

Fundamentals of Nursing CA Practice Test (Sample)

Study Guide



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SAMPLE

Questions

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- 1. What is the purpose of a physical assessment?**
 - A. To prescribe medication**
 - B. To evaluate a patient's physical health status**
 - C. To document patient history**
 - D. To coordinate care with specialists**
- 2. What is the primary responsibility of a nurse during a blood transfusion?**
 - A. Preparing the blood product for infusion**
 - B. Monitoring vital signs for adverse reactions**
 - C. Documenting the blood type used**
 - D. Performing a physical evaluation of the patient**
- 3. What important aspect should be included in the nurse's ongoing support for patients with chronic conditions?**
 - A. Regular financial assessments**
 - B. Motivational interviewing techniques**
 - C. Scheduling frequent follow-up surgeries**
 - D. Conducting laboratory tests**
- 4. Which of the following actions is considered unsafe during suctioning?**
 - A. Insertion of the catheter along the side of the mouth**
 - B. Apply suction as the tube is being inserted**
 - C. Each suction should last for 10-15 seconds only**
 - D. Lubricate the tip of the catheter with water soluble lubricant or NSS**
- 5. The four major concepts in nursing theory are:**
 - A. Promotive, Preventive, Curative, Rehabilitative.**
 - B. Nurse, Person, Environment, Cure.**
 - C. Person, Environment, Nursing, Health.**
 - D. Person, Environment, Nurse, Health.**

- 6. If the fluid in a pneumonectomy client's drainage tubing goes up and down, how should the nurse best respond?**
- A. Let us ask the doctor when he arrives**
 - B. Thank you for saying that, I will call the doctor immediately**
 - C. There is nothing to worry about; oscillations are normal**
 - D. It may mean profuse bleeding inside the lung cavity**
- 7. Which of the following is NOT an appropriate intervention to ensure the accuracy of a pulse oximeter reading?**
- A. Immobilize the client's monitoring site**
 - B. Cover the sensor with a towel**
 - C. Compare the pulse rate indicated by the oximeter to the radial pulse periodically**
 - D. Ask the client to frequently flex the wrist for better circulation**
- 8. Effective triage can significantly impact the outcomes for which of the following groups?**
- A. All hospital staff members**
 - B. Patients in emergency situations**
 - C. Insurance companies**
 - D. Healthcare administrators**
- 9. Which patient has the greatest predisposition to an adverse reaction when administering medications?**
- A. A 9-year-old boy with an ear infection**
 - B. A 75-year-old woman with cystitis**
 - C. A 50-year-old man with an upper respiratory tract infection**
 - D. A 30-year-old man with kidney disease**
- 10. Which of the following vital signs is typically checked last?**
- A. Pulse**
 - B. Temperature**
 - C. Respiratory rate**
 - D. Blood pressure**

Answers

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

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Explanations

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1. What is the purpose of a physical assessment?

- A. To prescribe medication
- B. To evaluate a patient's physical health status**
- C. To document patient history
- D. To coordinate care with specialists

The purpose of a physical assessment is to evaluate a patient's physical health status. This comprehensive examination allows healthcare providers to gather essential information about a patient's current health condition, including vital signs, organ function, and any signs of illness or abnormality. By systematically assessing each body system, nurses can identify potential health issues, monitor changes over time, and establish a baseline for further examinations or interventions. Understanding a patient's physical health status is critical for effective planning and delivery of care, enabling nurses to tailor interventions to the individual needs of the patient. This assessment is foundational to the nursing process, guiding clinical judgment and decision-making in providing quality patient care. The other options, such as prescribing medication, documenting patient history, and coordinating care with specialists, involve different aspects of patient management. While they are important components of healthcare, they do not specifically capture the primary goal of a physical assessment, which is focused on evaluating and understanding the patient's physical condition.

2. What is the primary responsibility of a nurse during a blood transfusion?

- A. Preparing the blood product for infusion
- B. Monitoring vital signs for adverse reactions**
- C. Documenting the blood type used
- D. Performing a physical evaluation of the patient

The primary responsibility of a nurse during a blood transfusion is to monitor vital signs for adverse reactions. This is essential because blood transfusions can lead to serious complications, including allergic reactions, febrile non-hemolytic reactions, or hemolytic reactions. Therefore, continuous monitoring of the patient's vital signs—such as temperature, heart rate, blood pressure, and respiratory rate—allows the nurse to detect any changes or signs of an adverse reaction early. Moreover, the nurse should establish a baseline set of vital signs before the transfusion begins and then continue to monitor them at regular intervals during and after the procedure. Prompt identification of any adverse reactions enables timely interventions, thereby ensuring patient safety. While preparing the blood product for infusion, documenting the blood type, and performing physical evaluations are important tasks within the transfusion process, they are not as critical during the actual transfusion as the ongoing monitoring of vital signs is. This highlights the nurse's primary role in safeguarding the patient's well-being during this potentially high-risk procedure.

3. What important aspect should be included in the nurse's ongoing support for patients with chronic conditions?

- A. Regular financial assessments**
- B. Motivational interviewing techniques**
- C. Scheduling frequent follow-up surgeries**
- D. Conducting laboratory tests**

Motivational interviewing techniques are essential for providing ongoing support to patients with chronic conditions because they focus on enhancing patients' motivation and commitment to change. This patient-centered approach encourages individuals to explore their own reasons for change, build confidence in their ability to manage their health, and actively participate in their care planning. By using motivational interviewing, nurses can foster a collaborative relationship with patients, helping them to set realistic goals, identify barriers to adherence, and develop strategies for overcoming those challenges. This process is particularly vital for chronic condition management, as it empowers patients to take charge of their health and make informed decisions that can lead to improved outcomes and better adherence to treatment regimens. In contrast, regular financial assessments, scheduling frequent follow-up surgeries, and conducting laboratory tests do not address the psychological and behavioral aspects of health management that motivational interviewing targets. While these other options may be necessary in certain contexts, they do not sufficiently support the ongoing motivational and educational needs of patients managing chronic conditions.

4. Which of the following actions is considered unsafe during suctioning?

- A. Insertion of the catheter along the side of the mouth**
- B. Apply suction as the tube is being inserted**
- C. Each suction should last for 10-15 seconds only**
- D. Lubricate the tip of the catheter with water soluble lubricant or NSS**

Applying suction while the catheter is being inserted is considered unsafe because it can cause injury to the airway and surrounding tissues. The primary purpose of suctioning is to remove secretions or obstructions once the catheter is properly in place. Suctioning during insertion can lead to trauma, discomfort, and potentially obstruct the airway further, as the catheter may push secretions instead of clearing them. It's important to first insert the catheter gently to the appropriate depth and only then apply suction for a prescribed duration. This ensures that the procedure is as effective and safe as possible, minimizing risks to the patient while maximizing the likelihood of successful secretion removal.

5. The four major concepts in nursing theory are:

- A. Promotive, Preventive, Curative, Rehabilitative.**
- B. Nurse, Person, Environment, Cure.**
- C. Person, Environment, Nursing, Health.**
- D. Person, Environment, Nurse, Health.**

The correct answer highlights the four major concepts in nursing theory: Person, Environment, Nursing, and Health. These concepts form the foundation of nursing practice and guide the development of nursing theories. The "Person" concept refers to the individual or group receiving care, emphasizing the uniqueness of each patient and their holistic needs. Understanding the person extends beyond mere biological aspects to include emotional, social, and spiritual dimensions. "Environment" encompasses various external factors that affect the patient's health, including physical, social, and cultural contexts. It recognizes that health does not exist in a vacuum and that external influences can significantly impact a person's well-being. "Nursing" itself is a vital concept that includes the actions and responsibilities of the nurse in providing care. It involves the application of knowledge, skills, and attitudes to support patients in achieving optimal health outcomes. Lastly, "Health" represents the overall state of well-being, which nursing aims to promote and maintain. This concept is dynamic and varies with each individual's circumstances, emphasizing the need for personalized care in nursing. These four interrelated concepts serve as a framework for nursing practice and education, guiding nurses in their efforts to provide comprehensive and effective care.

6. If the fluid in a pneumonectomy client's drainage tubing goes up and down, how should the nurse best respond?

- A. Let us ask the doctor when he arrives**
- B. Thank you for saying that, I will call the doctor immediately**
- C. There is nothing to worry about; oscillations are normal**
- D. It may mean profuse bleeding inside the lung cavity**

In the context of managing a client who has undergone a pneumonectomy, the fluctuation of fluid levels in the drainage tubing is often referred to as "oscillation." This is a normal phenomenon and is a result of changes in intrathoracic pressure during breathing. The mechanical aspects of breathing, such as inspiration and expiration, can cause the fluid within the drainage system to move up and down, which is expected in a properly functioning drainage system. Understanding that this oscillation indicates that the drainage system is effectively draining and is responsive to the client's ventilatory effort is crucial for nursing care. It reassures both the nurse and the patient that the drainage system is actively doing its job without indicating a complication. In contrast, concerns about the need to consult a doctor may lead to unnecessary anxiety, while indicating that oscillations are not a cause for concern directly addresses the patient's query and promotes understanding of their condition. Additionally, indicating that it could mean "profuse bleeding" would unnecessarily alarm the patient without sufficient grounds for concern in this scenario.

7. Which of the following is NOT an appropriate intervention to ensure the accuracy of a pulse oximeter reading?

- A. Immobilize the client's monitoring site**
- B. Cover the sensor with a towel**
- C. Compare the pulse rate indicated by the oximeter to the radial pulse periodically**
- D. Ask the client to frequently flex the wrist for better circulation**

When measuring pulse oximetry, ensuring an accurate reading is crucial, and the interventions chosen must support accurate sensor function and stable readings. The correct choice here involves the action of asking the client to frequently flex the wrist for better circulation, which is not appropriate. Frequent wrist flexing can lead to movement of the sensor or increased extraneous motion, which may interfere with the pulse oximeter's ability to provide a stable and accurate measurement. Motion can cause artifact, which affects the accuracy of the readings since the sensor relies on consistent blood flow and motion detection to assess oxygen saturation levels accurately. In contrast, immobilizing the monitoring site helps stabilize the sensor for more consistent readings. Covering the sensor with a towel is generally inappropriate as it can obstruct light transmission, which is critical for the accuracy of pulse oximeter readings. Comparing the pulse rate indicated by the oximeter to the radial pulse periodically ensures that the heart rate is being accurately monitored, supporting the validity of the oximeter's readings. All these interventions align with the objective of enhancing the reliability of the pulse oximeter, while wrist flexing does not.

8. Effective triage can significantly impact the outcomes for which of the following groups?

- A. All hospital staff members**
- B. Patients in emergency situations**
- C. Insurance companies**
- D. Healthcare administrators**

The correct answer is patients in emergency situations because effective triage is a critical process in emergency care that prioritizes patient treatment based on the severity of their condition. By quickly and accurately assessing patients, healthcare providers can ensure that those with life-threatening injuries or illnesses receive immediate attention. This enhances the chances of positive outcomes, such as survival rates and recovery times, particularly in high-pressure environments like emergency departments. The focus of triage is on optimizing patient care in scenarios where time is of the essence, which directly affects the well-being of patients experiencing emergencies. Proper triage can reduce wait times for critical patients and improve resource allocation, which ultimately leads to more effective clinical interventions and better overall health outcomes for those in urgent need of care. While other groups, like hospital staff and healthcare administrators, certainly benefit from a well-functioning triage system in terms of efficiency and resource management, the primary focus and most significant impact of effective triage is on the patients who are in urgent and emergency situations needing immediate medical attention.

9. Which patient has the greatest predisposition to an adverse reaction when administering medications?

- A. A 9-year-old boy with an ear infection**
- B. A 75-year-old woman with cystitis**
- C. A 50-year-old man with an upper respiratory tract infection**
- D. A 30-year-old man with kidney disease**

The 75-year-old woman with cystitis has the greatest predisposition to an adverse reaction when administering medications primarily due to age-related physiological changes. As individuals age, their bodies typically undergo various alterations in pharmacokinetics and pharmacodynamics, which can affect drug metabolism and excretion processes. In older adults, organ systems such as the liver and kidneys may not function as efficiently, leading to impaired clearance of medications from the body. This can heighten the risk of drug accumulation and, consequently, adverse drug reactions. Additionally, older populations often have multiple comorbidities and may be taking several medications concurrently, increasing the likelihood of drug-drug interactions and side effects. In comparison, while the other patients may also be at risk for adverse reactions, they do not have the same level of vulnerability associated with advanced age and its related physiological changes. For instance, the 9-year-old boy's physiology is generally more adaptable, the 50-year-old man's health status may not indicate significant risk factors, and while the 30-year-old man with kidney disease does have a specific concern, his age suggests a potentially more robust system in processing medications compared to the older woman.

10. Which of the following vital signs is typically checked last?

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

In assessing vital signs, it is common practice to check blood pressure last. This sequence allows for a more comprehensive assessment, as it minimizes patient discomfort and helps ensure accuracy in other measurements. Taking blood pressure can sometimes create a temporary sensation that might affect the patient's response or state of relaxation. By taking it at the end, after assessing pulse, temperature, and respiratory rate, the nurse can ensure that the patient has settled and remains calm, which contributes to more reliable blood pressure readings. Furthermore, assessing other vital signs first provides a broader picture of the patient's current health status and can help identify any immediate issues the nurse should address before measuring blood pressure. This practice is in line with the principles of nursing care, which emphasize the importance of accurate data collection and patient comfort.