

NACE Foundations of Nursing Practice Test (Sample)

Study Guide



Everything you need from our exam experts!

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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 most effective position for a patient to relieve dyspnea?**
 - A. Supine position**
 - B. Sitting upright in a forward-leaning position**
 - C. Prone position**
 - D. Side-lying position**

- 2. Hepatitis C is transmitted primarily through which means?**
 - A. Airborne pathogens**
 - B. Fecal-oral contact**
 - C. Body fluids, especially blood**
 - D. Direct skin contact**

- 3. What is the correct method for drawing up a urine sample from a catheter?**
 - A. Insert a syringe directly into the catheter**
 - B. Swab the collection port with an antiseptic swab, then aspirate urine**
 - C. Use a sterile cup to collect urine**
 - D. Disconnect the catheter and collect urine**

- 4. How should nurses prioritize patient care?**
 - A. By using the ABCs: Airway, Breathing, Circulation**
 - B. By treating every patient based on their emotional state**
 - C. By completing tasks in the order they are assigned**
 - D. By consulting with family members first before patient needs**

- 5. What practice is crucial for ensuring patient safety during medication administration?**
 - A. Following the five rights of medication administration**
 - B. Administering medications only once**
 - C. Giving medications without patient verification**
 - D. Relying solely on colleagues' instructions**

6. What is the length of a standard subcutaneous needle?

- A. 1/4"-5/8"
- B. 1/2"-3/4"
- C. 1"-1/2"
- D. 5/8"-1"

7. What should a nurse assess if a patient is unable to void?

- A. Client's overall hydration status
- B. Client's bladder
- C. Client's urine color
- D. Client's dietary intake

8. The sharing of feelings regarding trauma with the health care team is an example of what?

- A. Post trauma outcome
- B. Behavioral health intervention
- C. Patient advocacy
- D. Family involvement

9. Which principle is crucial for ensuring ethical nursing practice?

- A. Respecting patient autonomy and informed consent
- B. Maximizing nurse's authority over treatment decisions
- C. Standardizing care regardless of individual patient needs
- D. Prioritizing institutional policies above patient care

10. Which of the following are common signs of respiratory distress in a patient?

- A. Shortness of breath, increased respiratory rate, use of accessory muscles
- B. Fever, bradycardia, cyanosis
- C. Hypotension, dizziness, malaise
- D. General fatigue, headache, decreased appetite

Answers

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

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Explanations

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1. What is the most effective position for a patient to relieve dyspnea?

- A. Supine position**
- B. Sitting upright in a forward-leaning position**
- C. Prone position**
- D. Side-lying position**

Sitting upright in a forward-leaning position is the most effective position for a patient to relieve dyspnea due to several physiological mechanisms. This position enhances lung expansion by allowing for better diaphragmatic movement and increases the efficiency of respiratory muscles. When a patient sits upright and leans slightly forward, it facilitates gravity's natural effect, helping to pull the diaphragm downward, thus improving the lung capacity and reducing the work of breathing. Additionally, leaning forward can allow for more effective use of accessory muscles of respiration, which can assist in increasing airflow and oxygenation. In contrast, other positions such as supine can restrict lung expansion and increase the pressure that the abdominal organs place on the diaphragm, making breathing more laborious. The prone position, while beneficial in specific clinical situations such as during acute respiratory distress syndrome (ARDS), does not typically aid individuals experiencing general dyspnea. Side-lying positions may provide comfort but do not generally support optimal lung function for alleviating dyspnea since they can limit full lung expansion on the dependent side. In summary, the sitting upright and forward-leaning position maximizes lung capacity and minimizes the work of breathing, making it the most effective choice for alleviating dyspnea.

2. Hepatitis C is transmitted primarily through which means?

- A. Airborne pathogens**
- B. Fecal-oral contact**
- C. Body fluids, especially blood**
- D. Direct skin contact**

Hepatitis C is primarily transmitted through body fluids, especially blood. This virus is predominantly spread via direct exposure to infectious blood, which can occur through several means, such as sharing needles or other equipment used to inject drugs, accidental needle-stick injuries in healthcare settings, and transmission from mother to child during childbirth. The critical factor in understanding Hepatitis C transmission lies in recognizing that it is not spread through casual contact, respiratory droplets, or oral-fecal routes, which would explain why other options are not applicable. For instance, airborne pathogens are relevant for diseases like influenza or COVID-19, and fecal-oral contact pertains primarily to viruses like Hepatitis A or certain gastrointestinal infections. Direct skin contact does not typically lead to transmission of Hepatitis C unless there is a break in the skin allowing blood exposure. In summary, recognizing the primary transmission route as through body fluids, particularly blood, is essential for preventing and controlling the spread of Hepatitis C.

3. What is the correct method for drawing up a urine sample from a catheter?

- A. Insert a syringe directly into the catheter**
- B. Swab the collection port with an antiseptic swab, then aspirate urine**
- C. Use a sterile cup to collect urine**
- D. Disconnect the catheter and collect urine**

The correct method for drawing up a urine sample from a catheter involves swabbing the collection port with an antiseptic swab and then aspirating urine. This technique is crucial for several reasons. First, it helps minimize the risk of introducing pathogens into the urinary tract, which could lead to infections. By cleaning the collection port with an antiseptic, you reduce the microbial load on the surface that will come into contact with the sterile syringe. After the port has been disinfected, using a sterile syringe to aspirate urine from the port ensures that the sample collected is from the bladder rather than contaminated from the external environment. This method provides a more accurate representation of the patient's urine and is vital for diagnostic purposes. Other methods, such as inserting a syringe directly into the catheter or disconnecting the catheter, pose an increased risk of infection or contamination. These alternatives do not utilize the protective barrier that the collection port offers after proper antiseptic swabbing, making them less safe and effective for obtaining a urine sample.

4. How should nurses prioritize patient care?

- A. By using the ABCs: Airway, Breathing, Circulation**
- B. By treating every patient based on their emotional state**
- C. By completing tasks in the order they are assigned**
- D. By consulting with family members first before patient needs**

Prioritizing patient care is essential in nursing practice, and using the ABCs method—Airway, Breathing, and Circulation—is a well-established framework. This approach is based on the premise that maintaining a clear airway, ensuring proper breathing, and adequate circulation are the fundamental components necessary for sustaining life. When a nurse uses the ABCs to prioritize care, they can quickly assess and address life-threatening conditions, ensuring that the most critical needs of the patient are prioritized. For instance, if a patient is struggling to breathe, their airway must be addressed immediately, as this can be life-threatening and must take precedence over even urgent but less critical issues. The other approaches presented focus on different aspects of care that, while important, do not address immediate life-threatening situations as effectively. Evaluating patients solely based on emotional state can neglect urgent physical needs; completing tasks in the order assigned does not necessarily align with the urgency of medical needs; and consulting with family members, while valuable for support and information, should not supersede immediate patient care requirements. Therefore, using the ABCs provides a systematic way to ensure that the most urgent and critical needs of patients are addressed first.

5. What practice is crucial for ensuring patient safety during medication administration?

- A. Following the five rights of medication administration**
- B. Administering medications only once**
- C. Giving medications without patient verification**
- D. Relying solely on colleagues' instructions**

Following the five rights of medication administration is essential for ensuring patient safety during medication administration. The five rights include the right patient, right drug, right dose, right route, and right time. This framework provides a systematic approach to prevent medication errors and helps protect patients from adverse effects or potential harm. By verifying each of these aspects before administering medication, nurses and healthcare providers can significantly reduce the risk of mistakes that could lead to negative patient outcomes. In contrast, administering medications only once does not account for situations where ongoing treatment is necessary or for potential re-administration if a dose is missed. Giving medications without patient verification risks errors related to patient identity or medication adherence, which can lead to serious complications. Likewise, relying solely on colleagues' instructions bypasses the critical checks and balances that individual healthcare providers must maintain for patient safety, as this practice may not confirm whether the information is accurate or appropriate in the specific clinical context.

6. What is the length of a standard subcutaneous needle?

- A. 1/4"-5/8"**
- B. 1/2"-3/4"**
- C. 1"-1/2"**
- D. 5/8"-1"**

The standard length of a subcutaneous needle typically ranges from 1/4 inch to 5/8 inch. This size is designed for delivering medications or vaccines into the subcutaneous tissue, where the needle length allows for effective penetration without reaching deeper tissues. In practice, subcutaneous injections are generally administered in areas where there is adequate fatty tissue, such as the abdomen, thigh, or upper arm. The shorter needle length minimizes the risk of puncturing muscles or hitting large blood vessels, making it safer and more effective for this route of administration. While other lengths can be used in specific circumstances or for different types of injections, the range provided in the correct answer aligns best with standard practice and guidelines for subcutaneous injections.

7. What should a nurse assess if a patient is unable to void?

- A. Client's overall hydration status**
- B. Client's bladder**
- C. Client's urine color**
- D. Client's dietary intake**

When a patient is unable to void, assessing the client's bladder is crucial. The bladder's distension can indicate whether urine retention is occurring and how full the bladder has become. A distended bladder can lead to increased discomfort and potential complications, such as bladder overdistension or urinary tract infections. Additionally, palpation over the suprapubic region can provide immediate insight into the bladder's condition, informing necessary interventions. While hydration status, urine color, and dietary intake are important considerations in a broader assessment of urinary health and overall wellness, the immediate concern in this scenario is the state of the bladder and understanding the cause of the inability to void.

8. The sharing of feelings regarding trauma with the health care team is an example of what?

- A. Post trauma outcome**
- B. Behavioral health intervention**
- C. Patient advocacy**
- D. Family involvement**

The sharing of feelings regarding trauma with the health care team exemplifies post-trauma outcomes. In the context of trauma recovery, expressing feelings and emotions is an integral component of healing. When individuals communicate their traumatic experiences with health care providers, it helps create an understanding of their psychological state, which can lead to better care and support. This interaction not only facilitates the development of a therapeutic relationship but also allows the healthcare team to assess the emotional and psychological impact of the trauma on the patient. Recognizing these outcomes can help in tailoring treatment plans that address both physical and emotional aspects of recovery. It underscores the importance of emotional processing in healing and the role of healthcare professionals in fostering these discussions to provide holistic care.

9. Which principle is crucial for ensuring ethical nursing practice?

- A. Respecting patient autonomy and informed consent**
- B. Maximizing nurse's authority over treatment decisions**
- C. Standardizing care regardless of individual patient needs**
- D. Prioritizing institutional policies above patient care**

Respecting patient autonomy and informed consent is foundational to ethical nursing practice because it acknowledges the rights of patients to make their own healthcare decisions. This principle ensures that patients are fully informed about their condition, treatment options, and potential outcomes, allowing them to participate actively in decisions regarding their care. It emphasizes the importance of clear communication between healthcare providers and patients, fostering trust and partnership. When patients feel respected and their autonomy is honored, they are more likely to adhere to treatment plans and engage collaboratively with healthcare providers. This approach aligns with ethical principles such as beneficence, which focuses on promoting the well-being of patients, and justice, which ensures fair treatment. Ultimately, prioritizing patient autonomy maintains the integrity of nursing practice and reinforces the ethical obligation to treat patients with dignity and respect.

10. Which of the following are common signs of respiratory distress in a patient?

- A. Shortness of breath, increased respiratory rate, use of accessory muscles**
- B. Fever, bradycardia, cyanosis**
- C. Hypotension, dizziness, malaise**
- D. General fatigue, headache, decreased appetite**

The correct choice identifies common signs of respiratory distress, which are critical for nurses and healthcare professionals to recognize quickly. Shortness of breath, an increased respiratory rate, and the use of accessory muscles are hallmark indicators of a patient struggling to breathe effectively. Shortness of breath signifies that the body is not receiving enough oxygen, prompting the person to alter their breathing pattern. An increased respiratory rate occurs as the body attempts to compensate for lower oxygen levels or higher carbon dioxide levels in the blood. The use of accessory muscles, such as those in the neck and shoulders, indicates that the patient is employing additional muscles to assist in the breathing process, which is often a response to increased work of breathing or airway obstruction. Recognizing these signs is vital in assessing a patient's respiratory status and initiating prompt interventions to ensure oxygenation and respiratory function are maintained. Other options present signs that may indicate different medical issues not specifically related to respiratory distress.

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://nacefoundofnursing.examzify.com>

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

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