

NURSING DOCUMENTATION AND HEALTHCARE 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

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- 1. Which statement best describes nurses' self-care?**
 - A. It has no impact on patient outcomes
 - B. It is optional for licensure renewal
 - C. It reduces burnout and promotes patient safety and quality of care
 - D. It is irrelevant to professional performance

- 2. In medication administration, which step involves barcode scanning to verify patient identity and medication?**
 - A. Barcode scanning
 - B. Visual check
 - C. Manual entry
 - D. Phone confirmation

- 3. Which item addresses ensuring appropriate supervision for students and preventing role confusion?**
 - A. Student nurse role
 - B. The right supervision
 - C. Supervision of student nurses
 - D. Facility policies and procedures

- 4. In PIE, what is the correct order of components?**
 - A. Data, Action, Response
 - B. Plan, Data, Action
 - C. Data, Plan, Response
 - D. Action, Data, Response

- 5. Who is commonly assigned to determine whether a patient understands preoperative preparation?**
 - A. Assessing comprehension personally
 - B. Surgical consent verification
 - C. Preoperative education by RN
 - D. Delegation to PCT

- 6. What term describes the level of care a patient requires?**
- A. Patient's Acuity Level
 - B. Insurance Coverage
 - C. Room Type
 - D. Age Group
- 7. In PIE format, which component includes the data collected about the patient (subjective and objective)?**
- A. Action or nursing intervention
 - B. Data (subjective and objective)
 - C. Plan
 - D. Response of the patient
- 8. Which item is not typically required to be documented in preoperative preparation?**
- A. The assistance provided with toileting
 - B. Preoperative vital signs
 - C. The surgeon's personal opinion about the procedure
 - D. Current medications
- 9. A role for nurses who manage healthcare facilities or departments is called?**
- A. Nurse Administrator
 - B. Nurse Educator
 - C. Clinical Nurse Specialist
 - D. Nurse Practitioner
- 10. Before leaving for the operating room, why is it common to ask a patient to void?**
- A. To reduce anxiety.
 - B. To prevent urinary retention and catheterization.
 - C. To speed anesthesia.
 - D. To minimize bleeding.

Answers

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

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Explanations

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1. Which statement best describes nurses' self-care?

- A. It has no impact on patient outcomes
- B. It is optional for licensure renewal
- C. It reduces burnout and promotes patient safety and quality of care**
- D. It is irrelevant to professional performance

Self-care for nurses is essential because a well-supported clinician can provide safer, higher quality care. When nurses are rested, nourished, and able to manage stress, they think more clearly, communicate better with patients and the team, and respond to changes with patience and accuracy. That directly reduces burnout and protects patient safety and care quality. In contrast, claiming self-care has no impact on outcomes runs counter to evidence showing that nurse well being is linked to clearer judgment, fewer errors, and better patient experiences. Saying it's optional for licensure renewal ignores the professional expectation that ongoing competence includes maintaining one's own health to perform safely. And claiming it's irrelevant to performance overlooks how fatigue and burnout can undermine reliability, empathy, and effectiveness in care. So, prioritizing self-care supports both the nurse's well-being and the safety and quality of patient care. Self-care includes things like adequate rest, nutrition, stress management, boundaries, and using available support resources.

2. In medication administration, which step involves barcode scanning to verify patient identity and medication?

- A. Barcode scanning**
- B. Visual check
- C. Manual entry
- D. Phone confirmation

Barcode scanning is the step that verifies both patient identity and medication at the point of administration. By scanning the patient's armband, you confirm the patient's identity in the record, and by scanning the medication barcode, the system cross-checks the drug, dose, route, and time against the prescribed order. If everything matches, administration proceeds; if there's a mismatch, the system alerts and blocks the step, preventing potential errors. This real-time verification is essential for patient safety and aligns with practicing the "right patient, right drug, right dose, right route, right time" principles. Visual checks alone can miss electronic cross-checks, manual entry bypasses automatic safeguards, and phone confirmation isn't part of the standard verification workflow during administration.

3. Which item addresses ensuring appropriate supervision for students and preventing role confusion?

- A. Student nurse role
- B. The right supervision**
- C. Supervision of student nurses
- D. Facility policies and procedures

The main idea is having the right supervision in place so students are guided by someone qualified to oversee their work and to keep boundaries clear between learners and licensed staff. When supervision is appropriate, a competent supervisor is available to teach, observe, and intervene as needed, ensuring the student performs only tasks within their level of training and follows established protocols. This setup helps prevent role confusion by clearly delineating who has authority to delegate tasks to the student, who is responsible for patient care decisions, and when to escalate to a licensed nurse or clinician. It supports patient safety and ensures learning objectives are met in a structured way. Others describe aspects of the learning environment but don't centralize the mechanism that prevents role confusion and ensures proper oversight. Describing the student nurse role focuses on what the student should do, not on how supervision prevents missteps. Supervising student nurses captures the act of oversight but can be more about the process than ensuring the supervision is appropriate for the learner's level. Facility policies and procedures govern rules and standards, but they don't guarantee that meaningful, on-the-spot supervision and role clarity are actually in place in daily practice.

4. In PIE, what is the correct order of components?

- A. Data, Action, Response**
- B. Plan, Data, Action
- C. Data, Plan, Response
- D. Action, Data, Response

In PIE-style notes, the flow follows what you observe, what you do, and what happens as a result. You begin with data—the assessment findings, symptoms, and measurements that identify the problem. Then you record the actions or interventions you implemented to address that problem. Finally, you document the patient's response or the outcome of those actions. This order makes the note easy to follow: it shows why you acted (based on the data), what you did to help, and whether the intervention worked. Starting with plan or timing of actions before you've documented the data would detach rationale from the evidence, and noting a response before any action would be illogical.

5. Who is commonly assigned to determine whether a patient understands preoperative preparation?

- A. Assessing comprehension personally
- B. Surgical consent verification
- C. Preoperative education by RN

D. Delegation to PCT

Delegation within the care team and how comprehension of instructions is verified is the key idea here. In many settings, the nurse provides preoperative education, but tasks that involve confirming understanding can be delegated to a Patient Care Technician under the nurse's supervision. The PCT can use teach-back to verify that the patient can explain the preop instructions—what to do, what not to do, and what to expect—without requiring the nurse's direct, one-on-one assessment for every patient. This ensures the patient actually understands the plan and helps keep the preop process moving smoothly, with the RN remaining available to address any gaps or questions. Surgical consent verification focuses on ensuring that consent is properly obtained and documented, not on assessing the patient's understanding of preop prep. Preoperative education by the RN identifies who provides the education, but the question is about who commonly confirms understanding, which is where delegation to a PCT under supervision fits. If the patient shows confusion or difficulty, the RN should re-educate and intervene as needed.

6. What term describes the level of care a patient requires?

A. Patient's Acuity Level

- B. Insurance Coverage
- C. Room Type
- D. Age Group

Acuity is the term that describes the level of care a patient requires, based on how severe their illness is and how much nursing monitoring, interventions, and resources they need. This concept guides where a patient should be placed, how often they should be monitored, and what equipment or skills are necessary. For example, someone with unstable vital signs or organ support needs high-acuity care and ICU-level monitoring, while a stable patient after a routine procedure can be cared for on a general floor with standard checks. Insurance coverage, room type, and age group aren't measures of care intensity: insurance relates to payment, room type is a facility arrangement, and age is a demographic characteristic.

7. In PIE format, which component includes the data collected about the patient (subjective and objective)?

- A. Action or nursing intervention
- B. Data (subjective and objective)**
- C. Plan
- D. Response of the patient

In PIE documentation, the Data component is where you record all information gathered about the patient, combining subjective inputs and objective findings. Subjective data are what the patient reports—symptoms, concerns, and feelings—while objective data are what you observe or measure, such as vital signs, exam findings, or test results. Recording both types in the Data section provides a complete picture that supports identifying the nursing problem and guiding care. For example, a patient might report headache and dizziness (subjective), and you observe a blood pressure of 150/92, a temperature of 38.2°C, and facial pallor (objective). This data set informs the problem statement, after which you would plan and implement interventions and then evaluate the patient's response. The other components—interventions (what you do) and evaluation (how the patient responds)—do not house the initial data collection.

8. Which item is not typically required to be documented in preoperative preparation?

- A. The assistance provided with toileting
- B. Preoperative vital signs
- C. The surgeon's personal opinion about the procedure**
- D. Current medications

In preoperative documentation, the focus is on objective information that guides safe and effective care before surgery. The assistance the patient will need for toileting is recorded to plan safety and mobility support during the perioperative period. Baseline preoperative vital signs are documented to establish the patient's current status and to detect any instability or trends that could affect anesthesia or the surgical plan. Current medications are listed so that the team can manage drug interactions, timing of hold orders, and perioperative dosing. The surgeon's personal opinion about the procedure does not belong in the preoperative notes. Preop documentation should reflect the patient's status and actionable planning, while the surgeon's clinical judgments or recommendations are conveyed through the consent process or in operative planning notes, not as a routine item in preoperative preparation.

9. A role for nurses who manage healthcare facilities or departments is called?

- A. Nurse Administrator**
- B. Nurse Educator
- C. Clinical Nurse Specialist
- D. Nurse Practitioner

Understanding nursing leadership roles helps distinguish who oversees operations in healthcare settings. The role that involves managing facilities or departments centers on administration—planning, directing, and coordinating the daily workings of a unit or facility. A nurse administrator handles staffing, budgeting, policy implementation, regulatory compliance, and quality improvement across the organization, often holding titles like director of nursing or chief nursing officer. This focus on system-wide operations sets it apart from other roles: a nurse educator concentrates on teaching and curriculum development; a clinical nurse specialist provides advanced direct patient care within a specialty and leads practice improvements at the clinical level; a nurse practitioner delivers primary or specialized patient care with diagnosis and treatment. Therefore, the nurse administrator best fits the description of someone who manages healthcare facilities or departments.

10. Before leaving for the operating room, why is it common to ask a patient to void?

- A. To reduce anxiety.
- B. To prevent urinary retention and catheterization.
- C. To speed anesthesia.**
- D. To minimize bleeding.

Voiding before going to the operating room helps prevent bladder distension and the need for catheterization once anesthesia is underway. Anesthesia and the surgical environment can cause the bladder to become atonic or not contract effectively, increasing the risk of urinary retention if the bladder is full. An empty bladder reduces this risk, makes postoperative voiding easier, and lowers the chance of needing intraoperative or postoperative catheterization and its associated complications. It isn't about speeding up anesthesia, reducing bleeding, or easing anxiety.

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://nursingdocumentationhc.examzify.com>

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

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