

EAQ Fundamentals of Nursing Level 2 Practice Test (Sample)

Study Guide



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SAMPLE

Questions

SAMPLE

- 1. How should a nurse document a patient's assessment findings?**
 - A. In a long, narrative format**
 - B. In a clear, concise, and objective manner**
 - C. By using shorthand notations**
 - D. In a summary paragraph**
- 2. What is the minimum amount of time for hand sanitizing to be effective?**
 - A. 10 seconds**
 - B. 20 seconds**
 - C. 30 seconds**
 - D. 1 minute**
- 3. What is the normal international normalized ratio (INR) for clients on warfarin (Coumadin)?**
 - A. 1-2**
 - B. 2-3**
 - C. 3-4**
 - D. 4-5**
- 4. What condition is typically associated with elevated INR values?**
 - A. Dehydration.**
 - B. Deep vein thrombosis risk.**
 - C. Increased coagulation speed.**
 - D. Bleeding risk.**
- 5. What does the term "excoriation" refer to in dermatological terms?**
 - A. Small blisterlike elevation.**
 - B. Erosion into the dermis.**
 - C. Solid mass of fibrous tissue.**
 - D. Lesion filled with purulent drainage.**

- 6. When is the best time to assess a patient's pain levels?**
- A. During the night shift**
 - B. Before administering medication**
 - C. During routine assessments and after interventions**
 - D. Only when the patient complains**
- 7. What is the appropriate action when a patient has a sudden change in mental status?**
- A. Reassure them and check vital signs**
 - B. Immediate assessment and notification of the healthcare provider**
 - C. Document the change and monitor**
 - D. Wait to see if it resolves spontaneously**
- 8. What is the primary nursing intervention for a patient experiencing shortness of breath?**
- A. Administer oxygen and assess respiratory status**
 - B. Position the patient in a supine position**
 - C. Administer pain medication**
 - D. Initiate a breathing exercise**
- 9. What is an important aspect of informed consent?**
- A. It is a one-time event with no follow-up**
 - B. Patients must be coerced to agree**
 - C. Patients should be given information in an understandable way**
 - D. It requires patients to make immediate decisions**
- 10. How often should vital signs be assessed in a hospitalized patient?**
- A. Every hour or per physician's orders**
 - B. Every 2-3 hours or as needed**
 - C. Every 4-8 hours or as per physician's orders**
 - D. Once daily unless changes occur**

Answers

SAMPLE

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

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Explanations

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1. How should a nurse document a patient's assessment findings?

- A. In a long, narrative format
- B. In a clear, concise, and objective manner**
- C. By using shorthand notations
- D. In a summary paragraph

Documenting a patient's assessment findings in a clear, concise, and objective manner is essential for effective communication among healthcare providers and for maintaining accurate medical records. This approach ensures that anyone reading the documentation can quickly understand the patient's condition, the findings of the assessment, and the rationale for any subsequent interventions. Clear communication is critical in nursing to prevent misunderstandings that could potentially jeopardize patient safety or care continuity. Objective documentation minimizes personal bias and presents factual information that can be verified, which is vital in clinical settings. This practice also adheres to legal standards and guidelines for health documentation, fostering accountability. Long, narrative formats can lead to ambiguity and may take longer to read and comprehend, potentially delaying necessary care. Shorthand notations, while efficient, might not be universally understood among all members of the healthcare team, leading to potential misinterpretations. Summary paragraphs might omit important details that are necessary for a comprehensive understanding of the patient's status, which could affect treatment outcomes. Thus, the most effective approach to documenting assessment findings is to remain clear, concise, and objective.

2. What is the minimum amount of time for hand sanitizing to be effective?

- A. 10 seconds
- B. 20 seconds**
- C. 30 seconds
- D. 1 minute

The minimum amount of time recommended for hand sanitizing to be effective is 20 seconds. This duration is based on guidelines provided by health organizations, which emphasize that hand sanitizers can significantly reduce the presence of pathogens if applied correctly. Effective hand sanitization involves not only applying the product but also ensuring that it covers all surfaces of the hands, including the back of the hands, between the fingers, and under the nails. Rubbing hands together for at least 20 seconds helps ensure that the sanitizer works effectively by allowing enough contact time for the active ingredients to destroy germs. While shorter durations may seem convenient, they do not provide sufficient time for the sanitizer to work properly, which could leave harmful microorganisms behind. Longer durations, such as 30 seconds or 1 minute, may be excessive for the purpose of typical hand sanitization, especially when guidelines specifically recommend around 20 seconds for optimal effectiveness.

3. What is the normal international normalized ratio (INR) for clients on warfarin (Coumadin)?

A. 1-2

B. 2-3

C. 3-4

D. 4-5

The correct range for the international normalized ratio (INR) for clients on warfarin (Coumadin) is typically between 2 and 3. This therapeutic range is used to effectively manage anticoagulation therapy in patients to prevent blood clots while minimizing the risk of excessive bleeding. In patients who are receiving warfarin, achieving an INR within this range indicates that the blood's clotting ability is reduced appropriately to take therapeutic effect; this is crucial for conditions such as atrial fibrillation, deep vein thrombosis, and pulmonary embolism. Monitoring is essential as the INR can fluctuate based on diet, medications, and overall health, so maintaining it within the 2 to 3 range allows healthcare providers to balance the risks effectively. If an INR is too low (below 2), there is an increased risk of clot formation, and if it is too high (above 3), there is an elevation in the risk of bleeding. Therefore, it is significant to maintain INR levels within this normal range, ensuring optimal therapeutic outcomes.

4. What condition is typically associated with elevated INR values?

A. Dehydration.

B. Deep vein thrombosis risk.

C. Increased coagulation speed.

D. Bleeding risk.

Elevated INR (International Normalized Ratio) values indicate a prolonged clotting time, which is directly related to an increased risk of bleeding. INR is a standardized measure used to evaluate the coagulation status of patients, particularly those on anticoagulant therapy such as warfarin. A higher INR suggests that the blood takes longer to clot, which can lead to a greater likelihood of bleeding complications. Patients with elevated INR values may be at risk for spontaneous bleeding, easy bruising, or serious hemorrhagic events, depending on the level of elevation. This is particularly crucial in clinical settings, where maintaining an appropriate INR range is essential for patient safety, especially in those with conditions that necessitate anticoagulation therapy. Hence, recognizing elevated INR values as indicative of bleeding risk is vital for the management and care of these patients.

5. What does the term "excoriation" refer to in dermatological terms?

- A. Small blisterlike elevation.**
- B. Erosion into the dermis.**
- C. Solid mass of fibrous tissue.**
- D. Lesion filled with purulent drainage.**

In dermatological terms, "excoriation" refers specifically to a mechanical injury to the skin that results in the erosion of the epidermis, which can extend into the dermis. This term is often used to describe a form of abrasion caused by scratching or picking at the skin, leading to superficial loss of the skin's layers. The correct answer highlights that excoriation involves an erosion process, indicating that the skin's outer layer has been disrupted and can reveal the deeper layers. This can occur due to various conditions, such as dermatitis or infections, where patients might scratch due to itching, leading to this type of skin lesion. Understanding this term is vital for clinical assessment and can guide treatment decisions, such as the need for wound care, infection prevention, and addressing the underlying causes of pruritus (itching).

6. When is the best time to assess a patient's pain levels?

- A. During the night shift**
- B. Before administering medication**
- C. During routine assessments and after interventions**
- D. Only when the patient complains**

Assessing a patient's pain levels during routine assessments and after interventions is critical for effective pain management. This timing allows healthcare providers to have a comprehensive understanding of the patient's pain experiences throughout their care. Routine assessments provide a baseline measure of pain, enabling the nurse to monitor changes over time, recognize patterns, and evaluate the efficacy of treatments or interventions that have been implemented. Additionally, assessing pain after interventions—such as administering medication or non-pharmacological treatments—ensures that healthcare providers can determine how effective these measures have been in alleviating discomfort. Monitoring pain consistently and systematically enhances communication with the healthcare team, ensures that pain management plans are responsive to the patient's needs, and ultimately leads to improved patient outcomes. This approach advocates for ongoing evaluation rather than a reactive strategy that might overlook instances of pain that require management.

7. What is the appropriate action when a patient has a sudden change in mental status?

- A. Reassure them and check vital signs**
- B. Immediate assessment and notification of the healthcare provider**
- C. Document the change and monitor**
- D. Wait to see if it resolves spontaneously**

When a patient experiences a sudden change in mental status, immediate assessment and notification of the healthcare provider is crucial. This approach is appropriate because a sudden alteration in mental status can indicate serious underlying conditions such as stroke, infection, hypoxia, or metabolic imbalances that require prompt intervention. Performing an assessment allows the nurse to gather vital information about the patient's condition, which can include checking vital signs, assessing responsiveness, and evaluating neurological status. Notifying the healthcare provider ensures that further evaluation and treatment can be initiated without delay, potentially improving patient outcomes. The other options, while they may seem appropriate in less urgent situations, do not address the critical nature of a sudden change in mental status. Reassuring the patient and checking vital signs might provide comfort but does not sufficiently address the need for immediate and thorough evaluation. Documenting the change and monitoring could lead to delays in treatment, which is not advisable in the presence of acute changes that might signal life-threatening conditions. Waiting to see if it resolves can allow serious issues to escalate, putting the patient at greater risk. Thus, the correct course of action is always to conduct a thorough assessment and communicate with the healthcare provider without delay.

8. What is the primary nursing intervention for a patient experiencing shortness of breath?

- A. Administer oxygen and assess respiratory status**
- B. Position the patient in a supine position**
- C. Administer pain medication**
- D. Initiate a breathing exercise**

Administering oxygen and assessing respiratory status is the primary nursing intervention for a patient experiencing shortness of breath because it directly addresses the patient's immediate needs for adequate oxygenation. In cases of shortness of breath, assessing the respiratory status allows the nurse to determine the severity and potential causes of the symptoms. Oxygen therapy can alleviate hypoxia, improve respiratory function, and enhance patient comfort, making it an urgent and essential response in these situations. Positioning the patient is also important but placing them in a supine position may not always be beneficial, as many patients with respiratory distress are more comfortable in an upright or semi-Fowler's position to facilitate easier breathing. Administering pain medication may be necessary if pain is contributing to the patient's breathing difficulties, but it is not the first intervention to consider when the patient requires immediate respiratory support. Initiating breathing exercises may help with long-term management but will not provide the immediate assistance that is often necessary during acute episodes of shortness of breath. Therefore, focusing on oxygen delivery and assessing the respiratory status is crucial in this scenario.

9. What is an important aspect of informed consent?

- A. It is a one-time event with no follow-up**
- B. Patients must be coerced to agree**
- C. Patients should be given information in an understandable way**
- D. It requires patients to make immediate decisions**

An important aspect of informed consent is that patients should be given information in an understandable way. This ensures that individuals are fully aware of the risks, benefits, and alternatives to the proposed treatment or procedure. The information must be presented in clear, non-technical language that the patient can easily grasp, which enhances their ability to make an informed decision. Informed consent is rooted in the ethical principles of autonomy and respect for the patient, and when patients understand what they are consenting to, they can participate meaningfully in their healthcare choices. This process often involves the opportunity for patients to ask questions and have discussions with their healthcare providers, which further supports their understanding. The other options do not align with the fundamental principles of informed consent. For instance, treating informed consent as a one-time event overlooks the need for ongoing communication and understanding as the patient's situation may change. Coercion violates the ethical obligation to respect patient autonomy, as it removes the voluntary nature of the decision. Furthermore, requiring immediate decisions does not allow patients to reflect on the information provided, which is critical for informed decision-making.

10. How often should vital signs be assessed in a hospitalized patient?

- A. Every hour or per physician's orders**
- B. Every 2-3 hours or as needed**
- C. Every 4-8 hours or as per physician's orders**
- D. Once daily unless changes occur**

Assessing vital signs every 4-8 hours or as per physician's orders is considered standard nursing practice for hospitalized patients. This interval allows for regular monitoring of the patient's condition while balancing the need to minimize unnecessary disturbances, which can affect patient comfort and recovery. Frequent assessments are important to detect any changes in health status, especially in patients who are stable or recovering, as these changes can indicate deterioration or improvement in their condition. The physician's orders play a critical role in determining the frequency of vital sign assessments. In certain situations, for example with patients who are unstable or undergoing specific treatments, the frequency may be adjusted based on their individual health needs. This flexibility ensures that healthcare providers can respond quickly to any emerging abnormalities while adhering to established protocols. Further, adhering to this guideline supports effective communication within the healthcare team. Regularly scheduled assessments create a systematic approach to monitoring, allowing nurses to provide appropriate documentation and follow up on trends in a patient's vital signs over time.