

Delegation Health Management Practice Exam (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

- 1. What is the first action a nurse should take before treating a client whose eye has been splashed with a foreign agent?**
 - A. Put on gloves.**
 - B. Evaluate the client's visual acuity.**
 - C. Place the client in a supine position.**
 - D. Place a strip of pH paper in the lower sac of the client's affected eye.**
- 2. A client with pneumonia has a respiratory rate of 32 breaths/min. What action should the nurse take first?**
 - A. Administer antibiotics**
 - B. Encourage bed rest**
 - C. Apply oxygen**
 - D. Assess nutritional intake**
- 3. When developing a care plan for a family with a member who has anorexia nervosa, what important information should the nurse include?**
 - A. Coping mechanisms that have been used in the past.**
 - B. Concerns about changes in lifestyle and daily activities.**
 - C. Rejection of feedback from family and significant others.**
 - D. Appropriate eating habits and social behaviors centering on eating.**
- 4. When applying the nursing process, what is the most critical initial step?**
 - A. A. Implementation of care based on past assessments**
 - B. B. Comprehensive assessment of current client needs**
 - C. C. Evaluation of client outcomes and treatment effectiveness**
 - D. D. Documentation of care provided to clients**
- 5. Which task is suitable to assign to a licensed practical nurse (LPN) in a nursing care setting?**
 - A. Completing an admission assessment on a newly admitted client**
 - B. Administration of a new oral medication to a client with Alzheimer's disease**
 - C. A client who requires teaching about an insulin pump**
 - D. An assessment of a client whose pulse oximetry reading is 85% and who is having difficulty breathing**

- 6. Which clients can be safely assigned to the assistive personnel (AP)? Select all that apply.**
- A. The client receiving a blood transfusion**
 - B. The client recovering from Guillain-Barré syndrome**
 - C. The client on isolation for methicillin-resistant *Staphylococcus aureus***
 - D. The client receiving continuous oxygen at 2 L/min**
- 7. As part of their role, which task can an LPN complete for a patient on mechanical ventilation?**
- A. Conduct continuous respiratory assessment**
 - B. Administer IV fluids as prescribed**
 - C. Monitor vital signs in routine intervals**
 - D. Develop nursing care strategies**
- 8. Which tasks can be performed by assistive personnel (AP) in a nursing setting?**
- A. Ambulating a postoperative client**
 - B. Giving medications left by the nurse for the client to take**
 - C. Cleaning a client's dentures**
 - D. Monitoring vital signs immediately post-surgery**
- 9. In which condition should the nurse be vigilant with oxygen therapy during labor for the client?**
- A. preterm labor**
 - B. gestational diabetes**
 - C. sickle cell anemia**
 - D. preeclampsia**
- 10. After receiving assignments on a postoperative surgical unit, which client should the nurse prioritize care for?**
- A. A client lacking knowledge of postoperative home care.**
 - B. A client with airway clearing problems due to abdominal pain.**
 - C. A client with tissue perfusion alterations related to venous stasis.**
 - D. A client at risk for infection due to a history of smoking.**

Answers

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

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Explanations

1. What is the first action a nurse should take before treating a client whose eye has been splashed with a foreign agent?

A. Put on gloves.

B. Evaluate the client's visual acuity.

C. Place the client in a supine position.

D. Place a strip of pH paper in the lower sac of the client's affected eye.

In the scenario of a client whose eye has been splashed with a foreign agent, assessing the client's visual acuity serves as a critical initial action. This evaluation provides essential information regarding the extent of any potential damage to the eye and the client's ability to see, which can guide further treatment decisions. Determining visual acuity immediately after an eye injury helps in understanding the severity of the situation. If the client's vision is compromised, it may indicate a more serious injury that requires urgent care, potentially influencing the decision to initiate certain treatments or referrals to specialists. This baseline assessment is vital, as it allows for monitoring changes in vision as additional interventions are performed. Once visual acuity is evaluated, appropriate actions can follow, such as protecting the eye, flushing it with saline if necessary, and seeking additional care depending on the findings from the visual assessment. Prioritization of visual acuity assessment ensures that the nurse can address the most crucial aspects of the injury first.

2. A client with pneumonia has a respiratory rate of 32 breaths/min. What action should the nurse take first?

A. Administer antibiotics

B. Encourage bed rest

C. Apply oxygen

D. Assess nutritional intake

In the case of a client with pneumonia exhibiting a respiratory rate of 32 breaths per minute, the most immediate concern is the client's respiratory status. A respiratory rate that is significantly elevated, such as 32 breaths per minute, indicates increased work of breathing and potential hypoxia. The priority action for the nurse in this situation is to ensure adequate oxygenation. Applying oxygen is essential as it helps to maintain adequate oxygen levels in the blood, particularly in patients with pneumonia who may be experiencing impaired gas exchange due to the infection in the lungs. By administering oxygen, the nurse can alleviate symptoms of respiratory distress, improve oxygen saturation levels, and help stabilize the patient. While administering antibiotics and encouraging bed rest are important components of pneumonia treatment and overall patient care, they are not immediate actions. Antibiotics take time to exert their effect, and encouraging bed rest does not directly address the urgent need for improved respiratory function. Assessing nutritional intake, while relevant for overall recovery, is not a priority compared to addressing potential hypoxia in a patient with elevated respiratory distress. Therefore, the correct initial action is to apply oxygen.

3. When developing a care plan for a family with a member who has anorexia nervosa, what important information should the nurse include?

- A. Coping mechanisms that have been used in the past.**
- B. Concerns about changes in lifestyle and daily activities.**
- C. Rejection of feedback from family and significant others.**
- D. Appropriate eating habits and social behaviors centering on eating.**

The most relevant information to include in a care plan for a family with a member who has anorexia nervosa is the coping mechanisms that have been used in the past. Identifying and understanding these mechanisms is crucial because it helps the healthcare team to tailor interventions effectively. By recognizing what coping strategies have previously been employed, the nurse can build on existing strengths and adapt new strategies that are more effective in managing the condition. Incorporating past coping mechanisms allows for continuity in care and supports the family in dealing with the complexities of anorexia nervosa. It also opens up dialogue about what has or hasn't worked, fostering a collaborative environment where family members feel heard and involved in the treatment process. Alternative options, while related to the context of anorexia nervosa, do not provide the same foundation for developing an effective care plan tailored to the patient's needs. Concerns about lifestyle changes and daily activities address important aspects of patient care, but they do not directly focus on building a supportive framework based on the individual's previous experiences. Similarly, while rejection of feedback and appropriate eating habits are relevant considerations, they do not center on how the family can build upon past experiences to support the individual more effectively.

4. When applying the nursing process, what is the most critical initial step?

- A. A. Implementation of care based on past assessments**
- B. B. Comprehensive assessment of current client needs**
- C. C. Evaluation of client outcomes and treatment effectiveness**
- D. D. Documentation of care provided to clients**

The most critical initial step in the nursing process is the comprehensive assessment of current client needs. This step is fundamental because it involves collecting detailed information about the client's physical, emotional, social, and environmental factors that may influence their health. By accurately assessing these needs, nurses can identify the specific problems or potential issues that require attention and tailor care plans accordingly. A thorough assessment provides the foundation for all subsequent steps in the nursing process, including diagnosis, planning, implementation, and evaluation. Without a comprehensive understanding of the client's present situation, any interventions may be misguided or ineffective. This initial assessment ensures that the care provided is relevant and targeted, which ultimately improves client outcomes. Other steps in the nursing process, such as implementation, evaluation, and documentation, rely on the quality of the initial assessment. Therefore, ensuring a meticulous and thorough assessment is crucial before moving forward with care.

5. Which task is suitable to assign to a licensed practical nurse (LPN) in a nursing care setting?
- A. Completing an admission assessment on a newly admitted client
 - B. Administration of a new oral medication to a client with Alzheimer's disease**
 - C. A client who requires teaching about an insulin pump
 - D. An assessment of a client whose pulse oximetry reading is 85% and who is having difficulty breathing

Assigning the administration of a new oral medication to a client with Alzheimer's disease to a licensed practical nurse (LPN) is appropriate for several reasons. LPNs are trained to administer medications, which includes understanding the effects, potential side effects, and necessary monitoring while providing care. In this scenario, the LPN can effectively manage the medication administration process while following established protocols, which is crucial for maintaining the health and safety of clients, especially those with cognitive impairments like Alzheimer's disease who may have specific needs around medication management. Furthermore, medication administration falls within the scope of practice for LPNs, allowing them to utilize their training effectively while ensuring that the client's care plan is adhered to. This task does not require the extensive clinical judgment or assessment skills that a registered nurse (RN) might provide, particularly in complex situations, which is why it aligns well with the responsibilities of an LPN.

6. Which clients can be safely assigned to the assistive personnel (AP)? Select all that apply.
- A. The client receiving a blood transfusion
 - B. The client recovering from Guillain-Barré syndrome
 - C. The client on isolation for methicillin-resistant *Staphylococcus aureus*
 - D. The client receiving continuous oxygen at 2 L/min**

Assigning tasks to assistive personnel (AP) requires careful consideration of the complexity of the client's condition and the tasks being delegated. The choice of the client receiving continuous oxygen at 2 L/min is appropriate for delegation to AP. This task involves routine monitoring, such as ensuring the oxygen delivery system is functioning properly and that the client remains comfortable. Since the client's oxygen requirement is relatively stable and low-level, the care needed can be safely managed by AP, who can monitor for general signs of distress or changes in the client's condition. In contrast, clients receiving a blood transfusion require close monitoring for adverse reactions that can occur during the procedure. The complexities involved in assessing any complications associated with transfusions necessitate a higher level of skill and training, which is beyond the scope of what AP typically handles. For the client recovering from Guillain-Barré syndrome, their fluctuating condition can present unexpected challenges, requiring continuous assessment and potential intervention that should be overseen by a nurse or other skilled healthcare provider. Similarly, the client on isolation for methicillin-resistant *Staphylococcus aureus* (MRSA) presents specific risks that require careful monitoring and adherence to infection control protocols. Ensuring that the client does not have complications and that proper precautions are

7. As part of their role, which task can an LPN complete for a patient on mechanical ventilation?

- A. Conduct continuous respiratory assessment**
- B. Administer IV fluids as prescribed**
- C. Monitor vital signs in routine intervals**
- D. Develop nursing care strategies**

An LPN (Licensed Practical Nurse) is qualified to monitor vital signs at routine intervals for patients on mechanical ventilation. This task involves regularly checking parameters such as heart rate, blood pressure, respiratory rate, and oxygen saturation, which are crucial for assessing the patient's response to the ventilatory support. Monitoring vital signs helps detect any changes in the patient's condition, enabling timely interventions as needed, particularly in critically ill patients who are on mechanical ventilation. While conducting continuous respiratory assessments is important, it typically falls within the scope of practice for registered nurses (RNs) who have additional training and authority to perform more in-depth assessments and interventions related to respiratory function. Similarly, administering IV fluids typically requires an RN or higher-level provider to ensure appropriate evaluation and management of fluid therapy. Developing nursing care strategies also generally requires a higher level of clinical judgment and assessment skills, placing it outside the typical scope of practice for an LPN. Thus, monitoring vital signs aligns perfectly with what an LPN can appropriately and competently perform in the context of caring for patients on mechanical ventilation.

8. Which tasks can be performed by assistive personnel (AP) in a nursing setting?

- A. Ambulating a postoperative client**
- B. Giving medications left by the nurse for the client to take**
- C. Cleaning a client's dentures**
- D. Monitoring vital signs immediately post-surgery**

Assistive personnel (AP) play a crucial role in supporting nursing staff by performing specific tasks within their scope of practice. Cleaning a client's dentures is a task that falls well within the boundaries of what AP can do. This task is considered routine and assists in maintaining the client's hygiene and comfort, which is essential in patient care. Tasks delegated to assistive personnel must be clearly defined and should not require any specialized nursing knowledge or skills. Activities such as cleaning a client's dentures directly support the overall care plan and enable nurses to focus on more complex assessments and interventions that require their professional expertise. In contrast, tasks like ambulating a postoperative client and monitoring vital signs immediately after surgery involve considerations of the client's surgical status, which typically requires nursing judgment and assessment skills. Likewise, giving medications left by the nurse could pose risks if not managed correctly, as it requires an understanding of pharmacology and the nurse's responsibility for medication management. Thus, these actions are outside the appropriate delegation scope for assistive personnel.

9. In which condition should the nurse be vigilant with oxygen therapy during labor for the client?

- A. preterm labor**
- B. gestational diabetes**
- C. sickle cell anemia**
- D. preeclampsia**

Oxygen therapy during labor is particularly crucial for clients with sickle cell anemia due to the underlying pathophysiology of the condition. Sickle cell anemia can lead to vaso-occlusive crises, where sickled red blood cells obstruct blood vessels, resulting in significant pain and compromised oxygen delivery to tissues. During labor, the body's oxygen demand increases, and any compromise in oxygen supply can exacerbate the situation for a client with this condition. The risk of hypoxia is heightened during labor, as the stress of contractions and potential maternal hypovolemia can further reduce oxygenation. Therefore, maintaining adequate oxygen levels is critical to prevent complications such as maternal or fetal distress. Administering supplemental oxygen can help mitigate these risks and ensure that both the mother and fetus receive sufficient oxygen, supporting optimal outcomes during labor. While the other conditions mentioned may require monitoring and care, they do not present the same immediate risks related to oxygenation that sickle cell anemia poses during labor.

10. After receiving assignments on a postoperative surgical unit, which client should the nurse prioritize care for?

- A. A client lacking knowledge of postoperative home care.**
- B. A client with airway clearing problems due to abdominal pain.**
- C. A client with tissue perfusion alterations related to venous stasis.**
- D. A client at risk for infection due to a history of smoking.**

Prioritizing care for clients in a postoperative surgical unit involves assessing immediate physiological needs and potential complications. In this scenario, focusing on the client with airway clearing problems due to abdominal pain is critical. Postoperative patients are at risk for respiratory complications, particularly if they are experiencing pain that may inhibit effective coughing and deep breathing. Airway clearance is vital to prevent atelectasis and other respiratory issues, which can lead to severe outcomes. If a client is unable to clear their airway effectively, this could lead to impaired gas exchange and possibly respiratory distress. Therefore, addressing airway issues is a priority in the postoperative setting. While the other clients have significant needs, the presence of airway clearance problems due to abdominal pain poses a more immediate threat to the client's stability and recovery. Timely intervention for airway management is essential in ensuring the safety and overall health of the postoperative patient.

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://delegationhealthmgmt.examzify.com>

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