KAPLAN DIAGNOSTIC A PRACTICE TEST (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

1. **Immediately after a percutaneous liver biopsy, the nurse places the client in which position?**

   A. Semi Fowler's

   B. Supine

   C. Left side lying

   D. Right side lying

2. **Which observation five hours after a right total knee arthroplasty requires nursing intervention?**

   A. The CPM device extends the client's right leg 10°

   B. The client bends the left leg and pushes down to position itself on a fracture bedpan

   C. The Hemovac drain contains 75 mL of serosanguineous fluid

   D. The CPM device flexes the client's right leg 90°

3. **A prominent member of society is hospitalized; People are calling about the client's condition. Which action should the nurse take?**

   A. Provide them with the name of the client's healthcare provider

   B. Suggest that they speak to a family member

   C. Offer a time when they can speak directly to the client

   D. Inform them that the client is doing as well as can be expected

4. **When a four-month-old stops breathing, which action is the recommended first intervention by the nurse?**

   A. Hyperextends the infant's neck to open the airway

   B. The nurse uses the palm of the hand to compress the sternum rhythmically

   C. Palpates the carotid pulse with one finger

   D. Covers the infant's nose and mouth with the nurse's mouth

5. During a dressing change, after opening a sterile pack and donning sterile gloves, the nurse notices the dressings needed are missing. What action should be taken next?

A. Remove the gloves, obtain the missing dressings, and replace the gloves to continue with the procedure

B. Close the pack, obtain the missing dressing and new gloves, and reopen the pack to continue with the procedure

C. Presses the call light, asks the nurse assistive personnel to bring the missing dressings to the client's room, and then continues with the procedure

D. Remains in place at the client's bedside while the nursing assistive personnel obtains the missing dressings, and then continues with the procedure

6. The nurse supervises a nursing assistive personnel caring for a client after abdominal surgery. Which observation requires intervention?

A. The NAP massages the client's leg using long, firm strokes.

B. The NAP massages the client's arms using smooth, gentle strokes.

C. The NAP assists the client to put the joints through range of motion exercises.

D. The NAP positions the client side-lying and applies lotion to the back.

7. A client experiencing a panic attack says, 'Get out of here, and leave me alone.' What action should the nurse take?

A. Decreases environmental stimuli and remains with the client

B. Gently reminds the client that the nurse is there to help

C. Helps the client explore what is making the client anxious

D. Leave the room to allow the client to gain control of the client's behavior

8. Which milestone is expected for a 5-month-old infant?

A. Sits erect when propped with a pillow

B. Sits erect without support

C. Stands briefly

D. Crawls on hands and knees

9. The nurse is assigned to four clients. Which client should be seen first?

A. A 17 year old client who delivered a 5 lbs. 9 oz baby two hours ago and he plans to breast feed

B. An 18 year old client who had a C-section one hour ago and who has saturated three peripads

C. A 26-year-old client three hours after a normal badge in all delivery and he was experiencing hematuria

D. A 20 year old client who delivered a full term infant six hours ago and who has not voided

10. An hour and a half after admission to the nursery, the nurse observe spontaneous jerky movements of the limbs in an infant born to a mother with diabetes mellitus; Based on these signs, which condition does the nurse expect in the infant?

A. Hyperbilirubinemia

B. Cold stress

C. Hypoglycemia

D. Neurological impairment

Answers

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

Explanations

1. Immediately after a percutaneous liver biopsy, the nurse places the client in which position?

A. Semi Fowler's

B. Supine

C. Left side lying

D. Right side lying

The postprocedure goal is to tamponade the biopsy site and reduce the chance of bleeding. Placing the client on the right side after a percutaneous liver biopsy does this by pressing the puncture tract against the liver and abdominal wall, helping to compress the site and limit movement. This position minimizes the risk of hemorrhage and hematoma formation while the tract begins to seal. Other positions don't provide the same pressure on the biopsy site and could allow more movement or displacement of the liver, which is why right side lying is preferred for several hours after the procedure.

2. Which observation five hours after a right total knee arthroplasty requires nursing intervention?

A. The CPM device extends the client's right leg 10°

B. The client bends the left leg and pushes down to position itself on a fracture bedpan

C. The Hemovac drain contains 75 mL of serosanguineous fluid

D. The CPM device flexes the client's right leg 90°

The key idea is to keep the knee's motion within what the surgeon ordered after a total knee arthroplasty. Continuous passive motion (CPM) is used to promote range of motion without active muscle use, but the amount of flexion or extension the device imposes must stay within the prescribed limits to protect the new joint and surrounding tissues. Flexing the knee to 90 degrees five hours after surgery is typically beyond the initial postoperative range and could risk prosthesis strain or tissue injury, so this observation requires nursing intervention to adjust the device to the ordered ROM or pause it until further orders are obtained. In contrast, extending the leg a small amount (about 10°) with CPM is generally acceptable, the drain amount of 75 mL in the early hours post-op can be expected, and using the nonoperative leg to reposition onto a bedpan is common when weight bearing is restricted.

3. A prominent member of society is hospitalized; People are calling about the client's condition. Which action should the nurse take?

A. Provide them with the name of the client's healthcare provider

B. Suggest that they speak to a family member

C. Offer a time when they can speak directly to the client

D. Inform them that the client is doing as well as can be expected

The main idea here is protecting patient privacy and ensuring information is shared only with authorized people. When people call about a hospitalized patient, the nurse should direct them to a family member who is an authorized contact to receive and relay information. This respects confidentiality and avoids disclosing health details to someone who isn't authorized. Providing the provider's name, offering a direct conversation with the patient, or stating the patient's condition to the caller would risk sharing information without proper consent. By guiding the caller to speak with a family member, the nurse ensures that information is shared through the appropriate channel.

4. When a four-month-old stops breathing, which action is the recommended first intervention by the nurse?

A. Hyperextends the infant's neck to open the airway

B. The nurse uses the palm of the hand to compress the sternum rhythmically

C. Palpates the carotid pulse with one finger

D. Covers the infant's nose and mouth with the nurse's mouth

When a four-month-old stops breathing, the first priority is to restore ventilation. The nurse should open the airway and deliver rescue breaths to re-expand the lungs, watching for chest rise with each breath. In an infant, this rescue-breath step is typically done by mouth-to-mouth (or mouth-to-mouth with a barrier if available), delivering two breaths of about one second each. Avoid hyperextending the neck, since infants are best kept with a neutral head position to keep the airway open. Chest compressions are not started until there is no pulse; when they are needed, compressions for an infant are performed with two fingers on the center of the chest, not with the palm of the hand. Palpating the carotid pulse is not the correct first action in this age group; the initial focus is on breathing and airway, not pulse checks. So the recommended first intervention is providing rescue breaths to ventilate the infant.

5. During a dressing change, after opening a sterile pack and donning sterile gloves, the nurse notices the dressings needed are missing. What action should be taken next?

A. Remove the gloves, obtain the missing dressings, and replace the gloves to continue with the procedure

B. Close the pack, obtain the missing dressing and new gloves, and reopen the pack to continue with the procedure

C. Presses the call light, asks the nurse assistive personnel to bring the missing dressings to the client's room, and then continues with the procedure

D. Remains in place at the client's bedside while the nursing assistive personnel obtains the missing dressings, and then continues with the procedure

Maintaining sterility during a dressing change is the key idea here. Once you've opened the sterile pack and donned sterile gloves, the area around your hands and the immediate field must stay uncontaminated. If you realize that dressings are missing, you should not reach for or expose yourself to non-sterile items or move away from the patient to fetch things. Staying at the bedside with the sterile field intact while a nursing assistant retrieves the missing dressings keeps the risk of contamination lowest. Only after the missing supplies arrive should you proceed with the dressing change. This approach avoids contaminating the sterile field by not stepping away or re-prepping unnecessarily. It's appropriate to request help to bring in what's needed, but the critical point is to maintain your position at the patient's side and keep the sterile area secure until you can continue.

6. The nurse supervises a nursing assistive personnel caring for a client after abdominal surgery. Which observation requires intervention?

A. The NAP massages the client's leg using long, firm strokes.

B. The NAP massages the client's arms using smooth, gentle strokes.

C. The NAP assists the client to put the joints through range of motion exercises.

D. The NAP positions the client side-lying and applies lotion to the back.

Postoperative clients are at risk for venous thromboembolism, so any intervention that could move or dislodge a clot must be avoided until safety is established. Massaging the leg with long, firm strokes can dislodge a thrombus or push a clot toward the lungs, risking a pulmonary embolism. That is why this observation requires intervention—stop the massage and assess for signs of a DVT, report per protocol, and follow orders for safe care. In contrast, gentle arm massage, assisting with joint range-of-motion exercises, and positioning the patient side-lying with back lotion are not inherently risky in this context and are typically consistent with safe postoperative care when performed within ordered guidelines. The key is to prevent any manipulation that could mobilize a thrombus while monitoring the patient for DVT signs.

7. A client experiencing a panic attack says, 'Get out of here, and leave me alone.' What action should the nurse take?

A. Decreases environmental stimuli and remains with the client

B. Gently reminds the client that the nurse is there to help

C. Helps the client explore what is making the client anxious

D. Leave the room to allow the client to gain control of the client's behavior

Managing a panic attack hinges on establishing a supportive and trustworthy presence. When the client cries out to be left alone, responding with gentle reassurance that the nurse is there to help communicates safety and support, which helps counteract the intense fear and loss of control the client is experiencing. This calm, concrete reassurance lets the client know they are not alone and that help is available, making it easier to regain control. The nurse should stay present in a calm, nonthreatening way, speak in brief, clear phrases, and avoid arguing or minimizing what the client is feeling. While reducing environmental stimuli can be helpful, the crucial step is to convey that support is present and that the nurse will stay nearby to assist as needed. Leaving the room or pressuring the client to discuss the cause during the peak of the panic can worsen distress or lead to withdrawal.

8. Which milestone is expected for a 5-month-old infant?

A. Sits erect when propped with a pillow

B. Sits erect without support

C. Stands briefly

D. Crawls on hands and knees

Understanding age-appropriate gross motor milestones helps identify typical development. By five months, babies usually have enough neck and trunk control to sit upright when supported, such as being propped with a pillow or held up. This level of support sits between the earlier head-and-trunk control learned in the first few months and the ability to sit independently that develops a bit later. The other options reflect later milestones. Standing briefly requires more leg strength and the ability to bear weight, which typically appears closer to nine to twelve months. Crawling on hands and knees usually begins around seven to ten months, not as early as five. So the best match for a five month old is sitting erect when propped with a pillow. Variability among babies exists, but this is the common expectation for that age.

9. The nurse is assigned to four clients. Which client should be seen first?

A. A 17 year old client who delivered a 5 lbs. 9 oz baby two hours ago and he plans to breast feed

B. An 18 year old client who had a C-section one hour ago and who has saturated three peripads

C. A 26-year-old client three hours after a normal badge in all delivery and he was experiencing hematuria

D. A 20 year old client who delivered a full term infant six hours ago and who has not voided

The most urgent issue after delivery is preventing or treating postpartum hemorrhage. A client who is only one hour post-cesarean and has saturated three peripads is showing signs that bleeding may be heavy and ongoing. This raises concern for uterine atony or bleeding from the surgical site, and it can deteriorate quickly if not addressed. The immediate steps are to assess the fundus—feel if it is firm and midline or boggy—check lochia flow and any clots, and monitor vital signs. Prepare for rapid intervention: ensure IV access is established, be ready to administer uterotonic medications as ordered, and call for assistance so the team can respond quickly to control the bleed. The other scenarios are important but not as time-sensitive. A patient who delivered six hours ago and has not voided may be at risk for urinary retention, which requires prompt assessment of bladder distension and encouragement to void, but it is generally less immediately life-threatening than active postpartum bleeding. A patient three hours after vaginal delivery with hematuria may need evaluation for bladder injury or other causes of blood in the urine, but the priority remains ensuring the uterus is contracting and bleeding is controlled. The patient two hours after delivery who plans to breastfeed is a normal post-delivery task but does not present an immediate threat to stability. Prioritizing the hemorrhage risk aligns with the most dangerous potential complication in the early postpartum period.

10. An hour and a half after admission to the nursery, the nurse observe spontaneous jerky movements of the limbs in an infant born to a mother with diabetes mellitus; Based on these signs, which condition does the nurse expect in the infant?

A. Hyperbilirubinemia

B. Cold stress

C. Hypoglycemia

D. Neurological impairment

Infants of diabetic mothers are at high risk for neonatal hypoglycemia because elevated fetal insulin production continues after birth when maternal glucose is no longer available. The sudden drop in blood glucose, with insulin still high, leads to neuroglycopenia and can cause jittery, jerky movements of the limbs. This pattern—jerky movements soon after birth in a baby of a diabetic mother—is a classic indicator of low blood sugar and should prompt immediate glucose assessment and management. While other conditions can cause tremors or agitation, the context makes hypoglycemia the most likely explanation here. Hyperbilirubinemia would present with jaundice, cold stress would involve hypothermia with possible tremors but isn't as specifically tied to maternal diabetes, and neurological impairment can result from severe hypoglycemia rather than being the initial sign.

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!