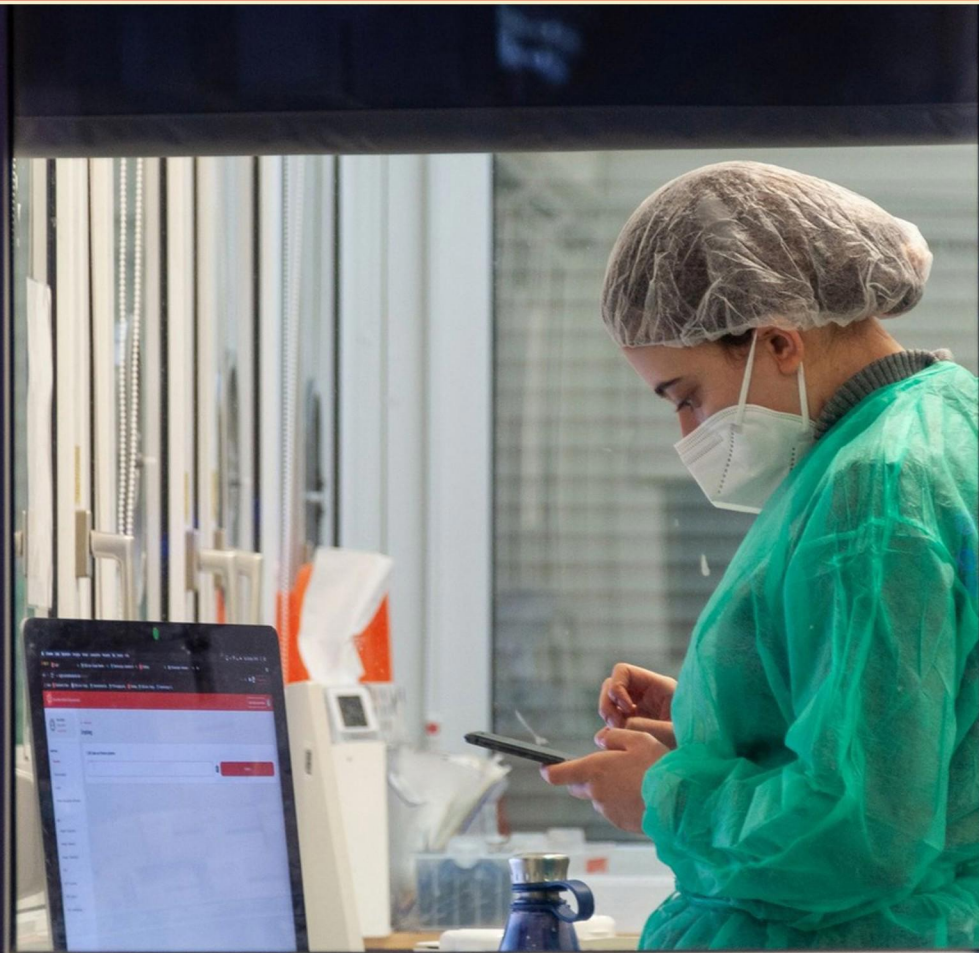


NURSING TRANSITION TO PRACTICE TEST 2 PRACTICE (SAMPLE)

STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

VISIT US ONLINE FOR
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. What is the purpose of an enteral or nasogastric tube in postoperative care?**
 - A. Gastric decompression, prevention of aspiration, and monitoring of GI function
 - B. Deliver oxygen
 - C. Restrict GI function
 - D. Provide a source of nutritional support only

- 2. How should a MAR discrepancy be handled?**
 - A. Investigate, verify, document resolution, and inform the provider if needed
 - B. Ignore the discrepancy
 - C. Change MAR without verification
 - D. Notify the patient

- 3. Which ECG changes are associated with hyperkalemia?**
 - A. ST segment depression with U waves.
 - B. Tall peaked T waves, widening of QRS, and potentially sine wave pattern.
 - C. Shortened QT interval.
 - D. Inverted T waves only.

- 4. For a patient with MRSA infection, which precautions are required to prevent transmission?**
 - A. Standard precautions
 - B. Contact precautions (gloves and gown; dedicated equipment)
 - C. Droplet precautions
 - D. Airborne precautions

- 5. During the primary survey, exposure refers to which action?**
 - A. Fully exposing the patient to assess for injuries
 - B. Keeping patient fully covered to protect modesty
 - C. Exposing only the injured area
 - D. Not performing exposure to avoid discomfort

- 6. What does SBAR stand for in healthcare communication?**
- A. Situation, Background, Assessment, Recommendation.
 - B. Subject, Background, Action, Response.
 - C. Status, Baseline, Analysis, Referral.
 - D. Situation, Background, Assessment, Recommendation.
- 7. In delegating to unlicensed assistive personnel (UAPs), what is essential?**
- A. Assign any nursing task, regardless of scope.
 - B. Provide instructions but do not supervise.
 - C. Assign tasks within scope, provide clear instructions, and supervise outcomes.
 - D. Withhold all decisions from UAPs.
- 8. During the transfusion, how frequently should vital signs be monitored in the first 15 minutes?**
- A. Every 15 minutes
 - B. Every minute
 - C. Every 5 minutes
 - D. Every 30 minutes
- 9. A patient reports chest pain and diaphoresis. What is the most appropriate immediate action?**
- A. Administer analgesia
 - B. Check blood sugar
 - C. Apply cold compress
 - D. Call emergency services and administer aspirin if not contraindicated; initiate STEMI protocol
- 10. A 1000 mL IV bag is to be infused over 8 hours using a macrodrip set of 15 gtt/mL. What is the required IV rate in mL/hr and gtt/min?**
- A. 125 mL/hr (≈ 31 gtt/min)
 - B. 150 mL/hr (≈ 38 gtt/min)
 - C. 80 mL/hr (≈ 20 gtt/min)
 - D. 200 mL/hr (≈ 50 gtt/min)

Answers

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

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Explanations

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1. What is the purpose of an enteral or nasogastric tube in postoperative care?

- A. Gastric decompression, prevention of aspiration, and monitoring of GI function
- B. Deliver oxygen
- C. Restrict GI function
- D. Provide a source of nutritional support only

After surgery, the stomach often contains secretions and gas and the bowel's movements are slowed. An enteral or nasogastric tube helps by decompressing the stomach, which reduces distention and nausea and lowers the risk of aspiration if regurgitation occurs. It also provides a way to monitor the GI tract's function through the drainage that comes out—the amount, color, and consistency can give clues about how well the stomach and intestines are healing and returning to normal. This option is best because it covers the primary postoperative roles: keeping the stomach empty to prevent complications, protecting the airway, and giving direct information about GI function. In contrast, delivering oxygen is not a function of an NG tube, restricting GI function is not the goal of decompression, and providing nutrition only is incomplete since the tube's main postoperative purposes are decompression and airway protection, with monitoring as an added benefit.

2. How should a MAR discrepancy be handled?

- A. Investigate, verify, document resolution, and inform the provider if needed
- B. Ignore the discrepancy
- C. Change MAR without verification
- D. Notify the patient

Discrepancies in the medication administration record are treated as a safety issue that requires careful verification. When you notice a mismatch, you don't proceed with the medication. Instead, you first compare the MAR with the patient's current orders and with the label on the medication, confirming the correct patient, drug, dose, route, and time. If anything doesn't align, you pause administration and investigate—check the chart, the pharmacy system, and any recent changes, and consult the prescribing clinician or nurse supervisor as needed. Once you determine the correct information, you document the discrepancy, the steps you took, and the final resolution, and you update the MAR accordingly. If the order appears wrong or unclear, you obtain a corrected order before administering. The provider is informed as part of the safety process to ensure the MAR and the order remain consistent. Choosing to ignore the discrepancy, change the MAR without verification, or notify the patient first does not support safe practice.

3. Which ECG changes are associated with hyperkalemia?

- A. ST segment depression with U waves.
- B. Tall peaked T waves, widening of QRS, and potentially sine wave pattern.
- C. Shortened QT interval.
- D. Inverted T waves only.

When potassium rises, the heart's electrical activity changes in a characteristic progression. Early on, you see tall, peaked T waves because ventricular myocytes repolarize more quickly. As potassium increases further, conduction slows, so the PR interval lengthens and the QRS complex widens. If hyperkalemia becomes severe, the QRS widening can progress to a sine-wave pattern, signaling a high risk of deadly arrhythmias. This sequence makes tall peaked T waves with widening of the QRS, and possibly a sine-wave pattern, the hallmark ECG finding of hyperkalemia. Other patterns described—such as ST depression with U waves, mere inverted T waves, or a shortened QT without the broader progression—do not align with the typical hyperkalemic changes.

4. For a patient with MRSA infection, which precautions are required to prevent transmission?

- A. Standard precautions
- B. Contact precautions (gloves and gown; dedicated equipment)**
- C. Droplet precautions
- D. Airborne precautions

MRSA spreads mainly by direct contact with infected skin or contaminated surfaces, so preventing transmission relies on contact precautions. This means wearing gloves and a gown whenever entering the patient's room or performing patient-care activities and using dedicated, nonshared equipment to avoid cross-contamination. Hand hygiene before and after care is essential to stop any transfer, and placing the patient in a private room (or cohorting with the same infection if needed) helps contain spread. Standard precautions are used for all patients, but MRSA requires an added layer of protection because its primary transmission route is contact. Droplet precautions address spreading through respiratory droplets, and airborne precautions address tiny particles that linger in the air; neither is the main route for MRSA, so those precautions aren't routinely required for MRSA unless another infection requiring them is present.

5. During the primary survey, exposure refers to which action?

- A. Fully exposing the patient to assess for injuries**
- B. Keeping patient fully covered to protect modesty
- C. Exposing only the injured area
- D. Not performing exposure to avoid discomfort

Exposure in the primary survey means removing clothing as needed so you can inspect the entire body for injuries and signs of trauma. This quick, full-body inspection is essential because injuries aren't always obvious through clothing, and you need to identify all life-threatening issues right away. While you do this, you should still take steps to keep the patient warm and preserve dignity once the necessary assessment is done. Fully covering the patient all the time would hide injuries, exposing only the injured area could miss problems elsewhere, and skipping exposure altogether would leave hidden injuries undiscovered.

6. What does SBAR stand for in healthcare communication?

- A. Situation, Background, Assessment, Recommendation.
- B. Subject, Background, Action, Response.
- C. Status, Baseline, Analysis, Referral.
- D. Situation, Background, Assessment, Recommendation.**

SBAR is a structured way to communicate critical patient information clearly and efficiently, especially during handoffs or when escalation is needed. It helps ensure nothing important is missed in a busy clinical environment. First, state the Situation: a concise, specific description of what is happening now that needs attention. Then, provide the Background: relevant context such as the patient's diagnosis, pertinent history, current medications, and events leading up to the issue. Next is the Assessment: your clinical interpretation, including what you think is going on and the level of concern. Finally, offer the Recommendation: what action you believe should be taken, suggested options, and any sense of urgency. The sequence that matches this approach is Situation, Background, Assessment, Recommendation. This order keeps information organized from the presenting issue through context and interpretation to a clear request for action. Other options either change the terms or jumble the order, which can reduce clarity and delay appropriate care.

7. In delegating to unlicensed assistive personnel (UAPs), what is essential?

- A. Assign any nursing task, regardless of scope.
- B. Provide instructions but do not supervise.
- C. Assign tasks within scope, provide clear instructions, and supervise outcomes.**
- D. Withhold all decisions from UAPs.

Delegation to unlicensed assistive personnel works best when you keep tasks inside their defined scope, give clear, specific instructions, and actively supervise the results. This ensures patient safety and quality of care while keeping you accountable for the outcomes. Tasks delegated to UAPs should be within what they are allowed to perform, not nursing procedures that require professional assessment or clinical judgment. Providing clear directions helps the UAP understand exactly what is expected, how to carry it out, and any safety precautions to follow. Supervision means monitoring how the task is performed and reviewing the results, with the ability to intervene if something isn't right or if the patient's condition changes. This combination protects patients, supports reliable care, and maintains professional responsibility. For example, a nurse can assign routine, protocol-based tasks such as helping with activities of daily living or taking vitals within a defined threshold, while staying present to observe the patient's response and stepping in if the measurements are out of expected range or if the patient shows signs of distress. By contrast, assigning tasks beyond the UAP's scope, not supervising, or withholding decision-making entirely would compromise safety and care quality.

8. During the transfusion, how frequently should vital signs be monitored in the first 15 minutes?

- A. Every 15 minutes
- B. Every minute
- C. Every 5 minutes**
- D. Every 30 minutes

The most critical moment for catching transfusion reactions is the first 15 minutes, when signs can develop quickly. Monitoring vital signs every 5 minutes during this period allows you to detect early changes—such as fever, chills, a rapid heart rate, low blood pressure, or shortness of breath—and stop the transfusion promptly if needed. Checking more frequently, like every minute, is unnecessary and disruptive, while waiting 15 minutes or longer could miss a developing reaction. Every 30 minutes would be too infrequent to ensure patient safety in this high-risk window.

9. A patient reports chest pain and diaphoresis. What is the most appropriate immediate action?

- A. Administer analgesia
- B. Check blood sugar
- C. Apply cold compress
- D. Call emergency services and administer aspirin if not contraindicated; initiate STEMI protocol**

Suspecting an acute coronary syndrome, the priority is rapid emergency response and initiation of reperfusion-oriented care. The most appropriate immediate action is to call emergency services and administer aspirin if not contraindicated, and start the STEMI protocol. Getting EMS involved quickly ensures early ECG assessment and activation of the cath lab, which speeds up reperfusion and reduces heart muscle damage. Giving aspirin at once helps inhibit platelet aggregation, lowering mortality and limiting infarct size when ACS is present. Other actions don't address the urgent need for rapid ACS evaluation and treatment. Analgesia may help pain but won't prevent ongoing myocardial injury and can delay definitive care. Checking blood sugar is useful in certain chest-pain contexts but isn't the priority when ACS is strongly suspected. A cold compress isn't beneficial for a suspected cardiac event.

10. A 1000 mL IV bag is to be infused over 8 hours using a macrodrip set of 15 gtt/mL. What is the required IV rate in mL/hr and gtt/min?

- A. 125 mL/hr (≈31 gtt/min)**
- B. 150 mL/hr (≈38 gtt/min)
- C. 80 mL/hr (≈20 gtt/min)
- D. 200 mL/hr (≈50 gtt/min)

The main idea is to convert the prescribed volume and time into a flow rate in mL per hour, then translate that into drops per minute using the drip factor. First, find the hourly infusion rate in mL/hr: 1000 mL divided by 8 hours equals 125 mL/hr. Next, convert that to drops per minute using the drop factor (15 gtt per mL): 125 mL/hr × 15 gtt/mL = 1875 gtt/hr. Then divide by 60 to get gtt/min: 1875 ÷ 60 ≈ 31.25, which rounds to about 31 gtt/min. So the required IV rate is 125 mL/hr and about 31 gtt/min. Other rates would not match both parts (for example, 150 mL/hr ≈ 38 gtt/min; 80 mL/hr ≈ 20 gtt/min; 200 mL/hr ≈ 50 gtt/min).

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://nursingtransition2.examzify.com>

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

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