

# Evolve HESI 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**

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- 1. For a client with a DNR order, what should be the nurse's primary focus during care?**
  - A. Preventing any deterioration of the client**
  - B. Ensuring the client is comfortable and at peace**
  - C. Encouraging the family to be involved in care**
  - D. Monitoring vital signs closely**
  
- 2. What are common signs of dehydration in a patient?**
  - A. Increased appetite and moist skin**
  - B. Stable heart rate and normal urine output**
  - C. Thirst, dry mucous membranes, and high heart rate**
  - D. Swollen extremities and low blood pressure**
  
- 3. What finding should the nurse recognize as a risk factor for pressure ulcers in a client who has been bedridden for a week?**
  - A. Presence of dry skin**
  - B. Brittle nails**
  - C. Rashes in the axillary, groin, and skin fold regions**
  - D. Shiny hairless skin**
  
- 4. If a client expresses a fear of hospitalization, what should the nurse's response include?**
  - A. Reassuring the client they are safe**
  - B. Acknowledging the client's feelings and providing information**
  - C. Telling the client to focus on their treatment**
  - D. Encouraging the client to think positively**
  
- 5. How does teamwork enhance healthcare delivery?**
  - A. By eliminating communication entirely**
  - B. By fostering collaboration and improving patient outcomes**
  - C. By allowing independent work among staff**
  - D. By creating distance among team roles**

**6. Which intervention is most crucial for a nurse when a client with acute hemorrhagic anemia is to receive four units of packed RBCs?**

- A. Prep the infusion equipment**
- B. Ensure the accuracy of the blood type match**
- C. Monitor vital signs during transfusion**
- D. Administer medications as prescribed**

**7. How should a nurse address a family's concerns about a patient's diagnosis?**

- A. Ignore their concerns**
- B. Listen actively and provide clear information**
- C. Respond with vague statements**
- D. Tell them not to worry**

**8. What is a common nursing intervention for a patient with diabetes?**

- A. Prescribing insulin without patient education**
- B. Educating the patient on blood glucose monitoring and dietary management**
- C. Performing surgery to manage the disease**
- D. Only checking blood glucose levels once a week**

**9. What are common side effects of opioids?**

- A. Headache and dizziness**
- B. Constipation and sedation**
- C. Increased appetite and insomnia**
- D. Dry skin and hair loss**

**10. What signifies that a client is ready to engage in a therapeutic conversation during emotional distress?**

- A. Expressing feelings verbally**
- B. Initiating the conversation themselves**
- C. Waiting for the nurse to ask questions**
- D. Demonstrating calm body language**

## **Answers**

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

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## **Explanations**

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**1. For a client with a DNR order, what should be the nurse's primary focus during care?**

- A. Preventing any deterioration of the client**
- B. Ensuring the client is comfortable and at peace**
- C. Encouraging the family to be involved in care**
- D. Monitoring vital signs closely**

The primary focus for a nurse caring for a client with a Do Not Resuscitate (DNR) order is to ensure the client is comfortable and at peace. This approach aligns with the objectives of palliative care, which prioritize quality of life and symptom management, especially for clients who are nearing the end of life. The presence of a DNR order indicates that the client has expressed a wish to avoid resuscitative efforts in the event of a cardiac or respiratory arrest, signaling a focus on comfort rather than aggressive treatment. By prioritizing comfort, the nurse can assess and manage pain, address emotional and spiritual needs, and create a peaceful environment for both the client and their family. This focus can also involve coordinating care with other healthcare providers to ensure that all aspects of the client's well-being are attended to, enhancing the overall experience for the client in their final days. While monitoring for deterioration, family involvement, and watching vital signs are important aspects of care in certain contexts, the presence of a DNR order shifts the goal toward providing comfort and quality of life rather than pursuing curative measures or intensive monitoring. Thus, ensuring the client is comfortable and at peace takes precedence in the context of a DNR order.

**2. What are common signs of dehydration in a patient?**

- A. Increased appetite and moist skin**
- B. Stable heart rate and normal urine output**
- C. Thirst, dry mucous membranes, and high heart rate**
- D. Swollen extremities and low blood pressure**

The identification of common signs of dehydration is critical for effective patient assessment and management. Thirst is often one of the earliest indicators that the body requires more fluids, as it signals a deficiency. Dry mucous membranes occur because dehydration reduces the moisture content in body tissues, making them less hydrated and more prone to dryness. Additionally, a high heart rate is a physiological response to dehydration; as fluid volume decreases, the heart compensates by increasing its rate to maintain adequate circulation and blood pressure. In contrast, the other options include signs that either do not correlate with dehydration or reflect conditions contrary to what one would expect in a dehydrated patient. For instance, increased appetite is not typically a sign of dehydration; rather, individuals may have reduced desire to eat due to the body's focus on maintaining hydration. Stable heart rate and normal urine output generally indicate adequate hydration, not dehydration. Lastly, swollen extremities do not signify dehydration; instead, they may suggest fluid retention or other underlying issues. In essence, option C accurately captures the physiological responses seen in a dehydrated patient.

**3. What finding should the nurse recognize as a risk factor for pressure ulcers in a client who has been bedridden for a week?**

- A. Presence of dry skin**
- B. Brittle nails**
- C. Rashes in the axillary, groin, and skin fold regions**
- D. Shiny hairless skin**

The presence of rashes in the axillary, groin, and skin fold regions is a significant risk factor for pressure ulcers in a client who has been bedridden for a week. Rashes in these high-friction areas can indicate skin irritation and breakdown, which are exacerbated by prolonged immobility. When a patient is bedridden, they are at risk for pressure injuries due to constant pressure on certain areas of the skin, especially where skin rubs together or where there are skin folds. Moisture from rashes can further contribute to skin maceration, making it more susceptible to ulceration. In the context of other options, while dry skin can also be a risk factor, it is more generalized and may not directly indicate immediate threat compared to rashes that suggest ongoing irritation and vulnerability. Brittle nails do not significantly contribute to the risk of pressure ulcers. Shiny hairless skin may suggest a lack of blood supply or a stage of skin breakdown, but it does not specifically denote the presence of a rash that would actively compromise skin integrity in the way that rashes do.

**4. If a client expresses a fear of hospitalization, what should the nurse's response include?**

- A. Reassuring the client they are safe**
- B. Acknowledging the client's feelings and providing information**
- C. Telling the client to focus on their treatment**
- D. Encouraging the client to think positively**

When a client expresses a fear of hospitalization, the most effective nurse's response would involve acknowledging the client's feelings and providing information. This approach is essential because it validates the client's emotional experience, making them feel heard and understood. Fear of hospitalization can stem from various sources, including fear of the unknown, concerns about treatment, or anxiety about being away from family and normal routines. By acknowledging these fears, the nurse demonstrates empathy, which helps build trust between the client and healthcare provider. Providing information serves a dual purpose: it addresses any misconceptions the client may have and helps to demystify the hospitalization process. Educating the client about what to expect during their stay, the purpose of the treatment, and how their fears will be managed can help reduce anxiety. This response empowers the client by involving them in their care and addressing their concerns directly, leading to a more collaborative and supportive healthcare experience.

## 5. How does teamwork enhance healthcare delivery?

- A. By eliminating communication entirely
- B. By fostering collaboration and improving patient outcomes**
- C. By allowing independent work among staff
- D. By creating distance among team roles

Teamwork enhances healthcare delivery primarily by fostering collaboration among healthcare professionals, which leads to improved patient outcomes. When healthcare providers work together as a cohesive unit, they share their expertise, knowledge, and skills, allowing for comprehensive care that addresses the multifaceted needs of patients. Collaborative teamwork facilitates better communication, promotes trust, and enables different healthcare professionals to contribute their unique perspectives, ultimately leading to more informed decision-making in patient care. In a team environment, healthcare workers can discuss and evaluate treatment plans collectively, ensuring that all aspects of a patient's condition are considered. This comprehensive approach often leads to quicker problem resolution and a higher standard of care. Effective teamwork also allows for the distribution of responsibilities, ensuring that tasks are completed efficiently and patients receive timely and appropriate interventions, which significantly enhances the overall quality of healthcare delivery.

## 6. Which intervention is most crucial for a nurse when a client with acute hemorrhagic anemia is to receive four units of packed RBCs?

- A. Prep the infusion equipment
- B. Ensure the accuracy of the blood type match**
- C. Monitor vital signs during transfusion
- D. Administer medications as prescribed

Ensuring the accuracy of the blood type match is pivotal when administering blood transfusions, particularly in a case of acute hemorrhagic anemia where the client may already be compromised. This step is essential to prevent severe transfusion reactions that can arise from mismatched blood types. The correct matching of blood types helps avoid hemolytic reactions, which can lead to serious complications such as kidney failure, shock, or even death. In acute situations where rapid transfusion of packed RBCs is required, establishing compatibility is critical because any discrepancy in the blood type could exacerbate the client's condition significantly, causing further hemolysis and additional complications. While preparing the infusion equipment, monitoring vital signs during the transfusion, and administering prescribed medications are also important nursing responsibilities, they are secondary to ensuring the blood type match. If the blood is not accurately matched, even the best-prepared equipment or diligent monitoring will not prevent the potential life-threatening consequences of a mismatched transfusion.

**7. How should a nurse address a family's concerns about a patient's diagnosis?**

- A. Ignore their concerns**
- B. Listen actively and provide clear information**
- C. Respond with vague statements**
- D. Tell them not to worry**

Listening actively and providing clear information is essential when addressing a family's concerns about a patient's diagnosis. This approach builds trust and rapport between the nurse, the patient, and the family, which is critical in healthcare settings. Active listening allows the nurse to fully understand the family's worries and emotions, ensuring that they feel heard and valued. By offering clear information, the nurse can clarify any misconceptions the family might have regarding the diagnosis, treatment options, and expected outcomes. This not only alleviates anxiety but also empowers the family, enabling them to be involved in the patient's care. Open communication is a key component of effective nursing practice, as it fosters a supportive environment where families can ask questions and express their concerns freely. This method contrasts with ignoring concerns, responding vaguely, or dismissing worries, all of which can lead to increased anxiety, distrust, and a feeling of alienation for the family.

**8. What is a common nursing intervention for a patient with diabetes?**

- A. Prescribing insulin without patient education**
- B. Educating the patient on blood glucose monitoring and dietary management**
- C. Performing surgery to manage the disease**
- D. Only checking blood glucose levels once a week**

The focus on patient education regarding blood glucose monitoring and dietary management is a fundamental nursing intervention for patients with diabetes. This approach empowers patients by providing them with the necessary knowledge and skills to manage their condition effectively. Understanding how to monitor blood glucose levels enables patients to recognize patterns that may necessitate changes in their treatment or lifestyle. Dietary management is equally critical, as a well-planned diet can significantly help in regulating blood sugar levels, preventing complications, and promoting overall wellness. Patients who are educated about their condition are more likely to engage in self-management practices, adhere to their treatment plans, and make informed decisions about their health. This proactive nursing intervention forms the cornerstone of diabetes care and supports the patient in leading a healthier life. The other options do not align with best practices in diabetes management; effective care relies on education and patient engagement rather than solely prescribing treatment or infrequent monitoring.

## 9. What are common side effects of opioids?

- A. Headache and dizziness**
- B. Constipation and sedation**
- C. Increased appetite and insomnia**
- D. Dry skin and hair loss**

Opioids are commonly used for pain relief but they come with a range of side effects that can significantly impact patient comfort and compliance. The correct answer identifies constipation and sedation as prevalent side effects associated with opioid use. Constipation occurs because opioids affect the gastrointestinal tract, slowing down peristalsis. This results in the decreased movement of food through the intestines, leading to harder stools and difficulty with bowel movements. This is a particularly important concern for patients on long-term opioid therapy, as it can lead to discomfort and complications like fecal impaction. Sedation is another common side effect of opioids, as these medications can depress the central nervous system (CNS). While sedation may be beneficial for some patients needing pain relief, it can also lead to excessive drowsiness, impaired coordination, and even respiratory depression at higher doses. The other options presented do not accurately reflect the primary side effects experienced by those taking opioids. Therefore, recognizing constipation and sedation as significant effects is crucial when assessing a patient's response to opioid therapy and managing their treatment effectively.

## 10. What signifies that a client is ready to engage in a therapeutic conversation during emotional distress?

- A. Expressing feelings verbally**
- B. Initiating the conversation themselves**
- C. Waiting for the nurse to ask questions**
- D. Demonstrating calm body language**

Expressing feelings verbally is a critical sign that a client is ready to engage in a therapeutic conversation during emotional distress. This verbal expression indicates that the client is willing and able to articulate their emotions, which is a foundational component of effective communication in a therapeutic setting. When clients share their feelings, they are opening up about their internal experiences, allowing the nurse to understand the situation better and provide appropriate support and interventions. While initiating the conversation themselves can also indicate readiness, it may not always reflect that a client is prepared to discuss their feelings comprehensively. Some clients may need prompting to begin sharing, which makes the act of expressing feelings even more significant. Waiting for the nurse to ask questions shows passivity and may indicate a reluctance to engage, while demonstrating calm body language, although positive, doesn't necessarily guarantee that the client is ready to delve into their emotional distress. Therefore, the act of expressing feelings verbally is the clearest indication of readiness for a therapeutic conversation.

# 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](mailto:hello@examzify.com).**

**Or visit your dedicated course page for more study tools and resources:**

**<https://evolve-hesi.examzify.com>**

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

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