

# ONS ONCC Chemotherapy Renewal Practice Exam (Sample)

## Study Guide



**Everything you need from our exam experts!**

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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. For anthracycline extravasation treated with the antidote, when should infusion be started after extravasation?**
  - A. Immediately (within minutes)**
  - B. Within Six Hours**
  - C. Within Twenty-Four Hours**
  - D. After Forty-Eight Hours**
  
- 2. Which is the lifetime cumulative dose of doxorubicin that should not be exceeded in a patient receiving cyclophosphamide as part of R-CHOP?**
  - A. 550 mg/m<sup>2</sup>**
  - B. 600 mg/m<sup>2</sup>**
  - C. 500 mg/m<sup>2</sup>**
  - D. 450 mg/m<sup>2</sup>**
  
- 3. What is the primary safety reason for using a containment device during chemo compounding?**
  - A. To improve odor control.**
  - B. To prevent exposure to staff and environment by containing aerosols and spills during preparation.**
  - C. To reduce costs.**
  - D. To speed up preparation.**
  
- 4. During dose verification, which elements should be compared against the prescription/order?**
  - A. The patient's age and weight**
  - B. The nurse's initials**
  - C. Drug, dose, route, and patient identity**
  - D. The physician's favorite color**
  
- 5. Which management step is commonly used for moderate to severe immune-related adverse events from checkpoint inhibitors?**
  - A. Steroids**
  - B. Antibiotics**
  - C. Increased chemotherapy dosing**
  - D. IV fluids only**

- 6. Which component is included in the FOLFOX6 regimen?**
- A. Irinotecan 100 mg/m<sup>2</sup>**
  - B. Oxaliplatin 100 mg/m<sup>2</sup> IV**
  - C. Cisplatin 75 mg/m<sup>2</sup>**
  - D. Paclitaxel 80 mg/m<sup>2</sup>**
- 7. What is a responsible practice when a patient reports a missed chemotherapy dose?**
- A. Do nothing and wait for the next scheduled dose.**
  - B. Reschedule all future doses without assessment.**
  - C. Assess reason for missed dose, consult the prescriber, determine whether to administer a missed dose or reschedule, and document the decision.**
  - D. Administer the missed dose immediately without consulting physician.**
- 8. During platinum-based chemotherapy, which laboratory measurements are most pertinent to assess nephrotoxicity risk?**
- A. Amylase and lipase levels.**
  - B. Serum creatinine, eGFR, and magnesium/potassium levels to monitor for nephrotoxicity and electrolyte disturbances.**
  - C. Complete blood count and liver enzymes.**
  - D. Blood glucose and HbA1c.**
- 9. What is the general approach to dosing of chemotherapy in elderly patients?**
- A. Assess physiologic age, comorbidities, organ function; adjust dose and schedule to balance efficacy and tolerability; monitor closely for toxicity.**
  - B. Always give standard adult dose.**
  - C. Discontinue chemotherapy in all elderly.**
  - D. Use only palliative regimens.**

**10. In a patient with catheter-related infection signs, what is an appropriate nursing action?**

- A. Notify clinician; obtain cultures if ordered; remove or replace the catheter per policy; institute infection-control precautions.**
- B. Increase IV fluids and vitamins.**
- C. Delay action until symptoms worsen.**
- D. Change the catheter dressing only.**

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## Answers

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

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## **Explanations**

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**1. For anthracycline extravasation treated with the antidote, when should infusion be started after extravasation?**

- A. Immediately (within minutes)**
- B. Within Six Hours**
- C. Within Twenty-Four Hours**
- D. After Forty-Eight Hours**

Prompt initiation of the antidote after anthracycline extravasation is crucial because it interrupts the tissue-damaging cascade driven by the drug leaking into surrounding tissues. Dexrazoxane works by chelating iron and preventing the formation of free radicals that cause local injury, reducing the risk of necrosis and preserving tissue integrity. The protective effect is strongest when the antidote is started as soon as extravasation is suspected, with a practical window of six hours after exposure. Initiating within this timeframe maximizes tissue salvage; waiting longer greatly diminishes the antidote's effectiveness in preventing severe damage. In practice, the first dose is given as soon as possible after extravasation, with subsequent doses at 24 and 48 hours to maintain protection during the period of ongoing drug exposure in the tissue. While earlier is better, the key rule for this scenario is starting within six hours.

**2. Which is the lifetime cumulative dose of doxorubicin that should not be exceeded in a patient receiving cyclophosphamide as part of R-CHOP?**

- A. 550 mg/m<sup>2</sup>**
- B. 600 mg/m<sup>2</sup>**
- C. 500 mg/m<sup>2</sup>**
- D. 450 mg/m<sup>2</sup>**

Doxorubicin has a dose-dependent risk of damaging the heart, so clinicians set a lifetime ceiling to protect cardiac function. The commonly used practical limit is about 450 mg/m<sup>2</sup>; some guidelines mention up to 550 mg/m<sup>2</sup> for select patients, but 450 mg/m<sup>2</sup> is the safer, widely cited threshold. In R-CHOP, doxorubicin is given at 50 mg/m<sup>2</sup> per cycle for six cycles (total 300 mg/m<sup>2</sup>), which stays well below the lifetime ceiling. However, if a patient has prior anthracycline exposure or chest radiation, that remaining allowance must be considered to avoid surpassing the limit. Therefore, the lifetime cumulative dose that should not be exceeded is 450 mg/m<sup>2</sup>.

**3. What is the primary safety reason for using a containment device during chemo compounding?**

**A. To improve odor control.**

**B. To prevent exposure to staff and environment by containing aerosols and spills during preparation.**

**C. To reduce costs.**

**D. To speed up preparation.**

The main safety principle here is protecting people and the environment from hazardous chemotherapy drugs by preventing aerosol release and spills during preparation. Chemotherapy manipulations can generate airborne particles and surface contamination; a containment device creates a controlled, often negative-pressure, work area with filtration that captures drug particles and prevents them from escaping into the room or being absorbed by staff. This setup directly reduces inhalation, dermal exposure, and environmental contamination, which is the core reason for using containment during compounding. Odor control, cost savings, or speeding up prep don't address the actual exposure risk or environmental spread as effectively.

**4. During dose verification, which elements should be compared against the prescription/order?**

**A. The patient's age and weight**

**B. The nurse's initials**

**C. Drug, dose, route, and patient identity**

**D. The physician's favorite color**

The main point is to verify that the medication being given matches the clinician's order in four critical aspects: the drug, the dose, the route, and the patient identity. Verifying the drug ensures you administer the exact medication intended and helps prevent mix-ups with similar-sounding names. Checking the dose confirms the amount and units are correct and align with what was ordered and what the preparation contains, which is especially vital in chemotherapy where dosing is precise and may be based on weight or body surface area. Confirming the route ensures the medication is given by the intended method (for example, IV versus oral), since changing the route can alter absorption, efficacy, and safety. Verifying the patient identity using two identifiers helps ensure the right person receives the right treatment, avoiding dangerous mix-ups. Age and weight can influence dosing calculations, but they are not the elements you compare against the prescription during the dose-verification step itself. Nursing initials are about documentation, and a physician's favorite color is unrelated to safe medication administration.

**5. Which management step is commonly used for moderate to severe immune-related adverse events from checkpoint inhibitors?**

**A. Steroids**

**B. Antibiotics**

**C. Increased chemotherapy dosing**

**D. IV fluids only**

Immune-related adverse events from checkpoint inhibitors are inflammatory reactions driven by an overactive immune system, so the treatment goal is to suppress that immune attack. For moderate to severe irAEs, the best and standard first step is systemic corticosteroids. They rapidly reduce immune-mediated inflammation across affected organs, helping symptoms improve and preventing progression. The typical approach is to start high-dose steroids (for example, prednisone about 1 mg/kg/day or an equivalent dose of methylprednisolone) and hold the immunotherapy until there is meaningful improvement, then taper the steroids over several weeks as symptoms resolve. If symptoms persist or recur during tapering, additional immunosuppressive therapies may be used depending on the organ involved. Antibiotics are reserved for confirmed or strongly suspected infections, not for treating irAEs. Increasing chemotherapy dosing would worsen toxicity and does not address the inflammatory process. IV fluids alone won't control immune-mediated inflammation.

**6. Which component is included in the FOLFOX6 regimen?**

**A. Irinotecan 100 mg/m<sup>2</sup>**

**B. Oxaliplatin 100 mg/m<sup>2</sup> IV**

**C. Cisplatin 75 mg/m<sup>2</sup>**

**D. Paclitaxel 80 mg/m<sup>2</sup>**

FOLFOX6 is built from a fluoropyrimidine combination with a platinum agent. The defining platinum drug in this regimen is oxaliplatin given IV, typically at 100 mg/m<sup>2</sup>, paired with 5-FU and leucovorin. Irinotecan belongs to a different colorectal regimen (FOLFIRI) and isn't part of FOLFOX. Cisplatin is another platinum drug but isn't used in FOLFOX due to differences in toxicity and compatibility with this combination. Paclitaxel is a taxane used in other cancers and is not part of colorectal regimens like FOLFOX. So, oxaliplatin is the component included in FOLFOX6.

7. What is a responsible practice when a patient reports a missed chemotherapy dose?
- A. Do nothing and wait for the next scheduled dose.
  - B. Reschedule all future doses without assessment.
  - C. Assess reason for missed dose, consult the prescriber, determine whether to administer a missed dose or reschedule, and document the decision.**
  - D. Administer the missed dose immediately without consulting physician.

When a patient misses a chemotherapy dose, the responsible practice is to assess the reason for the missed dose, consult the prescriber, determine whether to administer the missed dose or to reschedule within the cycle, and document the decision and plan. This approach ensures patient safety and treatment effectiveness. By identifying why the dose was missed—whether due to side effects, lab results, nonadherence, or scheduling issues—you can weigh risks and benefits in the context of the specific regimen and patient condition. Involving the prescriber ensures that any dose adjustments, timing changes, or the need for supportive measures align with the treatment plan and toxicity guidelines. Documenting the assessment, the decision, and the plan provides a clear, auditable record for future care and continuity. Doing nothing ignores potential safety and efficacy implications. Rescheduling without assessment could disrupt the intended dose intensity or overlook a contraindication. Administering the missed dose without physician input may lead to inappropriate dosing or adverse interactions if the regimen has strict timing, cumulative toxicity, or coordination with other agents. The correct approach keeps the patient's safety at the forefront while preserving treatment intent.

8. During platinum-based chemotherapy, which laboratory measurements are most pertinent to assess nephrotoxicity risk?
- A. Amylase and lipase levels.
  - B. Serum creatinine, eGFR, and magnesium/potassium levels to monitor for nephrotoxicity and electrolyte disturbances.**
  - C. Complete blood count and liver enzymes.
  - D. Blood glucose and HbA1c.

Nephrotoxicity from platinum-based chemotherapy, especially cisplatin, is driven by damage to the kidneys' ability to filter and reabsorb properly. The best way to detect and manage this risk is to closely monitor renal function and electrolytes. Serum creatinine and the estimated glomerular filtration rate reflect how well the kidneys are filtering waste, and rising creatinine or a decreasing eGFR signals decreasing kidney function that may require dose adjustments or supportive care. Magnesium and potassium levels are crucial to check because platinum drugs can cause tubular injury that wastes these electrolytes, leading to potentially serious imbalances if not treated. Together, these measurements let clinicians track kidney health and intervene early to prevent progression to significant nephrotoxicity. Other labs like amylase/lipase assess pancreatic injury, while complete blood count and liver enzymes monitor hematologic or hepatic toxicity, and blood glucose/HbA1c relate to metabolic control. They do not directly target nephrotoxicity risk.

**9. What is the general approach to dosing of chemotherapy in elderly patients?**

- A. Assess physiologic age, comorbidities, organ function; adjust dose and schedule to balance efficacy and tolerability; monitor closely for toxicity.**
- B. Always give standard adult dose.**
- C. Discontinue chemotherapy in all elderly.**
- D. Use only palliative regimens.**

Dosing chemotherapy in older adults is about tailoring therapy to the individual's physiologic reserve, comorbidities, and organ function to maximize benefit while minimizing harm. As people age, kidney and liver function, bone marrow reserve, and drug handling can change, and many have other health conditions or taking multiple medications that raise the risk of interactions and toxicity. Because of these factors, starting with a dose and schedule that are adjusted from standard recommendations, and then watching closely for side effects, gives the best chance of having meaningful treatment effects without overwhelming toxicity. This approach also leaves room to modify plans based on how well the patient tolerates treatment, changes in organ function, or shifts in goals of care. Giving the standard adult dose ignores age-related changes and can lead to unnecessary toxicity. Discontinuing chemotherapy in all elderly ignores individual variation in fitness and goals, and using only palliative regimens overlooks situations where adjusted regimens might still offer disease control or symptom relief. The best practice is individualized treatment planning that weighs potential benefits against risks for each patient, with ongoing assessment and adjustment as needed.

**10. In a patient with catheter-related infection signs, what is an appropriate nursing action?**

- A. Notify clinician; obtain cultures if ordered; remove or replace the catheter per policy; institute infection-control precautions.**
- B. Increase IV fluids and vitamins.**
- C. Delay action until symptoms worsen.**
- D. Change the catheter dressing only.**

When there are signs of catheter-related infection, the priority is to control the infection source and obtain appropriate assessment data. Notify the clinician promptly, and follow policy to obtain cultures if ordered (typically blood cultures from peripheral and/or catheter site and catheter tip cultures as indicated). Remove or replace the catheter per policy to eliminate the infection source, and implement infection-control precautions to prevent transmission. Simply changing the dressing addresses only the exterior site and does not treat the infection or its source, and delaying deeper evaluation and catheter management can allow the infection to progress. Early culture data and source control guide targeted therapy and improve outcomes.

## 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](mailto:hello@examzify.com).**

**Or visit your dedicated course page for more study tools and resources:**

**<https://onsonccchemotherapyrenewal.examzify.com>**

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

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