

Nursing Sciences Examination and Assessment Questionnaire (EAQ) Practice Exam (Sample)

Study Guide



Everything you need from our exam experts!

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SAMPLE

Questions

SAMPLE

- 1. What does the skin turgor assess?**
 - A. The thickness of the skin**
 - B. The elasticity and hydration status of the skin**
 - C. The pigmentation and blood flow to the skin**
 - D. The presence of skin lesions or rashes**
- 2. How can a nurse assess for signs of anxiety in a patient?**
 - A. By measuring blood pressure only**
 - B. By observing behavior and physiological responses**
 - C. By taking a complete medical history**
 - D. By reviewing laboratory test results**
- 3. Which terminal degree does The American Association of Colleges of Nursing (AACN) recommend for advanced practice registered nurses (APRNs)?**
 - A. Master of Science in Nursing (MSN)**
 - B. Doctor of Nursing Practice (DNP)**
 - C. PhD in Nursing**
 - D. Associate Degree in Nursing**
- 4. How can nurses best ensure effective communication during patient assessment?**
 - A. Using closed-ended questions**
 - B. Relying solely on written instructions**
 - C. Implementing open-ended questions**
 - D. Engaging in one-sided conversation**
- 5. What diagnostic test is most commonly used to confirm an acute myocardial infarction?**
 - A. Electrocardiogram (ECG)**
 - B. X-ray**
 - C. CT scan**
 - D. Complete blood count**

- 6. What is the primary indicator of adequate hydration in a patient?**
- A. Well-hydrated skin and normal urine output**
 - B. Frequent thirst and dark urine color**
 - C. Presence of edema in limbs**
 - D. Increased heart rate and blood pressure**
- 7. Which scenario represents the superego according to Sigmund Freud?**
- A. A client gives away food to someone in need.**
 - B. A client refrains from stealing medication despite having a craving.**
 - C. A client decides to eat healthy to avoid health issues.**
 - D. A client follows the law even when tempted to break it.**
- 8. What is one of the essential components the nurse should consider while completing the Resident Assessment Instrument (RAI)?**
- A. Minimum Data Set (MDS)**
 - B. Clinical Practice Guidelines**
 - C. Patient Satisfaction Metrics**
 - D. Drug Interaction Protocols**
- 9. What is the recommended sequence for conducting a physical assessment?**
- A. Auscultation, Palpation, Inspection, Percussion**
 - B. Inspection, Palpation, Percussion, Auscultation**
 - C. Palpation, Inspection, Percussion, Auscultation**
 - D. Percussion, Auscultation, Inspection, Palpation**
- 10. According to Jean Piaget, which stage of cognitive development is demonstrated when a baby seeks a hidden toy?**
- A. Preoperational**
 - B. Sensorimotor**
 - C. Concrete operational**
 - D. Formal operational**

Answers

SAMPLE

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

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Explanations

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1. What does the skin turgor assess?

- A. The thickness of the skin
- B. The elasticity and hydration status of the skin**
- C. The pigmentation and blood flow to the skin
- D. The presence of skin lesions or rashes

Skin turgor is primarily an assessment of the skin's elasticity and hydration status. When a healthcare provider evaluates skin turgor, they usually pinch a small section of skin, such as on the forearm or the back of the hand, and observe how quickly the skin returns to its normal state after being released. A quick return indicates good hydration and elasticity, whereas a slow return can suggest dehydration or loss of skin elasticity, which commonly occurs with age or certain health conditions. This assessment is particularly significant in clinical settings as it provides critical insights into a person's fluid status, which can be pivotal for evaluating overall health, especially in cases of dehydration or other related issues. Therefore, understanding skin turgor is vital for assessing hydration and guiding appropriate interventions.

2. How can a nurse assess for signs of anxiety in a patient?

- A. By measuring blood pressure only
- B. By observing behavior and physiological responses**
- C. By taking a complete medical history
- D. By reviewing laboratory test results

Observing behavior and physiological responses is an essential method for assessing signs of anxiety in a patient. Anxiety can manifest in various ways, including both visible behaviors and physiological changes. For instance, a nurse might observe a patient who appears restless, is pacing, or shows signs of agitation, as well as physiological signs such as increased heart rate or sweating. These observations provide important insights into the patient's emotional state and can guide further assessment and intervention. While measuring blood pressure can provide some information about a patient's physiological state, it does not capture the full range of signs indicative of anxiety. Similarly, taking a complete medical history is vital for understanding a patient's overall health but may not directly reveal immediate signs of anxiety. Reviewing laboratory test results can support the identification of underlying medical conditions but does not provide real-time insights into a patient's emotional and psychological state. Therefore, the most comprehensive approach to assess anxiety involves closely observing both behavioral patterns and physiological responses.

3. Which terminal degree does The American Association of Colleges of Nursing (AACN) recommend for advanced practice registered nurses (APRNs)?

- A. Master of Science in Nursing (MSN)**
- B. Doctor of Nursing Practice (DNP)**
- C. PhD in Nursing**
- D. Associate Degree in Nursing**

The American Association of Colleges of Nursing (AACN) recommends the Doctor of Nursing Practice (DNP) as the terminal degree for advanced practice registered nurses (APRNs). This recommendation reflects a shift in the nursing profession towards advanced clinical education and practice, ensuring that APRNs possess a high level of expertise and are prepared to meet the complex healthcare needs of patients. The DNP focuses on clinical practice and applies evidence-based research to enhance healthcare delivery, making it a suitable choice for those in advanced roles. The degree aims to prepare nurses to lead and influence healthcare systems, improve patient outcomes, and implement change in practice based on scientific evidence. In contrast, the Master of Science in Nursing (MSN) is typically the minimum requirement for APRNs but does not provide the same depth of clinical training and leadership skills that a DNP offers. A PhD in Nursing, while valuable for those pursuing research and academic positions, is more focused on generating new knowledge through research rather than applying it in a clinical setting. An Associate Degree in Nursing is an entry-level qualification and is not adequate for advanced practice roles. Overall, the DNP is aligned with the evolving healthcare environment that demands higher-level clinical skills, leadership capabilities, and an evidence-based approach to

4. How can nurses best ensure effective communication during patient assessment?

- A. Using closed-ended questions**
- B. Relying solely on written instructions**
- C. Implementing open-ended questions**
- D. Engaging in one-sided conversation**

Implementing open-ended questions during patient assessment is essential for effective communication because it encourages patients to express their thoughts, feelings, and concerns in their own words. This approach enables nurses to gather comprehensive information about the patient's condition, experiences, and needs, facilitating a more holistic understanding of their health situation. Open-ended questions invite elaboration and discussion, making patients feel more comfortable and encouraged to share details that might be crucial for their care. This type of questioning fosters a collaborative relationship where patients are seen as active participants in their health management, leading to more personalized and effective care. By creating an environment where patients feel heard and valued, nurses can establish trust and rapport, which are vital components of the patient-nurse relationship. In contrast, closed-ended questions limit responses to specific options, which may restrict the amount of information gathered. Relying solely on written instructions can lead to misunderstandings if the patient has questions or needs further clarification. Engaging in one-sided conversation does not allow for the exchange of information between the nurse and patient, ultimately undermining the assessment process. Therefore, using open-ended questions is the best practice for ensuring effective communication during patient assessments.

5. What diagnostic test is most commonly used to confirm an acute myocardial infarction?

A. Electrocardiogram (ECG)

B. X-ray

C. CT scan

D. Complete blood count

The electrocardiogram (ECG) is the most commonly used diagnostic test to confirm an acute myocardial infarction because it provides essential information about the heart's electrical activity. During an acute myocardial infarction, or heart attack, the ECG typically shows characteristic changes such as ST-segment elevation and T-wave inversions, which help healthcare providers identify the presence and severity of the infarction. The ECG is a non-invasive, rapid, and readily available test that can be performed in various settings, making it the first-line diagnostic tool for suspected myocardial infarction. Timely interpretation of the ECG is crucial for initiating appropriate treatment, such as administering medications or performing interventions like angioplasty. Other diagnostic tests may have their roles in evaluating heart conditions, but they do not provide the immediate and specific information about a heart attack that an ECG does. For example, X-rays and CT scans are more useful for assessing structural complications or other conditions rather than directly confirming a myocardial infarction. A complete blood count, while important for overall health assessment, does not specifically diagnose cardiac events. Therefore, the ECG stands out as the gold standard for confirming an acute myocardial infarction.

6. What is the primary indicator of adequate hydration in a patient?

A. Well-hydrated skin and normal urine output

B. Frequent thirst and dark urine color

C. Presence of edema in limbs

D. Increased heart rate and blood pressure

The primary indicator of adequate hydration in a patient is well-hydrated skin and normal urine output. Well-hydrated skin appears elastic, moist, and has good turgor, which indicates that the body is maintaining sufficient fluid levels. Additionally, normal urine output signifies that the kidneys are functioning appropriately and effectively excreting waste products while maintaining the body's fluid balance. Typically, adequate hydration correlates with urine that is light in color and clear, indicating the body is well-hydrated. While thirst and urine color can suggest hydration status, they are not as definitive. A person can experience thirst and dark urine due to dehydration, but this does not directly reflect current hydration status. Similarly, the presence of edema in limbs is often a sign of overhydration or fluid imbalance rather than adequate hydration. Increased heart rate and blood pressure can be indicators of various conditions, including dehydration, but they are not exclusive indicators of hydration status; other factors can influence these vital signs. Therefore, assessing skin quality and urine output provides a more immediate and reliable reflection of hydration levels in a patient.

7. Which scenario represents the superego according to Sigmund Freud?

- A. A client gives away food to someone in need.**
- B. A client refrains from stealing medication despite having a craving.**
- C. A client decides to eat healthy to avoid health issues.**
- D. A client follows the law even when tempted to break it.**

The scenario that best represents the superego according to Sigmund Freud is one where a client refrains from stealing medication despite having a craving. The superego is often described as the moral compass of the personality, encompassing the internalization of societal rules, ethics, and values. It functions to control the urges of the id (which seeks immediate gratification) and encourages behavior that is considered socially acceptable and morally right. In the specific scenario of refraining from stealing medication, the individual is exercising self-control and adhering to moral principles, even in the face of temptation. This reflects the superego's role in guiding behavior according to moral judgments and societal standards. The decision to not act on the craving is a demonstration of internalized ethics and a sense of responsibility towards the well-being of others, key elements associated with the superego. In contrast, the other scenarios might involve considerations of personal health or social behavior but do not explicitly highlight that moral struggle against immediate desires in the same way. For example, giving away food represents altruistic behavior but may not involve the same moral tension as refraining from theft. Choosing to eat healthy is often more aligned with self-care than with a moral imperative, and following the law addresses societal rules but does

8. What is one of the essential components the nurse should consider while completing the Resident Assessment Instrument (RAI)?

- A. Minimum Data Set (MDS)**
- B. Clinical Practice Guidelines**
- C. Patient Satisfaction Metrics**
- D. Drug Interaction Protocols**

The Minimum Data Set (MDS) is a critical element of the Resident Assessment Instrument (RAI) because it serves as a standardized assessment tool that captures key clinical and functional information about residents in long-term care facilities. This comprehensive assessment is fundamental in developing care plans and ensuring that residents receive appropriate and individualized care. The MDS includes data about a resident's medical conditions, cognitive functioning, daily living activities, and need for assistance. By utilizing the MDS within the RAI framework, nurses can ensure compliance with regulatory requirements while also identifying areas that need focused interventions. In contrast, the other components listed, while important in their own contexts, do not play a direct role in the completion of the RAI. Clinical practice guidelines provide general standards of care but do not offer the individualized assessment data that the MDS provides. Patient satisfaction metrics focus on the residents' perceptions and experiences but do not contribute to the clinical and functional assessment required for the RAI. Drug interaction protocols are relevant for medication management but do not pertain to the overall assessment and care planning that the RAI facilitates. Thus, the MDS is essential for effectively completing the RAI and ensuring that high-quality care is provided to residents.

9. What is the recommended sequence for conducting a physical assessment?

- A. Auscultation, Palpation, Inspection, Percussion**
- B. Inspection, Palpation, Percussion, Auscultation**
- C. Palpation, Inspection, Percussion, Auscultation**
- D. Percussion, Auscultation, Inspection, Palpation**

The recommended sequence for conducting a physical assessment is Inspection, Palpation, Percussion, and then Auscultation. This order is established based on the most effective way to gather information about a patient's physical condition systematically. Beginning with inspection allows the healthcare provider to gather an initial overview of the patient's overall health, noting any visible signs of injury, disease, or abnormalities. Following this, palpation is employed to further assess areas that appeared abnormal during the inspection. This method provides tactile feedback that can reveal warmth, texture, or tenderness that might not be visible. Next is percussion, which is used to assess the underlying structures by tapping on the body to produce sounds that indicate the condition of the organs beneath. Finally, auscultation is performed, typically using a stethoscope to listen for internal sounds such as heartbeat or lung sounds. This last step is advantageous because it can help verify findings observed through the previous assessments and is least likely to be influenced by physical contact or environmental factors. This sequence allows for a logical flow of information gathering, enhancing the accuracy and effectiveness of the physical assessment.

10. According to Jean Piaget, which stage of cognitive development is demonstrated when a baby seeks a hidden toy?

- A. Preoperational**
- B. Sensorimotor**
- C. Concrete operational**
- D. Formal operational**

The correct answer is the Sensorimotor stage, which is the first stage in Jean Piaget's theory of cognitive development. This stage occurs from birth to approximately 2 years of age and is characterized by infants learning about the world through their senses and actions. During the Sensorimotor stage, children explore their surroundings, learn to manipulate objects, and develop object permanence—the understanding that objects continue to exist even when they are not visible. When a baby seeks a hidden toy, it demonstrates their developing understanding of object permanence. Prior to this development, if a toy is hidden, the baby may not even search for it since they do not yet comprehend that the object still exists out of sight. The ability to search for and find a hidden toy is a clear indication that the infant is actively engaging with their environment and starting to form mental representations, which are foundational aspects of cognitive development during this stage.