# PALLIATIVE CARE AND END-OF-LIFE CARE PRACTICE TEST (SAMPLE)

## STUDY GUIDE

## SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

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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. Which of the following is NOT a component of decision-making capacity?**

A. Understanding of information.

B. Ability to communicate a choice.

C. Mood or emotional state.

D. Appreciation of consequences for self.

**2. Which statement best describes the purpose of the Edmonton Symptom Assessment System (ESAS) in palliative care?**

A. To measure nutritional status in chronic illness.

B. To quantify the severity of common distressing symptoms in palliative care.

C. To assess caregiver satisfaction with care.

D. To evaluate laboratory values for symptom management.

**3. A patient with terminal cancer is admitted to a family-centered hospice. The spouse visits daily and discusses wedding plans; which provisional nursing diagnosis best applies to the spouse?**

A. Ineffective coping related to lack of grieving

B. Anxiety related to complicated grieving process

C. Hopelessness related to knowledge deficit about cancer

D. Caregiver role strain related to spouse's complex care needs

**4. What is the role of exercise and physical therapy in palliative care?**

A. Exercise should be avoided in all palliative care

B. Help maintain function, reduce fatigue, improve QoL, and tailor to tolerance

C. Physical therapy is only for elite athletes

D. Exercise replaces medications

**5. You are visiting with the wife of a patient who is having difficulty making the transition to palliative care for her dying husband. What is the most desirable outcome for the couple?**

A. They express hope for a cure.

B. They comply with treatment options.

C. They set additional goals for the future.

D. They acknowledge the symptoms and prognosis.

**6. When discussing feeding at end of life, clinicians should consider which factors?**

A. Dietitian only opinions

B. Hospital policy only

C. Goals, values, risks/benefits, and cultural context.

D. Financial cost as the sole consideration

**7. Which agents are commonly used for palliative sedation?**

A. Midazolam alone is sufficient; no other agents used

B. Propofol and phenobarbital are never used

C. Short-acting benzodiazepines such as midazolam; sometimes propofol or phenobarbital

D. All sedation must be pharmacologically avoided

**8. Opioid rotation is best described as what?**

A. Continuing the same regimen without changes.

B. Doubling the same opioid dose.

C. Switching to non-opioid analgesics.

D. Switching from one opioid to another to improve analgesia or reduce adverse effects when current therapy is inadequate.

**9. Which non-opioid adjuvants are commonly used for cancer pain with neuropathic components?**

A. Antidepressants (e.g., amitriptyline, duloxetine) or anticonvulsants (gabapentin, pregabalin).

B. Steroids

C. NSAIDs

D. Opioids

**10. What is a common cause of constipation in palliative care and how is it managed?**

A. Opioid-induced constipation; managed with stimulant laxatives (senna) and osmotic agents (PEG), with stool softeners as needed.

B. Diet alone and hydration

C. Regular enemas for every patient

D. Antibiotics

# Answers

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

# Explanations

**1. Which of the following is NOT a component of decision-making capacity?**

A. Understanding of information.

B. Ability to communicate a choice.

C. Mood or emotional state.

D. Appreciation of consequences for self.

*Understanding information, expressing a choice, and appreciating the consequences are the essential elements used to judge decision-making capacity. Mood or emotional state, while it can influence how someone demonstrates those abilities, is not itself a formal component of capacity assessment. For example, a person who feels depressed may still understand the information, recognize the potential outcomes, reason about options, and clearly communicate a choice, which would indicate capacity. Capacity is specific to the decision and the moment, so a person can have capacity for one decision and not for another, depending on these core abilities.*

**2. Which statement best describes the purpose of the Edmonton Symptom Assessment System (ESAS) in palliative care?**

A. To measure nutritional status in chronic illness.

B. To quantify the severity of common distressing symptoms in palliative care.

C. To assess caregiver satisfaction with care.

D. To evaluate laboratory values for symptom management.

*The main idea is that the Edmonton Symptom Assessment System is used to quantify the severity of the common distressing symptoms that patients in palliative care experience. It is a quick, patient-reported tool where individuals rate how bad each symptom is on a numerical scale, usually from 0 to 10. By capturing ratings for core symptoms like pain, fatigue, nausea, depression, anxiety, drowsiness, appetite, sense of well-being, shortness of breath, and sleep, clinicians get a snapshot of overall symptom burden at a given moment and can monitor changes over time. This focus on patient-reported symptom severity makes ESAS particularly useful for guiding treatment decisions and adjusting interventions—if scores rise, clinicians can escalate or modify therapies; if they fall, treatment can be maintained or tapered. It helps ensure care remains centered on what the patient is feeling and prioritizes quality of life. The other options don't fit because ESAS is not designed to measure nutritional status or caregiver satisfaction, and it does not evaluate laboratory values. While appetite is one of the symptoms, the system as a whole aims to quantify subjective symptom distress rather than assess nutrition or objective lab data.*

**3. A patient with terminal cancer is admitted to a family-centered hospice. The spouse visits daily and discusses wedding plans; which provisional nursing diagnosis best applies to the spouse?**

A. Ineffective coping related to lack of grieving

B. Anxiety related to complicated grieving process

C. Hopelessness related to knowledge deficit about cancer

D. Caregiver role strain related to spouse's complex care needs

*Coping with a loved one's terminal illness involves how a family member processes the loss and adjusts to impending death. When a spouse repeatedly shifts focus to wedding plans and daily life events rather than expressing or working through feeling about the illness, it signals avoidance of the grieving process. This pattern reflects ineffective coping because the person isn't engaging in adaptive emotional processing or seeking support to manage the impending loss. In hospice care, recognizing this coping pattern helps the team address emotional needs, encourage expression of grief, and connect the spouse with counseling or bereavement resources. The other possibilities don't fit as well: anxiety linked to a complicated grieving process would imply persistent, pervasive worry rather than avoidance; hopelessness tied to a knowledge deficit doesn't align with the behavior shown; caregiver role strain would center on burdens of caregiving tasks rather than emotional processing of loss.*

**4. What is the role of exercise and physical therapy in palliative care?**

A. Exercise should be avoided in all palliative care

B. Help maintain function, reduce fatigue, improve QoL, and tailor to tolerance

C. Physical therapy is only for elite athletes

D. Exercise replaces medications

*In palliative care, the aim of exercise and physical therapy is to support daily functioning and comfort by tailoring activity to what the patient can tolerate and what matters most to them. This approach helps preserve independence, reduces fatigue, and can improve quality of life by gradually improving strength, endurance, and overall energy without pushing beyond the person's limits. PT plans are individualized, starting gently and increasing only as tolerated, with careful attention to pain, breathlessness, and other symptoms, so safety and comfort come first. In practice, this means simple activities like short walks, gentle stretching, balance and breathing exercises, and gradual resistance work that fit the patient's goals and prognosis. It works alongside medications and other treatments, rather than replacing them.*

**5. You are visiting with the wife of a patient who is having difficulty making the transition to palliative care for her dying husband. What is the most desirable outcome for the couple?**

A. They express hope for a cure.

B. They comply with treatment options.

C. They set additional goals for the future.

D. They acknowledge the symptoms and prognosis.

*Acknowledging what is happening—recognizing the symptoms and the prognosis—is what helps families move forward in a meaningful way. When the wife and her husband openly acknowledge the illness burden and that the illness is advancing toward end of life, they can have honest conversations about what matters most, what quality of life looks like now, and what kind of support is needed. This awareness lays the foundation for shifting goals from curative efforts to comfort-focused care, arranging appropriate symptom control, and planning for home or hospice support in a way that fits the patient's values. It also reduces the risk of pursuing treatments that may not improve quality of life and could cause unnecessary suffering. Choosing to hold out hope for a cure can keep focus on unlikely outcomes and delay necessary transitions in care. Simply complying with treatment options without aligning them to the patient's prognosis and preferences may lead to interventions that don't fit the situation. While setting additional future goals can be constructive, it's most effective when there is clear recognition of the current prognosis to ensure those goals are realistic and patient-centered.*

**6. When discussing feeding at end of life, clinicians should consider which factors?**

A. Dietitian only opinions

B. Hospital policy only

C. Goals, values, risks/benefits, and cultural context.

D. Financial cost as the sole consideration

*The key idea is that feeding decisions at the end of life should be guided by what matters to the patient—their goals and values—while carefully weighing the potential benefits and harms and honoring their cultural and family context. This means discussing what the patient hopes feeding will achieve (comfort, dignity, quality of life, or prolongation of life), what trade-offs exist (discomfort, risk of aspiration, burden of procedures, or potential side effects), and how cultural or personal beliefs about nourishment influence preferences. Relying solely on a dietitian's opinion or hospital policy misses the patient-centered focus, and financial cost should not drive the decision in isolation. The best approach is shared decision-making that integrates goals, values, risks/benefits, and cultural context to determine what aligns with the patient's wishes.*

## 7. Which agents are commonly used for palliative sedation?

A. Midazolam alone is sufficient; no other agents used

B. Propofol and phenobarbital are never used

C. Short-acting benzodiazepines such as midazolam; sometimes propofol or phenobarbital

D. All sedation must be pharmacologically avoided

*Palliative sedation is typically started with a short-acting benzodiazepine like midazolam because it allows precise, titratable control of distress with a rapid onset and manageable duration. This makes it easier to adjust the level of sedation to relieve suffering while monitoring the patient's response and stopping if symptoms improve. Sometimes deeper or longer-lasting relief is needed, and additional agents are used. Propofol can provide deeper sedation when agitation or distress persists despite benzodiazepines, but it requires careful monitoring for breathing and blood pressure and is usually used in settings with the capability to manage airway support. Phenobarbital is another option for refractory symptoms; it is longer-acting and can help when other sedatives are insufficient, though it also carries risks of accumulation and prolonged sedation, especially in organ dysfunction. So the best approach is to start with short-acting benzodiazepines such as midazolam, with consideration of adding propofol or phenobarbital in selected cases to achieve the desired level of comfort. The other statements are not accurate because they either claim midazolam alone is always sufficient, declare that propofol and phenobarbital are never used, or suggest avoiding pharmacologic sedation entirely, which contradicts standard palliative practice.*

## 8. Opioid rotation is best described as what?

A. Continuing the same regimen without changes.

B. Doubling the same opioid dose.

C. Switching to non-opioid analgesics.

D. Switching from one opioid to another to improve analgesia or reduce adverse effects when current therapy is inadequate.

*Opioid rotation is a strategy to improve pain control or reduce adverse effects by switching from the current opioid to a different one when the present therapy isn't providing adequate relief or is poorly tolerated. The reason this works is that different opioids have distinct receptor profiles, metabolism, and active metabolites, so a patient may respond better to another opioid even if the same dose is not effective. Additionally, cross-tolerance between opioids is not complete, so a switch can restore analgesia while potentially reducing troublesome side effects. This approach usually involves careful dose conversion and gradual titration with close monitoring for withdrawal, new or persisting side effects, and overall effectiveness. It is different from simply continuing the same regimen, doubling the same opioid dose, or moving away from opioids altogether to non-opioid options; the defining feature is changing to a different opioid to optimize relief and tolerability.*

## 9. Which non-opioid adjuvants are commonly used for cancer pain with neuropathic components?

A. Antidepressants (e.g., amitriptyline, duloxetine) or anticonvulsants (gabapentin, pregabalin).

B. Steroids

C. NSAIDs

D. Opioids

*Neuropathic cancer pain is best helped by adjuvant analgesics that quiet nerve signaling. Antidepressants such as amitriptyline or duloxetine and anticonvulsants like gabapentin or pregabalin are commonly used non-opioid options because they modulate pain pathways involved in neuropathy, reducing pain and often allowing lower opioid doses. They work by changing neurotransmitter activity and neuronal excitability rather than just blocking inflammation. In practice, these drugs are started at low doses and titrated while monitoring for side effects. TCAs can cause sedation, dry mouth, constipation, and potential heart rhythm effects; duloxetine can affect blood pressure and liver enzymes; gabapentin and pregabalin can cause dizziness, sedation, and swelling, with dosing adjustments needed for kidney function. Steroids or NSAIDs may help certain cancer pain aspects (like inflammation or nerve compression) but they are not the typical first-line non-opioid adjuvants for neuropathic components, and opioids are separate analgesics rather than non-opioid adjuvants.*

## 10. What is a common cause of constipation in palliative care and how is it managed?

A. Opioid-induced constipation; managed with stimulant laxatives (senna) and osmotic agents (PEG), with stool softeners as needed.

B. Diet alone and hydration

C. Regular enemas for every patient

D. Antibiotics

*Constipation in palliative care is most commonly caused by opioid medications used for pain control. Opioids slow bowel motility and increase fluid absorption, leading to hard, infrequent stools. The best management is a proactive bowel regimen that combines a stimulant laxative (such as senna) to stimulate movement with an osmotic agent (like polyethylene glycol) to soften and help move stool. Stool softeners can be added as needed, but alone they're usually insufficient. Start the bowel regimen early when opioids are initiated and adjust as the patient's pain meds or activity changes. In addition to laxatives, ensure adequate hydration and as much physical activity as tolerated. If constipation persists despite laxatives, reassess opioid dosing and consider additional options such as peripherally acting μ-opioid receptor antagonists while maintaining analgesia. Diet and hydration alone are not enough to manage opioid-induced constipation, enemas for every patient are not standard, and antibiotics do not treat constipation.*

# 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://palliativecareendoflifecare.examzify.com

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