

HESI LEVEL 2 PRACTICE TEST (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. What cardiovascular finding should the nurse assess further in a client at 20 weeks' gestation?**
 - A. Decrease in pulse rate.
 - B. Decrease in blood pressure.
 - C. Increase in heart sounds (S1, S2).
 - D. Increase in red blood cell production.
- 2. What additional drug allergy should the nurse assess before administering cefadroxil (Duricef)?**
 - A. Aminoglycosides
 - B. Penicillins
 - C. Erythromycins
 - D. Sulfonamides
- 3. What is an appropriate action when a client demonstrates signs of impending death?**
 - A. Provide them with pain medication.
 - B. Encourage family involvement.
 - C. Facilitate spiritual counseling.
 - D. Evaluate their preference for life support.
- 4. Which laboratory result should a nurse assess as a normal value for a two-hour postprandial glucose tolerance test?**
 - A. 140 mg/dl.
 - B. 160 mg/dl.
 - C. 180 mg/dl.
 - D. 200 mg/dl.
- 5. What is the primary concern of transplacental infections during pregnancy?**
 - A. Dehydration
 - B. Infections
 - C. Nutrient deficiencies
 - D. Hypertension

- 6. What is an essential aspect of the nurse-midwife's role in obstetric care for clients desiring home births?**
- A. Birth in the home setting is the preference for a using a midwife for delivery.
 - B. The pregnancy should progress normally and be considered low risk.
 - C. Natural childbirth without analgesia is used to manage pain during labor.
 - D. An obstetrician should also follow the client during pregnancy.
- 7. What does the nurse's role in witnessing a client's signature on an informed consent form primarily indicate?**
- A. The client voluntarily signed the form.
 - B. The client fully understands the procedure.
 - C. The client agrees with the procedure to be done.
 - D. The client authorizes continued treatment.
- 8. When monitoring a client after administering a fentanyl transdermal patch, which assessment is most important for the nurse to obtain?**
- A. Level of consciousness.
 - B. Moistness of mucosa.
 - C. Bowel sound activity.
 - D. Numeric pain scale.
- 9. When caring for a client with dehydration, what is a vital sign that indicates improving status?**
- A. Increased heart rate
 - B. Stable blood pressure
 - C. Recovery of urine output
 - D. Decreased skin turgor
- 10. What nursing diagnosis should a nurse include for a preschool-aged child experiencing distress in an English-speaking school?**
- A. Culture shock secondary to unfamiliar environment.
 - B. Growth and development, impaired.
 - C. Cultural incompetence due to inability to adjust.
 - D. Defiance behavior as evidenced by outbursts of crying.

Answers

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

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Explanations

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1. What cardiovascular finding should the nurse assess further in a client at 20 weeks' gestation?

- A. Decrease in pulse rate.**
- B. Decrease in blood pressure.
- C. Increase in heart sounds (S1, S2).
- D. Increase in red blood cell production.

In the context of a client at 20 weeks' gestation, a decrease in pulse rate would be an unusual finding that warrants further assessment. During pregnancy, there is an expected increase in blood volume and cardiac output, which typically leads to an elevation in heart rate rather than a decrease. As the body adapts to support the growing fetus, the heart works harder, and the pulse rate usually rises or stays within a normal range. A decrease in pulse rate could suggest potential complications or issues, such as bradycardia or other underlying cardiovascular concerns that might need to be evaluated and monitored closely. Ensuring that the mother's cardiovascular system is functioning optimally is essential for the health of both the mother and the developing fetus. The other options reflect physiological changes that are either normal or expected during pregnancy. For instance, while blood pressure can fluctuate, a decrease alone doesn't automatically indicate a problem unless it's significant or associated with alarming symptoms. An increase in heart sounds and heightened red blood cell production are also typical findings as the body adapts to pregnancy demands. Thus, a decrease in pulse rate stands out as a finding that may require further investigation.

2. What additional drug allergy should the nurse assess before administering cefadroxil (Duricef)?

- A. Aminoglycosides
- B. Penicillins**
- C. Erythromycins
- D. Sulfonamides

Cefadroxil is a cephalosporin antibiotic, and patients who are allergic to penicillin may also have cross-reactivity to cephalosporins, including cefadroxil. This is due to the structural similarities between the two classes of antibiotics. An allergy to penicillin could potentially result in an allergic reaction to cefadroxil, which is why it's crucial for the nurse to assess for a history of penicillin allergy prior to administration. Understanding this cross-reactivity helps safeguard the patient against possible adverse effects and ensures safe medication administration. While assessing allergies to other antibiotic classes, such as aminoglycosides, erythromycins, and sulfonamides, is important, the primary concern with cefadroxil involves penicillin allergy specifically due to their shared beta-lactam structure, highlighting the need for vigilance in patients with known penicillin allergies.

3. What is an appropriate action when a client demonstrates signs of impending death?

- A. Provide them with pain medication.
- B. Encourage family involvement.**
- C. Facilitate spiritual counseling.
- D. Evaluate their preference for life support.

Encouraging family involvement is a crucial action when a client demonstrates signs of impending death. Family members often play a vital role in the emotional and psychological support of the client during this significant time. Involving family can help create a supportive environment, allowing for shared moments, reflection, and conversations that may be important for both the client and their loved ones. It can also help to fulfill the wishes of the client regarding their end-of-life care, as family can assist in conveying these preferences. Moreover, family presence can alleviate feelings of isolation that the client may experience as they approach death. This involvement fosters communication and connection, which can be comforting for both the client and their family, making the process less daunting and more meaningful. While providing pain medication is essential to ensure comfort, and facilitating spiritual counseling can offer solace, these actions may not directly address the immediate emotional and relational needs present at the end of life. Evaluating preferences for life support is important in care planning but may not be the most suitable action at the moment when a client shows clear signs of impending death. Encouragement of family involvement stands out as a holistic and inclusive approach to care during this sensitive time.

4. Which laboratory result should a nurse assess as a normal value for a two-hour postprandial glucose tolerance test?

- A. 140 mg/dl.**
- B. 160 mg/dl.
- C. 180 mg/dl.
- D. 200 mg/dl.

In a two-hour postprandial glucose tolerance test, a normal blood glucose level is considered to be less than 140 mg/dl. This threshold indicates that the body is effectively processing the glucose from the meal consumed. Values above this level suggest potential glucose intolerance or diabetes. Specifically, a reading of 140 mg/dl or below typically indicates normal glycemic control after eating. Therefore, assessing a level of 140 mg/dl as normal aligns with established guidelines for glucose testing. Recognizing this helps healthcare professionals identify patients who may need further evaluation or management of their blood sugar levels.

5. What is the primary concern of transplacental infections during pregnancy?

- A. Dehydration
- B. Infections**
- C. Nutrient deficiencies
- D. Hypertension

The primary concern of transplacental infections during pregnancy is infections. This is because certain pathogens, such as viruses, bacteria, and parasites, can cross the placental barrier and adversely affect the developing fetus. These infections can lead to severe complications, including developmental defects, miscarriage, preterm labor, and even neonatal infections. Infections like toxoplasmosis, rubella, cytomegalovirus, and zika virus are known to cause significant morbidity and mortality in both the mother and the fetus. The ability of these pathogens to access the fetal circulation presents unique risks that can have long-lasting implications for the child's health. While dehydration, nutrient deficiencies, and hypertension are all concerns during pregnancy, they do not directly relate to the specific risks posed by transplacental infections. Dehydration and nutrient deficiencies can impact maternal health and fetal development but do not involve the transfer of pathogens. Hypertension primarily affects maternal health and can lead to conditions like preeclampsia but is not categorized under infections. Thus, infections pose a direct and significant risk in the context of transplacental transmission.

6. What is an essential aspect of the nurse-midwife's role in obstetric care for clients desiring home births?

- A. Birth in the home setting is the preference for a using a midwife for delivery.
- B. The pregnancy should progress normally and be considered low risk.**
- C. Natural childbirth without analgesia is used to manage pain during labor.
- D. An obstetrician should also follow the client during pregnancy.

The essential aspect of the nurse-midwife's role in obstetric care for clients desiring home births is that the pregnancy should progress normally and be considered low risk. This is crucial because nurse-midwives typically provide care for women who are experiencing a healthy pregnancy without complications. Home births are most suitable for low-risk pregnancies since they generally entail fewer interventions and a more natural birthing process. The focus is on creating a safe and supportive environment for the mother and baby, which aligns with the philosophy of midwifery. Intervening in high-risk situations or having a history of complications would typically contraindicate a home birth, as it could pose risks to both the mother and newborn. Therefore, a thorough assessment of the pregnancy's status is essential to ensure a safe home-birth experience for the clients.

7. What does the nurse's role in witnessing a client's signature on an informed consent form primarily indicate?

- A. The client voluntarily signed the form.**
- B. The client fully understands the procedure.
- C. The client agrees with the procedure to be done.
- D. The client authorizes continued treatment.

The nurse's role in witnessing a client's signature on an informed consent form primarily indicates that the client voluntarily signed the form. This means the nurse has observed the client sign the document and can attest that the signature is authentic and that the client acted of their own free will in making that decision. While the nurse also hopes that clients understand the procedure and the implications of their consent, the primary responsibility when witnessing the signature is to verify that the client was able to make that choice independently and without coercion. This gives legal validity to the consent and ensures that the client's autonomy and rights are respected. The other options suggest a level of understanding and agreement regarding the procedure that the nurse cannot guarantee simply by witnessing the signature, as these elements require comprehensive communication and explanation between the healthcare provider and the client prior to signing.

8. When monitoring a client after administering a fentanyl transdermal patch, which assessment is most important for the nurse to obtain?

- A. Level of consciousness.
- B. Moistness of mucosa.
- C. Bowel sound activity.
- D. Numeric pain scale.**

The most important assessment for a nurse to obtain after administering a fentanyl transdermal patch is the numeric pain scale. Fentanyl is a potent opioid analgesic used for managing severe pain, and its effectiveness can be monitored by assessing the client's pain levels. By utilizing a numeric pain scale, the nurse can quantify the client's pain and determine whether the fentanyl is adequately managing the pain. This assessment is critical because it directly indicates the therapeutic effectiveness of the medication. While other assessments like level of consciousness, moistness of mucosa, and bowel sound activity can provide valuable information about the client's overall well-being and potential side effects of opioid use, the primary goal after administering a pain management treatment is to assess the pain relief provided by the medication. If pain levels remain high or if the client reports inadequate relief, adjustments to the pain management plan may be necessary.

9. When caring for a client with dehydration, what is a vital sign that indicates improving status?

- A. Increased heart rate
- B. Stable blood pressure
- C. Recovery of urine output**
- D. Decreased skin turgor

In the context of caring for a client with dehydration, an important indicator of improving status is the recovery of urine output. When a patient is dehydrated, renal function can be compromised, leading to a decreased output of urine as the kidneys conserve water. As the patient begins to rehydrate and their fluid balance improves, urine output typically increases. This increase in urine output is a positive sign indicating that hydration status is being restored and kidney function is improving, which is crucial for overall health and recovery. Stable blood pressure can suggest that the patient is maintaining hemodynamic stability, but it does not specifically indicate improvement in hydration status. An increased heart rate might occur due to various reasons, including dehydration itself, but does not confirm improved hydration. Decreased skin turgor is often a sign of dehydration and would reflect worsening status rather than improvement. Thus, recovery of urine output is the clearest indicator of a positive change in the client's condition.

10. What nursing diagnosis should a nurse include for a preschool-aged child experiencing distress in an English-speaking school?

- A. Culture shock secondary to unfamiliar environment.**
- B. Growth and development, impaired.
- C. Cultural incompetence due to inability to adjust.
- D. Defiance behavior as evidenced by outbursts of crying.

The nursing diagnosis of culture shock secondary to an unfamiliar environment is relevant for a preschool-aged child experiencing distress in an English-speaking school. This diagnosis reflects the child's potential struggle to adapt to a new cultural setting, which can be particularly overwhelming for a young child who may not be familiar with the language, social norms, and customs of the new environment. Children in this age group are often still developing their coping mechanisms and social skills, making them more susceptible to feeling out of place or anxious when faced with significant changes in their surroundings. The symptoms of culture shock may manifest as distress, sadness, or withdrawal, which aligns with the experiences of a child adjusting to a new school where everything feels different. Other options, such as impaired growth and development, may not specifically relate to the child's current adjustment issue, since distress in this scenario is more about environmental adaptation rather than a fundamental developmental delay. Similarly, cultural incompetence implies a more complex understanding of cultural interactions and adjustments that may not accurately apply to a young child who is simply experiencing the personal effects of a new environment. Finally, defiant behavior can be a response to stress but does not encompass the broader context of adjustment difficulties related to cultural and environmental changes that the child is experiencing.

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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