

HESI LEVEL 1 PRACTICE EXAM (SAMPLE)

STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

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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. What is the best practice for nursing care when a patient is refusing to turn or move?**
 - A. Insist on turning the patient every two hours regardless of their consent.
 - B. Explain the importance of mobility and potential risks of immobility.
 - C. Allow the patient to decide whether to remain supine indefinitely.
 - D. Consult with a physician regarding possible need for restraints.

- 2. Which action by the nurse best demonstrates culturally sensitive care?**
 - A. Asks permission before touching a client.
 - B. Avoids questions about male-female relationships.
 - C. Explains the differences between Western medical care and cultural folk remedies.
 - D. Applies knowledge of a cultural group unless a client embraces Western customs.

- 3. How should a nurse assess a patient's pain level?**
 - A. By observing facial expressions
 - B. Using a standardized pain scale
 - C. Based on the patient's medical history
 - D. By checking vital signs

- 4. Which skill is emphasized for nursing students regarding patient interactions?**
 - A. Technical skill proficiency
 - B. Therapeutic communication
 - C. Time management
 - D. Medication administration

- 5. When documenting subjective findings for a client admitted for benign prostatic hypertrophy, which data is the nurse likely to record?**
 - A. Complaints of inability to empty bladder.
 - B. Temperature of 99.8°F and pulse of 108.
 - C. Post-voided residual volume of 750 ml.
 - D. Specimen collection for culture and sensitivity.

- 6. If a client refuses to look at her mastectomy incision at the first dressing change, how should the nurse respond?**
- A. "It is normal to feel angry and depressed, but the sooner you deal with this surgery, the better you will feel."
 - B. "Looking at your incision can be frightening, but facing this fear is a necessary part of your recovery."
 - C. "It is OK if you don't want to talk about your surgery. I will be available when you are ready."
 - D. "I will ask a woman who has had a mastectomy to come by and share her experiences with you."
- 7. In terms of pain management in older adults, which factor should be prioritized by the nurse?**
- A. Assessing only verbal complaints of pain.
 - B. Trying non-pharmacological interventions first.
 - C. Assessing for underlying conditions related to pain.
 - D. Maximizing the use of opioid medications.
- 8. What action should the nurse take after aspirating a blood return in a lumen of a triple lumen catheter before administering medication?**
- A. Flush the lumen with the saline solution and administer the medication through the lumen.
 - B. Determine if a PRN prescription for a thrombolytic agent is listed on the medication record.
 - C. Clamp the lumen and obtain a syringe of a dilute heparin solution to flush through the tubing.
 - D. Withdraw the aspirated blood into the syringe and use a new syringe to administer the medication.
- 9. What is the optimum time for obtaining the trough level for a client receiving antibiotic therapy?**
- A. Sixty minutes after the antibiotic dose is administered.
 - B. Immediately before the next antibiotic dose is given.
 - C. When the next blood glucose level is checked.
 - D. Thirty minutes before the next antibiotic dose is given.

10. A 17-year-old male student has a temperature of 100°F after football practice. What is the best action for the nurse to take?

- A. Tell the student to proceed directly to his regularly scheduled class.
- B. Call the parent and suggest re-taking the student's temperature at home.
- C. Give the student a glass of cool fluids, then retake his temperature.
- D. Send the student to class, but re-verify his temperature after lunch.

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Answers

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

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Explanations

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1. What is the best practice for nursing care when a patient is refusing to turn or move?

- A. Insist on turning the patient every two hours regardless of their consent.
- B. Explain the importance of mobility and potential risks of immobility.**
- C. Allow the patient to decide whether to remain supine indefinitely.
- D. Consult with a physician regarding possible need for restraints.

Explaining the importance of mobility and the potential risks of immobility is the best practice in this scenario. This approach respects the patient's autonomy while providing them with critical information about their health. Discussing the benefits of movement, such as improving circulation, preventing pressure ulcers, and enhancing overall well-being, can empower the patient to make an informed choice about their care. By conveying the consequences of remaining still for prolonged periods, the nurse helps the patient understand that their active participation in care is essential for optimal health outcomes. Open communication can also strengthen the nurse-patient relationship and increase the likelihood that the patient will reconsider their decision to avoid moving or turning. The other options do not adequately respect the patient's autonomy or focus on informed consent. A directive approach, such as insisting on turning the patient, may cause resistance or discomfort. Allowing a patient to remain supine without discussion may lead to serious health complications, while consulting with a physician about restraints should be a last resort and only after all other options, including education, have been exhausted.

2. Which action by the nurse best demonstrates culturally sensitive care?

- A. Asks permission before touching a client.**
- B. Avoids questions about male-female relationships.
- C. Explains the differences between Western medical care and cultural folk remedies.
- D. Applies knowledge of a cultural group unless a client embraces Western customs.

Asking permission before touching a client embodies the essence of culturally sensitive care because it emphasizes respect for personal boundaries and recognizes the diverse cultural norms regarding physical contact. Different cultures have varying beliefs about touch; for some, it is a sign of respect and empathy, while for others, it can be seen as intrusive or inappropriate. By seeking permission, the nurse is not only demonstrating cultural awareness but also fostering trust and rapport with the client, which is foundational in delivering effective and respectful healthcare. This approach ensures that clients feel safe and respected during their interactions with healthcare providers. It allows clients to express their comfort level and provides an opportunity for open communication about their preferences and cultural practices. This action reflects an understanding that culturally sensitive care goes beyond simply acknowledging cultural differences; it actively involves clients in their care and respects their individual experiences and beliefs. In contrast, the other options may not fully align with the principles of culturally sensitive care. Avoiding questions can lead to misunderstandings and prevent meaningful discussions about important aspects of a client's life. Explaining cultural differences without considering the client's personal views may not engage them in a productive dialogue. Applying knowledge of cultural groups while neglecting the individual beliefs of the client may lead to assumptions that do not provide the personalized care that truly

3. How should a nurse assess a patient's pain level?

- A. By observing facial expressions
- B. Using a standardized pain scale**
- C. Based on the patient's medical history
- D. By checking vital signs

Using a standardized pain scale is the most effective approach for assessing a patient's pain level. Pain is a subjective experience that varies from person to person, making it essential to use a consistent method for evaluation. Standardized pain scales, such as the Numeric Rating Scale or the Wong-Baker FACES Pain Rating Scale, provide patients with a clear way to communicate their level of pain. These scales allow nurses to quantify pain, facilitating better communication regarding the intensity of discomfort. By assigning numbers or facial expressions to pain levels, nurses can assess changes over time, which aids in developing an appropriate pain management plan and monitoring its effectiveness. While observing facial expressions can provide some insight into a patient's pain, this method lacks the precision and objectivity that a standardized scale offers. Relying solely on a patient's medical history or checking vital signs may not provide a complete picture of pain, as these methods do not directly measure the patient's current pain experience. Thus, utilizing a standardized pain scale is the most reliable way to assess a patient's pain level comprehensively.

4. Which skill is emphasized for nursing students regarding patient interactions?

- A. Technical skill proficiency
- B. Therapeutic communication**
- C. Time management
- D. Medication administration

Therapeutic communication is crucial for nursing students as it facilitates the establishment of a trusting relationship between the nurse and the patient. This type of communication goes beyond simply exchanging information; it involves actively listening, showing empathy, and understanding the patient's feelings and experiences. Effective therapeutic communication helps in assessing patients' needs, educating them about their conditions, and providing emotional support. In patient interactions, fostering a supportive environment enhances patients' willingness to share their concerns, which leads to better patient outcomes. Developing these communication skills is essential for nurses, who must navigate complex emotional and psychological issues that patients may face during their healthcare journey. This emphasis on therapeutic communication distinguishes nursing practice, as it is not solely about providing medical care but about caring for the whole person.

5. When documenting subjective findings for a client admitted for benign prostatic hypertrophy, which data is the nurse likely to record?

- A. Complaints of inability to empty bladder.**
- B. Temperature of 99.8°F and pulse of 108.
- C. Post-voided residual volume of 750 ml.
- D. Specimen collection for culture and sensitivity.

When documenting subjective findings for a client with benign prostatic hypertrophy (BPH), the nurse typically focuses on the client's personal report of symptoms and experiences, which are defined as subjective data. Complaining of the inability to empty the bladder is a classic symptom of BPH, as the condition often leads to urinary obstruction and related discomfort. Patients frequently describe feelings of incomplete bladder emptying, urgency, frequency, and nocturia, all of which can significantly affect their quality of life. This report is vital for assessing the severity of the condition and guiding treatment options. In contrast, the other options present objective data such as vital signs and laboratory results, which are important but do not fall under the category of subjective findings. The temperature and pulse, post-void residual volume, and specimen collection are all measurements or results typically documented as objective observations. They can certainly support the overall assessment but do not represent the subjective experiences and complaints of the patient regarding their condition.

6. If a client refuses to look at her mastectomy incision at the first dressing change, how should the nurse respond?

- A. "It is normal to feel angry and depressed, but the sooner you deal with this surgery, the better you will feel."
- B. "Looking at your incision can be frightening, but facing this fear is a necessary part of your recovery."
- C. "It is OK if you don't want to talk about your surgery. I will be available when you are ready."**
- D. "I will ask a woman who has had a mastectomy to come by and share her experiences with you."

The response that indicates it is acceptable for the client to refrain from discussing her surgery, while also making it clear that support is available when she decides to engage, is particularly sensitive to the emotional state of the client. This approach respects her autonomy and acknowledges her feelings without pressure, creating a safe space for her to process her experience at her own pace. By stating that the nurse will be available when the client is ready, this option promotes a supportive and empathetic environment. It fosters trust in the nurse-client relationship, allowing the client to feel in control of her healthcare journey, which is crucial during emotionally charged situations like recovering from surgery. While other options may offer encouragement or suggest facing fears, they may inadvertently pressure the client to confront her feelings before she is ready. This can lead to increased anxiety rather than fostering a sense of safety and patience in emotional processing. The selected response values the client's readiness and emotional well-being, aligning with person-centered care principles.

7. In terms of pain management in older adults, which factor should be prioritized by the nurse?

- A. Assessing only verbal complaints of pain.
- B. Trying non-pharmacological interventions first.
- C. Assessing for underlying conditions related to pain.**
- D. Maximizing the use of opioid medications.

Prioritizing the assessment for underlying conditions related to pain is crucial in managing pain effectively in older adults. This population often experiences complex health issues, including comorbidities that can contribute to the experience or expression of pain. An accurate assessment of these underlying conditions allows the nurse to identify the root causes of pain, which can lead to a more targeted and effective intervention strategy. Moreover, older adults may exhibit atypical presentations of pain due to age-related physiological changes or cognitive impairments that affect their ability to communicate discomfort. Understanding the medical history, current diagnoses, and potential sources of pain can assist in developing a holistic pain management plan tailored to each individual. While non-pharmacological interventions and opioid use are present in pain management strategies, they should not take precedence over understanding the underlying conditions that may be causing pain. Identifying and treating these underlying issues can often mitigate the need for more aggressive treatment measures, thereby improving the patient's overall well-being.

8. What action should the nurse take after aspirating a blood return in a lumen of a triple lumen catheter before administering medication?

- A. Flush the lumen with the saline solution and administer the medication through the lumen.**
- B. Determine if a PRN prescription for a thrombolytic agent is listed on the medication record.
- C. Clamp the lumen and obtain a syringe of a dilute heparin solution to flush through the tubing.
- D. Withdraw the aspirated blood into the syringe and use a new syringe to administer the medication.

After aspirating a blood return in a lumen of a triple lumen catheter, the appropriate action is to flush the lumen with saline and then administer the medication through that lumen. This procedure ensures that the medication is delivered through a patent line, confirming that the lumen is functioning properly, and that the medication will reach the systemic circulation without any obstruction. Flushing with saline also helps to clear any blood that may have pooled in the catheter, minimizing the risk of clot formation or medication interaction with previously infused substances in the line. Using saline to flush is an established protocol to maintain the patency of intravenous lines, especially after verifying blood return, which indicates that the catheter is correctly positioned within the vascular system. This step is crucial before administering medications to ensure that the full dose of the medication is delivered effectively and to prevent complications associated with administering medication into a blocked or non-functioning line. The other options presented do not align with standard nursing practices for medication administration via an intravenous line. For instance, using a PRN prescription for a thrombolytic agent is not appropriate unless there is evidence of a clot that needs to be addressed, which is not indicated simply by observing blood return. Clamping the lumen and preparing a heparin solution is unnecessarily complicated if the

9. What is the optimum time for obtaining the trough level for a client receiving antibiotic therapy?

- A. Sixty minutes after the antibiotic dose is administered.
- B. Immediately before the next antibiotic dose is given.**
- C. When the next blood glucose level is checked.
- D. Thirty minutes before the next antibiotic dose is given.

The optimum time for obtaining the trough level of an antibiotic is immediately before the next antibiotic dose is given. This timing ensures that the lowest concentration of the drug in the bloodstream is measured, reflecting the elimination of the drug from the body since the last dose. Monitoring the trough level at this point allows healthcare providers to assess whether the antibiotic is being maintained at therapeutic levels, which is critical for evaluating the effectiveness of the treatment and avoiding potential toxicity. Conversely, measuring the trough level too soon after administration or at different times would not provide an accurate reflection of the drug concentration during its elimination phase. Therefore, this timing is standard practice in pharmacokinetics to ensure optimal dosing and effectiveness of antibiotic therapy.

10. A 17-year-old male student has a temperature of 100°F after football practice. What is the best action for the nurse to take?

- A. Tell the student to proceed directly to his regularly scheduled class.
- B. Call the parent and suggest re-taking the student's temperature at home.
- C. Give the student a glass of cool fluids, then retake his temperature.**
- D. Send the student to class, but re-verify his temperature after lunch.

The best action is to give the student a glass of cool fluids and then retake his temperature. This approach is appropriate because a temperature of 100°F, while slightly elevated, does not necessarily indicate a serious problem, especially after physical exertion like football practice. It is possible that his temperature may be a result of exertion rather than illness, so providing hydration can help lower the temperature and is important for recovery after physical activity. Additionally, retaking the temperature after hydration allows for a more accurate assessment of the student's condition. This option also prioritizes the student's immediate well-being by addressing potential dehydration and the effects of the heat, which are relevant concerns in a physical activity setting. It avoids sending the student to class without further evaluation, ensuring that the nurse takes responsible steps to monitor the student's health before making any further recommendations about his attendance in class.

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:

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

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