NURSING ETHICS AND LAW PRACTICE EXAM (SAMPLE)

STUDY GUIDE

Prepare with structure. Pass with confidence

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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. What are the legal/ethical requirements for using physical restraints on a hospitalized patient?

A. Use routinely on all agitated patients.

B. Use only with family consent; no clinician order.

C. Use only when necessary to prevent harm, with a clinician's order, ongoing monitoring, documentation, consent where possible, and least restrictive methods.

D. Apply for any reason as long as patient remains in bed.

2. What is a nurse's legal duty when abuse is suspected?

A. Document and wait for guidance.

B. Report only if patient consents.

C. Mandatory reporting with immediate or timely reporting and protections from retaliation.

D. Address it within the patient-nurse relationship without involving authorities.

3. Under the emergency doctrine of implied consent, when may treatment proceed without explicit patient consent?

A. If delay would cause harm to the patient

B. If the family approves immediately

C. If hospital policy allows it

D. If the clinician believes it is best

4. A patient threatens to harm a coworker; what is the nurse's obligation regarding confidentiality?

A. Do not tell anyone; maintain confidentiality.

B. Break confidentiality to warn/protect potential victim where permitted by law and document the rationale, while notifying a supervisor and following policy.

C. Call the police only if the patient is convicted.

D. Warn the coworker directly without documenting.

5. Authorized consent is described as which of the following for pediatric care?

A. Authorized consent is identical to informed consent.

B. Parents cannot give informed consent for medical care of a child but can give authorized consent instead.

C. Authorized consent is only used in emergencies.

D. Authorized consent is not legally recognized.

6. In what situations should nurses escalate to ethics consultation to support patient autonomy and safety?

A. When there are moral distress, conflicting values, or unresolved ethical questions.

B. Only after a policy violation is identified.

C. Never; clinical decisions should be made by physicians alone.

D. Only for end-of-life decisions.

7. If a patient regains capacity after an emergency, what should occur regarding ongoing treatment?

A. Ignore previous treatment decisions made during the emergency

B. Obtain consent for continued treatment once capacity is regained

C. Stop all ongoing treatments after capacity is regained

D. Defer any consent until the next visit

8. Which of the following constitutes chart falsification or alteration in nursing records?

A. Entries that are false or misleading, backdating, or deleting information; results in disciplinary action, civil liability, and possibly criminal charges.

B. Keeping records updated accurately and promptly with no changes.

C. Printing charts for archival purposes only.

D. Deleting nonessential notes without justification.

9. During a life-threatening emergency, what should a nurse do as soon as feasible after initial treatment?

A. Continue treatment without consent

B. Obtain consent for ongoing treatment

C. Seek a court order

D. Notify the ethics committee

10. Under direct supervision, where is the supervisor positioned?

A. In the Building and Continuously Present to Coordinate, Direct, or Inspect Nursing Care

B. A Physician's Order Is Given to an RN by a Physician, Dentist or Podiatrist

C. Nondisclosure of Patient Information

D. Direct Supervision

Answers

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

Explanations

1. What are the legal/ethical requirements for using physical restraints on a hospitalized patient?

A. Use routinely on all agitated patients.

B. Use only with family consent; no clinician order.

C. Use only when necessary to prevent harm, with a clinician's order, ongoing monitoring, documentation, consent where possible, and least restrictive methods.

D. Apply for any reason as long as patient remains in bed.

Restraints are a safety measure that should be used only when there is a real risk of harm and no less restrictive option is appropriate. The use must be authorized by a clinician through an order, and the patient's safety requires continuous monitoring, thorough documentation, and a plan to remove the restraint as soon as it is safe. When possible, consent should be obtained, and decisions should be guided by least restrictive means—trying de-escalation or other alternatives first. This is why the best approach is to require a clinician's order, ongoing monitoring, and careful documentation, with consent where possible and a commitment to using the least restrictive method. Restraints should not be routine for all agitated patients, nor should they be based on family consent alone or used for any reason as long as the patient remains in bed.

2. What is a nurse's legal duty when abuse is suspected?

A. Document and wait for guidance.

B. Report only if patient consents.

C. Mandatory reporting with immediate or timely reporting and protections from retaliation.

D. Address it within the patient-nurse relationship without involving authorities.

When abuse is suspected, a nurse has a legal obligation to report it to the appropriate authorities promptly. This mandatory reporting is in place to protect vulnerable individuals and trigger timely investigation, not to seek patient consent. The nurse should document what was observed, who was involved, and any injuries or disclosures, then report to the designated agency (such as child or elder protective services or law enforcement) within the required timeframe. There are protections from retaliation for reporters, making it permissible to act without fear of punishment for reporting. While thorough documentation is important, it cannot replace the need to report; handling the issue solely within the patient-nurse relationship without involving authorities would fail to meet legal duties and could leave the patient at continued risk.

3. Under the emergency doctrine of implied consent, when may treatment proceed without explicit patient consent?

A. If delay would cause harm to the patient

B. If the family approves immediately

C. If hospital policy allows it

D. If the clinician believes it is best

In emergencies, treatment can proceed without explicit patient consent when delaying care would cause harm to the patient. This reflects implied consent: if the patient cannot respond and there is no time to obtain consent or a legally authorized surrogate, clinicians are allowed to act to prevent imminent death or serious injury. The priority is to preserve life and reduce harm, with the understanding that consent will be sought as soon as feasible or from a surrogate once available. Relying on family approval, hospital policy alone, or a clinician's personal belief does not justify bypassing consent in non-emergency situations, and actions should be documented and reviewed as soon as possible to ensure ethical and legal correctness.

4. A patient threatens to harm a coworker; what is the nurse's obligation regarding confidentiality?

A. Do not tell anyone; maintain confidentiality.

B. Break confidentiality to warn/protect potential victim where permitted by law and document the rationale, while notifying a supervisor and following policy.

C. Call the police only if the patient is convicted.

D. Warn the coworker directly without documenting.

The main idea being tested is that confidentiality has an important exception: when a patient presents a credible threat to someone else, the nurse has a duty to take steps to prevent harm. In practice, this means balancing patient privacy with safety obligations. When there is a real risk to a coworker, you don't keep silent. You break confidentiality to warn or protect the potential victim, but you do so within the bounds of the law and policy, and you document why disclosure was necessary. You also inform a supervisor and follow organizational procedures so the action is properly guided, justified, and trackable. This approach is grounded in the principle of protecting others from harm and is supported by legal and professional standards that allow disclosure to warn or protect a specific individual when there is a credible threat. Documentation matters because it shows the reasoning, the steps taken, and that the decision followed policy. Involving a supervisor ensures that the disclosure aligns with agency rules and local laws and that additional protections or interventions (like safety planning or referral for treatment) can be coordinated. Other options fall short because they either keep the information completely confidential in a situation where safety is at stake, wait for a formal conviction before acting, or warn the person without any documentation or policy-driven oversight.

5. Authorized consent is described as which of the following for pediatric care?

A. Authorized consent is identical to informed consent.

B. Parents cannot give informed consent for medical care of a child but can give authorized consent instead.

C. Authorized consent is only used in emergencies.

D. Authorized consent is not legally recognized.

In pediatric care, the person who can authorize treatment for a child is the one who acts as the child's legal decision-maker, usually a parent or guardian. Because a child typically cannot understand and consent to medical options, the parent's or guardian's permission is used instead. The idea of authorized consent describes this arrangement: the parent authorizes the specific medical care on behalf of the child after being informed about the plan, risks, benefits, and alternatives. This authorization is the legally recognized form of consent for the child's treatment, not the child's own informed consent. This fits best because it emphasizes that the parent's role is to authorize care as the child's representative, rather than the child providing consent themselves. It also clarifies that this authorization is distinct from the patient's own informed consent, and that it isn't limited to emergencies—authorized consent can occur in routine care when a parent approves the proposed treatment. The other statements misstate the relationship between informed and authorized consent, or the scope and legality of authorized consent.

6. In what situations should nurses escalate to ethics consultation to support patient autonomy and safety?

A. When there are moral distress, conflicting values, or unresolved ethical questions.

B. Only after a policy violation is identified.

C. Never; clinical decisions should be made by physicians alone.

D. Only for end-of-life decisions.

When patient autonomy and safety are at stake, ethics consultation is a valuable resource to resolve moral distress, conflicting values, or unresolved ethical questions. Nurses often encounter situations where a patient's preferences aren't clear, family or care-team values clash, or there's no clear policy guidance, and these complexities can affect both the patient's rights and safety. An ethics consultant or committee helps explore goals of care, assess decisional capacity, review informed consent, and consider cultural, legal, and professional obligations, so care aligns with what matters most to the patient while protecting safety. This support is not limited to end-of-life scenarios and is not reserved for physicians alone; it's a collaborative process that enhances interprofessional decision-making and patient advocacy. In short, escalate when moral distress, value conflicts, or ethical questions arise that impede respecting patient autonomy or ensuring safety.

7. If a patient regains capacity after an emergency, what should occur regarding ongoing treatment?

A. Ignore previous treatment decisions made during the emergency

B. Obtain consent for continued treatment once capacity is regained

C. Stop all ongoing treatments after capacity is regained

D. Defer any consent until the next visit

When a patient regains decision-making capacity, their autonomy is restored and they must be involved in ongoing care. The appropriate step is to obtain explicit consent for continued treatment. This means offering a clear explanation of what is proposed, the benefits and risks, any alternatives, and the option to accept or refuse, then documenting the patient's decision. Emergency decisions made under impaired capacity or by a surrogate do not automatically carry over; they should be revisited with the patient's current preferences in mind. If there is an advance directive or previously stated wishes, those inform the discussion, but the patient's present consent is still required. Deferring consent, stopping treatment without the patient's current input, or continuing without re-consent would violate the patient's autonomy and ethical standards.

8. Which of the following constitutes chart falsification or alteration in nursing records?

A. Entries that are false or misleading, backdating, or deleting information; results in disciplinary action, civil liability, and possibly criminal charges.

B. Keeping records updated accurately and promptly with no changes.

C. Printing charts for archival purposes only.

D. Deleting nonessential notes without justification.

The key idea is that nursing records must accurately reflect what happened, when, and by whom. Chart falsification or alteration means manipulating the record to mislead others about the care given. This includes making entries that are false or misleading, backdating to make events appear to have occurred earlier than they did, or deleting information to hide what actually happened. These actions directly undermine patient safety and accountability, and they carry serious consequences: professional discipline, civil liability, and, in some cases, criminal charges. Keeping records accurate and prompt with no changes represents proper documentation. Printing charts for archival purposes is a routine administrative task. Deleting notes without justification is not acceptable, but the clearest and most definitive form of falsification is described in the option that specifies false or misleading entries, backdating, or deleting information.

9. During a life-threatening emergency, what should a nurse do as soon as feasible after initial treatment?

A. Continue treatment without consent

B. Obtain consent for ongoing treatment

C. Seek a court order

D. Notify the ethics committee

In emergencies you can act to save a life without consent, but once the patient is stabilized and capable, you must obtain informed consent for ongoing treatment. This respects the patient's autonomy and legal rights by ensuring they participate in decisions about their care after the immediate danger has passed. If the patient cannot decide, a legally authorized surrogate or advance directive should guide ongoing decisions. Delaying care to seek a court order or routinely involving the ethics committee is not appropriate for standard post-emergency decisions, and continuing treatment without consent would violate autonomy.

10. Under direct supervision, where is the supervisor positioned?

A. In the Building and Continuously Present to Coordinate, Direct, or Inspect Nursing Care

B. A Physician's Order Is Given to an RN by a Physician, Dentist or Podiatrist

C. Nondisclosure of Patient Information

D. Direct Supervision

Direct supervision means the supervisor is in the same building and continuously present to coordinate, direct, or inspect nursing care, ready to intervene immediately. The question is asking for the designation of the supervision arrangement itself, not just a location description, so the best answer is the term that defines this arrangement: Direct Supervision. The other options either describe a specific location (being in the building and continually present) or refer to unrelated concepts (physician orders, confidentiality) that don't capture the supervision label being tested.

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://nursingethicsandlaw.examzify.com

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