

NURSING (NR446) READINESS CJE PRACTICE TEST (SAMPLE)

STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

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THE FULL VERSION STUDY GUIDE

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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 action demonstrates culturally sensitive dietary planning for a patient with religious dietary restrictions?**
 - A. Accommodate religious dietary restrictions in meal planning
 - B. Ignore beliefs and provide standard meals
 - C. Force a specific diet
 - D. Remove all restrictions

- 2. What does PDSA stand for in quality improvement?**
 - A. Plan, Do, Study, Act
 - B. Prepare, Do, Standardize, Assess
 - C. Plan, Design, Start, Apply
 - D. Process, Deliver, Analyze, Act

- 3. Discharge planning for a client with obsessive-compulsive disorder who is planning to go home tomorrow; which action is most appropriate?**
 - A. Hold discharge teaching in the morning and notify the health care provider of the findings
 - B. Proceed with discharge teaching tonight
 - C. Discharge home now
 - D. Increase the medication dose today

- 4. What is the first action after a needlestick injury?**
 - A. Apply pressure for 10 minutes
 - B. Wash the area with soap and water and report the incident for follow-up and exposure protocol
 - C. Immediately begin post-exposure prophylaxis
 - D. Discard the needle in the trash

- 5. A client is 5 hours postpartum and has completely saturated a perineal pad within 15 minutes. What is the priority nursing action?**
 - A. Massage the client's fundus
 - B. Call the provider immediately
 - C. Administer more oxytocin without assessment
 - D. Empty the bladder

6. Which statement reflects effective teaching?

- A. The incidence of opioid addiction in clients with sickle cell disease is quite low.
- B. The client's subjective report is the most reliable indicator of pain severity.
- C. It's important to give report where clients or visitors cannot overhear you.
- D. The words and tone we use can actually affect the care a client receives.

7. Two nurses report suspected narcotics diversion by the charge nurse. Which action best reflects ethical conduct?

- A. Notify the police immediately
- B. Meet with the charge nurse to discuss the issue but do not divulge the source of the information
- C. File a formal complaint with the state board
- D. Ignore the report because there is no evidence that supports it

8. What does the PICO framework stand for?

- A. Population/Patient, Intervention, Comparison, Outcome
- B. Problem, Intervention, Control, Outcome
- C. Patient, Input, Change, Output
- D. Population, Intervention, Condition, Observation

9. After trauma, tachycardia is noted. Which statement best explains the tachycardia in this patient?

- A. The patient's heart is beating quickly due to blood loss and pain
- B. The tachycardia indicates a rhythm requiring immediate cardioversion
- C. The patient's heart rate is elevated due to dehydration
- D. The patient's heart rate is normal

10. A nurse assesses a client 12 hours post vaginal birth and finds a boggy uterus displaced above and to the right of the umbilicus. Which immediate nursing action is most appropriate?

- A. Assist the client in emptying her bladder
- B. Begin fundal massage
- C. Administer oxytocin
- D. Place the client in Trendelenburg

Answers

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

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Explanations

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1. Which action demonstrates culturally sensitive dietary planning for a patient with religious dietary restrictions?

- A. Accommodate religious dietary restrictions in meal planning
- B. Ignore beliefs and provide standard meals**
- C. Force a specific diet
- D. Remove all restrictions

Recognizing and respecting a patient's religious dietary restrictions is essential in meal planning. The best action is to accommodate religious dietary restrictions in meal planning. This approach honors the patient's autonomy, supports their comfort and adherence to the plan, and helps ensure meals align with beliefs (for example avoiding pork or alcohol, following halal or kosher guidelines, or observing fasting periods). In practice, ask about dietary rules, document them, consult the dietitian, and provide compliant meal options and alternatives. Ignoring beliefs or forcing a diet or removing restrictions undermines trust, safety, and patient-centered care, which can lead to dissatisfaction and nonadherence.

2. What does PDSA stand for in quality improvement?

- A. Plan, Do, Study, Act**
- B. Prepare, Do, Standardize, Assess
- C. Plan, Design, Start, Apply
- D. Process, Deliver, Analyze, Act

PDSA stands for Plan, Do, Study, Act, a four-step cycle used in quality improvement to test changes on a small scale and learn from the results before wider implementation. In Plan, you set a clear aim, predict what will happen, and outline the steps and measures. In Do, you carry out the change on a limited basis and collect data. In Study, you analyze the data to see if the change produced the expected improvement and compare results to your predictions. In Act, you decide whether to adopt the change, adapt it, or abandon it and start another cycle. This iterative, data driven approach helps nurses test improvements—like a new hand hygiene tactic or a care checklist—so real-world practice can be refined safely before spreading. Other phrasing of the cycle isn't the standard set of terms used to describe this process.

3. Discharge planning for a client with obsessive-compulsive disorder who is planning to go home tomorrow; which action is most appropriate?

- A. Hold discharge teaching in the morning and notify the health care provider of the findings**
- B. Proceed with discharge teaching tonight
- C. Discharge home now
- D. Increase the medication dose today

The main idea here is ensuring the patient is ready to understand and carry out discharge instructions before leaving, with a plan that includes caregiver involvement and provider oversight. Holding discharge teaching until morning lets the client be rested and more capable of processing information, ask questions, and demonstrate understanding (teach-back). This timing reduces the risk of miscommunication about medications, follow-up appointments, safety plans, and warning signs, which is crucial for a condition like obsessive-compulsive disorder where anxiety and routine can affect engagement with new expectations. Also, informing the health care provider about the findings from the morning teaching ensures any concerns—such as incomplete understanding, persistent symptoms, or safety risks—are addressed before discharge, allowing for any necessary adjustments in the plan. Why the other options fit less well: teaching this evening may be less effective if the client is fatigued, which can impair learning and retention. Discharging home now would cut against the planned timeline and may be unsafe if the client hasn't been adequately assessed or educated. Increasing the medication dose today without an order could cause harm and is outside the nurse's scope, since dose changes require provider authorization.

4. What is the first action after a needlestick injury?

- A. Apply pressure for 10 minutes
- B. Wash the area with soap and water and report the incident for follow-up and exposure protocol**
- C. Immediately begin post-exposure prophylaxis
- D. Discard the needle in the trash

The action that matters first is to wash the exposed area with soap and water and report the incident for follow-up and the exposure protocol. Cleaning the wound promptly helps remove as much blood and potential pathogens as possible and reduces transmission risk. Reporting triggers the official exposure protocol, which guides immediate steps such as documentation, baseline testing (e.g., HIV, hepatitis B and C), and a risk assessment to determine whether post-exposure prophylaxis is needed. Post-exposure prophylaxis is considered after evaluation; it should not be started automatically without assessment, because it may be unnecessary or inappropriate and could cause side effects. Discarding the needle or applying excessive pressure isn't part of the proper first response and could increase harm or delay proper care.

5. A client is 5 hours postpartum and has completely saturated a perineal pad within 15 minutes. What is the priority nursing action?

- A. Massage the client's fundus**
- B. Call the provider immediately
- C. Administer more oxytocin without assessment
- D. Empty the bladder

The priority is to treat potential postpartum hemorrhage from uterine atony by stimulating the uterus to contract. A completely soaked pad within 15 minutes five hours after birth signals heavy bleeding likely caused by a boggy, noncontracting uterus. Massaging the fundus firmly helps the uterus contract, which compresses bleeding vessels and reduces blood loss. While you massaged, you would also check that the uterus is midline and assess for bladder distention, but the immediate move to firm the uterus comes first. After achieving a firm fundus, reassess bleeding and vital signs, and follow protocol for any further treatment (such as uterotonics) if bleeding continues.

6. Which statement reflects effective teaching?

- A. The incidence of opioid addiction in clients with sickle cell disease is quite low.
- B. The client's subjective report is the most reliable indicator of pain severity.
- C. It's important to give report where clients or visitors cannot overhear you.
- D. The words and tone we use can actually affect the care a client receives.**

Effective teaching in nursing hinges on how we communicate; the words we choose and the tone we use can directly shape a client's experience and the care they receive. When language is respectful, clear, and compassionate, it builds trust, reduces anxiety, and helps clients understand instructions, which improves adherence and outcomes. This is why the statement about our words and tone affecting care is the best reflection of effective teaching. The other ideas miss important aspects: assuming opioid addiction risk in a specific disease group is a stereotype that can bias care; claiming the patient's subjective report is the most reliable measure of pain oversimplifies assessment, since combining subjective input with objective cues and standardized tools provides a fuller picture; and focusing on privacy for reports is important, but it doesn't capture how our communication style itself drives learning and care quality.

7. Two nurses report suspected narcotics diversion by the charge nurse. Which action best reflects ethical conduct?

- A. Notify the police immediately
- B. Meet with the charge nurse to discuss the issue but do not divulge the source of the information**
- C. File a formal complaint with the state board
- D. Ignore the report because there is no evidence that supports it

Addressing suspected narcotics diversion through the proper channels while protecting privacy is the ethical approach. Consulting with the charge nurse in a private, nonconfrontational manner allows you to verify facts, assess patient safety risks, and avoid spreading rumors. Importantly, you keep the reporters' identities confidential, which encourages reporting without fear of retaliation and preserves trust in the process. If the discussion uncovers concerning facts or patterns, you escalate through the appropriate organizational channels (risk management, administration) and pursue formal action as indicated by policies, which may include further investigation or, if warranted, formal reporting to the state board. Immediate police involvement isn't the first step, and filing a formal board complaint or ignoring the report bypasses proper internal processes or neglects patient safety.

8. What does the PICO framework stand for?

- A. Population/Patient, Intervention, Comparison, Outcome**
- B. Problem, Intervention, Control, Outcome
- C. Patient, Input, Change, Output
- D. Population, Intervention, Condition, Observation

PICO helps you shape a clinical question into a precise, searchable query by naming four elements: who you're asking about (Population/Patient), what you're doing (Intervention), what you're comparing it to (Comparison), and what outcome you want to impact or measure (Outcome). This structure guides both how you search for evidence and how you appraise it. The standard components are Population/Patient, Intervention, Comparison, and Outcome. Other options mix terms that aren't the accepted four parts—terms like Input/Output, Problem/Control, or Observation don't align with how clinical questions are typically framed, which can lead to vague or inconsistent searches. Example: In adults with hypertension, does aerobic exercise (Intervention) versus usual care (Comparison) reduce systolic blood pressure (Outcome) over 12 weeks (Population context helps specify the group and time frame). This kind of framing makes finding relevant studies straightforward and applying the evidence clearer.

9. After trauma, tachycardia is noted. Which statement best explains the tachycardia in this patient?

- A. The patient's heart is beating quickly due to blood loss and pain**
- B. The tachycardia indicates a rhythm requiring immediate cardioversion
- C. The patient's heart rate is elevated due to dehydration
- D. The patient's heart rate is normal

In the aftermath of trauma, tachycardia is usually a compensatory response to decreased circulating blood volume. When bleeding occurs, venous return and preload drop, which lowers stroke volume. To maintain cardiac output and keep blood flow to vital organs, the body increases heart rate through sympathetic stimulation. The stress and pain of the injury also trigger catecholamine release, further elevating the heart rate. This combination best explains why the heart is beating faster in this patient. While dehydration can raise heart rate, the acute trauma scenario makes hypovolemia from blood loss the more likely cause. A normal heart rate would not match the observed tachycardia.

10. A nurse assesses a client 12 hours post vaginal birth and finds a boggy uterus displaced above and to the right of the umbilicus. Which immediate nursing action is most appropriate?

- A. Assist the client in emptying her bladder**
- B. Begin fundal massage
- C. Administer oxytocin
- D. Place the client in Trendelenburg

The situation reflects uterine atony after birth, with the uterus boggy and displaced upward and to the right. When the bladder is full, it pushes the uterus out of position and prevents it from contracting effectively. Emptying the bladder is the fastest way to relieve this displacement and allow the uterus to contract, helping it regain tone and descend toward its normal position. After the bladder is emptied, reassess the uterus. If it remains boggy, perform fundal massage to stimulate contraction and, if needed, administer an oxytocic per protocol. Placing the patient in Trendelenburg isn't appropriate here, as it doesn't address the underlying issue and has potential risks.

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://nursingnr446readinesscje.examzify.com>

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

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