

UWorld Leadership Practice Test (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. Which condition is a red flag that requires immediate attention for an LPN being assigned clients?**
 - A. Electrolyte imbalance**
 - B. 5-day post-op complications**
 - C. Recent sustained trauma**
 - D. Gout with acute symptoms**

- 2. Which client should the nurse assess first upon receiving report?**
 - A. 1-day postoperative client with lower abdominal pain and no urine output for 6 hours**
 - B. An elderly client with blood pressure 190/88 mm Hg who is asymptomatic**
 - C. Client with hepatitis C virus with 4 times the normal ALT/AST values**
 - D. Client post-thyroidectomy with a positive Troussseau's sign**

- 3. Which client should the nurse assess first after a change-of-shift report?**
 - A. Client with abdominal distension and nausea**
 - B. Client with a low-grade fever and serosanguineous drainage**
 - C. Client experiencing incisional pain**
 - D. Client with urine output of 100 mL in 8 hours**

- 4. What is the most important information missing from the nurse's SBAR communication regarding a lethargic client?**
 - A. Basic demographic information**
 - B. Current temperature and its trend**
 - C. Requesting action by the healthcare provider**
 - D. Significant past medical history**

- 5. What task can a nurse appropriately delegate to an unlicensed assistive personnel?**
 - A. Evaluating the patency of a medical device**
 - B. Providing perineal care around a catheter**
 - C. Assessing vital signs of critical patients**
 - D. Managing wound care for complex injuries**

6. When monitoring a client following a femoral-popliteal angioplasty, what should the nurse expect?

- A. Client remains free of leg pain during ambulation**
- B. Client reports intermittent leg pain**
- C. Client experiences swelling in the feet**
- D. Client has cold extremities**

7. Which client in severe pain should be evaluated first for possible infection?

- A. 10-month-old with congestion and cough**
- B. 10-year-old with an active nosebleed**
- C. 12-year-old with fever and burning during urination**
- D. 15-year-old with painful hip and limited motion**

8. What is the greatest risk factor for a spinal cord injury patient to develop autonomic dysreflexia?

- A. Above T6 injury causing bowel distension**
- B. Below T6 injury leading to pressure ulcers**
- C. Chronic urinary tract infections**
- D. Severe headaches due to medication withdrawal**

9. What vital sign change would be most critical for the nurse to assess first in a post-operative patient?

- A. Blood pressure drop**
- B. Heart rate increase**
- C. Temperature drop**
- D. Respiratory rate increase**

10. If a client on methadone wants to leave against medical advice, what should the nurse say?

- A. "You have the right to make your own decisions."**
- B. "I will talk to the healthcare provider about your concerns."**
- C. "It's vital that you stay so we can treat you quickly."**
- D. "I will arrange for your discharge right away."**

Answers

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

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Explanations

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1. Which condition is a red flag that requires immediate attention for an LPN being assigned clients?

- A. Electrolyte imbalance**
- B. 5-day post-op complications**
- C. Recent sustained trauma**
- D. Gout with acute symptoms**

The presence of recent sustained trauma is indeed a critical condition that warrants immediate attention for an LPN assigned to clients. This scenario indicates potential complications or acute health problems that could arise due to the trauma, such as internal bleeding, organ damage, or other serious injuries. Prompt assessment and intervention are necessary to address any life-threatening conditions that may result from the trauma. Furthermore, depending on the severity of the trauma, the client may require stabilization, pain management, or even urgent surgical intervention. The nursing role in this context would involve monitoring vital signs, assessing physical injury, and coordinating with other healthcare professionals to ensure the client receives the necessary care. In contrast, while electrolyte imbalance, post-operative complications, and gout with acute symptoms can also be serious and require attention, they do not typically represent an immediate threat to life or require urgent intervention in the same way that recent trauma does. Electrolyte imbalances, for example, can be managed, but they may not be as critical as a patient with a recent significant injury.

2. Which client should the nurse assess first upon receiving report?

- A. 1-day postoperative client with lower abdominal pain and no urine output for 6 hours**
- B. An elderly client with blood pressure 190/88 mm Hg who is asymptomatic**
- C. Client with hepatitis C virus with 4 times the normal ALT/AST values**
- D. Client post-thyroidectomy with a positive Troussseau's sign**

The situation involving the client post-thyroidectomy with a positive Troussseau's sign is the priority for assessment. A positive Troussseau's sign indicates latent tetany caused by hypocalcemia, which can occur after a thyroidectomy if the parathyroid glands were inadvertently damaged or removed. This condition can lead to severe complications such as muscle spasms, seizures, and cardiac issues if not promptly addressed. In a postoperative context, immediate assessment is critical, especially since hypocalcemia can manifest quickly and requires timely intervention, typically through calcium supplements or other clinical measures. This scenario emphasizes the need for vigilance in monitoring potential complications following surgery, particularly in cases involving the endocrine system, where hormone balance is crucial for the overall function of the body. The other clients, while needing assessment, do not present with issues that are as urgent. The 1-day postoperative client experiencing abdominal pain and anuria may require attention, but the absence of urine output for 6 hours does not immediately signal a life-threatening condition. The elderly client with high blood pressure is asymptomatic, indicating a stable situation that can wait for further evaluation, and the client with hepatitis C, despite having elevated liver enzymes, does not require urgent intervention. Therefore, prioritizing the client

3. Which client should the nurse assess first after a change-of-shift report?

- A. Client with abdominal distension and nausea**
- B. Client with a low-grade fever and serosanguineous drainage**
- C. Client experiencing incisional pain**
- D. Client with urine output of 100 mL in 8 hours**

The priority should be given to the client with urine output of 100 mL in 8 hours. This level of urine output indicates potential acute kidney injury or hydration issues, as a healthy adult typically produces about 30 mL of urine per hour or more. The significant reduction in urine output can suggest underlying complications such as dehydration, obstructive processes, or renal impairment, which require immediate assessment and intervention. Assessing this client first allows for timely identification of any serious complications that could arise from inadequate kidney function and helps in preventing further deterioration of the client's condition. Managing urinary output is crucial in maintaining fluid and electrolyte balance and addressing possible complications from conditions like sepsis or renal failure. In contrast, while abdominal distension and nausea, a low-grade fever with serosanguineous drainage, and incisional pain are also significant concerns, they may not signify as immediate a risk to the client's stability as the drastic decrease in urine output. Therefore, prioritizing the assessment of the client with reduced urine output ensures the most critical needs of the clients are met first.

4. What is the most important information missing from the nurse's SBAR communication regarding a lethargic client?

- A. Basic demographic information**
- B. Current temperature and its trend**
- C. Requesting action by the healthcare provider**
- D. Significant past medical history**

In SBAR communication, which stands for Situation, Background, Assessment, and Recommendation, it is crucial to convey not only the current status of the patient but also a clear request for action or intervention from the healthcare provider. The recommendation component is essential for guiding the recipient on the next steps that need to be taken. For a lethargic client, the nurse must specify what action is necessary—whether that involves immediate medical intervention, further assessment, or another specific task. This directive ensures that the healthcare provider understands the urgency of the situation and can respond appropriately, thereby facilitating timely and effective patient care. While basic demographic information, current temperature and its trend, and significant past medical history all contribute valuable context, they do not directly call for an action that is critical for addressing the patient's condition. Without a clear request for action, the SBAR communication may lack the necessary urgency needed to address a potentially serious issue, such as lethargy, which could indicate a worsening clinical condition. Thus, including a specific action request is paramount in guiding the healthcare provider to respond promptly and effectively.

5. What task can a nurse appropriately delegate to an unlicensed assistive personnel?

- A. Evaluating the patency of a medical device**
- B. Providing perineal care around a catheter**
- C. Assessing vital signs of critical patients**
- D. Managing wound care for complex injuries**

Delegating tasks to unlicensed assistive personnel (UAP) requires careful consideration of the complexity and requirements of the task being assigned. Providing perineal care around a catheter fits within the scope of practice for UAP because it is a routine and non-invasive procedure that doesn't require nursing judgment or assessment skills. This task also aligns with the UAP's role, which typically includes assisting with activities of daily living and basic personal care. Such tasks can be performed safely and effectively by UAP, allowing licensed nurses to focus on more complex duties that require clinical assessment and critical thinking. In contrast, evaluating the patency of a medical device, assessing vital signs of critical patients, and managing wound care for complex injuries all require a level of clinical judgment, knowledge, and assessment skills that UAP do not possess. These activities are integral to a nurse's responsibilities and involve significant decision-making regarding patient care that goes beyond the capabilities of unlicensed personnel.

6. When monitoring a client following a femoral-popliteal angioplasty, what should the nurse expect?

- A. Client remains free of leg pain during ambulation**
- B. Client reports intermittent leg pain**
- C. Client experiences swelling in the feet**
- D. Client has cold extremities**

When monitoring a client after a femoral-popliteal angioplasty, one key expectation is that the client remains free of leg pain during ambulation. This procedure is often performed to improve blood flow to the lower extremities, and a successful angioplasty should alleviate claudication and discomfort associated with peripheral artery disease. Following the procedure, improved circulation should lead to a reduction or elimination of pain during walking or any form of movement. Monitoring the client for the absence of pain is essential, as it indicates that the intervention was effective and that blood flow has been restored adequately. Persistent or new leg pain could suggest complications or inadequate blood supply, requiring further assessment and intervention. While leg pain is a common symptom associated with vascular insufficiency, the aim of the angioplasty is to resolve that issue, thus allowing for normal activity without discomfort. Therefore, expecting the client to remain free of leg pain is important in evaluating the success of the procedure and the effectiveness of ongoing care.

7. Which client in severe pain should be evaluated first for possible infection?

- A. 10-month-old with congestion and cough**
- B. 10-year-old with an active nosebleed**
- C. 12-year-old with fever and burning during urination**
- D. 15-year-old with painful hip and limited motion**

The client with the painful hip and limited motion should be evaluated first for possible infection because these symptoms can suggest a serious underlying condition such as septic arthritis or osteomyelitis, particularly if assessed in the context of other signs like fever or systemic illness. Infections in the bones and joints can develop rapidly and lead to significant morbidity if not treated promptly. The hip joint is particularly vulnerable in adolescents, as growth and development can create changes in bone and joint structure that make infections more likely or more severe. While other options present concerning symptoms (such as fever and burning during urination, which could indicate a urinary tract infection), the combination of hip pain and limited motion in a 15-year-old raises the suspicion of a potentially life-altering condition that necessitates immediate attention. Rapid assessment and intervention can prevent complications and promote better outcomes in suspected infections. Therefore, prioritizing the evaluation of this client aligns with the urgency of managing possible severe infections.

8. What is the greatest risk factor for a spinal cord injury patient to develop autonomic dysreflexia?

- A. Above T6 injury causing bowel distension**
- B. Below T6 injury leading to pressure ulcers**
- C. Chronic urinary tract infections**
- D. Severe headaches due to medication withdrawal**

The greatest risk factor for a spinal cord injury patient to develop autonomic dysreflexia is an injury at or above the T6 level, particularly when it leads to bowel distension. This condition arises because individuals with spinal cord injuries above this level often lose normal autonomic control below the site of injury. When a noxious stimulus, such as a full bowel, occurs, it can trigger an inappropriate sympathetic nervous system response that can result in severe hypertension and other symptoms characteristic of autonomic dysreflexia. In the context of autonomic dysreflexia, bowel distension is particularly significant as it can provoke reflexes that the body can no longer properly regulate due to the disconnect in neural communication caused by the spinal cord injury. This makes it critical for patients and caregivers to recognize the signs and address potential triggers such as bowel impaction or distension immediately to prevent the potentially life-threatening complications associated with autonomic dysreflexia.

9. What vital sign change would be most critical for the nurse to assess first in a post-operative patient?

- A. Blood pressure drop**
- B. Heart rate increase**
- C. Temperature drop**
- D. Respiratory rate increase**

In a post-operative patient, a drop in blood pressure is particularly critical to assess first because it can indicate potential complications such as hemorrhage or fluid loss, which require immediate intervention. Blood pressure is a key indicator of hemodynamic stability; a significant drop may signal inadequate perfusion of vital organs, potentially leading to shock. This drop can occur rapidly in surgical patients due to various factors such as blood loss during surgery, adverse reactions to anesthesia, or fluid shifts. Therefore, monitoring blood pressure closely is vital for identifying these critical changes early on to ensure prompt treatment and prevent further complications. While other vital signs, such as an increased heart rate, elevated respiratory rate, or changes in temperature, are important as well, they are often secondary indicators that can stem from various causes. A delayed response to a significant drop in blood pressure, however, can lead to serious and potentially life-threatening situations, making this assessment the priority in a post-operative setting.

10. If a client on methadone wants to leave against medical advice, what should the nurse say?

- A. "You have the right to make your own decisions."**
- B. "I will talk to the healthcare provider about your concerns."**
- C. "It's vital that you stay so we can treat you quickly."**
- D. "I will arrange for your discharge right away."**

In situations where a client expresses a desire to leave against medical advice, it is essential for the nurse to practice effective communication and advocacy. By stating, "I will talk to the healthcare provider about your concerns," the nurse acknowledges the client's autonomy while also prioritizing their safety and well-being. This response allows the client to feel heard and validated in their feelings, which is crucial for maintaining trust. It also opens a dialogue about potential risks associated with leaving the treatment program prematurely, especially in the context of methadone use, which requires careful management. By involving the healthcare provider, the nurse can ensure that the client receives a full explanation of their situation and any possible consequences of leaving, facilitating informed decision-making. The other responses, while relevant in different contexts, do not balance the need for client autonomy with the need for continued care as effectively. For instance, simply affirming the client's right to make decisions does not address their health needs or concerns. Emphasizing the urgency of treatment without further engagement may pressure the client and could lead to resistance. Finally, arranging for immediate discharge overlooks the responsibility to provide adequate support and information to help the client make an informed choice.

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://uworldleadership.examzify.com>

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

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