

HESI REGISTERED NURSE EXIT PRACTICE EXAM (SAMPLE)

STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

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THE FULL VERSION STUDY GUIDE

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Table of Contents

Copyright	1
Table of Contents	2
Introduction	3
How to Use This Guide	4
Questions	5
Answers	8
Explanations	10
Next Steps	16

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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. Why is it important to monitor blood pressure in clients taking antipsychotic medications?**
 - A. Orthostatic hypotension is a common side effect
 - B. Most cause elevated blood pressure
 - C. Provides sodium intake information
 - D. Indicates need for anti-parkinsonian drugs

- 2. What term describes the sudden feeling of euphoria associated with cocaine use?**
 - A. High
 - B. Rapture
 - C. Thrill
 - D. Buzz

- 3. What is the most common nutritional disorder in school-aged children?**
 - A. Bulimia
 - B. Anorexia
 - C. Obesity
 - D. Malnutrition

- 4. When is the best time for a nurse to check a client's vital signs after administering a new medication?**
 - A. Immediately after administration.
 - B. During the next scheduled vital signs check.
 - C. According to the medication's side effect profile.
 - D. As instructed by the physician.

- 5. What would the nurse expect to find when evaluating the therapeutic effectiveness of Lanoxin (digoxin) in a client with heart failure?**
 - A. Diaphoresis with decreased urinary output
 - B. Increased heart rate with increased respirations
 - C. Improved respiratory status and increased urinary output
 - D. Decreased chest pain and decreased blood pressure

- 6. What action confirms delayed gross motor development in a 3-year-old child?**
- A. Stand on 1 foot
 - B. Catch a ball
 - C. Skip on alternate feet
 - D. Ride a bicycle
- 7. What is a common nursing intervention for a patient experiencing anxiety?**
- A. Encourage participation in group therapy sessions
 - B. Advise medication adherence only when severe
 - C. Teach controlled breathing techniques
 - D. Recommend complete bed rest
- 8. What is the main aim of preoperative education for patients scheduled for surgery?**
- A. To reduce anxiety and provide clear instructions
 - B. To ensure patients arrive on time
 - C. To inform about potential complications
 - D. To emphasize the importance of follow-up care
- 9. In assessing a patient recovering from surgery, which finding is most concerning?**
- A. Blood pressure of 120/80 mmHg
 - B. Heart rate of 95 beats per minute
 - C. Temperature of 101°F
 - D. Respiratory rate of 24 breaths per minute
- 10. If a client states they have important information to share and asks for confidentiality, how should the nurse respond?**
- A. I must document and report any information disclosed.
 - B. I cannot make such a promise of confidentiality.
 - C. It depends on the nature of the information.
 - D. I must report all information to the treatment team.

Answers

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

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Explanations

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1. Why is it important to monitor blood pressure in clients taking antipsychotic medications?

- A. Orthostatic hypotension is a common side effect**
- B. Most cause elevated blood pressure
- C. Provides sodium intake information
- D. Indicates need for anti-parkinsonian drugs

Monitoring blood pressure in clients taking antipsychotic medications is crucial primarily because orthostatic hypotension, which is a significant drop in blood pressure upon standing, is a common side effect of these medications. Patients on antipsychotics may experience this condition due to the medications' effects on the autonomic nervous system, which can lead to dizziness, fainting, or falls when the client transitions positions from lying down to standing. Responsible management of these clients involves regular blood pressure assessments to detect any changes early, allowing for timely interventions. This proactive monitoring helps ensure patient safety, as untreated orthostatic hypotension can lead to serious complications. While some antipsychotics can elevate blood pressure, the primary concern is typically related to the risk of orthostatic changes. Sodium intake information and the indication of the need for anti-parkinsonian drugs are not directly relevant to the primary reason for monitoring blood pressure in this context.

2. What term describes the sudden feeling of euphoria associated with cocaine use?

- A. High**
- B. Rapture
- C. Thrill
- D. Buzz

The term that best describes the sudden feeling of euphoria associated with cocaine use is "high." When individuals use cocaine, it significantly boosts the levels of dopamine in the brain, leading to intense feelings of pleasure and excitement. This experience is commonly referred to as a "high," which is a widely recognized and used term in the context of substance use. While "rapture," "thrill," and "buzz" may imply feelings of excitement or intense pleasure, they do not specifically capture the overwhelming euphoria and altered state of consciousness that characterizes the experience of being under the influence of cocaine. The term "high" specifically denotes the heightened state created by drugs, making it the most accurate choice in this context.

3. What is the most common nutritional disorder in school-aged children?

- A. Bulimia
- B. Anorexia
- C. Obesity**
- D. Malnutrition

Obesity is recognized as the most common nutritional disorder in school-aged children, largely due to the increasing prevalence of sedentary lifestyles and the consumption of high-calorie, nutrient-poor foods. Factors contributing to obesity in this age group include poor dietary habits, lack of physical activity, and increased screen time, which limit opportunities for physical exercise. The consequences of obesity are significant, leading to an increased risk of various health issues such as diabetes, hypertension, and psychosocial problems. While options like bulimia and anorexia are serious eating disorders, they are less common compared to the widespread issue of obesity among school-aged children. Malnutrition, which can occur in various forms (including undernutrition), is also a concern but does not occur as frequently as obesity in this demographic. Therefore, obesity stands out as the most prevalent nutritional disorder affecting children in this age group today.

4. When is the best time for a nurse to check a client's vital signs after administering a new medication?

- A. Immediately after administration.
- B. During the next scheduled vital signs check.
- C. According to the medication's side effect profile.**
- D. As instructed by the physician.

The optimal time for a nurse to check a client's vital signs after administering a new medication is based on the medication's side effect profile. When medications are introduced to a patient, they can produce various physiological responses that may affect vital signs. Different medications have specific peak times for their effects after administration, and monitoring vital signs during these peak times is crucial. By checking vital signs in line with the expected side effects, the nurse can accurately assess the patient's response to the medication and identify any adverse effects early. For instance, if a medication is known to cause hypotension or tachycardia, monitoring vital signs closely allows for timely interventions if these issues arise. This approach ensures patient safety and enhances the quality of care provided. Timing vital signs checks according to the medication's known effects enables a proactive nursing practice that prioritizes patient well-being over routine schedules or arbitrary timings.

5. What would the nurse expect to find when evaluating the therapeutic effectiveness of Lanoxin (digoxin) in a client with heart failure?

- A. Diaphoresis with decreased urinary output
- B. Increased heart rate with increased respirations
- C. Improved respiratory status and increased urinary output**
- D. Decreased chest pain and decreased blood pressure

When evaluating the therapeutic effectiveness of Lanoxin (digoxin) in a client with heart failure, the expectation of improved respiratory status and increased urinary output is based on the medication's mechanism of action. Digoxin works by increasing the force of myocardial contractions, which improves cardiac output. An increase in cardiac output leads to better circulation, ultimately reducing symptoms of heart failure, including respiratory distress. As the heart's efficiency improves, the lungs typically become less congested, which enhances the respiratory status of the patient. Additionally, adequate renal perfusion is a direct outcome of improved cardiac function. With better blood flow to the kidneys, the expected result is an increase in urinary output, indicating that the kidneys are functioning well and effectively excreting excess fluid that often accumulates in heart failure cases. This outcome aligns with the goals of therapy for heart failure, which include alleviating symptoms, improving functional status, and enhancing overall quality of life for the patient.

6. What action confirms delayed gross motor development in a 3-year-old child?

A. Stand on 1 foot

B. Catch a ball

C. Skip on alternate feet

D. Ride a bicycle

To confirm delayed gross motor development in a 3-year-old child, the action of standing on one foot is particularly telling. By the age of 3, most children are expected to demonstrate a variety of gross motor skills, including the ability to stand on one foot for a few seconds. This milestone indicates not only balance but also strength and coordination. Gross motor development milestones for children often include a sequence where they start with simpler skills and progress to more challenging ones. If a child struggles to perform an action that is typically expected at this age—like standing on one foot—it suggests that their gross motor skills may not be developing as they should. Skills such as catching a ball, skipping on alternate feet, or riding a bicycle are generally expected at older ages, making them less effective indicators of delays at the 3-year mark. Understanding the context of these developmental milestones helps gauge the child's physical development appropriately, making the action of standing on one foot a clear marker for potential delays in gross motor development.

7. What is a common nursing intervention for a patient experiencing anxiety?

A. Encourage participation in group therapy sessions

B. Advise medication adherence only when severe

C. Teach controlled breathing techniques

D. Recommend complete bed rest

Teaching controlled breathing techniques is a fundamental nursing intervention for patients experiencing anxiety because these techniques are effective in managing acute anxiety symptoms and helping to promote relaxation. Controlled breathing methods, such as diaphragmatic breathing, help decrease physiological symptoms of anxiety by promoting oxygenation, reducing heart rate, and facilitating a calm state of mind. This intervention can empower patients by providing them with a practical skill they can use to manage their anxiety in real time. While encouraging participation in group therapy sessions is beneficial for long-term support and coping strategies, it may not be as immediately applicable as teaching breathing techniques. Advising medication adherence is crucial, but it should not be limited to only severe cases, as consistency in medication can be essential for managing anxiety effectively. Recommending complete bed rest is not appropriate since it can lead to increased feelings of isolation and may exacerbate anxiety symptoms rather than provide relief. Thus, teaching controlled breathing techniques stands out as a direct and impactful method to help patients cope with anxiety.

8. What is the main aim of preoperative education for patients scheduled for surgery?

- A. To reduce anxiety and provide clear instructions**
- B. To ensure patients arrive on time
- C. To inform about potential complications
- D. To emphasize the importance of follow-up care

The primary aim of preoperative education for patients scheduled for surgery is to reduce anxiety and provide clear instructions. When patients are well-informed about what to expect before, during, and after the surgical procedure, they are likely to experience less fear and anxiety. This education can include details about the surgical process, preparation steps, pain management, and postoperative care, all of which help to empower patients and improve their overall experience. By clarifying procedures, answering questions, and fostering an understanding of the surgical journey, healthcare providers can significantly alleviate the uncertainties that often accompany surgical interventions. As a result, the focus on emotional support and clear communication during preoperative education plays a critical role in enhancing patient outcomes and satisfaction.

9. In assessing a patient recovering from surgery, which finding is most concerning?

- A. Blood pressure of 120/80 mmHg
- B. Heart rate of 95 beats per minute
- C. Temperature of 101°F**
- D. Respiratory rate of 24 breaths per minute

A temperature of 101°F following surgery is the most concerning finding among the options provided. Although a slight elevation in temperature can be common after surgical procedures due to inflammation and the body's healing response, a persistent fever or one that reaches 101°F or higher could indicate the presence of an infection, which is a critical complication post-operatively. In the context of recovery from surgery, monitoring for signs of infection is crucial, as it can lead to serious complications if not addressed promptly. A fever can also be indicative of other issues like atelectasis or deep vein thrombosis, which are significant risks post-surgery. The other findings, while they may require monitoring, are not as immediately alarming. A blood pressure of 120/80 mmHg is within a normal and stable range. A heart rate of 95 beats per minute is slightly elevated but may be attributable to pain, anxiety, or an early response to surgery, and is generally not a cause for immediate concern unless accompanied by other symptoms. A respiratory rate of 24 breaths per minute, while higher than the normal range, could be due to pain, anxiety, or shallow breathing post-surgery but does not present the same level of immediate concern as an elevated temperature, especially in the

10. If a client states they have important information to share and asks for confidentiality, how should the nurse respond?

- A. I must document and report any information disclosed.
- B. I cannot make such a promise of confidentiality.**
- C. It depends on the nature of the information.
- D. I must report all information to the treatment team.

When a client expresses the need for confidentiality while sharing important information, the nurse's response of indicating that they cannot guarantee confidentiality is grounded in the principles of ethical nursing practice and legal obligations. Nurses are required to maintain a professional boundary with clients, which includes understanding the limits of confidentiality. This response highlights that while nurses strive to create a safe environment for patients to share information, there are certain situations—such as when there is a risk of harm to the patient or others, or if there is evidence of abuse—where confidentiality cannot be upheld. Legally and ethically, nurses must balance a client's right to confidentiality with their duty to protect the client and others. This rule not only empowers clients to share their experiences but also informs them about potential limitations that may arise during their care. The other options imply different approaches that do not fully address the essential nature of patient confidentiality and the responsibility of the nurse to inform patients about the limitations of that confidentiality. Therefore, indicating the impossibility of making an absolute promise of confidentiality accurately reflects the complexities involved in the nurse-client relationship and ensures that patients are fully aware of how their information might be handled, especially in sensitive situations.

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://hesi-registerednurseexit.examzify.com>

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

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