

HESI Leadership Exit Practice Exam (Sample)

Study Guide



Everything you need from our exam experts!

This is a sample study guide. To access the full version with hundreds of questions,

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Table of Contents

Copyright	1
Table of Contents	2
Introduction	3
How to Use This Guide	4
Questions	6
Answers	9
Explanations	11
Next Steps	17

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. Don't worry about getting everything right, 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, and take breaks to retain information better.

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.

7. Use Other Tools

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!

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Questions

- 1. What is an essential action for the nurse when a central venous catheter dressing is found loose?**
 - A. Reapply the dressing without any evaluation**
 - B. Secure the dressing and report the condition**
 - C. Notify the client to avoid touching the area**
 - D. Remove the catheter due to risk of infection**
- 2. What should the nurse do first if a patient has a significant change in a lab value?**
 - A. Recheck the lab order for accuracy**
 - B. Contact the healthcare provider immediately**
 - C. Document the findings and monitor the patient**
 - D. Assess the patient for related symptoms**
- 3. If a nurse is unsure about a new medication order provided by a healthcare provider due to erroneous dosage, what is the best course of action?**
 - A. Administer half the dosage indicated**
 - B. Consult with a more experienced nurse**
 - C. Contact the healthcare provider for clarification**
 - D. Wait until the next shift to report**
- 4. What should the charge nurse do upon observing an argument between UAP and a nurse at the station?**
 - A. Ignore the argument since it is a minor issue**
 - B. Inform both individuals that their behavior is inappropriate**
 - C. Join the argument to mediate the situation**
 - D. Separate them and assign new tasks**
- 5. Which client requires the most immediate intervention by the nurse on a post-surgical unit?**
 - A. A client experiencing chest pain**
 - B. A client who fell from a ladder with drainage in a chest tube**
 - C. A client requesting pain medication**
 - D. A client showing signs of infection**

- 6. In the event of a needlestick injury, what report should a nurse complete as a priority?**
- A. A medication administration record**
 - B. A work injury report**
 - C. Incident report**
 - D. Nursing assessment report**
- 7. What assessment finding should the nurse emphasize during a report for a client with bacterial meningitis?**
- A. Stable blood pressure**
 - B. Decreasing body temperature**
 - C. Increasing pulse pressure**
 - D. Improving neurological status**
- 8. When delegating blood sugar monitoring to a UAP, what is the most critical action for the nurse?**
- A. Review the UAP's previous documentation**
 - B. Observe the UAP obtain the glucose level**
 - C. Ensure the UAP is trained on the glucometer**
 - D. Explain the reason for obtaining the glucose level**
- 9. A young adult client with a brain tumor refuses treatment. What is the nurse's best course of action?**
- A. Arrange for palliative care**
 - B. Respect the client's wishes without further discussion**
 - C. Initiate a review with the hospital's ethics committee**
 - D. Convince the client to continue treatment**
- 10. What is the most important intervention for a client with heart failure who has multiple bruises and is on various medications?**
- A. Administer anticoagulant therapy as prescribed**
 - B. Continuous electrocardiogram monitoring**
 - C. Encourage a low-sodium diet and fluid intake**
 - D. Educate the client about recognizing signs of heart failure**

Answers

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

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Explanations

1. What is an essential action for the nurse when a central venous catheter dressing is found loose?

- A. Reapply the dressing without any evaluation**
- B. Secure the dressing and report the condition**
- C. Notify the client to avoid touching the area**
- D. Remove the catheter due to risk of infection**

When a central venous catheter dressing is found to be loose, the most essential action for the nurse is to secure the dressing and report the condition. This approach ensures that the integrity of the catheter site is maintained and reduces the risk of complications, such as infection or dislodgement of the catheter. By securing the dressing, the nurse helps to protect the insertion site from foreign contaminants and maintains sterile conditions. Additionally, reporting the condition is crucial as it informs other healthcare team members about the status of the catheter, prompting further evaluation of the catheter site if necessary. This collaborative communication is vital in managing patient care and ensuring patient safety. Taking the time to secure the dressing effectively while also documenting or reporting any changes in the catheter's status reflects adherence to best practices in clinical nursing care, emphasizing both patency and sterility.

2. What should the nurse do first if a patient has a significant change in a lab value?

- A. Recheck the lab order for accuracy**
- B. Contact the healthcare provider immediately**
- C. Document the findings and monitor the patient**
- D. Assess the patient for related symptoms**

When a patient shows a significant change in a lab value, the first step a nurse should take is to assess the patient for related symptoms. This approach is crucial because it helps determine the immediate impact of the altered lab result on the patient's health and well-being. By conducting a thorough assessment, the nurse can identify any signs of distress, changes in vital signs, or other physical symptoms that may be linked to the abnormal lab value. This assessment is foundational for providing safe and effective patient care. Following the assessment, the nurse can then determine whether it is necessary to contact the healthcare provider or take other actions based on the patient's condition. Prioritizing patient assessment allows for a more informed and responsive approach to care, ensuring that any potential complications arising from the lab changes are addressed promptly.

3. If a nurse is unsure about a new medication order provided by a healthcare provider due to erroneous dosage, what is the best course of action?

- A. Administer half the dosage indicated**
- B. Consult with a more experienced nurse**
- C. Contact the healthcare provider for clarification**
- D. Wait until the next shift to report**

When a nurse encounters a medication order with an erroneous dosage, the most appropriate and safe course of action is to contact the healthcare provider for clarification. This decision prioritizes patient safety and the standard of care by ensuring that the medication is administered as intended and at the correct dosage. Clarifying the order with the healthcare provider helps prevent potential medication errors, which can lead to serious patient harm. It is crucial for the nurse to advocate for the patient by addressing uncertainties directly with the person who has the authority to modify or confirm the order. This action aligns with the nurse's responsibility to practice safely and to uphold professional standards. While consulting with a more experienced nurse could provide insight or guidance, it does not directly resolve the issue of the erroneous dosage and may delay necessary action. Administering half the indicated dosage puts the patient at risk of receiving an incorrect amount of the medication, which could lead to ineffective treatment or adverse effects. Waiting until the next shift to report the issue further compromises patient safety and does not adhere to the urgency required in situations involving medication orders.

4. What should the charge nurse do upon observing an argument between UAP and a nurse at the station?

- A. Ignore the argument since it is a minor issue**
- B. Inform both individuals that their behavior is inappropriate**
- C. Join the argument to mediate the situation**
- D. Separate them and assign new tasks**

When the charge nurse observes an argument between a UAP and a nurse at the station, addressing the behavior is critical for maintaining a professional and collaborative work environment. It is essential to recognize that conflicts can affect team dynamics, patient care, and overall morale. By informing both individuals that their behavior is inappropriate, the charge nurse takes a proactive approach to conflict resolution. This action helps to set clear expectations regarding professional conduct and encourages a culture of respect within the team. It also emphasizes the importance of maintaining a focus on patient care and encourages open communication among staff to prevent similar incidents in the future. Choosing to ignore the argument overlooks the potential negative consequences of unresolved conflicts. Mediating by joining the argument may lead to further confusion and escalation rather than resolution. Separating the individuals and assigning new tasks without addressing the root of the conflict may only provide a temporary solution and does not foster constructive communication or behaviors. Addressing the situation directly not only resolves the immediate conflict but also reinforces the importance of professionalism and teamwork, which are vital in healthcare settings.

5. Which client requires the most immediate intervention by the nurse on a post-surgical unit?

- A. A client experiencing chest pain**
- B. A client who fell from a ladder with drainage in a chest tube**
- C. A client requesting pain medication**
- D. A client showing signs of infection**

The client who fell from a ladder and has drainage in a chest tube requires the most immediate intervention because they may be at risk for serious complications such as a pneumothorax or hemothorax. The presence of drainage from a chest tube signifies that there may be a need to assess the adequacy of lung expansion and the function of the chest tube itself. Any changes in respiratory status, such as difficulty breathing or decreased breath sounds, could indicate a critical situation that needs urgent attention. In post-surgical care, airway, breathing, and circulation are paramount, and an injury that involves the chest can severely compromise these vital functions. Therefore, it is essential for the nurse to prioritize this situation by quickly assessing the patient's respiratory status, the functioning of the chest tube, and intervening appropriately to ensure the safety of the client. Other clients may also require attention, such as those experiencing chest pain or showing signs of infection, but those situations may not necessitate immediate intervention with the same urgency as a potential chest injury with drainage in a post-surgical setting. The request for pain medication, while valid, usually does not indicate a life-threatening situation that needs immediate action compared to the risks associated with the client who fell and has a chest tube.

6. In the event of a needlestick injury, what report should a nurse complete as a priority?

- A. A medication administration record**
- B. A work injury report**
- C. Incident report**
- D. Nursing assessment report**

In the case of a needlestick injury, the nurse should prioritize completing a work injury report. This report is crucial as it documents the details of the incident related to workplace safety and health standards. It is specifically designed to outline circumstances surrounding work-related injuries, ensuring that the incident is officially recognized and that the healthcare facility can address any potential safety concerns or changes needed in protocols to prevent future injuries. A work injury report also serves to initiate any necessary follow-up actions, such as medical evaluations and treatment for the nurse who experienced the injury. This type of report may be required for insurance purposes and can help the organization track incidents and implement systemic changes to enhance safety protocols. While other reports like an incident report or a nursing assessment report are important, they serve different functions. The incident report typically addresses various types of clinical incidents and may not focus specifically on the worker's compensation aspect, while the nursing assessment report is related to the patient's ongoing care and does not address workplace injuries. A medication administration record pertains strictly to the documentation of medications given to patients and does not apply to this scenario. Thus, the work injury report stands out as the most appropriate and immediate action in the event of a needlestick injury.

7. What assessment finding should the nurse emphasize during a report for a client with bacterial meningitis?

- A. Stable blood pressure**
- B. Decreasing body temperature**
- C. Increasing pulse pressure**
- D. Improving neurological status**

In the context of a client with bacterial meningitis, the emphasis on increasing pulse pressure is particularly significant due to its implications for changes in intracranial pressure and overall hemodynamic status. Meningitis can lead to complications such as increased intracranial pressure, which may be reflected in alterations in vital signs, including pulse pressure. A widening pulse pressure, which is defined as an increase in the difference between systolic and diastolic blood pressure, can indicate a decline in cardiovascular function, particularly as the condition progresses or leads to complications like neurogenic shock. This can also suggest that the central nervous system is under significant stress due to the infection and inflammation caused by meningitis, requiring heightened vigilance and intervention from the healthcare team. In contrast, while stable blood pressure and a decreasing body temperature may seem positive, they do not specifically indicate the severity or progression of the meningitis itself. Observations regarding improving neurological status are also important, yet they are often a response to treatment rather than an immediate indicator of the critical state of the client. Therefore, focusing on increasing pulse pressure is crucial for assessing and responding to the clinical status of a client with bacterial meningitis.

8. When delegating blood sugar monitoring to a UAP, what is the most critical action for the nurse?

- A. Review the UAP's previous documentation**
- B. Observe the UAP obtain the glucose level**
- C. Ensure the UAP is trained on the glucometer**
- D. Explain the reason for obtaining the glucose level**

Observing the UAP obtain the glucose level is the most critical action for the nurse because it ensures that the procedure is being carried out correctly and safely. While training and understanding the rationale behind the task are important, the direct observation allows the nurse to assess the UAP's technique and confirm that they are following the proper protocols and procedures. Monitoring blood glucose levels requires accuracy and precision because the results can significantly impact patient care decisions. By watching the UAP perform the task, the nurse can immediately address any potential errors or concerns, ensuring patient safety and maintaining standards of care. Furthermore, while ensuring the UAP is trained on the glucometer is essential for competency, it does not provide the immediate oversight required to confirm that the monitoring is being done correctly in a specific instance. Likewise, reviewing previous documentation and explaining the rationale are valuable actions but do not directly influence the quality and accuracy of the blood sugar monitoring at that moment. Therefore, direct observation is the most critical support for ensuring accurate patient assessment in this delegated task.

9. A young adult client with a brain tumor refuses treatment. What is the nurse's best course of action?

- A. Arrange for palliative care**
- B. Respect the client's wishes without further discussion**
- C. Initiate a review with the hospital's ethics committee**
- D. Convince the client to continue treatment**

In a situation where a young adult client with a brain tumor refuses treatment, the best course of action involves initiating a review with the hospital's ethics committee. This is crucial because it acknowledges the complex interplay between a patient's autonomy, the implications of their treatment decisions, and the ethical considerations surrounding such choices. The refusal of treatment in individuals with serious health conditions can often lead to significant ethical dilemmas, especially when the patient is capable of making informed decisions but might not fully comprehend the potential consequences of their choice. Engaging with the ethics committee allows for a multidisciplinary approach to addressing the ethical concerns while ensuring that the patient's rights are respected. It also provides an opportunity to discuss the patient's wishes in a safe environment and consider any additional support or information they may need to make an informed choice. This process highlights the importance of communication, advocacy, and respect for the client's autonomy, while also seeking guidance in navigating the ethical complexities involved. The other options may not fully respect the ethical considerations or the need for comprehensive discussions surrounding the patient's decision.

10. What is the most important intervention for a client with heart failure who has multiple bruises and is on various medications?

- A. Administer anticoagulant therapy as prescribed**
- B. Continuous electrocardiogram monitoring**
- C. Encourage a low-sodium diet and fluid intake**
- D. Educate the client about recognizing signs of heart failure**

The choice of continuous electrocardiogram (ECG) monitoring as the most important intervention for a client with heart failure who has multiple bruises and is on various medications is rooted in the need for ongoing assessment of the heart's electrical activity in a potentially unstable patient. Patients with heart failure are at an elevated risk for arrhythmias, particularly when they are on multiple medications that can affect heart rhythm. This risk might be further compounded if the client has abnormalities in blood coagulation due to anticoagulant therapy or other medications. Continuous monitoring allows healthcare providers to quickly identify any dangerous changes that could lead to complications such as cardiac arrest or other serious issues. Moreover, the presence of multiple bruises raises concern for potential bleeding issues, which could indicate that the client is experiencing side effects from their medications, particularly anticoagulants or antiplatelet agents. Continuous monitoring helps ensure timely intervention if the patient develops any rhythm disturbances or shows signs of cardiovascular instability. In this context, while other interventions like encouraging a low-sodium diet and educating the client on heart failure signs are important for long-term management, the immediate safety and monitoring of cardiac function take precedence, particularly when the patient may be at a higher risk for acute complications.

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://hesileadershipexit.examzify.com>

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