

Clinical Judgment Exam (CJE) 1 Practice (Sample)

Study Guide



Everything you need from our exam experts!

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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 unexpected finding might a nurse observe in a client receiving lactulose for hepatic encephalopathy?**
 - A. Ca 8.5.**
 - B. Na 155.**
 - C. Urine positive for ketones.**
 - D. Potassium level 3.0.**

- 2. In interpreting arterial blood gases, what should be done first to confirm metabolic acidosis?**
 - A. Analyze the HCO₃ as acidotic.**
 - B. Determine pH is acidotic.**
 - C. Determine the O₂ saturation is normal.**
 - D. Determine the CO₂ is decreasing.**

- 3. How do nursing diagnoses primarily differ from medical diagnoses?**
 - A. They focus on the pathophysiology of diseases**
 - B. They focus on patient responses to health issues**
 - C. They are only concerned with physical symptoms**
 - D. They prioritize diagnostic testing over patient assessment**

- 4. What is the nurse's priority action for a client with a C4 spinal cord injury exhibiting bradycardia?**
 - A. Prepare the client for intubation.**
 - B. Obtain arterial blood gases (ABG's).**
 - C. Initiate intravenous fluid replacement.**
 - D. Administer atropine.**

- 5. Which action should the nurse prioritize for delegation to a nursing assistant following an ORIF?**
 - A. Asking the client about pain**
 - B. Feeding the client during meals**
 - C. Applying sequential compression devices**
 - D. Administering medication**

- 6. What is an unsuitable action if there is no drainage and tubing is assessed as clear?**
- A. Continue to monitor**
 - B. Adjust the patient's position**
 - C. Notify the Rapid Response Team**
 - D. Strip the chest tube**
- 7. Which client is at greatest risk of developing osteoarthritis based on age and genetic predisposition?**
- A. A 50-year-old female who smokes.**
 - B. A 55-year-old female who is overweight.**
 - C. A 40-year-old male who never had children.**
 - D. A 65-year-old female with a family history.**
- 8. What does "reflexive practice" refer to in nursing?**
- A. A method of taking notes**
 - B. A process to finalize care plans**
 - C. The ongoing process of reflection that helps improve clinical judgment and care**
 - D. Only documenting patient interactions**
- 9. What assessment finding is concerning for a client receiving intravenous therapy?**
- A. Urine output of 30 mL over two hours.**
 - B. Stable blood pressure.**
 - C. Increase in heart rate.**
 - D. Intake of 1000 mL of fluid.**
- 10. What is the outcome expected from effective intervention in nursing?**
- A. Increased hospital stay duration**
 - B. Improved patient outcomes and satisfaction**
 - C. Reduced patient involvement in care**
 - D. Higher costs for patients**

Answers

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

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Explanations

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1. What unexpected finding might a nurse observe in a client receiving lactulose for hepatic encephalopathy?

A. Ca 8.5.

B. Na 155.

C. Urine positive for ketones.

D. Potassium level 3.0.

In the context of a client receiving lactulose for hepatic encephalopathy, it is important to recognize the physiological effects of the drug. Lactulose is a non-absorbable synthetic sugar that functions as an osmotic laxative. It decreases the absorption of ammonia in the intestines, which helps to reduce the levels of ammonia in patients with hepatic encephalopathy. When a client is receiving lactulose, one expected effect is increased bowel movements, which can lead to a number of metabolic changes. A possible and somewhat unexpected finding is the presence of ketones in the urine. The use of lactulose can cause diarrhea, which may lead the body to enter a state of ketosis due to insufficient carbohydrate intake or absorption. In cases of prolonged diarrhea, the body may start breaking down fat for energy, resulting in the accumulation of ketones. Thus, finding urine positive for ketones is indicative of altered metabolism due to the effects of lactulose therapy and could be construed as an unexpected but plausible outcome in this context. The other options relate to specific electrolyte imbalances or metabolic conditions not directly associated with the typical administration of lactulose or its side effects, making them less relevant to the scenario presented.

2. In interpreting arterial blood gases, what should be done first to confirm metabolic acidosis?

A. Analyze the HCO₃ as acidotic.

B. Determine pH is acidotic.

C. Determine the O₂ saturation is normal.

D. Determine the CO₂ is decreasing.

To confirm metabolic acidosis in arterial blood gases (ABGs), the first step should be determining if the pH is acidotic. The pH provides direct insight into the body's acid-base status. In metabolic acidosis, the pH typically falls below the normal range (7.35-7.45), indicating acidosis. Once the pH is established as acidotic, further evaluation can include looking at the bicarbonate (HCO₃) levels, which will usually be low in metabolic acidosis as the body is attempting to compensate for the acidemia. However, analyzing the pH first gives the foundational understanding needed to guide the interpretation of the other values in the ABGs. The other options, while important in the overall assessment, do not serve as the first confirmation for metabolic acidosis. Analyzing HCO₃ can indicate if there is a primary metabolic process, but it presumes that one has already determined the pH status, which is not the most effective first step. Assessing O₂ saturation is more relevant for respiratory issues and does not directly indicate acid-base status. Evaluating CO₂ levels can show respiratory compensation or opposite pathology but is secondary to establishing the pH's status first. Thus, confirming that the

3. How do nursing diagnoses primarily differ from medical diagnoses?

- A. They focus on the pathophysiology of diseases
- B. They focus on patient responses to health issues**
- C. They are only concerned with physical symptoms
- D. They prioritize diagnostic testing over patient assessment

Nursing diagnoses primarily differ from medical diagnoses in that they focus on the patient's responses to health issues rather than the diseases or conditions themselves. This approach emphasizes the holistic nature of nursing care, which encompasses not only the physical aspects of a patient's condition but also their emotional, social, and psychological responses. By understanding how a patient reacts to their health challenges, nurses can develop individualized care plans that address the unique needs of each patient. Medical diagnoses, on the other hand, are centered around identifying specific illnesses or conditions based on established criteria and pathophysiological understanding. While medical diagnoses are crucial for determining the appropriate medical interventions, nursing diagnoses take a broader view by considering how those conditions impact the patient's overall well-being and quality of life. The other options focus on aspects that do not accurately reflect the primary distinction. Emphasizing pathophysiology, physical symptoms, or prioritization of diagnostic testing overlooks the core nursing philosophy of patient-centered care that is integral to nursing diagnoses. This understanding facilitates effective nursing interventions that align with the patient's personal experiences and needs.

4. What is the nurse's priority action for a client with a C4 spinal cord injury exhibiting bradycardia?

- A. Prepare the client for intubation.
- B. Obtain arterial blood gases (ABG's).
- C. Initiate intravenous fluid replacement.
- D. Administer atropine.**

In the case of a client with a C4 spinal cord injury exhibiting bradycardia, the priority action is to administer atropine. This is because bradycardia in a patient with a high cervical spine injury may be a result of autonomic dysreflexia or loss of sympathetic tone, leading to a significant decrease in heart rate. Atropine is an anticholinergic medication that works by blocking the effects of the vagus nerve, which can help to increase heart rate in this situation. Administration of atropine is often the first-line treatment for bradycardia in the context of a spinal cord injury, as it can quickly alleviate the acute condition and stabilize the patient. Timely intervention is critical in such cases since severe bradycardia can lead to decreased cardiac output and potential cardiovascular complications. While other actions such as preparing the client for intubation, obtaining ABGs, or initiating intravenous fluid replacement may be considerations in a comprehensive care plan, they do not directly address the immediate concern of bradycardia. Intubation would be warranted if the patient is unable to maintain their airway, and ABGs could provide data on respiratory function and acid-base status, but neither acts to correct the bradycardia itself.

5. Which action should the nurse prioritize for delegation to a nursing assistant following an ORIF?

- A. Asking the client about pain**
- B. Feeding the client during meals**
- C. Applying sequential compression devices**
- D. Administering medication**

Delegating the application of sequential compression devices to a nursing assistant is an appropriate choice following an Open Reduction and Internal Fixation (ORIF) procedure. This task involves applying devices that help prevent deep vein thrombosis (DVT) by promoting circulation in the lower extremities, which is a fundamental aspect of post-operative care. Nursing assistants are typically trained to understand how to properly apply and manage such equipment, ensuring that the devices are functioning correctly and that the patient is comfortable. Delegating this task helps to free the nurse to focus on higher-level assessments and interventions that require clinical judgment. Other tasks, like asking about pain, are critical assessments that require the nurse's expertise to interpret the patient's responses in the context of overall clinical judgment and pain management strategies. Feeding the client, while it may seem straightforward, also requires an understanding of the patient's dietary needs and potential for aspiration which is best managed by a nurse. Administering medication is a task that requires keen assessment skills and the ability to monitor for possible adverse effects and interactions, making it essential that this responsibility remains with the nursing staff.

6. What is an unsuitable action if there is no drainage and tubing is assessed as clear?

- A. Continue to monitor**
- B. Adjust the patient's position**
- C. Notify the Rapid Response Team**
- D. Strip the chest tube**

Stripping the chest tube is considered an unsuitable action in the scenario where there is no drainage and the tubing is assessed as clear. Stripping involves pulling and squeezing the chest tube to create suction and may increase the risk of creating a negative pressure in the pleural space. This can lead to complications such as damage to the tissue, causing a pneumothorax, or facilitating an infection due to external contaminants. In cases where there is no drainage and the tubing appears clear, it's generally prudent to first assess the situation thoroughly before taking more invasive actions. Monitoring the patient ongoingly allows for observation of any changes in condition while adjusting the patient's position may help facilitate drainage by promoting gravity flow. Notifying the Rapid Response Team is reserved for more severe or urgent situations, which would likely involve other clinical signs and symptoms warranting immediate intervention. Thus, stripping the chest tube does not align with the safest practices for patient management under these circumstances.

7. Which client is at greatest risk of developing osteoarthritis based on age and genetic predisposition?

- A. A 50-year-old female who smokes.**
- B. A 55-year-old female who is overweight.**
- C. A 40-year-old male who never had children.**
- D. A 65-year-old female with a family history.**

The selection of the 65-year-old female with a family history as the client at greatest risk of developing osteoarthritis is based on two significant factors: age and genetic predisposition. Osteoarthritis is primarily associated with aging, as the wear and tear on joints accumulate over time, leading to the degeneration of cartilage and changes in the bone structure. Individuals over 60, especially women, are at a notably higher risk for developing this condition due to factors such as hormonal changes and the natural aging process. Additionally, genetic predisposition plays a crucial role in the development of osteoarthritis. A family history suggests that there may be hereditary factors or genetic markers that increase the likelihood of someone developing the disease. In this case, the combination of being 65 years old and having a family history aligns closely with the known risk factors for osteoarthritis, thereby placing this client at the highest risk compared to the others. While factors like smoking and obesity can contribute to various health-related issues, including joint problems, they do not specifically correlate to the age and genetic predisposition as strongly as the chosen answer. The other options present factors that either do not weigh as heavily as age in relation to osteoarthritis risk or lack the element of family history, which is critical

8. What does "reflexive practice" refer to in nursing?

- A. A method of taking notes**
- B. A process to finalize care plans**
- C. The ongoing process of reflection that helps improve clinical judgment and care**
- D. Only documenting patient interactions**

Reflexive practice in nursing refers to the ongoing process of reflection that allows nurses to improve their clinical judgment and care. This approach emphasizes the importance of critically analyzing one's own actions, decisions, and the outcomes they produce in various clinical scenarios. By engaging in reflexive practice, nurses can identify areas for improvement, adapt their strategies, and ultimately enhance patient outcomes. This practice also fosters a deeper understanding of the complexities involved in patient care, enabling nurses to learn from their experiences and apply this knowledge to future situations. The other choices do not capture the essence of reflexive practice. Simply taking notes or only documenting patient interactions lacks the depth of reflection and critical analysis inherent in reflexive practice. Finalizing care plans may require thoughtful consideration but doesn't embody the continuous learning aspect that reflexive practice entails. Therefore, the definition focused on the ongoing reflection process aligns accurately with the true meaning of reflexive practice in the nursing profession.

9. What assessment finding is concerning for a client receiving intravenous therapy?

- A. Urine output of 30 mL over two hours.**
- B. Stable blood pressure.**
- C. Increase in heart rate.**
- D. Intake of 1000 mL of fluid.**

A urine output of 30 mL over two hours raises a significant concern for a client receiving intravenous therapy. This finding indicates a potential issue with kidney function or fluid balance. Normal urine output is typically about 30 mL per hour, so a total of 30 mL over two hours falls below this benchmark, suggesting the client may be experiencing inadequate renal perfusion or dehydration. It may also indicate that the body is retaining fluid due to potential heart failure or other complications related to intravenous therapy. In contrast, stable blood pressure is generally considered a positive sign, indicating that the client's hemodynamic status is stable and may not be experiencing significant fluid volume overload or deficit. An increase in heart rate could potentially signal an adverse reaction or the body's response to fluid status changes, but it must be assessed in the context of other vitals and symptoms. Lastly, an intake of 1000 mL of fluid might not inherently be concerning, especially if it aligns with what the client needs according to their treatment plan; it could indicate adequate hydration rather than a problem.

10. What is the outcome expected from effective intervention in nursing?

- A. Increased hospital stay duration**
- B. Improved patient outcomes and satisfaction**
- C. Reduced patient involvement in care**
- D. Higher costs for patients**

The outcome expected from effective intervention in nursing is improved patient outcomes and satisfaction. This outcome is essential because the primary focus of nursing care is to enhance the overall well-being of patients through evidence-based practices, timely interventions, and compassionate care. When nurses effectively implement interventions, patients typically experience better recovery rates, reduced complications, and a greater sense of well-being. Additionally, high-quality nursing care contributes to higher levels of patient satisfaction, as patients feel cared for, understood, and actively involved in their care processes. Effective interventions not only improve physical health but also address emotional and psychological needs, leading to a holistic approach that promotes both short-term and long-term health and satisfaction. This improvement can also help in fostering patient trust and fostering positive relationships between patients and healthcare providers. The other options represent outcomes that are generally considered negative or counterproductive in the context of effective nursing care. For example, increased hospital stay duration and higher costs for patients imply inefficiencies in care that could typically be avoided through well-planned interventions. Reduced patient involvement in care signifies a lack of patient engagement, which is contrary to the goals of nursing, which aim to empower patients to take an active role in their health. Thus, the correct answer emphasizes the positive results that nursing interventions are designed

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://cjeexam1.examzify.com>

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