility**
- C. To encourage more fluid intake**
- D. To ensure proper wound care**

The purpose of patient teaching about deep vein thrombosis (DVT) prevention centers on reducing the risk of complications associated with immobility. DVT is a condition where blood clots form in deep veins, often in the legs, and is primarily a concern for individuals who may be immobile for extended periods, such as those recovering from surgery, those on bed rest, or individuals with certain medical conditions. Educating patients about DVT prevention involves practical strategies such as encouraging movement, the use of compression stockings, the importance of leg exercises, and understanding the signs and symptoms of DVT. By addressing these aspects, the teaching aims to enhance patient awareness and encourage proactive measures to maintain circulation and prevent the formation of clots, thereby significantly lowering the risk of serious complications such as pulmonary embolism. While medication administration, fluid intake, and wound care are important aspects of overall patient health, they do not directly target the primary prevention of DVT related to immobility, making them less relevant to the specific focus of this question.

**7. Which assessment tool is most effective for determining pain levels?**

- A. The visual analog scale**
- B. The numeric pain rating scale (0-10)**
- C. The 5-point Likert scale**
- D. The faces pain scale**

The numeric pain rating scale (0-10) is a highly effective tool for assessing pain levels because it allows patients to express the intensity of their pain in a clear and quantifiable manner. This scale provides a straightforward way for patients to communicate their pain on a continuum, where 0 represents no pain and 10 signifies the worst pain imaginable. This simplicity supports both patients and healthcare providers in establishing a common understanding of pain severity, which can facilitate timely and appropriate interventions. In addition to its effectiveness in communication, the numeric rating scale can be easily incorporated into clinical practice and can be used across different settings and populations, making it versatile for various patient demographics. It encourages patients to reflect on their pain levels and can be reassessed over time, allowing for effective monitoring of pain management strategies. This ongoing assessment is crucial for tailoring care plans to meet a patient's specific needs. Other scales, while useful in specific contexts, may not offer the same level of straightforward numerical representation or may be better suited for particular populations. For example, the visual analog scale relies on a mark along a line to indicate pain, which might be less intuitive for some individuals. The 5-point Likert scale offers limited granularity in assessing pain, while the faces pain scale serves well

**8. What would be an appropriate response by the nurse when a patient's wife expresses concern that her husband might have had a stroke?**

- A. It's really too early to be concerned about that. Let's wait until the test results come back.**
- B. If it is a stroke, your husband is in the right hospital for treatment.**
- C. Yes, he does have symptoms of a stroke. That's what the tests will help us find out.**
- D. I'm going to get you some information to read about strokes and their treatment.**

In this scenario, the most appropriate response by the nurse when a patient's wife expresses concern that her husband might have had a stroke is option C. By acknowledging the wife's concern and stating that the symptoms her husband is experiencing are consistent with a stroke, the nurse shows empathy and provides reassurance that the appropriate steps are being taken to investigate further through tests. This response validates the wife's perception while also maintaining a professional and informative approach.

**9. Which outcome is most expected from proper wound care management?**

- A. Full recovery in all patients**
- B. Minimal pain during dressing changes**
- C. Decreased chance of infection**
- D. Aesthetic improvement of surgical sites**

Proper wound care management is essential for promoting healing and preventing complications, and one of the primary goals is to decrease the chance of infection. Effective wound care practices, such as keeping the wound clean, applying appropriate dressings, and monitoring for signs of infection, significantly reduce the risk of pathogenic organisms entering the wound. This is critical because infections can lead to delayed healing, increased pain, and potentially serious complications that may require further medical intervention. While minimal pain during dressing changes, full recovery in all patients, and aesthetic improvement of surgical sites are desirable outcomes, they are not the primary expectations associated with effective wound care management. Pain can be managed with appropriate analgesia, and aesthetic outcomes depend on many factors beyond just wound care, including the type of injury or surgery and individual patient factors. Full recovery is an ideal but not guaranteed outcome since patients may have varying responses to treatment based on their health status and comorbidities. Thus, the cornerstone of effective wound care is infection prevention and management, making decreased chance of infection the most expected outcome from proper wound care management.

**10. A patient with an arterial ulcer over the left lateral malleolus complains of pain at the ulcer site. The pain is most commonly caused by:**

- A. Edema**
- B. Exudate**
- C. Infection**
- D. Ischemia**

In this scenario, the patient has an arterial ulcer, which is typically caused by ischemia or inadequate blood supply to the area. Ischemia leads to tissue damage, which in turn causes pain at the ulcer site. Therefore, the pain experienced by the patient is most commonly caused by ischemia. Edema, exudate, and infection are potential complications associated with ulcers; however, in this case, the patient's pain is primarily attributed to the underlying ischemia characteristic of arterial ulcers.