

EAQ FUNDAMENTALS OF NURSING LEVEL 2 PRACTICE TEST (SAMPLE)

STUDY GUIDE



**SAMPLE STUDY GUIDE
WITH LIMITED QUESTIONS**

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

<https://eaqfundofnursinglvl2.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	15

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. Which vital sign is typically assessed last during a physical examination?**
 - A. Pulse
 - B. Blood pressure
 - C. Temperature
 - D. Respiratory rate

- 2. What is the appropriate response for a nurse when a family member asks about normal hemoglobin levels for women?**
 - A. 8-12 g/dL
 - B. 12-16 g/dL
 - C. 14-18 g/dL
 - D. 10-14 g/dL

- 3. What assessments are critical for a post-operative patient?**
 - A. Pain level, medication history, and mental status
 - B. Vital signs, pain level, and incision site inspection
 - C. Fluid intake, appetite, and activity level
 - D. Bowel sounds, mobility, and patient education

- 4. What is an important consideration when caring for a patient recovering from surgery?**
 - A. Prevention of infection is a priority
 - B. Encouraging immediate physical therapy
 - C. Ensuring the patient always remains active
 - D. Minimizing fluid intake

- 5. What are the signs of hypoglycemia?**
 - A. Sweating, hypertension, and tachycardia
 - B. Sweating, shakiness, confusion, and irritability
 - C. Dry skin, lethargy, and frequent urination
 - D. Nausea, vomiting, and headache

- 6. Which vital sign is typically assessed first upon patient admission?**
- A. Respiratory rate
 - B. Pulse rate
 - C. Temperature
 - D. Blood pressure
- 7. What is the primary reason older adults may become dehydrated despite appearing alert and capable?**
- A. The body's fluid needs decrease with age.
 - B. Access to fluid may be insufficient.
 - C. Memory declines with age.
 - D. The thirst reflex diminishes with age.
- 8. What is the classification of medication that decreases heart rate and workload?**
- A. Diuretics
 - B. Beta-blockers
 - C. Calcium channel blockers
 - D. ACE inhibitors
- 9. What does the Z-track technique help to avoid during intramuscular injections?**
- A. Administering medication too quickly
 - B. Leakage of medication into the subcutaneous tissue
 - C. Use of larger needles
 - D. Infections at the injection site
- 10. What is the priority nursing intervention for a client during the immediate postoperative period?**
- A. Monitoring vital signs
 - B. Observing for hemorrhage
 - C. Maintaining a patent airway
 - D. Recording the intake and output

Answers

SAMPLE

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

SAMPLE

Explanations

SAMPLE

1. Which vital sign is typically assessed last during a physical examination?

- A. Pulse
- B. Blood pressure
- C. Temperature**
- D. Respiratory rate

During a physical examination, temperature is typically assessed last because it can be influenced by various factors, including the physical activity level of the patient prior to the assessment. Additionally, measuring temperature, particularly if using an oral thermometer, often requires the patient to be calm and not engaged in any activity that could elevate their body temperature. By assessing temperature at the end, healthcare professionals can obtain the most accurate reading without the interference that might occur from previous assessments or physical movements. This practice also helps in establishing a systematic approach to the examination, allowing the clinician to focus first on the other vital signs that can indicate more immediate physiological status.

2. What is the appropriate response for a nurse when a family member asks about normal hemoglobin levels for women?

- A. 8-12 g/dL
- B. 12-16 g/dL**
- C. 14-18 g/dL
- D. 10-14 g/dL

The appropriate response regarding normal hemoglobin levels for women is 12-16 g/dL. This range aligns with established medical guidelines and reflects the typical hemoglobin concentration found in healthy adult females. Maintaining hemoglobin levels within this range is crucial for ensuring adequate oxygen-carrying capacity in the blood, which is vital for overall health and proper physiological function. When discussing hemoglobin levels, it's important to understand that variations can exist due to factors such as age, altitude, and individual health status, but the 12-16 g/dL range is widely accepted as standard for women. This information assists healthcare providers in evaluating a patient's health and identifying potential anemia or other underlying conditions that may require further assessment or intervention.

3. What assessments are critical for a post-operative patient?

- A. Pain level, medication history, and mental status
- B. Vital signs, pain level, and incision site inspection**
- C. Fluid intake, appetite, and activity level
- D. Bowel sounds, mobility, and patient education

Focusing on a post-operative patient, the most critical assessments include vital signs, pain level, and inspection of the incision site. Vital signs provide essential information about the patient's physiological status and help detect potential complications like hypovolemic shock, infection, or respiratory distress. Changes in vital signs can indicate inadequate recovery or other serious issues that require immediate attention. Assessing pain level is crucial since effective pain management is a key aspect of recovery. Uncontrolled pain can affect a patient's ability to participate in post-operative care and can delay healing. Furthermore, the inspection of the incision site is vital for early detection of infection or complications, such as dehiscence or necrosis, which can significantly impact recovery. While the other options include important assessments, they are not as critical in the immediate post-operative period as the vital signs, pain level, and incision site inspection. These three assessments form a foundational basis for ensuring the patient's safety and successful recovery following surgery.

4. What is an important consideration when caring for a patient recovering from surgery?

- A. Prevention of infection is a priority**
- B. Encouraging immediate physical therapy
- C. Ensuring the patient always remains active
- D. Minimizing fluid intake

In the context of a patient recovering from surgery, prevention of infection is critical due to the risk of surgical site infections and other complications that can arise postoperatively. After surgery, patients have open wounds and a compromised immune system, making them vulnerable to infections. Nurses play a key role in monitoring for signs of infection, maintaining aseptic technique during dressing changes, and educating the patient about the importance of hand hygiene and recognizing symptoms that require medical attention. While encouraging physical therapy and maintaining activity levels are essential elements of recovery, it is more important to first ensure that the patient is stable and free from infection. Minimizing fluid intake is generally not advisable during recovery, as adequate hydration is vital for healing and recovery. Thus, prioritizing infection prevention creates a safer environment for recovery and helps to promote healing outcomes effectively.

5. What are the signs of hypoglycemia?

- A. Sweating, hypertension, and tachycardia
- B. Sweating, shakiness, confusion, and irritability**
- C. Dry skin, lethargy, and frequent urination
- D. Nausea, vomiting, and headache

The signs of hypoglycemia predominantly include sweating, shakiness, confusion, and irritability. These symptoms arise due to the body's response to low blood sugar levels. When glucose levels drop, the body activates its stress response, leading to the release of adrenaline (epinephrine), which triggers sweating and shakiness. Additionally, low blood glucose levels can adversely affect brain function, leading to confusion and irritability as the brain lacks the necessary fuel to function optimally. The other choices include symptoms that are not typically associated with hypoglycemia. For instance, dry skin, lethargy, and frequent urination are more indicative of hyperglycemia or dehydration rather than a low blood sugar state. Similarly, nausea, vomiting, and headache can occur for various reasons but are not characteristic signs of hypoglycemia. Therefore, the combination of sweating, shakiness, confusion, and irritability provides a clear picture of the body's response to inadequate glucose levels, making this option the most fitting representation of hypoglycemia.

6. Which vital sign is typically assessed first upon patient admission?

- A. Respiratory rate
- B. Pulse rate
- C. Temperature
- D. Blood pressure**

The first vital sign typically assessed upon patient admission is blood pressure. This is essential because it provides immediate insight into the patient's cardiovascular status and overall homeostasis. Blood pressure measurements help in quickly identifying conditions such as hypertension or hypotension, which can indicate serious health issues that need to be addressed promptly. Establishing a baseline for blood pressure allows healthcare providers to monitor any changes over time, especially when administering medications or during a patient's treatment plan. It can also alert the healthcare team to potential complications that may arise from certain medical conditions, guiding further assessment or intervention. In contrast, while respiratory rate, pulse rate, and temperature are also important vital signs, they are typically assessed after blood pressure in the context of an admission assessment. Each vital sign contributes valuable information, but blood pressure often serves as a critical starting point for evaluating a patient's initial status.

7. What is the primary reason older adults may become dehydrated despite appearing alert and capable?

- A. The body's fluid needs decrease with age.
- B. Access to fluid may be insufficient.
- C. Memory declines with age.

D. The thirst reflex diminishes with age.

The primary reason older adults may become dehydrated despite appearing alert and capable is that the thirst reflex diminishes with age. As individuals age, physiological changes affect their homeostatic mechanisms, including the ability to sense thirst. The decline in the physiological responsiveness to thirst stimuli means that older adults may not feel thirsty even when their bodies require hydration. This can lead to inadequate fluid intake, as they might not drink enough water or fluids to meet their body's needs. Consequently, this reduction in thirst perception increases the risk of dehydration, even if the older adult may seem cognitively alert and functional. It emphasizes the importance of caregivers and healthcare providers proactively ensuring that older adults are consuming enough fluids, irrespective of their self-reported thirst levels. Understanding this aspect of aging is vital in nursing practice, as it guides interventions aimed at preventing dehydration in this vulnerable population.

8. What is the classification of medication that decreases heart rate and workload?

- A. Diuretics
- B. Beta-blockers**
- C. Calcium channel blockers
- D. ACE inhibitors

The classification of medication that decreases heart rate and workload is beta-blockers. These medications work by blocking the effects of adrenaline (epinephrine) on beta receptors in the heart. This action slows down the heart rate and reduces the force of contraction of the heart muscle, leading to a decrease in the heart's workload. Beta-blockers are particularly useful in managing conditions such as hypertension, heart failure, and certain types of arrhythmias. By reducing heart rate and workload, they help prevent complications like myocardial infarctions and promote better overall cardiovascular health. In contrast, diuretics are primarily used to reduce fluid overload and lower blood pressure by promoting urine production. Calcium channel blockers reduce heart rate and dilate blood vessels, but they do so through a different mechanism that may not specifically target heart rate reduction as effectively as beta-blockers. ACE inhibitors work by blocking the conversion of angiotensin I to angiotensin II, which ultimately helps manage blood pressure but does not directly decrease heart rate or workload in the same manner as beta-blockers. Thus, beta-blockers are the most effective class of medication for specifically addressing both heart rate and workload reduction.

9. What does the Z-track technique help to avoid during intramuscular injections?

- A. Administering medication too quickly
- B. Leakage of medication into the subcutaneous tissue**
- C. Use of larger needles
- D. Infections at the injection site

The Z-track technique is specifically designed to prevent the leakage of medication into the subcutaneous tissue during intramuscular injections. This method enhances the sealing of the medication in the muscle by creating a zig-zag path through the tissue layers. When the skin is pulled laterally during the injection and released after the needle is withdrawn, it helps ensure that the medication is properly deposited into the muscle rather than escaping into the surrounding subcutaneous tissue. This technique is particularly useful for medications that can cause irritation or staining of the tissues if they leak out. Therefore, the primary advantage of the Z-track method lies in its ability to keep the medication contained within the muscle, reducing the risk of adverse effects associated with improper administration.

10. What is the priority nursing intervention for a client during the immediate postoperative period?

- A. Monitoring vital signs
- B. Observing for hemorrhage
- C. Maintaining a patent airway**
- D. Recording the intake and output

In the immediate postoperative period, maintaining a patent airway is crucial as it directly impacts the patient's ability to breathe and receive adequate oxygenation. After surgery, patients are often under the influence of anesthesia, which can depress their respiratory drive and lead to airway obstruction due to muscle relaxation or secretions. Ensuring that the airway remains open is essential to prevent complications such as hypoxia or respiratory arrest. This includes positioning the patient correctly, performing suctioning if needed to clear secretions, and observing for any signs of airway compromise. While monitoring vital signs, observing for hemorrhage, and recording intake and output are all important nursing interventions, they become secondary to ensuring that the patient's airway is secure and functional during this critical time following surgery.

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://eaqfundofnursinglvl2.examzify.com>

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

SAMPLE