

DELEGATION HEALTH MANAGEMENT PRACTICE EXAM (SAMPLE)

STUDY GUIDE



**SAMPLE STUDY GUIDE
WITH LIMITED QUESTIONS**

**VISIT US ONLINE FOR
THE FULL VERSION STUDY GUIDE**

<https://delegationhealthmgmt.examzify.com>



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. A patient post-right upper lobectomy has constant bubbling in the water seal chamber. What should the nurse check first?**
 - A. Lung sounds
 - B. Vital signs
 - C. The chest tube connections
 - D. The amount of drainage

- 2. What is the typical therapeutic range for digoxin?**
 - A. 0.1-0.5 ng/mL
 - B. 0.6-2 ng/mL
 - C. 2-4 ng/mL
 - D. 0.5-1.5 ng/mL

- 3. 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

- 4. In triage, which client would be categorized as emergent?**
 - A. A confused client with a fever
 - B. A client with severe abdominal pain
 - C. A client with bright red blood pulsating from an open femur fracture
 - D. A client with stable vital signs

- 5. What is the most crucial action for a child exhibiting ineffective airway clearance?**
 - A. Suctioning the child's secretions
 - B. Providing adequate oral fluids
 - C. Reducing the child's anxiety
 - D. Administering medications as ordered

- 6. Which nursing action is prioritized for a patient with high fever and pneumonia?**
- A. Initiate IV antibiotics promptly
 - B. Perform physical therapy to strengthen lungs
 - C. Assess patient's dietary intake
 - D. Clarify the patient's medication list
- 7. Which components of a general survey may be delegated to assistive personnel (AP)? Select all that apply.**
- A. Measuring the client's height and weight
 - B. Inspecting skin surfaces
 - C. Monitoring oral intake and urinary output
 - D. Assessing the client's general appearance
- 8. Which task can be delegated to a nursing assistant for a COPD patient?**
- A. Instruct the patient to cough effectively
 - B. Auscultate breath sounds every 4 hours
 - C. Teach the patient to use incentive spirometry
 - D. Assist the patient to sit up on the side of the bed
- 9. What is the nurse's priority intervention when caring for a client with type 1 diabetes who is disoriented and diaphoretic?**
- A. Administer 1 mg of glucagon subcutaneously.
 - B. Call the healthcare provider for an additional insulin order.
 - C. Check blood glucose level.
 - D. Give 10 to 15 g of carbohydrate orally.
- 10. 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.

Answers

SAMPLE

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

SAMPLE

Explanations

SAMPLE

1. A patient post-right upper lobectomy has constant bubbling in the water seal chamber. What should the nurse check first?

- A. Lung sounds
- B. Vital signs
- C. The chest tube connections**
- D. The amount of drainage

In the scenario following a right upper lobectomy, the presence of constant bubbling in the water seal chamber of the chest tube system indicates a potential air leak or that the chest tube is not functioning as intended. Checking the chest tube connections is the most critical initial action because it helps determine if the bubbling is due to a disconnect or malfunction in the system. If the connections are loose or dislodged, it can compromise the integrity of the chest tube system, leading to inadequate lung re-expansion and potentially risking further complications for the patient. Ensuring that all connections are secure may resolve the issue without necessitating further interventions or assessments. While assessing lung sounds, vital signs, and the amount of drainage are important components of the patient's overall evaluation, addressing the potential source of the bubbling first—by ensuring the chest tube is properly connected and functioning—is essential for patient safety and effective management of their recovery. Thus, prioritizing the check of the chest tube connections is appropriate in this situation.

2. What is the typical therapeutic range for digoxin?

- A. 0.1-0.5 ng/mL
- B. 0.6-2 ng/mL**
- C. 2-4 ng/mL
- D. 0.5-1.5 ng/mL

The typical therapeutic range for digoxin is indeed critical for ensuring its effectiveness while minimizing toxicity. A therapeutic range of 0.6-2 ng/mL is widely accepted in clinical practice, as this concentration range helps to provide adequate control of heart rate and rhythm in patients with conditions such as atrial fibrillation or heart failure. Within this range, digoxin exerts its positive inotropic effects, improving cardiac output and managing symptoms of congestive heart failure, while still staying low enough to reduce the risk of adverse effects like nausea, vomiting, or potentially life-threatening arrhythmias, which can occur at higher levels. The importance of maintaining digoxin levels within this specific therapeutic range cannot be overstated, as both subtherapeutic and supratherapeutic levels can lead to significant clinical complications. This understanding is fundamental in the practice of medication management and patient safety.

**3. 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*

4. In triage, which client would be categorized as emergent?

- A. A confused client with a fever
- B. A client with severe abdominal pain
- C. A client with bright red blood pulsating from an open femur fracture**
- D. A client with stable vital signs

In triage, the categorization of clients is based on the severity and immediacy of their medical needs. The scenario involving a client with bright red blood pulsating from an open femur fracture is classified as emergent because it indicates a high risk of severe hemorrhage, which can quickly become life-threatening. The presence of bright red blood suggests that arterial bleeding is occurring, which requires immediate medical intervention to prevent shock and potential loss of life. Clients in emergent situations must be prioritized for treatment because their conditions can deteriorate rapidly without prompt care. This is particularly true in the case of severe trauma, where bleeding needs to be controlled as quickly as possible. The need for urgency is underscored by the fact that an open femur fracture not only poses immediate threats due to significant blood loss but also the potential for further complications, such as infection or paralysis if not treated swiftly. In contrast, the other clients mentioned exhibit less immediate life-threatening conditions. A confused client with a fever may require evaluation and treatment, but they do not present an immediate threat to their life. A client with severe abdominal pain is concerning and may require prompt attention, but without additional life-threatening signs, their situation is not categorized as emergent. A client with

5. What is the most crucial action for a child exhibiting ineffective airway clearance?

- A. Suctioning the child's secretions**
- B. Providing adequate oral fluids
- C. Reducing the child's anxiety
- D. Administering medications as ordered

The most crucial action for a child exhibiting ineffective airway clearance is suctioning the child's secretions. When a child struggles with airway clearance, it often indicates an accumulation of mucus or other secretions that obstruct the airways, making it difficult for them to breathe effectively. Suctioning is a direct intervention that helps remove these secretions, thereby clearing the airways and improving respiratory function. Removing secretions not only alleviates obstruction but also reduces the risk of respiratory infections that can arise from retained mucus. By maintaining a clear airway, the child can breathe more easily, which is essential for proper oxygenation and overall health. While providing fluids, reducing anxiety, and administering medications are also important components of care, they do not address the immediate risk of airway obstruction as effectively as suctioning does. Prioritizing airway clearance is critical in situations where breathing is compromised.

6. Which nursing action is prioritized for a patient with high fever and pneumonia?

- A. Initiate IV antibiotics promptly**
- B. Perform physical therapy to strengthen lungs
- C. Assess patient's dietary intake
- D. Clarify the patient's medication list

In a scenario involving a patient with high fever and pneumonia, the priority action is to initiate IV antibiotics promptly. This is because pneumonia can quickly progress to more severe complications, and antibiotics are essential in effectively treating the infection that is causing the fever. Swift intervention is crucial to control the infection, reduce fever, and prevent the potential for respiratory failure or sepsis, which are serious risks associated with pneumonia. Prompt administration of IV antibiotics allows for direct and effective treatment of bacterial pneumonia, ensuring that the patient receives the necessary medications to combat the infection. This action aligns with the principles of prioritizing patient safety and addressing immediate health threats in a clinical setting. While the other actions listed may have their own importance in the patient's overall care, initiating antibiotics directly targets the underlying cause of the patient's acute condition, making it the most critical nursing action at that moment.

7. Which components of a general survey may be delegated to assistive personnel (AP)? Select all that apply.

- A. Measuring the client's height and weight
- B. Inspecting skin surfaces
- C. Monitoring oral intake and urinary output**
- D. Assessing the client's general appearance

Measuring a client's height and weight is a fundamental task that can be delegated to assistive personnel (AP). This is a straightforward procedure that does not require professional judgment or assessment skills, making it suitable for delegation. Monitoring oral intake and urinary output is also appropriate for APs, as it entails tracking quantitative data rather than evaluating qualitative aspects of the client's condition. This task is vital for ongoing patient care and can be effectively performed by APs under the direction of a licensed nurse. While inspecting skin surfaces and assessing the client's general appearance require professional assessment skills and clinical judgment, the other tasks are more objective and can be delegated without compromising patient safety or care quality. This highlights the importance of knowing which tasks are appropriate for delegation based on their complexity and the level of skill required.

8. Which task can be delegated to a nursing assistant for a COPD patient?

- A. Instruct the patient to cough effectively
- B. Auscultate breath sounds every 4 hours
- C. Teach the patient to use incentive spirometry
- D. Assist the patient to sit up on the side of the bed**

The correct choice is to assist the patient to sit up on the side of the bed. Delegating this task to a nursing assistant is appropriate because it is a basic level of care that involves physical assistance and does not require clinical judgment or specialized nursing skills. Nursing assistants are trained to assist patients with mobility and positioning, which is particularly important for a patient with Chronic Obstructive Pulmonary Disease (COPD) to help improve lung expansion and ease breathing. Moreover, tasks such as instructing a patient on effective coughing, auscultating breath sounds, and teaching how to use incentive spirometry require a deeper understanding of nursing principles, patient assessment skills, and critical thinking. These activities are integral to nursing practice and should be performed by a licensed nurse who can evaluate the patient's response and modify care accordingly if needed.

9. What is the nurse's priority intervention when caring for a client with type 1 diabetes who is disoriented and diaphoretic?

- A. Administer 1 mg of glucagon subcutaneously.
- B. Call the healthcare provider for an additional insulin order.
- C. Check blood glucose level.**
- D. Give 10 to 15 g of carbohydrate orally.

In this scenario, the correct priority intervention involves checking the blood glucose level, as it is crucial to determine the cause of the client's disorientation and diaphoresis. In patients with type 1 diabetes, these symptoms can indicate either hypoglycemia (low blood sugar) or hyperglycemia (high blood sugar). By checking the blood glucose level first, the nurse can obtain objective data to guide further interventions. If the blood glucose is low, the nurse would need to administer carbohydrates or glucagon to address hypoglycemia. Conversely, if the blood glucose is high, the approach would differ, possibly necessitating insulin administration or other treatments. While administering glucagon or giving carbohydrates can be important steps if hypoglycemia is confirmed or suspected, the immediate priority is to confirm the blood glucose level. Calling the healthcare provider for additional insulin would not be appropriate in this situation without first understanding the patient's current glucose status. Therefore, assessing the blood glucose level is the most critical initial step in this situation.

10. 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.

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!

SAMPLE