

EVOLVE HESI PRACTICE EXAM (SAMPLE)

STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

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THE FULL VERSION STUDY GUIDE

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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. Which approach is effective for managing a patient's pain?**
 - A. Assessing pain only if the patient complains
 - B. Using the same pain regimen for all patients
 - C. Assessing pain regularly and adjusting interventions
 - D. Pretending the patient is not in pain to reduce anxiety
- 2. 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
- 3. What is a critical skill assessed in the HESI exam related to nursing practice?**
 - A. Basic knowledge of medical terminology
 - B. Application of theoretical knowledge to practical scenarios
 - C. Understanding of historical nursing practices
 - D. Mastery of hospital policy documentation
- 4. Which of the following is NOT a role of the nurse in patient education?**
 - A. Providing resources for better understanding
 - B. Customizing information to fit the patient's needs
 - C. Taking over the patient's decision-making process
 - D. Encouraging questions for clarity
- 5. When assessing a NPO client's fluid and electrolyte balance, which value is least critical for the nurse to monitor?**
 - A. Blood urea nitrogen (BUN)
 - B. Serum glucose level
 - C. Serum potassium level
 - D. Weight

- 6. What benefit does effective teamwork provide for healthcare staff members?**
- A. It isolates them from others
 - B. It improves staff satisfaction
 - C. It complicates patient care
 - D. It has no impact on employee morale
- 7. What should the nurse do first for a client with a nasogastric tube who reports nausea and has no drainage for two hours?**
- A. Administer an anti-nausea medication
 - B. Reposition the client on her side
 - C. Check the suction settings
 - D. Consult a dietitian
- 8. For a client who is unresponsive following a CVA, what is the most appropriate feeding approach?**
- A. Oral feeding
 - B. Enteral feeding via nasogastric tube
 - C. Bolus enteral feeding through a gastrostomy tube
 - D. Parenteral nutrition
- 9. What should a nurse do first when observing blue fingers on a client wearing wrist restraints?**
- A. Notify the physician of the condition.
 - B. Loosen the right wrist restraint.
 - C. Check the circulation of the left hand.
 - D. Apply a warm compress to the affected hand.
- 10. What outcome statement best demonstrates a postoperative client's readiness to manage daily dressing changes at home?**
- A. The client verbalizes feeling ready for discharge.
 - B. The client demonstrates the wound care procedure correctly.
 - C. The client expresses concerns about pain management.
 - D. The client understands the importance of keeping the dressing clean.

Answers

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

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Explanations

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1. Which approach is effective for managing a patient's pain?

- A. Assessing pain only if the patient complains
- B. Using the same pain regimen for all patients
- C. Assessing pain regularly and adjusting interventions**
- D. Pretending the patient is not in pain to reduce anxiety

Regularly assessing pain and adjusting interventions is essential for effectively managing a patient's pain. This approach acknowledges that pain is subjective and can vary significantly from patient to patient. By routinely evaluating the patient's pain level, the healthcare provider can tailor the pain management plan to meet the individual's specific needs, which may include altering medications, dosages, or incorporating additional therapies. Such proactive management fosters open communication between the patient and healthcare provider, ensuring that any changes in the patient's pain experience are promptly addressed. This not only helps in achieving optimal pain control but also enhances patient satisfaction and overall outcomes. The dynamic and continuous assessment recognizes that pain management often requires adjustments throughout a patient's treatment, taking into account their unique experiences and responses to therapy.

2. 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.

3. What is a critical skill assessed in the HESI exam related to nursing practice?

- A. Basic knowledge of medical terminology
- B. Application of theoretical knowledge to practical scenarios**
- C. Understanding of historical nursing practices
- D. Mastery of hospital policy documentation

The critical skill assessed in the HESI exam related to nursing practice is the application of theoretical knowledge to practical scenarios. This skill is essential for nursing students and professionals as it demonstrates their ability to integrate what they have learned in the classroom with real-world clinical situations. Nursing is not only about understanding the fundamental concepts and theories; it requires the capability to apply that knowledge effectively in various patient care contexts. This involves critical thinking, decision-making, and problem-solving skills, which are necessary for providing safe and effective patient care. The focus is on how well candidates can utilize their knowledge to assess patient needs, make informed clinical judgments, and implement appropriate interventions based on evidence and best practices. Other options, while relevant to nursing, do not capture the critical practicality and execution aspect that the HESI exam emphasizes. Mastery of medical terminology, historical practices, and hospital policy documentation are important but do not directly reflect the core competency of applying knowledge in clinical settings, which is a primary focus of nursing education and assessment.

4. Which of the following is NOT a role of the nurse in patient education?

- A. Providing resources for better understanding
- B. Customizing information to fit the patient's needs
- C. Taking over the patient's decision-making process**
- D. Encouraging questions for clarity

In patient education, nurses play several essential roles that support patient empowerment and understanding. One of these roles is providing resources for better understanding, which helps patients gain knowledge about their health conditions and treatments. Customizing information to fit the patient's individual needs ensures that the education is relevant and comprehensible, taking into consideration factors such as the patient's literacy level, cultural background, and specific health concerns. Encouraging questions for clarity is another vital aspect of education, as it fosters an environment where patients feel comfortable seeking further information and clarifying doubts, which enhances their understanding and retention of the information. Taking over the patient's decision-making process, however, is not a role of the nurse in patient education. Instead, nurses support patients in making informed choices about their health. They provide the necessary information and resources, but the ultimate decisions should always lie with the patient, respecting their autonomy and right to choose their path of care. This distinction is critical, as empowering patients through education enables them to be active participants in their health care rather than passive recipients of care.

5. When assessing a NPO client's fluid and electrolyte balance, which value is least critical for the nurse to monitor?

- A. Blood urea nitrogen (BUN)
- B. Serum glucose level
- C. Serum potassium level

D. Weight

In the context of a client who is NPO (nothing by mouth), monitoring fluid and electrolyte balance is essential. The values assessed are important indicators of the client's hydration status and overall metabolic function. Weight is certainly a useful measure when assessing fluid status, but it may not be as immediately critical as the other laboratory values listed. It is often influenced by factors such as recent food or fluid intake, fluctuations in body water content, and other variables that might not directly reflect the immediate electrolyte balance or renal function of an NPO client. Blood urea nitrogen (BUN) is a crucial parameter because elevated levels can indicate dehydration or impaired kidney function, both of which are significant risks in an NPO patient. Serum glucose levels are monitored closely, especially since fasting can affect a patient's blood sugar, and hypo- or hyperglycemia can lead to serious complications. Serum potassium levels are critical too, as they directly affect cardiac function and neuromuscular stability; any imbalance can lead to dangerous arrhythmias or muscle weakness. Therefore, while monitoring weight is relevant and can provide information about fluid status over time, it is the least critical compared to the more direct implications of the other values.

6. What benefit does effective teamwork provide for healthcare staff members?

- A. It isolates them from others
- B. It improves staff satisfaction**
- C. It complicates patient care
- D. It has no impact on employee morale

Effective teamwork among healthcare staff significantly enhances staff satisfaction. When team members collaborate effectively, there is often a greater sense of belonging and support within the workplace. This environment fosters positive relationships among colleagues, which can lead to improved communication, shared responsibilities, and a collective approach to problem-solving. Such dynamics not only alleviate the stress associated with demanding healthcare environments but also contribute to a sense of achievement and motivation, ultimately leading to higher job satisfaction. In a well-functioning team, staff members can rely on one another, share their expertise, and feel valued for their contributions. This mutual respect and cooperation can make the workday more enjoyable and less isolating. As a result, staff members are more likely to engage positively with their roles and remain committed to their colleagues and patients.

7. What should the nurse do first for a client with a nasogastric tube who reports nausea and has no drainage for two hours?

- A. Administer an anti-nausea medication
- B. Reposition the client on her side**
- C. Check the suction settings
- D. Consult a dietitian

In this scenario, the most appropriate initial action is to reposition the client on her side. This intervention can help alleviate nausea by promoting gastric emptying and preventing aspiration, which is particularly important when a nasogastric tube is present. Nausea often arises from impaired gastric function, and positional changes can play a significant role in managing symptoms related to gastrointestinal distress. Repositioning the client may help facilitate drainage through the tube, as gravity can assist in moving contents through the tube and into the collection device if the client is receiving suction or feedings. If there has been no drainage for two hours, it is crucial to take immediate action that can potentially resolve the issue and provide comfort before administering medication or making other interventions. While checking suction settings and administering anti-nausea medication are important considerations, they do not directly address the immediate mechanical aspect of the nasogastric tube. Consulting a dietitian is well-suited for dietary concerns but is not pertinent to the urgent safety and comfort needs presented in this scenario. Prioritizing actions that may provide instant relief is key in nursing care.

8. For a client who is unresponsive following a CVA, what is the most appropriate feeding approach?

- A. Oral feeding
- B. Enteral feeding via nasogastric tube
- C. Bolus enteral feeding through a gastrostomy tube**
- D. Parenteral nutrition

For a client who is unresponsive following a cerebrovascular accident (CVA), the safest and most appropriate approach to feeding would be bolus enteral feeding through a gastrostomy tube. This method allows for nutrition to be directly delivered into the stomach, which is essential for clients who may have difficulty swallowing or are at risk for aspiration due to their unresponsive state. Bolus feeding can provide adequate nutrition while minimizing the risk of complications that can arise from oral or nasogastric feeding. Enteral feeding via a gastrostomy tube is particularly suitable for long-term nutritional support when oral intake is not possible or safe, as it bypasses the risk of aspiration that comes with oral feeding and the potential for misplacement associated with nasogastric tubes. In contrast, oral feeding is not suitable for an unresponsive client since they cannot safely swallow, which greatly increases the risk of aspiration. Similarly, while nasogastric tube feeding could be considered in some situations, it often requires a level of alertness and cooperation from the patient to ensure correct placement, and there's still a risk of aspiration. Parenteral nutrition involves delivering nutrients intravenously and is typically used when there is a complete inability to digest or absorb food through the gastrointestinal tract.

9. What should a nurse do first when observing blue fingers on a client wearing wrist restraints?

- A. Notify the physician of the condition.
- B. Loosen the right wrist restraint.**
- C. Check the circulation of the left hand.
- D. Apply a warm compress to the affected hand.

When a nurse observes blue fingers on a client wearing wrist restraints, the priority action is to ensure the circulation is adequate and that the restraint is not causing impairment. Loosening the right wrist restraint is the appropriate first step because it can immediately alleviate any pressure or restriction that might be causing compromised blood flow to the hand. Considering the condition indicated by the blue fingers, this could signify inadequate circulation, possibly due to tight restraints. By loosening the restraint, the nurse can help restore normal circulation and assess the situation further. Additionally, intervention to improve circulation should occur before notifying the physician or applying a warm compress, as those steps may not address the immediate problem of potential restraint-induced injury. Thus, addressing the cause of the altered color through loosening the restraint aligns with prioritizing patient safety and comfort, confirming that circulation is being effectively restored before proceeding with other interventions or notifications.

10. What outcome statement best demonstrates a postoperative client's readiness to manage daily dressing changes at home?

- A. The client verbalizes feeling ready for discharge.
- B. The client demonstrates the wound care procedure correctly.**
- C. The client expresses concerns about pain management.
- D. The client understands the importance of keeping the dressing clean.

The outcome statement that best demonstrates a postoperative client's readiness to manage daily dressing changes at home is when the client demonstrates the wound care procedure correctly. This indicates that the client has not only received the necessary education but has also applied that knowledge in a practical setting. Demonstrating the wound care procedure means that the client can effectively show how to clean and change the dressing, which is crucial for preventing infections and promoting healing after surgery. The ability to perform the procedure signifies competence and confidence, essential components for safely managing their own care at home. It reflects the successful transfer of knowledge and skills from the healthcare provider to the client, ensuring that the client is equipped to handle their postoperative needs independently. Thus, this option is the clearest indication that the client is ready for discharge and can adhere to follow-up care instructions appropriately.

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://evolve-hesi.examzify.com>

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

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