

SHERPATH CLINICAL JUDGEMENT 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

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1. What does the plan of care summarize?

- A. The patient's condition, goals, and planned interventions.
- B. The patient's dietary preferences and exercise routine.
- C. The hospital's daily staffing schedule.
- D. The provider's administrative tasks.

2. Which outcome is promoted by nursing documentation?

- A. Continuity of patient care
- B. Decreased communication
- C. Increased legal liability
- D. Longer hospital stay

3. Which statement about the scope of nursing practice is true?

- A. The scope of practice describes the actions a licensed nurse should be qualified and competent to perform.
- B. It describes physician duties
- C. It describes hospital administrative tasks
- D. It prescribes medications

4. Which sequence correctly describes the CJMM steps for evaluating outcomes?

- A. Examine outcome criteria; Review evaluative measures; Determine actual outcomes; Compare actual to expected; Consider degree of match; Determine next action
- B. Implement interventions; Observe outcomes; Discharge patient; Reassess later
- C. Collect data only after discharge
- D. Compare outcomes before collecting data

5. What is the cornerstone of patient safety that must be observed before procedures?

- A. Hand hygiene and standard precautions
- B. Verify patient identity
- C. Use of sterile technique for all procedures
- D. Hand hygiene and standard precautions; verify patient identity

- 6. Which sequence best represents the steps to implement quality improvement in nursing?**
- A. Review data about nursing care; Determine factors contributing to positive patient results; Make changes in nursing practice
 - B. Make changes in nursing practice; Review data about nursing care; Determine factors contributing to positive patient results
 - C. Determine factors contributing to positive patient results; Review data about nursing care; Make changes in nursing practice
 - D. Review data about nursing care; Make changes in nursing practice; Determine factors contributing to positive patient results
- 7. For a patient scheduled for knee surgery, when does the planning step of the nursing process begin?**
- A. After surgery is complete
 - B. When the patient is admitted to the hospital
 - C. Just before discharge from hospital
 - D. When the nurse contacts the patient to schedule surgery
- 8. Which laboratory value is commonly used to estimate renal function for dosing?**
- A. ALT
 - B. Creatinine or eGFR
 - C. Platelet count
 - D. Bilirubin
- 9. During CJMM evaluation, which question helps determine whether to change the plan?**
- A. Is the original priority hypothesis still the primary problem?
 - B. What is the next action the nurse should take?
 - C. Are there new diagnostic tests required?
 - D. Should documentation be updated?
- 10. Which cue would be categorized as 'important' for a patient with a femur fracture?**
- A. Temperature 102.4°F (39°C)
 - B. Headache
 - C. Itching at the site
 - D. Normal blood pressure

Answers

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

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Explanations

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1. What does the plan of care summarize?

- A. The patient's condition, goals, and planned interventions.**
- B. The patient's dietary preferences and exercise routine.
- C. The hospital's daily staffing schedule.
- D. The provider's administrative tasks.

The plan of care is the integrated roadmap for a patient's treatment. It summarizes the patient's current condition, the goals for recovery or management, and the planned interventions designed to achieve those goals. It connects the nurse's assessments with prioritized problems, specifies actions across disciplines (medications, therapies, teaching, safety measures), and sets expected outcomes with timelines so progress can be evaluated and the plan adjusted as needed. This shared document guides coordinated care, communication with the patient and family, and continuity across shifts and providers. It isn't primarily about dietary preferences or exercise routines, which relate to lifestyle, nor about administrative staffing or the clinician's clerical tasks.

2. Which outcome is promoted by nursing documentation?

- A. Continuity of patient care**
- B. Decreased communication
- C. Increased legal liability
- D. Longer hospital stay

Nursing documentation promotes continuity of patient care by creating a complete, chronological record of the patient's condition, the care provided, and the responses to that care. This record travels with the patient across shifts and settings, so every member of the team can understand what has been done, what needs to be done next, and how the patient is responding. That shared, up-to-date information supports seamless handoffs and consistent, coordinated care. Documentation also enhances communication, providing clear, objective data for all team members to reference, which reduces gaps during transitions. It does not decrease communication; it strengthens it. Thorough, accurate notes do not increase legal liability; they often protect care decisions by showing exactly what actions were taken and why. And it does not inherently lengthen hospital stays; detailed documentation supports efficient discharge planning and appropriate use of resources.

3. Which statement about the scope of nursing practice is true?

- A. The scope of practice describes the actions a licensed nurse should be qualified and competent to perform.**
- B. It describes physician duties
- C. It describes hospital administrative tasks
- D. It prescribes medications

The scope of nursing practice defines the actions a licensed nurse is qualified and competent to perform. It sets the boundaries for what nurses can do based on their education, licensure, and regulatory standards, ensuring safe and legal patient care. This concept fits the statement because it emphasizes the nurse's own responsibilities and capabilities, not the duties of physicians, administrative tasks, or activities like prescribing medications (which may be restricted to certain advanced practice roles under specific regulations). In practice, a nurse can perform assessments, implement care plans, monitor patients, and provide education within the allowed scope, while prescriptive authority is typically limited to authorized roles and governed by state laws and professional standards.

4. Which sequence correctly describes the CJMM steps for evaluating outcomes?

- A. Examine outcome criteria; Review evaluative measures; Determine actual outcomes; Compare actual to expected; Consider degree of match; Determine next action**
- B. Implement interventions; Observe outcomes; Discharge patient; Reassess later
- C. Collect data only after discharge
- D. Compare outcomes before collecting data

Evaluating outcomes in CJMM is about closing the loop on the care plan: first you clarify what success looks like and how you'll measure it, then you gather information on what actually happened, compare the actual results to the expected outcomes, interpret how closely they match, and decide what to do next. This sequence ensures you have a clear standard for success, reliable data to judge performance, and a concrete action plan based on the comparison. So this choice starts by identifying outcome criteria and evaluative measures, then determines the actual outcomes, then compares those outcomes to what was expected, assesses how well they match, and finally determines the next action. That logical flow—define criteria and measures, collect data, compare, interpret the match, and decide next steps—is what makes it the best answer. The other options miss essential parts of this evaluative loop. One option jumps to implementing interventions and discharge without first establishing what success looks like or how to measure it, which undermines evaluation. Another suggests collecting data only after discharge, which delays or prevents timely assessment. A different one proposes comparing outcomes before data collection, which is illogical because you need actual data to compare to expectations.

5. What is the cornerstone of patient safety that must be observed before procedures?

- A. Hand hygiene and standard precautions
- B. Verify patient identity
- C. Use of sterile technique for all procedures
- D. Hand hygiene and standard precautions; verify patient identity**

Before any procedure, safety hinges on both preventing infection and ensuring you're treating the correct patient. Hand hygiene and standard precautions form the foundation: clean hands before touching the patient, use the appropriate PPE, and follow safe practices for injections and equipment handling. Verifying the patient's identity is equally crucial to prevent wrong-patient or wrong-procedure errors. This is typically done using two identifiers (such as name and date of birth or medical record number) and confirming with the patient or chart. When you combine these steps, you address both infection prevention and accuracy of care, which is why this combined approach is the best choice. While sterile technique is essential for specific invasive procedures, the universal baseline before any procedure is hand hygiene and standard precautions plus patient identification.

6. Which sequence best represents the steps to implement quality improvement in nursing?

- A. Review data about nursing care; Determine factors contributing to positive patient results; Make changes in nursing practice**
- B. Make changes in nursing practice; Review data about nursing care; Determine factors contributing to positive patient results
- C. Determine factors contributing to positive patient results; Review data about nursing care; Make changes in nursing practice
- D. Review data about nursing care; Make changes in nursing practice; Determine factors contributing to positive patient results

Quality improvement in nursing is a data-driven, iterative process. You begin by reviewing data about nursing care to establish a baseline and understand what's happening. Next, you determine factors contributing to the observed patient results, using that data to identify root causes or drivers of outcomes. Finally, you implement changes in nursing practice tailored to those factors to improve care. The sequence shown—reviewing data, identifying contributing factors, then making changes—fits this approach. For example, if data reveal delays in pain assessment, you'd analyze contributing factors and then implement targeted changes such as new assessment protocols and staff education, followed by re-checking data to gauge impact.

7. For a patient scheduled for knee surgery, when does the planning step of the nursing process begin?

- A. After surgery is complete
- B. When the patient is admitted to the hospital
- C. Just before discharge from hospital
- D. When the nurse contacts the patient to schedule surgery**

Planning in the nursing process is about organizing goals and the steps needed to meet the patient's needs for upcoming care. In perioperative care, this begins as soon as care is being arranged for the procedure. When the nurse contacts the patient to schedule the knee surgery, that initiates the planning phase by laying out what must be done before, during, and after surgery—such as preoperative tests, consent, medication adjustments, education, and postoperative instructions. This early coordination helps ensure safety and continuity of care. It isn't after the surgery is completed, which would fall under evaluation and post-op care, nor is it limited to admission or discharge timing; those phases come later in the process, while the initial planning starts with scheduling and preoperative coordination.

8. Which laboratory value is commonly used to estimate renal function for dosing?

- A. ALT
- B. Creatinine or eGFR**
- C. Platelet count
- D. Bilirubin

Renal function is what guides how we dose many medications, because the kidneys are responsible for clearing a large number of drugs. Creatinine is a waste product produced by muscles and is filtered by the kidneys; measuring serum creatinine and calculating the estimated glomerular filtration rate (eGFR) give a practical picture of how well the kidneys are filtering. eGFR is especially useful because it adjusts for factors like age, sex, and body size, providing a more accurate overall sense of renal function across different patients. When kidney function is reduced, drug clearance drops and the risk of accumulation and toxicity rises, so dosing is often adjusted based on CrCl or eGFR. Other labs listed—ALT, bilirubin, and platelet count—are not measures of kidney function; ALT and bilirubin assess liver function, while platelets relate to hematologic status, not how the kidneys handle drugs.

9. During CJMM evaluation, which question helps determine whether to change the plan?

- A. Is the original priority hypothesis still the primary problem?**
- B. What is the next action the nurse should take?
- C. Are there new diagnostic tests required?
- D. Should documentation be updated?

The main idea being tested is reassessing whether the original priority problem remains the primary issue driving the plan. This question directly informs whether to keep or change the plan: if the original priority is still the main problem, the current approach stays appropriate; if it's no longer the main issue, the plan should be adjusted to address the new priority. The other options focus on what to do next, potential new tests, or updating documentation—useful steps, but they don't indicate whether the fundamental problem guiding the plan has changed.

10. Which cue would be categorized as 'important' for a patient with a femur fracture?

- A. Temperature 102.4°F (39°C)**
- B. Headache
- C. Itching at the site
- D. Normal blood pressure

In this context, focus on cues that signal a potential complication requiring action. A high fever is the most important cue to monitor for a patient with a femur fracture because it can indicate infection at the fracture site, a systemic infection, or fat embolism syndrome—conditions that demand prompt assessment and intervention. A temperature of 102.4°F is a clear red flag that warrants immediate evaluation and communication with the clinician. Headache is a nonspecific symptom that can arise from pain, dehydration, or medication effects and does not by itself point to a fracture-related complication. Itching at the fracture site is typically related to healing processes or opioid use and is not an urgent indicator of deterioration. Normal blood pressure is reassuring and does not suggest an acute complication in this immediate context.

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://sherpathclinicaljudgement.examzify.com>

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

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