Multiple Choice Practice Questions

1) Mrs X informs the nurse that she has lost her job due to excessive absences related to her wound. (2 correct answers) The nurse should:
   a. Encourage the patient to express her feelings about the job loss
   b. Contact social services to assist the patient with accessing available resources
   c. Evaluate Mrs X’s understanding of her wound management
   d. Explain to Mrs X that she can no longer be seen at the clinic without a job

   Answer: a and b – job loss and subsequent loss of income can be an important factor in non-concordance with wound management, which can lead to delayed wound healing. Understanding how the patient feels about this is an important step in helping them manage the issues.

2) A nurse should be able to show awareness of his/her role in health promotion and supporting a healthy lifestyle. Whilst providing health education to a group of patients with cancer about management of their non-healing wounds, it is important for one to:
   a. Consider individual wound management priorities
   b. Review the patient’s treatment plan
   c. Determine the locations of the wounds
   d. Verify the types of cancer

   Answer: a – The nurse must consider what issues are important to each patient in order to improve compliance to treatment.

3) Which sign or symptom is a key indication of progressive arterial insufficiency?
   a. Oedema
   b. Hyperpigmentation of the skin
   c. Pain
   d. Cyanosis

   Answer: c – Pain is the most common presenting symptom in arterial disease with or without an ulcer.

4) External factors which increase the risk of pressure damage are:
   a. Equipment, age and pressure
   b. Moisture, pressure and diabetes
   c. Pressure, shear and friction
   d. Pressure, moisture and age

   Answer: c – pressure, shear and friction

5) Sharp debridement may cause trauma to underlying structures, the procedure should only be carried out by:
   a. A health care assistant on working full time
   b. A qualified nurse with at least 3 years experience
   c. A doctor of any type of speciality
   d. A qualified healthcare professional with appropriate training

   Answer: d – Sharp debridement carries some risk to the patient and should only be carried out by a healthcare professional with the appropriate education and training.

6) Mrs X has been ordered 100 ml to be infused over 45 minutes via a 20 drops/ml giving set. What drip rate should be set?
   a. 50 drops per minute
   b. 44 drops per minute
   c. 41 drops per minute
   d. 52 drops per minute

   Answer: b

   Volume x drop factor = drops per minute

   Time in minutes (100 ml x 20 drops) / 45 minutes = 44.44 drops per minute
7) A patient has been prescribed 1L of a saline solution. The rate is set at 150 ml/hr. How long will the infusion take?
   a. 5 hours and 20 minutes
   b. 4 hours and 40 minutes
   c. 6 hours and 10 minutes
   d. 6 hours and 36 minutes

**Answer: d**

\[ \text{Time} = \frac{\text{volume (mL)}}{\text{rate (mL/hr)}} \]

\[ \frac{1000 (mL)}{150(mL/hr)} = 6.66 \text{ hours or 6 hours and 36 minutes} \]

8) Mrs X has been admitted in the hospital due to Oedema of her thighs. One of her medications was Furosemide 40 mg tablets to be administered once daily. What should be done prior to administering Furosemide?
   a. Check patient’s blood pressure, and withhold Furosemide if it is low
   b. Check patient’s pupils, and withhold Furosemide if it is constricted
   c. Swab your patient’s wound and send the sample to pathology
   d. Assess each of your patient’s thighs by measuring its girth

**Answer: a**

Furosemide is a diuretic used to treat fluid build up among patients with Congestive Heart Failure, Liver Cirrhosis or Kidney Disease. Blood pressure needs to be assessed prior to administering Furosemide. Medication needs to be withheld if BP is low.

9) A patient who has had Parkinson’s Disease for 7 years has been experiencing aphasia. Which health professional should you make a referral to with regards to his aphasia?
   a. Occupational Therapist
   b. Community Matron
   c. Psychiatrist
   d. Speech and Language Therapist

**Answer: d**

Speech and language therapists (SLT) assess and treat speech, language and communication problems in people of all ages to help them better communicate. They also work with people who have eating and swallowing problems.

10) Margaret has been diagnosed with Hepatic Adenoma. Her results are as follows – benign tumor as shown on triphasic CT Scan and alpha feto proteins within normal range. She is asymptomatic and does not appear jaundiced, but she appears to be very anxious. As a nurse, what will you initially do?
   a. Sit down with Margaret and discuss about her fears; use therapeutic communication to alleviate anxiety
   b. Refer her to a psychiatrist for treatment
   c. Discuss invasive procedure with patient, and show her videos of the operation
   d. Take her to the surgeon’s clinic and discuss about consent for invasive procedure

**Answer: a**

Margaret needs support from the people around her, and being there for her is one way to relieve her anxiety. The nurse may also involve Margaret’s family to make decisions regarding her wellbeing.

11) Mrs X has developed Stevens-Johnson syndrome whilst on Carbamazepine. She is now being transferred from the ITU to a bay in a Medicine Ward. Which patients can Mrs X share a bay with?
   a. A patient with MRSA
   b. A patient with diarrhoea
   c. A patient with fever of unknown origin
   d. A patient with Stevens-Johnson Syndrome

**Answer: d**

Patients with SJS is likely to have severe skin integrity issues, including blistering and skin shedding, which can place the client at high risk for infection.

12) As the nurse on duty, you have noted that there has been an increasing number of cases of pressure sores in your nursing home. Which of the following is the best intervention?
   a. Collaboration with the Multidisciplinary Team
   b. Patient Advocacy

**Answer:**

As the nurse on duty, you have noted that there has been an increasing number of cases of pressure sores in your nursing home. Which of the following is the best intervention?
c. Reduce fragmentation and costs

d. Identify opportunities and develop policies to improve nursing practice

Answer: d – Quality improvement – implementation of policies and procedures to improve healthcare delivery will help in reducing the number of pressure sore cases.

13) Fiona, 70 years old, has recently been diagnosed with Type 2 Diabetes. You have devised a care plan to meet her nutritional needs. However, you have noted that she has poorly fitting dentures. Which of the following is the least likely risk to the service user?

a. Malnutrition
b. Hyperglycemia
c. Dehydration
d. Hypoglycemia

Answer: b – Hyperglycaemia is more likely to occur. Having denture problems will cause your patients to tolerate only fluids or pureed foods eaten slowly. This may also decrease the patient’s nutritional intake.

14) You are dispensing Morphine Sulphate in the treatment room, which has been witnessed by another qualified nurse. Your patient refuses the medication when offered. What will you do next?

a. Go back to the treatment room and write a line across your documentation on the CD book; sign it as refused
b. Dispose the medication using the denaturing kit, document as refused and disposed on the MARS, and write it on the nurse’s notes.
c. Dispose the medication and document it on the patient’s care plan
d. Store the medication in the CD pod for an hour, and then ask your patient again if he/she wants to take his medication

Answer: b – Refused controlled drugs should be disposed using the denaturing kit. Then this should be documented on the MARS, logbook and nurse’s notes.

15) Mr Smith has been diagnosed with Multiple Sclerosis 20 years ago. Due to impaired mobility, he has developed a Grade 4 pressure sore on his sacrum. Which health professional can provide you prescriptions for his dressing?

a. Dietician
b. Tissue Viability Nurse
c. Social Worker
d. Physiotherapist

Answer: b – The Tissue Viability Nurse specialises in chronic and complex wound management, and provides advice and support for patients with complex tissue viability needs. Medicated dressings will have to be prescribed by the TVN for a patient with Grade 4 Pressure Sore.

16) A resident is due for discharge from your nursing home. You have been his keyworker for the last five years, and his family has been appreciative of the care you have provided. One of the relatives has offered you cash in an envelope after saying goodbye. What should you do?

a. Say thank you, but refuse the offer politely.
b. Say thank you and accept the offer.
c. Accept the offer, and share it to your colleagues.
d. Accept the offer and keep it to yourself.

Answer: a

17) One of your residents has been transferred from the hospital to your nursing home after having been admitted for a week due to a chest infection. On transfer, you have noted that he had several dressings on his thighs, which he has not had before. What should you do?

a. If the dressings are intact, document it on the nursing notes and indicate that the dressings need to be changed after 48 hours.
b. Change the dressings if they look soiled and document this on the wound assessment form.
c. Remove the dressings whether they are intact or not, assess the wounds, document this on the wound assessment form and redress the wounds.
d. All of the above.

Answer: c – On admission or transfer, the nurse should carry out the necessary assessment of the service user’s skin integrity. One should check the wound bed tissue by removing the dressing and keeping records of the assessment made. A wound photograph needs to be attached with the skin inspection record.
18) You have answered a phone call after receiving handover. The person you were talking to has explained that he needs to find out about his sister's condition. What should you initially do?
   a. Discuss about his sister's condition and provide treatment options such as access to other resources in the community.
   b. Check the patient's record and verify the caller's identity.
   c. Refuse to divulge any information to the caller.
   d. Discuss about his sister's condition and book an appointment for him to attend care plan reviews.

Answer: b – One needs to verify the caller’s identity and check it on the patient’s record.

NMC Code of Conduct – Confidentiality.

19) A carer has reported that she has seen a resident fall off his bed. What initial assessment should be done?
   a. Check the patient’s Early Warning Score along with the Glasgow Coma Scale immediately.
   b. Ask the patient if he is in pain; if so, administer painkillers immediately.
   c. Dial 999 and request for an ambulance to take your patient to the hospital.
   d. Contact the out-of-hours GP and request for a home visit.

Answer: a – The Early Warning Score and Glasgow Coma Scale are used in acute healthcare settings and have been proven to be effective in the early detection of physical deterioration.

20) During your medical rounds, you have noted that Mrs X was upset. She has verbalised that she misses her family very much, and that no one has been to visit lately. What would likely be your initial intervention?
   a. Contact Mrs X’s family and encourage them to visit her during the weekend.
   b. Sit next to Mrs X and listen attentively. Allow her to talk about things that cause her anxiety.
   c. Collaborate with the GP for a care plan review and request for antidepressants to be prescribed.
   d. All of the above.

Answer - c – Risk assessments for pressure sores should take place within 6 hours at the start of admission. This should be done by somebody who has undergone appropriate and adequate training to recognise the risk factors contributing to pressure sores. If considered not at risk on initial assessment, reassessments should be done if there is a change on the individual’s condition. (RCN, 2001).

21) After having done your medication rounds, you have realised that your patient has experienced the adverse effect of the drug. What will be your initial intervention?
   a. You must do the physical observations and notify the General Practitioner.
   b. You must ring the General Practitioner and request for a home visit.
   c. You must administer medication from the Homely Remedy Pod after having spoken to the General Practitioner.
   d. You must observe your patient until the General Practitioner arrives at your nursing home.

Answer - a – Standard 25-NMC Medicines Management – As a registrant, if a patient experiences an adverse drug reaction to a medication, you must take any action to remedy harm caused by the reaction. You must record this in the patient’s notes, notify the prescriber and notify via the Yellow Card Scheme immediately.

22) On admission of a service user, you have done an informal risk assessment for pressure sores, and you have noted that the patient is currently not at risk. What will be your next step?
   a. Include the Repositioning Chart on your patient’s daily notes, and instruct your carers/HCA’s to turn your patient every two hours.
   b. Alert the General Practitioner about your patient’s condition.
   c. Reassess your patient on a regular basis and document your observations.
   d. Modify your patient’s diet to maintain intact skin integrity.

Answer - c – Risk assessments for pressure sores should take place within 6 hours at the start of admission. This should be done by somebody who has undergone appropriate and adequate training to recognise the risk factors contributing to pressure sores. If considered not at risk on initial assessment, reassessments should be done if there is a change on the individual’s condition. (RCN, 2001).
23) You were on the phone with a family member, and one of the carers has reported that one of your residents has stopped breathing and turned blue. What should you do first?

a. End your conversation with the family member, attend to your patient and do the CPR.

b. End your conversation with the family member, go to your patient’s bedroom and assess for airway, breathing and circulation.

c. End your conversation with the family member, and dial 999 to request for an ambulance.

d. Dial 111, and request for an urgent visit from the General Practitioner.

Answer: b – Basic Life Support – Initial assessment should be done prior to doing the Cardiopulmonary Resuscitation. One should check for Airway, Breathing and Circulation.

24) Mr Smith has just been certified dead by the General Practitioner. However, no arrangements have been made by the family. What should you do first?

a. Check patient’s records for the next of kin details, and contact them to discuss about funeral services.

b. Ring the co-operative and arrange for the undertaker to pick up Mr Smith as soon as possible.

c. Contact the GP and discuss about how to deal with Mr Smith.

d. Contact your manager and enquire about dealing with Mr Smith.

Answer – a – One should verify the next of kin’s details on the patient’s records, and contact them to discuss about the funeral services. Some family members have the power of attorney to make decisions in behalf of the patient. Sometimes the patient makes a request to donate his/her organs for study/research. In this case, documentation should be available in patient’s records.

25) Mr Marriott, 21 years old, has been complaining of foul smelling urine, pain on urination and night sweats. What further assessment should be done to check if he has Urinary Tract Infection?

a. Assess his blood pressure.

b. Take a urine sample and send it to the lab.

c. Do the buccal swab and send the specimen to the lab.

d. Check his prothrombin time and signs of bleeding.

Answer – b – Urinalysis for patients with UTI usually indicates blood in the urine. The presence of bacteria in the urine can indicate a bacterial infection of the urinary tract. Increased WBC count indicates inflammation.

26) A patient with a nutritional deficit and a MUST Score of 2 and above is of high risk. What should be done?

a. Refer the patient to the dietician, the Nutritional Support Team and implement local policy.

b. Observe and document dietary intake for three days.

c. Repeat screening weekly or monthly depending on the patient’s food intake during the last 72 hours.

d. All of the above.

Answer – a – MUST Management Guidelines; Nutrionally high risk patients need to be treated as soon as possible. They will need referral to a dietician or the Nutritional Support Team. Goals need to be set and overall nutritional intake has to be increased. Care plans also need to be monitored and reviewed regularly.

27) According to the National Institute for Health and Care Excellence (NICE) Guidelines, examples of the Personal Protective Equipment are:

a. Tunic top, vascular access devices, surgical scissors

b. Gloves, aprons, face mask and goggles

c. Gloves, cannula, aprons and syringes

d. All of the above

e. None of the above

Answer – b – Personal Protective Equipment are equipment that are intended to be worn or held by a person to protect them from risks to health and safety while at work. Examples are gloves, aprons, and eye and face protection.

28) Based on the National Institute for Health and Care Excellence (NICE) Guidelines, which of the following is incorrect about sharps container?

a. It must be located in a safe position and height to avoid spillage.
b. It should be temporarily closed when not in use.
c. It must not be filled above the fill line.
d. It must not be filled below the fill line.

Answer – c – The sharps container must not be filled above the fill line to avoid the overflow and spillage of sharps in a clinical setting/treatment room.

29) How do you prevent the spread on infection when nursing a patient with long term urinary catheters?

a. Patients and carers should be educated about and trained in techniques of hand decontamination, insertion of intermittent catheters where applicable, and catheter management before discharge from hospital.
b. Urinary drainage bags should be positioned below the level of the bladder, and should not be in contact with the floor.
c. Bladder instillations or washouts must not be used to prevent catheter-associated infections.
d. All of the above.

Answer – d – All of the above. Healthcare professionals need to be educated with regards to preventing the spread of infection among patients on long term urinary catheter. Aseptic technique should be practiced at all times. Gloves should be worn when emptying urine bags and taking samples from the sampling port.

30) Mrs Hannigan has been assessed to be on nutritional deficit with a MUST Score of 1, which means that she is on medium risk. One of your interventions is to modify her diet for her to meet her nutritional needs. What should you consider?

a. Mrs Hannigan’s meal preferences.
b. Mrs Hannigan’s intake and output records.
c. Mrs Hannigan’s x-ray results.
d. A and B
e. B and C

Answer – d – One should practice according to the service user’s best interest. Mrs Hannigan needs to be asked of her meal preferences before modifying her diet, as healthy options will be available to meet her preferences. Dietary intake needs to be documented for 3 days, and screening needs to be repeated in regular intervals.

31) In a nursing and residential home setting, how will you manage your time and prioritise patients’ needs whilst doing your medication rounds in the morning?

a. Start administering medications from the patient nearest to the treatment room.
b. Start administering medications to patients who are in the dining room, as this is where most of them are for breakfast.
c. Check the list of patients and identify the ones who have Diabetes Mellitus and Parkinson’s disease.
d. All of the above.

Answer – c – Patient’s needs have to be prioritised whilst doing medication rounds. In this case, one should check the BMs of the ones who are diabetic prior to administering insulin. Patients with Parkinson’s disease should take their medications on time to promote consistent therapeutic blood levels and prevent disabling symptoms.

32) Your patient has been recently prescribed with PEG feeding with a resting period of 4 hours. After two weeks of starting the routine, he has been having episodes of loose stool. What could be done?

a. Refer him to a dietician and review for a longer resting period between feeds.
b. Refer him to the tissue viability nurse for his peg site.
c. Examine his abdomen and assess for lumps.
d. Examine his peg site, and apply metronidazole ointment if swollen.

Answer – c – Continuous feeding needs a break of at least 4 hours in a 24 hour-period. This will allow the stomach to re-acidify. Low stomach acid can cause diarrhoea.

33) It is important to read the label on every IV bag because:

a. Different IV solutions are packaged similarly
b. The label contains the expiration date of the IV fluid
c. A and B
d. A only
Answer – c – IV labels need to be checked in accordance to the NMC Safe Drug Administration Guidelines.

34) You have noticed that the management wants all residents to be up and about by 8:30 am, so they can be ready for breakfast. Mrs X has refused to get up at 8 am, and she wants to have a bit of a lie in, but one of the carers insisted to wash and dress her, and took her to the dining room. What type of abuse in in place?

a. Financial Abuse
b. Psychological Abuse
c. Sexual Abuse
d. Institutional Abuse

Answer – d – Institutional Abuse - the mistreatment of people brought about by poor or inadequate care or support, or systematic poor practice that affects the whole care setting. It occurs when the individual’s wishes and needs are sacrificed for the smooth running of a group, service or organisation.

35) You are preparing a client with Acquired Immunodeficiency Syndrome (AIDS) for discharge to home. Which of the following instructions should the nurse include?

a. Avoid sharing things such as razors and toothbrushes.
b. Do not share eating utensils with family members.
c. Limit the time you spend in public places.
d. Avoid eating food from serving dishes shared with others.

Answer: a – The Human Immunodeficiency Virus (HIV), which causes AIDS, is concentrated mostly in blood and semen. The client should not share articles that may be contaminated with blood, such as razors and toothbrushes.

36) You are preparing to administer a Tuberculin (Mantoux) Skin Test to a client suspected of having tuberculosis (TB). The nurse knows that the test will reveal which of the following?

a. How long the client has been infected with TB
b. Active TB Infection
c. Latent TB Infection
d. Whether the client has been infected with TB bacteria

Answer: d – A Tuberculin Skin Test is performed to determine if a person has ever had TB.

37) You have discovered that the last dose of intravenous antibiotic administered to service user was the wrong dose. Which of the following should you do?

a. Document the event in the service user’s medical record only.
b. File an incident report, and document the event in the service user’s medical record.
c. Document in the service user’s medical record that an incident report was filed.
d. File an incident report, but don’t document the event on the service user’s record, because information about the incident is protected.

Answer: b – The event should be recorded using an incident report, and written on the service user’s nursing notes.

38) There has been a bomb threat at the medical centre. The emergency response team informs the staff that the threat is legitimate and that service users should start being evacuated. Which of the following should you do?

a. Ambulatory Patients
b. Bedridden Patients
c. ITU Patients
d. Infants

Answer: a – Ambulatory patients have the potential to wander and end up in an unsafe place if not directed correctly.

39) A patient with a Bipolar Disorder makes a sexually inappropriate comment to the nurse. One should take which of the following actions?

a. Ignore the comment because the client has a mental health disorder and cannot help it.
b. Report the comment to the nurse manager.
c. Ignore the comment, but tell the incoming nurse to be aware of the client’s propensity to make inappropriate comments.
d. Tell the client that it is inappropriate for clients to speak to any nurse that way.

Answer: d – The nurse should notify the client that this is inappropriate behaviour and set up appropriate boundaries.

40) You are nursing an adult patient with a long-bone fracture. You encourage your patient to move fingers and toes hourly, to change positions slightly every hour, and to eat high-iron foods as part of a balanced diet. Which of the following foods or beverages should you advise the client to avoid whilst on bed rest?

a. Fruit juices
b. Large amounts of milk or milk products
c. Cranberry juice cocktail
d. No need to avoid any foods while on bed rest

Answer: b - Too much milk increases the demand on the kidneys to excrete calcium and can lead to kidney stones.

41) The nurse is preparing to make rounds. Which client should be seen first?

a. 1 year old with hand and foot syndrome
b. 69 year old with congestive heart failure
c. 40 year old resolving pancreatitis
d. 56 year old with Cushing's disease

**CHF patient? – read about cashings, and hand and foot syndrome**

42) The nurse sat an older man on the toilet in a six-bed hospital bay. Using her judgement, she recognised that he was at risk of falling and so left the toilet door ajar. In the meantime, the nurse went to make his bed on the other side of the bay. On turning around, she noticed that the patient had fallen onto the toilet floor. What should be her initial intervention?

a. Immobilise the patient and conduct a thorough assessment, checking for injuries
b. Call for help immediately
c. Press the emergency call button immediately
d. Check the patient for injuries and transfer him to the wheelchair

Answer: a – It is of importance and highest priority to assess the patient first before calling for help. Patient should be immobilised to prevent further injuries.

43) A patient with Leukaemia was about to receive a transfusion of blood platelets. The experiences nurse on duty in the ward noticed small clumps visible in the platelet pack and questions whether the transfusion should proceed. What should the nurse do?

a. Proceed with platelet transfusion and monitor for signs of rejection
b. Withhold platelet transfusion and document it on the patient’s chart
c. Ring the blood bank and enquire about the platelet pack received
d. All of the above

Answer: C – Supplier of blood/platelets need to be informed about the changes noted, or anything that is unusual. Platelet pack may be contaminated by microorganisms such as E Coli, which may lead to death.

44) You are about to administer Morphine Sulfate to a paediatric patient. The information written on the controlled drug book was not clearly written – 15 mg or 0.15 mg. What will you do first?

a. Not administer the drug, and wait for the General Practitioner to do his rounds
b. Administer 0.15 mg, because 15 mg is quite a big dose for a paediatric patient
c. Double check the medication label and the information on the controlled drug book; ring the chemist to verify the dosage
d. Ask a senior staff to read the medication label with you

Answer: C – NMC Safe Medicines Management; If you are not sure about the dose for the medication to administer, it is advised that you should have the dosage verified both on records and by the chemist.
45.) Mr Smith is 89 years old with Prostate Cancer. He was advised that the only treatment available for him was palliative care after Transurethral Resection of the Prostate. What is your main task as a coordinator of care in the multidisciplinary team?

a.) One should be able to organise the services identified in the care plan and across other agencies.
b.) Assess the patient for respiratory complications caused by gas exchange alterations due to old age.
c.) Sit down with the patient and ask for the frequency of his bowel elimination
d.) Document the patient’s capability of self-care activities and the support he needs to carry out activities of daily living.

Answer: A – One should collaborate effectively with the multidisciplinary team by organising how the patient’s needs can be met. One way is to liaise with McMillan Nurses and the Palliative Care Team to achieve the aims and goals of care.

46.) A diabetic patient with suspected Liver Tumor has been prescribed with Triphasic CT Scan. Which medication needs to be on hold after the scan?

a.) Furosemide
b.) Metformin
c.) Docusate Sodium
d.) Paracetamol

Answer: B – Metformin should be on hold after the triphasic ct scan due to the fact that the contrast media used for the triphasic ct scan will react to metformin causing lactic acidosis with signs and symptoms of muscle pain or weakness, numbness of limbs, breathing problems, nausea and vomiting, slow heart rate and dizziness.

47.) Which of the following statements is true?

a.) Someone is only an abuser if they deliberately intend to cause harm.
b.) Abuse only happens to children.
c.) Only people over 70 can be vulnerable.
d.) Abuse can occur unintentionally without the person meaning to cause harm.

Answer: C – Abuse can be due to poor practice. It might be – the person does not know how to deal with the situation, has not been trained, or thinks he/she is doing the best thing for the patient.

48.) Which of the following statements is false?

a.) Abuse mostly happens in nursing and residential homes.
b.) Abuse can take place anywhere there is a vulnerable adult.
c.) Abuse can take place in a day care centre.
d.) Abuse can be carried out by anyone – doctors, nurses, carers and even family members.

Answer: B – Abuse can take place anywhere there is a vulnerable adult. Any person over the age of 18 who is unable to look after oneself or is at a high risk of harm, with a disability whether mental or physical are more vulnerable to being harmed than other adults.

49.) During the day, Mrs X was sat on a chair and has a table put in front of her to stop her getting up and walking about. What type of abuse is this?

a.) Physical Abuse
b.) Psychological Abuse
c.) Emotional Abuse
d.) Discriminatory Abuse

Answer: A – This can include hitting, pushing, pulling hair, rough handling, misuse of medication, or inappropriate use of restraint.

50.) Michael feels very uncomfortable when the carer visiting him always gives him a kiss and holds him tightly when he arrives and leaves his home. What type of abuse is this?

a.) Emotional Abuse
b.) Psychological Abuse
c.) Discriminatory Abuse
d.) Sexual Abuse
Answer: D - Sexual abuse can include rape, sexual assault, being forced to look at sexual images or any sexual activity that is not freely consensual.

51.) Anna has been told that unless she does what the ward staff tell her, the consultant will stop her family from visiting. What type of abuse is this?
   a.) Psychological Abuse
   b.) Discriminatory Abuse
   c.) Institutional Abuse
   d.) Neglect
   Answer: A - Psychological Abuse can include name calling, bullying, treating someone like a child, being shouted at, verbal abuse, threats, intimidation and coercion.

52.) Christine cannot get herself a drink because of her disability. Her carers only give her drinks three times a day so she does not wet herself. What type of abuse is this?
   a.) Physical Abuse
   b.) Institutional Abuse
   c.) Neglect
   d.) Sexual Abuse
   Answer: C - Neglect can include ignoring medical needs, not providing personal care or withholding necessities such as food, drink, medication or heating.

53.) Gabriella is a 26 year old woman with severe learning disabilities. She is usually happy and outgoing. Her mobility is good, her speech is limited but she is able to be involved if carers take time to use simple language. She lives with her mother, and is being assisted with personal care. Her home care worker has noticed bruising on upper insides of her thighs and arms. The genital area was red and sore. She told the care worker that a male care worker is her friend and he has been cuddling her but she does not like the cuddling because it hurts. What could possibly be the type of abuse Gabriella is experiencing?
   a.) Discriminatory Abuse
   b.) Financial Abuse
   c.) Sexual Abuse
   d.) Institutional Abuse
   Answer: C - Sexual abuse can include rape, sexual assault, being forced to look at sexual images or any sexual activity that is not freely consensual.

54.) An 82 year old lady was admitted to the hospital for assessment of her respiratory problems. She has been a long term smoker in spite of her daughter advising her to stop. Based on your assessment, she has lost a substantial amount of weight. How will you assess her nutritional status?
   a.) Check her height and weight, so you can determine her BMI, BMI Score and Nutritional Care Plan
   b.) Use the respiratory and perfusion assessment chart on admission
   c.) Check if she is struggling to chew and swallow, and make a referral to the Speech and Language Therapist
   d.) All of the above
   Answer: A - To assess your patient’s nutritional status, you will need her height, weight, BMI scores. This will help you plan your patient’s nutritional care plan throughout admission and discharge.

55.) John, 26 years old, was admitted to the hospital due to multiple gunshot wounds on his abdomen. On nutritional assessment in the ICU, the patient’s height and weight were estimated to be 1.75 m and 75 kg, respectively, with a normal body mass index (BMI) of 24.5 kg/m2. He was started on Parenteral Nutrition support on day one post admission. Postoperatively, the patient developed worsening renal function and required dialysis. In critical care, what would be most likely recommended for him to meet his nutritional need?
   a.) Starting Parenteral Nutrition early in patients who are unlikely to tolerate enteral intake within the next three days
   b.) Starting with a slightly lower than required energy intake (25 kCal/kg)
   c.) A range of protein requirements (1.3-1.5 g/kg)
   d.) All of the above
   e.) None of the above
   Answer: D - All of the above are recommended to meet the nutritional needs of the ICU patient as discussed.

56.) You are currently working in a nursing home. One of the service users is struggling to swallow or chew his food. To whom do you make a referral to?
   a.) Tissue Viability Nurse
b.) Social Worker

c.) Speech and Language Therapist

d.) Care Manager

Answer: C – Speech and Language Therapists (SALT) assess and treat speech, language and communication problems in people of all ages to help them better communicate. They’ll also work with people who have eating and swallowing problems.

57.) What are the six physiological parameters incorporated into the National Early Warning Scores?

a.) Respiratory rate, oxygen saturation, temperature, systolic blood pressure, pulse rate and level of consciousness

b.) Biomarkers, oxygen saturation, temperature, systolic blood pressure, pulse rate and level of consciousness

c.) Oxygen saturation, temperature, systolic blood pressure, pulse rate, level of consciousness and oedema

d.) Temperature, systolic blood pressure, pulse rate, level of consciousness, oedema and pupillary reaction

e.) all of the above

Answer: A - Respiratory rate, oxygen saturation, temperature, systolic blood pressure, pulse rate and level of consciousness; these are all readily measures in patients, either in the prehospital or hospital setting and can be repeatedly measured to document trends and assess changes in illness severity.

58.) Mr C’s mother was admitted to hospital following a fall at home and it was clearly documented that his mother suffered from diabetes. Mr C contacted the Trust concerning the Trust’s failure to make adequate discharge arrangements for his mother including the necessary arrangements to ensure that his mother would be provided with insulin following her discharge. What needs to be implemented to avoid such concern/complaint in the future?

a.) Diabetic Liaison Nurse to work with service users in the community

b.) On-line training for blood glucose monitoring introduced within the Trust

c.) Diabetics to have their blood sugar recorded within four hours prior to discharge

d.) A and C only

e.) all of the above

Answer: E – A single set of criteria will not identify all anaphylactic reactions. There is a range of signs and symptoms, none of which are entirely specific for anaphylactic reactions. However, certain combinations of signs make the diagnosis of an anaphylactic reaction more likely.

59.) Which of the following is not a criteria for anaphylactic reaction:

a.) sudden onset and rapid progression of symptoms

b.) life-threatening airway and/or breathing and/or circulation problems

c.) skin and/or mucosal changes (flushing, urticarial and angioedema)

d.) skin and mucosal changes only

e.) A and B only

f.) all of the above

e.) A, B and C

Answer: E – A single set of criteria will not identify all anaphylactic reactions. There is a range of signs and symptoms, none of which are entirely specific for anaphylactic reactions. However, certain combinations of signs make the diagnosis of an anaphylactic reaction more likely.

60.) Mrs X was taken to the Accident and Emergency Unit due to anaphylactic shock. The treatment for Mrs X will depend on the following except:

a.) Location

b.) Number of Responders

c.) Equipment and Drugs available

d.) Triage system in the A&E

Answer: D – The specific treatment of an anaphylactic reaction depends on location, training and skills of rescuers, number of responders, and equipment and drugs available.

61.) Mark, 48 years old, has been exhibiting signs and symptoms of anaphylactic reaction. You want to make sure that he is in a comfortable position. Which of the following should you consider?

a.) Mark should be sat up if he is experiencing airway and breathing problems.

b.) Mark should be lying on his back if he is assessed to be breathing and unconscious.

c.) Mark should be sat up if his blood pressure is too low.

d.) A and B only

e.) all of the above
d.) Mark should be encouraged to stand up if he feels faint.

Answer: A – All patients should be placed in a comfortable position. The following factors should be considered:

Patients with airway or breathing problems may prefer to sit up as this will make breathing easier.

Lying flat with or without leg elevation is helpful for patients with low blood pressure. If the patient feels faint, do not sit or stand them up – may cause cardiac arrest.

Patients who are breathing and unconscious should be placed on their side (recovery position).

Pregnant patients should lie on their left side to prevent caval compression.

62.) The following are ways to remove factors that trigger anaphylactic reaction except for one.

a.) It is not recommended to make the patient should not be forced to vomit after food-induced anaphylaxis.

b.) Definitive treatment should not be delayed if removing a trigger is not feasible.

c.) Any drug suspected of causing an anaphylactic reaction should be stopped.

d.) After a bee sting, do not touch the stinger for about a maximum of 3 hours.

Answer: D – Removing the trigger for an anaphylactic reaction is not always possible. Any intravenous transfusion or antibiotic causing anaphylaxis should be discontinued. Stinger should be removed immediately after a bee sting.

63.) Mrs Smith has been assessed to have a cardiac arrest after anaphylactic reaction to a medication. Cardiopulmonary Resuscitation (CPR) was started immediately. According to the Resuscitation Council UK, which of the following statements is true?

a.) Intramuscular route administration of adrenaline is always recommended during cardiac arrest after anaphylactic reaction.

b.) Intramuscular route for adrenaline is not recommended during cardiac arrest after anaphylactic reaction.

c.) Adrenaline can be administered intradermally during cardiac arrest after anaphylactic reaction.

d.) None of the Above

Answer: B – Resuscitation Council (UK) recommends adrenaline not to be administered intramuscularly when on cardiac arrest after anaphylactic reaction.

64.) Julie, 50 years old, was admitted to the hospital with gastrointestinal bleed presumed to be oesophageal varices. It has been recommended that she needs to be transfused with blood; however, due to her religious and personal beliefs, she needed volume expanding agents. Unfortunately, she died a few hours after admission. Before dying, she said that it was God’s will, which she believed was right. Which of the following statements is false?

a.) Health professionals should be aware of imposing one’s world view upon others and strive to be more receptive and sensitive to the needs of others.

b.) Individual choice, consent and the right to refuse treatment is important.

c.) It is important for all health professionals to do any means to keep a patient alive regardless of traditions and beliefs.

d.) None of the Above

Answer: C – This case study raises some important issues about the relationship between personal beliefs and professional practice. We should be aware of imposing our views upon others and strive to be more sensitive of their needs. Patients have the right to refuse treatment and inform health professionals involved of their preferences in care.

65.) Pauleena, 57 years old, suffered from a very dense left sided Cerebrovascular Accident / Stroke. She was unconscious and unresponsive for several days with IV fluids for hydration. Since her recovery from stroke, she has been prescribed to commence enteral feeding through a fine bore nasogastric tube, in which she signed her consent in front of her who have always been supportive of her decisions. However, she tends to pull out her NGT when she is by herself in her room. She died of malnutrition after a few days. Which of the following statements is true?

a.) Nurses should have the empathy to listen to more than just the spoken word.

b.) Nurses should practice in accordance to Pauleena’s best interest while providing support to the family and listening to their concerns and wishes.

c.) Pauleena needs to be supported with questions related to mortality and meaning of life. Therapeutic communication is also essential.

d.) All of the above

Answer: D – all of the above

66.) An adult patient with Nasogastric Tube died in a medical ward due to aspiration of fluids. Staff nurse on duty believes that she has flushed the tube and believed it is patent. What should NOT have been done?
a.) Nothing should be introduced down the tube before gastric placement is confirmed.

b.) Internal guidewires should not be lubricated before gastric placement is confirmed.

c.) Auscultate the patient’s stomach as you push some air in, and if you cannot hear anything, flush it.

d.) It is important to check the position of the tube by measuring the pH value of stomach contents.

Answer: C – Bowel sounds and pH of contents need to be checked to confirm if the tube is in place. Otherwise, this may lead to harmful flushing of the NGT.

67.) The following are ways to assess a patient’s fluid and electrolyte status except:

a.) pulse, blood pressure, capillary refill and jugular venous pressure

b.) presence of pulmonary or peripheral oedema

c.) presence of postural hypertension

d.) biomarkers

Answers: D – Biomarkers are used to assess the severity of a disease entity.

68.) Mrs X is 89 years old and very frail. She has renal impairment and history of myocardial infarction. She needs support from staff to meet her nutritional needs. Which IV fluids are recommended for Mrs X?

a.) consider prescribing less fluid

b.) consider prescribing more fluid

c.) either of the above

d.) none of the above

Answer: A – Less fluids are prescribed to patients who are older/frail, have renal impairment or cardiac failure, are malnourished and at risk of refeeding syndrome.

69.) Population groups at higher risk of having a low vitamin D status include the following except:

a.) People who have darker skin

b.) People who have high exposure to the sun

c.) People who have low exposure with the sun

d.) People who cover their skin for cultural reasons

Answer: B – Population groups at higher risk of having a low vitamin D status include:

All pregnant and breastfeeding women, particularly teenagers and young women

Infants and children under 5 years

People over 65 years old

People who have low exposure to the sun.

People with darker skin

70.) Which of the following is considered a medication?

a.) whole blood

b.) albumin

c.) blood clotting factors

d.) antibodies

Answer: Blood is not classified as a medicinal product although some blood components are. Products derived from the plasma component of blood such as blood clotting factors, antibodies and albumin are licensed and classified as considered to be medicinal products.

71.) You were running a shift and a pack of controlled drugs were delivered by the chemist/pharmacist whilst you were giving the morning medications. What would you do first?

a.) keep the controlled drugs in the trolley first, then store it after you have done morning drugs

b.) Count the controlled drugs, store them in controlled drug cabinet and record them on the controlled drug book
c.) Count the controlled drugs, store them in the medication trolley and record them on the controlled drug book

d.) Record them in the controlled drug book and delegate one of the carers to store them in the controlled drug cabinet

Answer: B – On receipt of controlled drugs from the pharmacy, one should count the stocks received with a witness, store them in the controlled drug cabinet, then record it on the controlled drug book and Medication Administration Record Sheet.

72.) One of the following is not true about a delegation responsibility of a medication registrant:

a.) Nurses are accountable to ensure that the patient, carer or care assistant is competent to carry out the task.

b.) Nurses can delegate medication administration to student nurses / nurses on supervision.

c.) Nurses can delegate medication administration to unregistered practitioners to assist in ingestion or application of the medicinal product.

d.) All of the above

Answer: B – Student nurses are not considered as registrants until they receive their NMC pins. They should be under the direct supervision of a sign off mentor. Qualified nurses are allowed to delegate to someone who has been trained to do medications, such as senior carers and support workers.

73.) General guidance for the storage of controlled drugs should include the following except:

a.) cupboards must be kept locked when not in use

b.) keys must only be available to authorised member of staff

c.) regular drugs can also be stored in the controlled drug storage

d.) the cupboard must be dedicated to the storage of controlled drugs

Answer: General guidance for the storage of controlled drugs should include the following:

Cupboards must be kept locked when not in use

The lock must not be common to any other lock in the hospital

Keys must only be available to authorised members of staff

The cupboard must be dedicated to the storage of controlled drugs. No other medicines or items may be stored in the controlled drug cupboard. Controlled drugs must be locked away when not in use.

74.) You were on a night shift in a ward and has been allocated to dispose controlled medications. Which of the following is correct?

a.) Controlled drugs destruction and pharmacy stock check should be done at different times.

b.) Controlled drugs should be destroyed with the use of the Denaturing Kit.

c.) Excessive quantities of controlled drugs can be stored in the cupboard whilst awaiting for destruction.

d.) None of the Above

Answer: B – Controlled drugs disposal and destruction

Destruction on ward may take place at the same time as a pharmacy stock check.

CDs should be destroyed in such a way that the drug is denatured or destroyed so that it cannot be retrieved, reconstituted or used.

Destruction must occur in a timely fashion, so that excessive quantities are not stored awaiting destruction.

All destruction must be documented in the appropriate section of the register, it must be witnessed by a second competent professional.

75.) You were assigned to change the dressing of a patient with diabetic foot ulcer. You were not sure if the wound has sloughy tissues or pus. How will you carry out your assessment?

a.) Sloughy tissue is a mass of dead tissues in your wound bed, while pus is a thick yellowish/greenish opaque liquid produced in an infected wound.

b.) Sloughy tissues are exactly the same as pus, and they both have a yellowish tinge.

c.) Sloughy tissues and pus are similar to each other; both are found on the wound bed tissue and indicative of a dying tissue.

d.) The presence of sloughy tissues and pus are an indication of non-surgical debridement.

e.) All of the above
f.) None of the above

*Answer: a*

76.) Annie, one of the residents in the nursing home, has not yet had her mental capacity assessment done. She has been making decisions that you personally think are not beneficial for her. Which of the following should not be implemented?

a.) Force her to change her mind every time she makes a decision
b.) Explain the benefits of making the right decision
c.) Allow her to make her own decision, as she still has mental capacity
d.) All of the above

*Answer: a – A person who has not yet been assessed as unable to make decisions is still considered to have his or her mental capacity. Hence, Annie’s decision should be respected, and she should be allowed to make decisions for herself. Staff’s preconceptions and prejudices should be set aside, so this will not affect the care delivered.*

77.) A complaint has been raised by one of the service user’s relatives. Which of the following should you not document?

a.) the person’s name
b.) the date and time of complaint made
c.) the complaint itself
d.) the person’s country of origin

*Answer: d*

78.) Which of the following sets of needs should be included in your service user’s person centred care plan?

a.) social, spiritual and academic needs
b.) medical, psychological and financial needs
c.) physical, medical, social, psychological and spiritual needs
d.) a and b only
e.) all of the above

*Answer: c*

79.) Which of the following is an open ended question?

a.) Do you enjoy the activities in this care home?
b.) Do you like the food in the ward?
c.) Would you like me to take you out for a walk in the garden?
d.) What are your favourite activities in the home?

*Answer: d*

80.) Adam has not been able to communicate with the nurses on duty. Using nonverbal communication and gestures to help one identify a service user’s needs is important because:

a.) the ability to communicate may be affected by illness
b.) It saves time and makes one more efficient.
c.) the service user may be distracted and might not enjoy talking to staff
d.) all of the above

*Answer: a*

81.) Which of the following tasks is crucial in therapeutic communication?

a.) Listening attentively to a service user’s story
b.) Assessment of signs and symptoms
c.) Documenting an incident report
d.) All of the other answers

*Answer: d*

82.) Mr Z called for your assistance and wanted you to sit with him for a bit. He has disclosed confidential information about his personal life. Which of the following should you urgently deal with?

a.) history of gall stones
b.) presence of pacemaker
c.) suicidal connotations
d.) loss of appetite due to depression

Answer: c – The service user’s safety is a priority at all times. He should be observed for the signs and symptoms of a suicidal patient.

83.) You were on duty, and you have noticed that the syringe driver is not working properly. What should you do?

a.) ask someone to fix it
b.) report this to your supervisor immediately
c.) leave this for the senior staff to sort out
d.) recommend a person to repair it

Answer: b – Any faulty equipment should be reported to the supervisor/person in charge so this can be dealt with and sent for maintenance.

84.) A patient in one of your bays has called for staff. She needed assistance with “spending a penny”. What will you do?

a.) Ask her if she wants a hot or cold drink, and give her one as requested
b.) Assist her to walk to the vending machine, and let her choose what she wants to buy
c.) Assist her to walk to the toilet, and provide her with some privacy
d.) Help her find her purse, and ask her what time she will be ready to go out

Answer – c

85.) Betty has been assessed to be very confused and with impaired mobility. She wants to go to the dining room for her meal, but she wants a cardigan before doing so. What will you do?

a.) Give her wet wipes for her hands before dinner
b.) Disregard the cardigan and take her to the dining room
c.) Ask her what she means by a cardigan
d.) Make her comfortable in a wheelchair, and cover her legs with a blanket

Answer: c

86.) Alan Smith has a history of Congestive Heart Failure. He has also been complaining of general weakness. After taking his physical observations, you have noticed that he has pitting oedema on both feet. Which of the following is incorrect?

a.) The Water Pill can be prescribed to manage fluid retention.
b.) Lasix can be prescribed for the pitting oedema.
c.) Furosemide and Digoxin can be combined for patients with CHF.
d.) Furosemide will increase Alan’s blood pressure, and lessen pitting oedema.

Answer: d – Furosemide / Lasix, which is also known as the water pill is usually prescribed for patients with CHF. This is used to manage pitting edema, and manage fluid retention; hence, the blood pressure will be lowered. Digoxin is usually combined with Furosemide in different doses.

87.) Maisie is 86 years old, and has been in the nursing home for 5 years now. She has been complaining of burning sensation in her chest and sour taste at the back of her throat. What would she most likely to be prescribed with?

a.) Ranitidine
b.) Zantac
c.) Paracetamol
d.) Levothyroxine
e.) a and b
f.) b and d

Answer: e – Maisie will be most likely prescribed with Zantac (Ranitidine). This is used to treat hyperacidity in her stomach. It blocks the action of histamine in the stomach, reduces the acid the stomach makes.

88.) Mrs A is 90 years old and has been admitted to the nursing home. The staff seem to have difficulty dealing with her family. One day, during your shift, Mrs A fell off a chair. You have assessed her, and no injuries have been noted. Which of the following is a principle of the Duty of Candour?

a.) You will not ring the family since there is no injury caused by the fall.
b.) You have liaised with the lead nurse, and she decided not to ring the family due to no harm.
c.) Observe the patient, take her physical observations, and ask if you must call the family.
d.) All of the above
e.) None of the above

Answer: e – Duty of Candour - openness and honesty as a professional duty when things go wrong

89.) Maggie has been very physically and verbally aggressive towards other patients and staff for the last few weeks. She is now on one-to-one care, 24 hours a day. According to her person centred care plan, the nurses are looking after her very well preventing her from causing any harm. Behaviour has been discussed with the social worker, and clinical lead has applied for DoLS. Which of the following is correct?

a.) DoLS will allow staff to intervene depriving Maggie from doing something to hurt herself, other residents, and staff
b.) DoLS refers to protecting the other patients only from Maggie’s destructive behaviour.
c.) DoLS protects the nurses and doctors only when providing care for Maggie.
d.) DoLS protects Maggie only from committing suicide.

Answer: a

90.) You were assisting Mrs X with personal care and hygiene. She has been assessed to have mental capacity. In her wardrobe, you have seen a dress that is quite difficult to wear and a pair of trousers, which is quite easy to put on. You are trying to make a decision which one to put on her. Which of the following is a person centred intervention?

a.) Ask her what she prefers; show her the clothes and let her choose
b.) Let Mrs X wear her trousers
c.) Explain to her that the dress is so difficult to put on
d.) Tell her that the trousers will make her more comfortable if she chooses it

Answer: a

91.) You were a new nurse in a geriatric ward. The son of one of your patients discussed that he has noticed his mother is not being treated well in the ward, and that she looks very dehydrated and malnourished. How do you deal with the scenario?

a.) Do not do anything, because it is not much of a concern
b.) Discuss the case with a colleague
c.) Report this to your supervisor
d.) Make a decision not to intervene – it will be dealt with by management

Answer: c

92.) Documentation confirms that Amy has MRSA. You walked into her bedroom with coffee and biscuits on a tray. Which of the following is incorrect?

a.) Put the coffee and biscuits on her bedside table and leave the tray on the other table
b.) Wash your hands thoroughly before leaving her room
c.) Dispose your gloves and apron before washing your hands
d.) Use the alcohol gel on Amy’s bedside before leaving her room

Answer: d

93.) Which of the following is the most important in infection control and prevention?

a.) Wearing gloves and apron at all times
b.) Hand washing
c.) Immediate prescription of antibiotics
d.) Use of hand rubs in the bedside

Answer: b

94.) There has been an outbreak of the Norovirus in your clinical area. Majority of your staff have rang in sick. Which of the following is incorrect?

a.) Do not allow visitors to come in until after 48h of the last episode
b.) Tally the episodes of diarrhoea and vomiting
c.) Staff who has the virus can only report to work 48h after last episode

d.) Ask one of the staff who is off-sick to do an afternoon shift on same day

**Answer:** d

95.) Mrs X is diabetic and on PEG feed. Her blood sugar has been high during the last 3 days. She is on Nystatin Oral Drops QID, regular PEG flushes and insulin doses. Her Humulin dose has been increased from 12 iu to 14 iu. The nurse practitioner has advised you to monitor her BM’s for the next two days. What will be your initial intervention if her BM drops to 2.8 mmol after 2 morning doses of 14 iu?

a.) Offer her a chocolate bar and a glass of orange juice

b.) Flush glucose syrup through her PEG Tube

c.) Ring the nurse practitioner and ask if the insulin dose can be dropped to 12 iu

d.) Contact the General Practitioner and request for a visit

**Answer:** b

96.) Annie is on Cefalexin QID. You were working on a night shift and have noticed that the previous nurse has not signed for the last two doses. What should you do?

a.) Document the incident and speak to your Manager

b.) Check the rota, find out when he is back and leave a note on the MARS for him to sign

c.) Find out what the whistle blowing policy is about

d.) Ask the qualified nurse to sign it on handover if it is definitely been administered

**Answer:** a

97.) Alan appears to be very confused today. He seems to be quite verbally aggressive towards staff. His urine has also got a bit of foul smell. How would you assess this resident?

a.) Check his papillary response to light

b.) Collect a urine sample for MSU

c.) Carry out the urine dipstick

d.) b and c

e.) None of the above

**Answer:** d

98.) Mrs Z has been very chesty the last few days. She has been having difficulty with breathing. You have referred her to the GP, and requested for a home visit. What would probably be prescribed by the GP?

a.) Stalevo 200

b.) Digoxin 40 mg

c.) Trimethoprim 100 mg

d.) Simvastatin 100 mg

**Answer:** c

99.) Cherry has been prescribed with Estradiol tablet to be inserted twice a week at night. You entered her bedroom and noticed she is fast asleep. What would you do?

a.) Try to gently wake her up and insert her vaginal tablets.

b.) Allow her to get some sleep and try to insert the vaginal tablet on your next turn rounds.

c.) Speak to her and ask her to spread her legs, so you can insert her vaginal tablet.

d.) Document that the tablet cannot be administered at all because the patient has refused.

**Answer:** b

100.) You are the night nurse in a nursing home. Maxine, 81 years old, has been prescribed with Lorazepam PRN. You have assessed her to be wandering and talking to staff. When do you administer the Lorazepam?

a.) Immediately due to wandering

b.) As soon as possible so she can go to bed

c.) When you see signs of confusion

d.) When you see signs of agitation

**Answer:** d
101.) Mr Jones has been having Type 6 and 7 stools today. As you are doing his medications, which of the following would you not omit?

a.) Docusate Sodium 2 Capsules
b.) Lactulose 5 mL
c.) Senna 10 mL
d.) Simvastation 100 mg

Answer: d

c.) Check bowel charts and cancel Macrogol on MARS if bowels are fine.
d.) Change the prescription to PRN.

102.) You are working in a nursing home (morning shift), and one of your residents is still in the hospital. Nothing has been documented since admission. What would you do?

a.) Ring the family and find out what happened to the resident
b.) Speak to your manager and tell her about it
c.) Ring the ward and request for an update from the nurse on duty
d.) Document that the resident is still in the hospital

Answer: c

103.) One of your residents in the nursing home has requested for a glass of whiskey before she goes to bed. What would you do?

a.) Refuse to give it / ignore the request
b.) Explain that the whiskey will cause her harm
c.) Give her a shot of whiskey, as requested
d.) Give her a glass of apple juice and tell her it is whiskey

Answer: c

104.) The MARS says that Benedict is on TID Macrogol. You have notice that the nurses have been writing “A” for refused. What do you do?

a.) Write “A” on the MARS, because Benedict is expected to refuse it.
b.) Offer the Macrogol, and write “A” if the patient refuses it.

c.) Check bowel charts and cancel Macrogol on MARS if bowels are fine.
d.) Change the prescription to PRN.

105.) Maria has ran out of Cavilon Cream. You have noted that her groins are very red and sore. You can see that David has spare Cavilon tubes after checking the stocks. What will you do?

a.) Borrow a tube from David’s stock as Maria’s groins are red and sore
b.) Use Canesten for now and apply Cavilon once stock has arrived
c.) Request for a repeat prescription from the GP, and have the stock delivered by the chemist
d.) Ring the GP and ask him to see Maria’s groins, then prescribe Cavilon.

Answer: c

106.) Manu is in persistent pain and has Oromorph PRN. All your carers are on their rounds, and you are about to administer this drug. What would you do?

a.) Dispense 10 mL Oromorph and administer immediately to relieve pain
b.) Dispense 10 mL Oromorph and call one of the carers to witness
c.) Call one of the carers to witness dispensing and administering the drug
d.) Administer the drug and ask one of the carers to sign the book after their pad rounds

Answer: c

107.) You were on your rounds with one of the carers. You were turning a patient from his left to his right side. What would you do?

a.) Both of you can stay on one side of the bed as you turn your patient
b.) You go on the opposite side of the bed and use the bed sheet to turn your patient
c.) You keep the bed as low as possible because the patient might fall
d.) You go on the opposite side and grab the slide sheet to use

Answer: d
108.) You were on your medication rounds and the emergency alarm goes off. What will you do first?
   a.) Lock your trolley
   b.) Rush to your patient's bedroom
   c.) Check first if everyone had their meds
   d.) a and c
   Answer: a

109.) Your patient has had Diverticulitis for about a decade now. You have assessed her to be having soft stools of Type 4/5. Which of the following will need urgent intervention?
   a.) She is losing a lot of electrolytes in her body, and this needs to be replaced.
   b.) There is no urgency in this case, because patients with Diverticulitis are expected to have soft to loose stools.
   c.) She needs to be prescribed with fluid retention pills.
   d.) There is no urgency in this case because the stool is quite hard, and it should be fine.
   Answer: b

110.) One of your health care assistants came to you saying that she could not continue with her rounds due to a bad back. What will you do first?
   a.) Document the incident and report to the manager.
   b.) Ring for agency staff to cover the shift.
   c.) Assess your colleague’s back and administer pain killers.
   d.) Send her home and cover her work yourself to help the team.
   Answer: c

1) You are assisting a doctor who is trying to assess and collect information from a child who does not seem to understand all that the doctor is telling and is restless. What will be your best response:
   - stay quite and remain with the doctor
   - Interrupt the doctor and ask the child the questions
   - Remain with the doctor and try to gain the confidence of the child and politely assess the child’s level of understanding and help the doctor with the information he is looking for

2) You are nurse at the community care centre and an elderly complains to you that his neighbour is stealing money from him. He sends his for shopping and sometimes the neighbour does not shop and keeps the money with him. You will:
   - Confront the neighbour when he visits you next time
   - Remain quite and ignore the complaint
   - request the elderly to talk to the hospital chaplin for further assistance
   - Raise a complaint in the incident report form and investigate the matter and inform the concerned

3) You are training the staffs on medication errors. Which is the most common error that occurs due to stressful clinical environment?
   - Wrong dose and identity
   - failure to capture allergies
   - Wrong contraindications
   - Wrong constitution of drug

4) A client wants to leave the hospital. The medical team is not happy with his clinical condition and judgement as per the mental health act. What will you do?
   - let the client leave the hospital as he does not posses any threat to the public or is visibly ill
- inform the security to hold the patient and not let him go away
- inform the police
- counsel the patient to stay back in the hospital for his betterment

5) What is the purpose of clinical audit
- it helps to understand the functioning and effectiveness of nursing activities
- helps to understand the outcomes and processes for medical and surgical procedures
- helps to identify areas of improvement in the system pertaining to Nursing and medical personnel
- helps to understand medical outcomes and processes only

6) While brushing the teeth the nurse observes bleeding gums in the client. The nurse understands that the probable cause for this gingivitis is:
- Poor diet
- Poor flossing
- Poor tarter removal
- Infection

7) A client diagnosed of cancer visits the OPD and after consulting the doctor breaks down in the corridor and begins to cry. What would the nurses best action?
- Ignore the client and let her cry in the hallway
- Inform the client about the preparing to come for the next appointment for further discussion on the treatment planned
- Take her to a room and try to understand her worries and do the needful and assist her with further information if required

8) Who among the list below are more prone to coronary artery disease:
- Hypotension, smoker, DM, obese women, non sedentary lifestyle
- Hypertension, smoker, obese men, sedentary lifestyle

9) A client with CVA is found to have difficulty in swallowing. Whom do you think should be informed for further assessment:
- neurological physiotherapist
- occupational physiotherapist

1. Last sense lost of a dying pt?
- hearing

2. Holistic care?
- person centred care with dignity and respect

3. Adverse reaction reporting
- yellow card

4. Old COPD pt in homecare, dyspnoea, anxious?
- administer oramorph

5. Clinical benchmarking?
- to improve standards in health care
- a new initiate in health care system

6. Controlled drug usage in homecare setup?
- strict to local policies and guidelines
- don't give rest of the medication to relatives
7. Nurse and colleague found a discrepancy of controlled drug. How to report?
- Inform police
- Inform pharmacy
- Recheck, inform incharge. If not found, inform senior nurse

8. While mentoring a final year student dispensing medication, nurse role?
- Direct supervision
- Before delegating, find out he is competent
- Ask him to tell after the administration is complete

9. Electronic data transfer is more these days, which of the report is not suitable to send to a discharged client?
- Confusing blood report
- Smoking cessation policy

10. Not a sign of ectopic pregnancy?
- Vaginal bleed
- Shoulder pain
- Dysuria
- Positive pregnancy test

11. Not a sign of meconium aspiration syndrome?
- Baby crying
- Floppy appearance
- Dark greenish appearance

12. In a queue, pt collapses?
- Run to bring AED
- Shout for help
- Assess for response

13. Compassionate care?
Ans: Deep awareness of the suffering of another coupled with the wish to relieve it.

14. Primary care?
- Care provided in acute settings
- First hand care approach made by pt

15. Why old people afebrile even if they are infected?
- Immature mast T- lymphocytes
- Interruption of non-adrenaline activity

16. Postural hypotension? Hypotension when standing

17. Intermediate care?
Operative care beginning from 4-12 hrs

18. Pt suspected of UTI?
- Ask doctors to wear gloves, gown
- Use PPE while dealing with body fluids
- Use PPE and act as an infection control link nurse
- Review antimicobials daily and report healthcare team

19. A pt who attempted suicide is at high risk when?
- He appears happy
20. You saw a pt unhappy who has been admitted in hospital for more than one week, you ask him whether he is ok, he answers he is ok. Your response?

- Accept it
- You don’t seem to be ok, are you sure you are ok

1. Speed shock complication?

22. Clostridium difficile pt discharged, which measures is ineffective?

- Alcohol hand rub usage

23. Motion mixed with blood and mucus, which condition does not show this as a sign?

- Hashimotos syndrome
- Ulcerative colitis
- Pseudo membraneous colitis
- Crohns disease

24. Dehydration in old adult?

- Skin turgor
- Elasticity

25. Dehydration?

- Skin turgor

26. Which drug causes fall in elderly?

- Loop diuretics
- Beta blockers
- NSAIDs
- Hypnotics

27. 1 gm paracetamol advised. 500 mg tab available?

- Ans 2

28. 40 mg advised. 2.5 mg available

- Ans 16

29. 125 mg available in 5ml 50 mg to be given?

- Ans 2ml

30. 6 year old child who is dyspagic restless, visiting hours over your role?

- Allow mother to stay
- Tell her visiting hours are over
- Tell her you will take care of the child

31. Removing plaster cast of a child who is not co-operating?

- Explain to him according to his own understanding in age appropriate language
- Force fully remove

32. When can you disclose information of pt?

- Public interest and law and order
- Law and order

33. When confidentiality can be revealed?

- Puts any one at risk or harm

34. NMC stands for?

- NMC stands code and conduct for nurses

34. Steps in nursing process?

- Assessment, planning, implementation, evaluation
- Assessment, planning, audit
35. After completion of nursing notes, nurse should?
- Sign, printed name, designation, time, date
- Sign, designation, time, date
- Sign, time, date of birth

36. During shift change nurse gets over from incharge of an infected pt, your role?
- Using PPE <standard precautions>

37. Correct procedure to get informed consent from pt scheduled for surgery?
- Get consent on the day of surgery
- Explain to him details of everything and makes sure his participation in the process

40. Registered RN role, while administering medicine?
- Should know about all medications
- Should know about medicines, explain to pt to make them understand why they are taking them
- For giving IV medicines get help of other nurse

41. While putting IV line, doctor leaves to emergency, you have not done it before
- Don't insert as you are incompetent

42. You noticed medical equipment not working while you joined a new team and the team members are not using it, your role?
- During audit raise your concern
- Inform in written to management
- Inform NMC
- Take photograph

43. Biohazard label on a bottle in nursing counter?
- Double bag it
- Use gloves
- Inform lab before transferring

44. How to check position of enteric tube?
- Aspirate and check PH

45. National early warning score?
- Helps nurses to early assess any deterioration of physiological features in pts

46. Heart rate below 50?
- Bradycardia

47. While using crutches where to give weight?
- Arms of chair and stand up
- Move frame, 10 feet, take small steps
- Move 10 feet, take large wide steps
- Move 12 feet
- Transform weight to walker and walk

48. Proper technique to use walker<Zimmer s frame>?
- Use outside
- Use only while standing
- When getting up raise from chair by pushing with palms on armrest

49. Which step is not right to follow while using walker?
- Use only while standing

50. Digoxin administration, heart rate 58, your role?
- Inform doctor
ans.omit dose,record,raise your concern

51. atrial arrhythmias in ecg
ans. atrial fibrillation

52. an old admitted patient comes up with a new confusion?
-alzheimers
-dementia
-normal ageing
-UTI

53. advice for a dementia patient while giving discharge teaching?
-predictable environment

54. while iv administration finds swelling and redness
ans. remove the cannula

55. old dysphagic pt, orders by doctors and therapist does not include?
-giving water to drink

56. why pts kept on npo
-prevent reflux and inhalation of gastric content
-prevent vomitting

57. proper way to remove vaccum drainage?
-release vaccum and remove
-pullout
-get doctor to do it

58. why double clamp applied to remove chest drainage?

ans. prevent pneumothoacx

59. leg stockings used. why?
ans. promote venous return

60. when to keep pts privacy and dignity?
-under all circumstances

- not in emergency

61. proliferative phase in wound healing, how long?
ans. 3 to 2 days

62. ideal wound dressing characteristics?
-gaseous exchange, adherence, insulation, low humidity, high humidity, anaerobic

63. ideal site for IM INJECTIONS in buttocks region?
ans. upper outer quadrant

64. after abdominal surgery, pt complains of pain even after administration of analgesics little ago?
-re administer analgesics

-apply heat

-position to 45 degree angle

65. pt bring own medication to hospital and wants to self administer. your role?

-allow him

-give medications back to relatives to take back to home

-keep it in locker, use from medication trolley

-explain to pt about medication before he administer it
66. After LP pt becomes unconscious, reason?
- CSF leak
- Headache
- Herniation

67. Not a policy in palliative care?
- Pain relief
- CPR

68. Pt frequently urinates in night
Ans: Polyuria

69. Accountability means?
- Responsible
- Responsive

70. Tibia, fibula fracture correction done, which sign and symptom leads to the suspicion that it is leading to compartment syndrome?
- Pain not relieved by analgesics
- Numbness and tingling sensation

71. A pt's relative is seen praying in a dark place, your role?
- Complain to security that the chaplin is not open
- Provide him a peaceful place
- Tell him it is against the rule

72. After laminectomy how to turn patient?
- As a unit

73. How nurse should improve his practice?
- Experience
- Feedback
- Reflection

Ans: All of above

74. While formulating and giving advice, nurse is performing which role?
- Advocate
- Educator
- Healthcare
- Researcher

75. Advocacy means?
- Act as a liaison between pt and health care team
- Help pt to make informed decisions

76. Pt states "I hate cancer", according to Kbler theory this is
- Anger
- Denial
- Acceptance

77. Proper method to collect urine sample?
Ans: Clean meatus and collect midstream

78. Needle stick injury proper way to report?
The incharge and infection control nurse

79. How frequent vitals must be recorded?
80. A nurse is advised one hour vital charting of a pt. How frequently it should be recorded?
- Every one hour
- Whenever the vital signs shows deviation from normal

81. When discharge should be planned?
- Within 24 hours of admission

82. Oxygen administration order should include?
- Initiation time, device, route, how long etc
- No need to write order

83. One the day of discharge spouse of a pt is tensed about discharge?
- Cancel discharge
- Fix time for consultation

84. Cancer pt scheduled for CT, worried. Your role?
- Encouraging him to tell about how he feels and about his fears

85. Movement away from midline?
- Abduction

86. Where to assess edema?
- Ankles

87. In which type of wound, wound care plan to be implemented?
- All type of wounds

88. How to assess respiratory status?
- Ease, rate, rhythm, pattern

89. Potassium sparing diuretic
- Spironolactone

90. After iv dose pt develops rashes, itching, flushed skin
- Septicemia
- Adverse reaction

91. Indication of chest tube drainage
- Pneumothorax

92. Health care assistant task delegation criteria?
- Make sure he is competent
- Make sure he is experienced
- Confirm that he is a staff having same designation
- He is an employee of the same institution

93. A pt had complained several times, now that pt registered a new complaint about your colleague. Your role?
- Tell staff members to be careful to avoid mistakes in future
- Be honest and impartial and complete investigation

94. Acute illness?

95. Positive fluid balance?
- Intake greater than output

96. Paracentesis position. How to position client?
- Head end elevation to 45 degree
97. When can we perform LP?
- ICP normal

98. How can we identify health problems of a patient?
- Lifestyle
- Medical notes
- Discussion
- Interview

99. How to collect details of a pt?
- Open ended questions
- Listen to their concerns
- Ask relatives

100. While dealing with a pt, sexuality against nurses belief?
Ans: Acceptance

101. When you provide care for a pt of different culture?
- Whenever possible provide sensible care

102. Haemorrhoids risk factor?
- Straining of stools
- Veg diet
- Fibre rich food
- Non-processed food

103. Comprehensive nursing care?
- Critical and advanced care

104. When can we realise actual and potential problems of a pt?
- Assessment

105. Pt comes to emergency in shock, signs?
- Tachycardia, Hypotension (Ans)
- Tachycardia, Hypertension
- Bradycardia, Hypotension

106. Pt centred care, who is the centre of approach?

107. Signs of infection?
- WBC raised, blood sugar low
- Tachycardia, shivering, temp 38.6°C
- Temp 36°C

108. Nursing home bill does not include?
- Laundry
- Food
- Social activities

110. IV administration benefit?
- Fast acting

111. After NJ feeding how to position the client?
- Fowlers

112. In head injury pt, unequal pupils?
- Consider this as an emergency, follow ABCDE approach

110. IV administration benefit?
- Fast acting
112. What criteria do you base while giving care?
- All criteria emotional, spiritual, cultural...

113. While in outside setup, what care will you give if exposed to a situation?
- Keeping up to professional standards
- Above what is expected
- No involvement

114. Measures to prevent fall in an unconscious pt in bed
- Side rails
- Call bell

115. How to act in an emergency
- According to our competence
- According to situation

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1. The code is concerned about focusing on which of the following criteria?
   A. Clinical expertise
   B. Conduct, behavior, ethics & professionalism
   C. Hospital policies
   D. Disciplinary actions

2. When communicating with a client who speaks a different language, which best practice should the nurse implement?
   A. Speak loudly & slowly
   B. Arrange for an interpreter to translate
   C. Speak to the client & family together
   D. Stand close to the client & speak loudly

3. A nurse is not trained to do the procedure of IV cannulation, so she tries to do the procedure. You are the colleague of this nurse. What will be your action?
   A. You should tell the nurse to not do this again
   B. You should report the incident to someone in authority
   C. You must threaten the nurse, that you will report this to the authority
   D. You should ignore her act

4. An antihypertensive medication has been prescribed for a client with HTN. The client tells the clinic nurse that they would like to take an herbal substance to help lower their BP. The nurse should take which action?
   A. Tell the client that herbal substances are not safe & should never be used.
   B. Teach the client how to take their BP so that it can be monitored closely
   C. Encourage the client to discuss the use of an herbal substance with the health care provider
   D. Tell the client that if they take the herbal substance they will need to have their BP checked frequently

5. Which professional organizations are responsible for establishing the code?
   A. NHS
   B. NMC
   C. American Nurses Association, National League of Nursing, and American Association of Nurse Executives
   D. State Boards of Nursing, state and national organizations, and specialty organizations

6. Nurses who seek to enhance their cultural-competency skills and apply sensitivity toward others are committed to which professional nursing value?
   A. Autonomy
   B. Strong commitment to service
   C. Belief in the dignity and worth of each person
   D. Commitment to education

7. When trying to make a responsible ethical decision, what should the nurse understand as the basis for ethical reasoning?
   A. Ethical principles & code
   B. The nurse’s experience
   C. The nurse’s emotional feelings
   D. The policies & practices of the institution
8. A fully alert & competent 89 year old client is in end stage liver disease. The client says, “I'm ready to die,” & refuses to take food or fluids. The family urges the client to allow the nurse to insert a feeding tube. What is the nurse’s moral responsibility?
   A. The nurse should obtain an order for a feeding tube
   B. The nurse should encourage the client to reconsider the decision
   C. The nurse should honor client’s decision
   D. The nurse must consider that the hospital can be sued if she honors the client’s request

9. A mentally competent client with end stage liver disease continues to consume alcohol after being informed of the consequences of this action. What action best illustrates the nurse’s role as a client advocate?
   A. Asking the spouse to take all the alcohol out of the house
   B. Accepting the patient’s choice & not intervening
   C. Reminding the client that the action may be an end-of-life decision
   D. Refusing to care for the client because of the client’s noncompliance

10. A client is diagnosed with methicillin resistant staphylococcus aureus pneumonia. What type of isolation is MOST appropriate for this client?
   1) Reverse isolation
   2) Respiratory isolation
   3) Standard precautions
   4) Contact isolation

11. Several clients are admitted to an adult medical unit. The nurse would ensure airborne precautions for a client with which of the following medical conditions?
   1) A diagnosis of AIDS and cytomegalovirus
   2) A positive PPD with an abnormal chest x-ray
   3) A tentative diagnosis of viral pneumonia
   4) Advanced carcinoma of the lung

12. A young adult is being treated for second and third degree burns over 25% of his body and is now ready for discharge. The nurse evaluates his understanding of discharge instructions relating to wound care and is satisfied that he is prepared for home care when he makes which statement?
   1) “I will need to take sponge baths at home to avoid exposing the wounds to unsterile bath water.”
   2) “If any healed areas break open I should first cover them with a sterile dressing and then report it.”
   3) “I must wear my Jobst elastic garment all day and can only remove it when I’m going to bed.”
   4) “I can expect occasional periods of low-grade fever and can take Tylenol every 4 hours.”

13. Contact precautions are initiated for a client with a health care associated infection caused by MRSA. Which protective equipments the nurse should wear while providing colostomy care?
   1) Gloves & gown
   2) Gloves & goggles
   3) Gloves, gown & shoe protectors
   4) Gloves, gown, goggles & face shield

14. The charge nurse observes a new staff nurse who is changing a dressing on a surgical wound. After carefully washing her hands the nurse dons sterile gloves to remove the old dressing. After removing the dirty dressing, the nurse removes the gloves and dons a new pair of sterile gloves in preparation for cleaning and redressing the wound. The most appropriate action for the charge nurse is to:
   1) interrupt the procedure to inform the staff nurse that sterile gloves are not needed to remove the old dressing.
   2) congratulate the nurse on the use of good technique.
   3) discuss dressing change technique with the nurse at a later date.
   4) interrupt the procedure to inform the nurse of the need to wash her hands after removal of the dirty dressing and gloves.

15. The Nurse is caring for a patient with heart failure. On Assessment, the nurse notes that the patient is dyspnoic & crackles are audible on auscultation. What additional signs would the nurse expect to note in this client if excess fluid volume is present?
   A. Weight loss
   B. Flat neck & hand veins
   C. An increase in BP
   D. Decreased central venous pressure (CVP)

16. The nurse is preparing to care for a patient with a potassium deficit. The nurse reviews the patient’s record & determines that the client was at risk for developing the potassium deficit because of which situation?
   A. Sustained tissue damage
   B. Requires nasogastric suction
   C. Has a history of Addison’s disease
   D. Is taking a potassium–retaining diuretic

17. A 27-year old adult male is admitted for treatment of Crohn’s disease. Which information is most significant when the nurse assesses his nutritional health?
   A. Anthropometric measurements
   B. Bleeding gums
18. An adult woman is admitted with metabolic acidosis. Which set of arterial blood gases should the nurse expect to find in a client with metabolic acidosis?
   A. Ph 7.28; pCO2 -55; HCO3 -26
   B. Ph 7.50; pCO2 -40; HCO3 -31
   C. Ph 7.48; pCO2 -30; HCO3 -22
   D. Ph 7.30; pCO2 -36; HCO3 -18

19. The nurse is assigned to care for a group of patients. On review of the patient’s medical records the nurse determines that which patient is at risk for fluid volume excess?
   A. The patient taking diuretics
   B. The patient with kidney disease
   C. The patient with an ileostomy
   D. The patient who requires gastrointestinal suctioning

20. An adult who has gastroenteritis & is on digitalis has lab values of; K 3.2 mEq/L, Na 136 mEq/L, Ca 4.8 mEq/L, & Cl 98 mEq/L. The nurse puts which of the following on patient’s plan of care?
   A. Monitor for hyperkalemia
   B. Avoid foods rich in potassium
   C. Observe for digitalis toxicity
   D. Observe for Trousseau’s & Chvostek’s signs

21. The nurse is reading a health care provider’s ( HCP) progress notes in the patient’s record & reads that the HCP has documented “insensible fluid loss of approx 800 ml daily”. The nurse interprets that this type of fluid loss can occur through which route?
   A. The skin
   B. Urinary output
   C. Wound drainage
   D. The gastrointestinal tract

22. The nurse is preparing to change the parenteral nutrition (PN) solution bag & tubing. The patient’s central venous line is located in the right subclavian vein. The nurse asks the client to take which essential action during the tubing change?
   A. Breathe normally
   B. Turn the head to the right
   C. Exhale slowly & evenly
   D. Take a deep breath, hold it, & bear down

23. Which of the following actions would place a client at the greatest risk for a shearing force injury to the skin?
   1) Walking without shoes

24. The client at greatest risk for postoperative wound infection is:
   1) A 3-month-old infant postoperative from pyloric stenosis repair
   2) A 78-year-old postoperative from inguinal hernia repair
   3) An 18-year-old drug user postoperative from removal of a bullet in the leg
   4) A 32-year-old diabetic postoperative from an appendectomy

25. Black wounds are treated with debridement. Which type of debridement is most selective and least damaging?
   1) Debridement with scissors
   2) Debridement with wet to dry dressings
   3) Mechanical debridement
   4) Chemical debridement

26. A client’s wound is draining thick yellow material. The nurse correctly describes the drainage as:
   1) Sanguineous
   2) Serous-sanguineous
   3) Serous
   4) Purulent

27. The nurse cares for a client with a wound in the late regeneration phase of tissue repair. The wound may be protected by applying a:
   1) Transparent film
   2) Hydrogel dressing
   3) Collagenase dressing
   4) Wet to dry dressing

28. A client has a diabetic stasis ulcer on the lower leg. The nurse uses a hydrocolloid dressing to cover it. The procedure for application includes:
   1) Cleaning the skin and wound with betadine
   2) Removing all traces of residues for the old dressing
   3) Choosing a dressing no more than quarter-inch larger than the wound size
   4) Holding in place for one minute to allow it to adhere
A client is admitted to the Emergency Department after a motorcycle accident that resulted in the client's skidding across a cement parking lot. Since the client was wearing shorts, there are large areas on the legs where the skin is ripped off. This wound is best described as:

1) Abrasion
2) Unapproximated
3) Laceration
4) Eschar

30. TRUE/FALSE

1. Standard precautions are the daily practices (e.g., hand washing, use of personal protective equipment, cleansing of equipment) that will reduce the transmission of infections.

2. Gowns and gloves should not be worn in common use areas such as nursing stations, eating areas, and elevators.

3. Masks and goggles must be worn for care activities such as care of patients who have a cough or are vomiting.

4. The use of gloves is an effective substitute for hand washing.

5. You must wash your hands after removing your gloves.

6. In a hospital, routine precautions are the responsibility of doctors and nurses only.

MULTIPLE CHOICE – Choose the MOST CORRECT response.

31. The objective of standard precautions is to prevent the spread of infection within the health care institution:
   a. From patient to patient.
   b. From patient to staff.
   c. From staff to patient.
   d. From staff to staff.
   e. All of the above.

32. The most important procedure for the prevention of infection from germs and viruses is:
   a. Wearing gloves.
   b. Properly bagging used linen.
   c. Effective hand washing.
   d. Wearing protective eyewear.

33. Which of the major theories of aging suggests that older adults may decelerate the aging process?
   1) Disengagement theory
   2) Activity theory
   3) Immunology theory
   4) Genetic theory

34. Which of the following is a guiding principle for the nurse in distinguishing mental disorders from the expected changes associated with aging?
   1) A competent clinician can readily distinguish mental disorders from the expected changes associated with aging.
   2) Older people are believed to be more prone to mental illness than young people.
   3) The clinical presentation of mental illness in older adults differs from that in other age groups.
   4) When physical deterioration becomes a significant feature of an elder's life, the risk of comorbid psychiatric illness rises.

35. A normal sign of aging in the renal system is
   1) Intermittent incontinence
   2) Concentrated urine
   3) Microscopic hematuria
   4) A decreased glomerular filtration rate

36. A 76 year old man who is a resident in an extended care facility is in the late stages of Alzheimer's disease. He tells his nurse that he has sore back muscles from all the construction work he has been doing all day. Which response by the nurse is most appropriate?
   1) "You know you don't work in construction anymore"  
   2) "What type of motion did you do to precipitate this soreness?"
   3) "You're 76 years old & you've been here all day. You don't work in construction anymore."
   4) "Would you like me to rub your back for you?"

37. An 86 year old male with senile dementia has been physically abused & neglected for the past two years by his live in caregiver. He has since moved & is living with his son & daughter-in-law. Which response by the client's son would cause the nurse great concern?
   1) "How can we obtain reliable help to assist us in taking care of Dad? We can't do it alone."
   2) "Dad used to beat us kids all the time. I wonder if he remembered that when it happened to him?"
   3) "I'm not sure how to deal with Dad's constant repetition of words."
4) “I plan to ask my sister & brother to help my wife & me with Dad on the weekends.”

38. Knowing the difference between normal age-related changes & pathologic findings, which finding should the nurse identify as pathologic in a 74 year old patient?
1) Increase in residual lung volume
2) Decrease in sphincter control of the bladder
3) Increase in diastolic BP
4) Decreased response to touch, heat & pain.

39. Convert 40mg into gram
40. Digoxin 400 mcg is prescribed, the ampule of digoxin is labeled 250mcg/ml. How many mls will you draw up?

41. Which of the following is an important principle of delegation?
1) No transfer of authority exists when delegating.
2) Delegation is the same as work allocation.
3) Responsibility is not transferred with delegation
4) When delegating, you must transfer authority.

42. A staff nurse has delegated the ambulating of a new post-op patient to a new staff nurse. Which of the following situations exhibits the final stage in the process of delegation?
1) Having the new nurse tell the physician the task has been completed
2) Supervising the performance of the new nurse
3) Telling the unit manager the task has been completed
4) Documenting that the task has been completed

43. Which of the following is a specific benefit to an organization when delegation is carried out effectively?
1) Delegates gain new skills facilitating upward mobility
2) Managers devote more time to tasks that cannot be delegated
3) The organization benefits by achieving its goals more efficiently

44. To prepare a client for discharge home from an acute care facility, a nurse knows that the planning process must begin at what point?
1) The night before discharge.
2) Upon admission to the hospital.
3) Prior to discharge.
4) When the client indicates the readiness for discharge planning and teaching.

45. What is likely to be true of a nurse’s duties when she acts as a case manager providing community-based nursing services to a specific group of individuals?
1) The nurse will care for clients at the center, in their homes, and in the hospital.
2) The nurse sees only clients who come to the office.
3) The nurse works independently of other health care professionals.
4) The nurse will not continue client care if it involves long-term needs.

46. A client is to be discharged home from a hospital using crutches or a wheelchair. The client lives alone with three cats. Which assessment parameter is most important on the initial home visit?
1) Whether the client will be able to keep medical appointments
2) Whether the client desires spiritual counseling
3) Whether the home has stairs and/or throw rugs
4) Whether the client has financial resources for payment

47. A nurse demonstrates patient advocacy by becoming involved in which of the following activities?
1) Taking a public stand on quality issues and educating the public on “public interest” issues
2) Teaching in a school of nursing to help decrease the nursing shortage
3) Engaging in nursing research to justify nursing care delivery
4) Supporting the status quo when changes are pending

48. In the role of patient advocate, the nurse would do which of the following?
1) Emphasize the need for cost-containment measures when making health care decisions
2) Override a patient’s decision when the patient refuses the recommended treatment.
3) Support a patient’s decision, even if it is not the decision desired by the nurse.
4) Foster patient dependence on health care providers for decision making.

49. A patient is recovering from surgery has been advanced from a clear liquid diet to a full liquid diet. The patient is looking forward to the diet change because he has been “bored” with the clear liquid diet. The nurse should offer which full liquid item to the patient?
1) Tea
2) Gelatin
3) Custard
4) Ice pop

50. Before administering a tube feeding the nurse knows to perform which of the following assessments?
1) The gastrointestinal tract, including bowel sounds, last BM, & distention.
2) The client’s neurologic status, especially gag reflex
3) The amount of air in stomach
4) That the formula is used directly from the refrigerator
51. A client, who has had visitors the last two evenings during the unit's regular evening visitors hours, 6:00 p.m. to 8:00 p.m., asks, "What time can I have visitors this evening?" Which of the following would be the best response to this question?

1) "Don't you remember what time you visitor have been coming?"
2) "You are worried about visiting hours."
3) "You want to know when you can have visitors?"
4) "Visiting hours are from 6:00 p.m. to 8:00 p.m."

52. A client breathes shallowly and looks upward when listening to the nurse. Which sensory mode should the nurse plan to use with this client?

1) Auditory
2) Kinesthetic
3) Touch
4) Visual

53. A nurse has been told that a client's communications are tangential. The nurse would expect that the client's verbal responses to questions would be

1) long and wordy
2) loosely related to the questions.
3) rational and logical
4) simplistic, short, and incomplete.

54. Which of the following statements by a nurse would indicate an understanding of intrapersonal communications?

1) "Intrapersonal communications occur between two or more people."
2) "Intrapersonal communications occur within a person."
3) "Interpersonal communications is the same as intrapersonal communications."
4) "Nurses should avoid using intrapersonal communications."

55. According to the therapeutic communication theory, what criteria must be met for successful communication?

1) The communication needs to be efficient, appropriate, flexible, and include feedback.
2) The individuals communicating with each other must share a similar perception of the conversation.
3) The communication must be intrapersonal, interpersonal, group, or societal in nature.
4) Nonverbal communication is consistent with verbal communication.

56. The nonverbal communication that expresses emotion is:

1) Body positioning.
2) Eye contact
3) Cultural artifacts.
4) Facial expressions.

57. The nurse is interacting with a client and observes the client's eyes moving from side to side prior to answering a question. The nurse interprets this behavior as:

1) The client being bored with the interaction.
2) The client processing auditory information.
3) The client engaging in intrapersonal communication.
4) The client responding to auditory hallucinations

58. To provide effective feedback to a client, the nurse will focus on:

1) The present and not the past.
2) Making inferences of the behaviors observed.
3) Providing solutions to the client.
4) The client.

59. After the death of a 46 year old male client, the nurse approaches the family to discuss organ donation options. The family consents to organ donation and the nurse begins the process. Which of the following would be most helpful to the grieving family during this difficult time?

1) calling the client a "donor"
2) provide care to the deceased client in a careful and loving way
3) encourage the family to make a quick decision
4) tell them that there is no time to call other family members for advice

60. A critically ill client asks the nurse to help him die. Which of the following would be an appropriate response for the nurse to give this client?

1) tell me why you feel death is your only option
2) how would you like to do this
3) everyone dies sooner or later
4) assisted suicide is illegal in this state

61. A 42 year old female has been widowed for 3 years yet she becomes very anxious, sad, and tearful on a specific day in June. Which of the following is this widow experiencing?

1) preparatory depression
2) psychological isolation
3) acceptance
4) anniversary reaction

62. The 4 year old son of a deceased male is asking questions about his father. Which of the following activities would be beneficial for this young child to participate in?

1) nothing because he is too young to understand death
2) tell him his father has gone away, never to return
3) tell him his father is sleeping
4) explain that his father has died and give him the option of attending the funeral.

63. The hospice nurse has been working for two weeks without a day off. During this time, she has been present at the deaths of seven of her clients. Which of the following might be beneficial for this nurse?
   1) Nothing
   2) provide her with an assistant
   3) suggest she take a few days off
   4) assign her to clients that aren’t going to die for awhile

64. The wife of a recently deceased male is contacting individuals to inform them of her husband’s death. She decides, however, to drive to her parent’s home to tell them in person instead of using the telephone. Of what benefit did this communication approach serve?
   1) she needed to get out of the house
   2) for the family to gain support from each other
   3) no benefit
   4) she was having a pathological grief response

65. While providing care to a terminally ill client, the nurse is asked questions about death. Which of the following would be beneficial to support the client’s spiritual needs?
   1) Nothing
   2) ask if they want to die
   3) ask if they want anything special before they die
   4) provide support, compassion, and love

66. An emergency room nurse is working when an Amtrak train derails. The emergency room nurse knows that reverse triage may need to be instituted. What is the rationale for using reverse triage?
   1) Mass casualty is an event with greater than 20 victims
   2) A very basic reverse triage system is to categorize or label victims needing the most support and emergency care as red.
   3) Victims most likely to survive are color coded as black.
   4) Reverse triage works on the principle of the greatest good for the greatest number.

67. Which of the following would be an appropriate strategy in reorienting a confused patient to where her room is?
   1) Place pictures of her family on the bedside stand
   2) Put her name in large letters on her forehead
   3) Remind the patient where her room is
   4) Let the other residents know where the patient’s room is

68. Which therapeutic communication technique is being used in this nurse-client interaction?
   Client: “When I get angry, I get into a fistfight with my wife or I take it out on the kids.”
   Nurse: “I notice that you are smiling as you talk about this physical violence.”
   1) Encouraging comparison
   2) Exploring
   3) Formulating a plan of action
   4) Making observations

69. Which therapeutic communication technique is being used in this nurse-client interaction?
   Client: “My father spanked me often.”
   Nurse: “Your father was a harsh disciplinarian.”
   1) Restatement
   2) Offering general leads
   3) Focusing
   4) Accepting

70. Which therapeutic communication technique is being used in this nurse-client interaction?
   Client: “When I am anxious, the only thing that calms me down is alcohol.”
   Nurse: “Other than drinking, what alternatives have you explored to decrease anxiety?”
   1) Reflecting
   2) Making observations
   3) Formulating a plan of action
   4) Giving recognition

71. The nurse is interviewing a newly admitted psychiatric client. Which nursing statement is an example of offering a “general lead”?
   1) “Do you know why you are here?”
   2) “Are you feeling depressed or anxious?”
   3) “Yes, I see. Go on.”
   4) “Can you chronologically order the events that led to your admission?”

72. A nurse maintains an uncrossed arm and leg posture. This nonverbal behavior is reflective of which letter of the SOLER acronym for active listening?
   1) S
   2) O
   3) L
   4) E
   5) R

73. What is the purpose of a nurse providing appropriate feedback?
   1) To give the client good advice
   2) To advise the client on appropriate behaviors
3) To evaluate the client’s behavior
4) To give the client critical information

74. Which example of a therapeutic communication technique would be effective in the planning phase of the nursing process?
1) “We’ve discussed coping skills. Let’s see if these coping skills can be effective now.”
2) “Please tell me in your own words what brought you to the hospital.”
3) “This new approach worked for you. Keep it up.”
4) “I notice that you seem to be responding to voices that I do not hear.”

75. During a nurse-client interaction, which nursing statement may belittle the client’s feelings and concerns?
1) “Don’t worry. Everything will be alright.”
2) “You appear uptight.”
3) “I notice you have bitten your nails to the quick.”
4) “You are jumping to conclusions.”

Answer key

1. B- Conduct, behavior, ethics & professionalism (refer to the code)
2. B- Arrange for an interpreter to translate { arranging a interpreter would be the best practice when communicating with a client who speaks a different language. Options A & D are inappropriate & are ineffective ways to communicate. Option C violates privacy & does not ensure correct answer }
3. B- You should report the incident to someone in authority (refer to the code)
4. C- Encourage the client to discuss the use of an herbal substance with the health care provider ( herbal substance may have some beneficence, not all herbs are safe to use . Clients with conventional therapy should be encouraged to avoid herbal substance with similar pharmacological effects because the combination may lead to an excessive reaction or to unknown interaction effects)
5. B- NMC
6. C- Belief in the dignity and worth of each person
7. A - Ethical principles & code
8. C - The nurse should honor client’s decision { refer revised code }
9. B - Accepting the patient’s choice & not intervening { revised code }

10. Answer 4. Contact or Body Substance Isolation (BSI) involves the use of barrier protection (e.g. gloves, mask, gown, or protective eyewear as appropriate) whenever direct contact with any body fluid is expected. When determining the type of isolation to use, one must consider the mode of transmission. The hands of personnel continues to be the principal mode of transmission for methicillin resistant staphylococcus aureus (MRSA). Because the organism is limited to the sputum in this example, precautions are taken if contact with the patient’s sputum is expected. A private room and BSI, along with good hand washing techniques, are the best defense against the spread of MRSA pneumonia.

11. Answer 2. The client who must be placed in airborne precautions is the client with a positive PPD (purified protein derivative) who has a positive x-ray for a suspicious tuberculin lesion.

12. Answer 2. Bathing or showering in the usual manner is permitted, using a mild detergent soap such as Ivory Snow. This cleanses the wounds, especially those that are still open, and removes dead tissue. The client is taught to report changes in wound healing such as blister formation, signs of infection, and opening of a previously healed area. Sterile dressings are applied until the wound is assessed and a plan of care developed. The Job’s garment is designed to place constant pressure on the new healthy tissue that is forming to promote adherence to the underlying structure in order to prevent hypertrophic scarring. In order to be effective, the garment must be worn for 23 hours daily. It is removed for wound assessment and wound care and to permit bathing. The client must be aware that infection of the wound may occur; signs of infection, including fever, redness, pain, warmth in and around the wound and increased or foul smelling drainage must be reported immediately.

13. Answer 4. There is a possibility of splashes of body secretions therefore a nurse must wear goggles, gown & face shield

14. Answer 4. Nonsterile gloves are adequate to remove the old dressing. However, the use of sterile gloves does not put the client in danger so discussion of this can wait until later. The staff nurse is doing two things incorrectly. Nonsterile gloves are adequate to remove the old dressing. The nurse should wash her hands after removing the soiled dressing and before donning sterile gloves to clean and dress the wound. The nurse should wash her hands after removing the soiled dressing and before donning the sterile gloves to clean and dress the wound. Not doing this compromises client safety and should be brought to the immediate attention of the nurse. The staff nurse is doing two things incorrectly. Nonsterile gloves are adequate to remove the old dressing. However, the use of sterile gloves does not put the client in danger so discussion of this
can wait until later. However, the nurse should wash her hands after removing the soiled dressing and before donning sterile gloves to clean and dress the wound. Not doing this compromises client safety and should be brought to the immediate attention of the nurse.

15. C - An increase in BP
   Rationale: A fluid volume excess is also known as overhydration or fluid overload & occurs when fluid intake or fluid retention exceeds the fluid needs of the body. Assessment findings associated with fluid volume excess include cough, dyspnea, crackles, tachypnea, tachycardia, elevated BP, bounding pulse, elevated CVP, weight gain, edema, neck & hand vein distention, altered level of consciousness & decreased hematocrit.

16. B - Requires nasogastric suction
   Rationale - potassium rich gastrointestinal fluids are lost through gastrointestinal suction, placing the client at risk for hypokalemia.

17. A - Anthropometric measurements
   Rationale – anthropometric measurements are the prime parameters used to evaluate fat & muscle stores in the body. Bleeding gums & dry skin are associated several systemic problems & can be signs of micronutrient deficiencies as well. Facial rubor is not a parameter used to evaluate nutritional health.

18. D - pH 7.30; pCO2 - 36; HCO3 - 18
   Rationale - the pH is below the normal range of 7.35 - 7.45. The pCO2 is within normal range 35 - 45 & HCO3 is below normal limits of 21 - 28. These values indicate a metabolic problem because the pCO2 is within normal limits & acidosis because the pH is below normal.

19. B - The patient with kidney disease
   Rationale: A fluid volume excess is also known as overhydration or fluid overload & occurs when fluid intake or fluid retention exceeds the fluid needs of the body. The causes of fluid volume excess include decreased kidney function, heart failure, use of hypotonic fluids to replace isotonic fluid losses, excessive irrigation of wounds & body cavities & excessive ingestion of sodium.

20. C - Observe for digitalis toxicity
   Rationale - hypokalemia enhances digitalis toxicity & must be observed carefully.

21. A - The skin
   Rationale - insensible loss may occur without the person's awareness. Insensible losses occur daily through the skin & the lungs. Sensible losses are those of which the person's aware, such as through urination, wound drainage & gastrointestinal tract losses.

22. D - Take a deep breath, hold it, & bear down
   Rationale - The client should be asked to perform the valsalva maneuver during tubing changes. This helps avoid air embolism during tubing changes. The nurse asks the client to take a deep breath, hold it, & bear down.

23. Answer 2. Rationale: None of the other movements or situations creates the combination of friction and pressure with downward movement seen in bedridden clients positioned in Fowler's position.

24. Answer 3. Rationale: All are at risk for infection. Answer 3 is at greatest risk, because the bullet is unclean, and a drug user is at great risk for immune deficiency.

25. Answer 4. Rationale: Chemical debridement is either done with enzyme agents or autolytic agents. Answer 1 is a type of sharp debridement. Answers 2 and 3 are mechanical and less precise than chemical.

26. Answer 4. Rationale: Drainage is described as purulent. Sanguineous and Serous-sanguineous contain blood. Serous is clear and watery.

27. Answer 1. Rationale: Wounds in the regeneration phase of healing need to be protected as new tissue grows. Answers 2, 3, and 4 are dressings used to remove nonviable tissue.

28. Answer 4. Rationale: The skin is cleansed with normal saline or a mild cleanser. Residue of old dressings will dissolve. The dressing size is to be 3-4 cm (1.5 inches) larger than the size of the wound.

29. Answer 3. Rationale: Laceration best describes the wound, because skin is ripped off. An abrasion is a scrape. Unapproximated is a general term for a wound that is not closed. Eschar is a scab-like covering over a wound.

30. 1 - true
    2 - true
    3 - true
    4 - false
    5 - true
    6 - false

31. Answer e

32. Answer c

33. Answer: 2.
   Rationales:
   1. Disengagement theory. In contrast to activity theory, disengagement theory views withdrawal from social contact and responsibilities as an inevitable and deliberate process. First proposed in the 1960s, this theory is not supported by the current trend for many older adults to remain engaged and responsible into later life.
   2. Activity theory. This theory proposes that the way to age successfully is to stay active...
and involved. Activity theory focuses on the current behavior of the older adult.
3. Genetic theory. According to genetic theory, an individual's lifespan is predetermined and people's aging experience is programmed by their genetic makeup.
4. Immunology theory. According to this theory, the body misidentifies older cells as foreign bodies, rendering them vulnerable to attack by the immune system. This theory implies that care of the cells over the lifespan is of primary importance if the individual is to decelerate the aging process.

34. Answer: 3.
Rationales:
1. The clinical presentation of mental illness in older adults differs from that in other age groups. Currently, there are few age-specific descriptors or criteria. However, research and identification of diagnostic criteria in children experiencing bipolar disorder is likely to appear in a future edition of the DSM, suggesting that specific criteria for older adults may appear in future editions as well.
2. Older people are believed to be more prone to mental illness than young people. This belief is an example of an ageist attitude that blurs important distinctions. It is the old-old group that tends to have the greatest incidence of depression, dementia, delirium, and other chronic disabling conditions.
3. When physical deterioration becomes a significant feature of an elder's life, the risk of comorbid psychiatric illness rises. This statement will not assist the nurse in distinguishing mental disorders from the expected changes associated with aging. It may, however, provide a rationale for the ageist observation, as most individuals' physiological needs become more complex as they age.
4. A competent clinician can readily distinguish mental disorders from the expected changes associated with aging. Even expert clinicians experience difficulty in distinguishing mental illness from age-related changes.

35. Answer 4. The GFR is decreased dramatically in the elderly due to changes in the renal tubules.

36. Answer 4. In the late stages of Alzheimer's disease, it is better to go along with the client's reality rather than confront him with logic & reasoning. Asking close-ended, simple questions that relate to his reality is nonthreatening & calming. Note that the nurse responds in a way that is congruent with his main concern, which is his sore back.

37. Answer 2. This statement is a cause for concern. Victims of abuse may alternate between generations. Abusive patterns are highly likely to be passed from parents to children when children grow up & move into positions where they are caring for their aged parents (role reversal), the abusive behavior can surface.

38. Answer 3. A modest increase in systolic blood pressure, not diastolic BP, is an expected age-related change due to an increase in vascular resistance & vessel rigidity. An increase in diastolic BP, however, is not an expected age-related change. It is pathologic & needs to be monitored.
Reference: ques no.58, pg no. 184, NCLEX – RN review 5th edition NSNA

39. 1 mg = 0.001 gm
40. 1.6 ml

41. Answer 4. Along with responsibility, one must transfer authority when delegating.

42. Answer 2. Monitoring performance and providing feedback is the final stage of effective delegation.

43. Answer 4.

44. Answer 2. Rationale: Discharge planning should begin when the client is admitted to the acute care facility. With the admissions process, the nurse can begin to assess the home environment, family and community support, as well as the client's readiness to be in the home. The process can be multifaceted and involve collaboration; therefore, the earlier the process begins, the better prepared the health care team and client are for a successful transition to the home.

45. Answer 1. Rationale: The case manager in a community-based nursing service will see clients in all settings. The case manager often is involved in wellness care, acute care, long-term care, hospice services, etc. The community-based case manager often consults with other health care professionals.

46. Answer 3. Rationale: Safety comes first in this case. Stairs and/or throw rugs while using a wheelchair or crutches are safety hazards. The other items are important, but are not most important on initial contact with the client.

47. Answer 1. Nurses need to advocate for public policy that promotes and protects the health of the public by taking public stands on quality care issues and educating the public on "public interest" issues.

48. Answer 3. An important component of advocacy is supporting the patient’s decision, which might not be the decision the nurse desires but must be supported.

49. Answer 3. Rationale: Full liquid food items include items such as plain ice cream, sherbet, breakfast drinks, milk, pudding, & custard, soups, that are strained, refined cooked cereals & strained vegetable juices. A clear liquid diet consists of foods that are relatively transparent. The food items in the incorrect options are clear liquids.

50. Answer 1. Rationale: The GI tract should be assessed before each feeding to ensure functioning & minimal problems.
Reference: ques no. 21, pg no. 171, NCLEX RN review, 5th edition NSNA
51. Answer 4.
Reference: www.wps.prenhall.com
Location on Site: Home > Therapeutic Communication > NCLEX Review

52. Answer 4. Shallow breathing and looking upward reflect the visual mode. Nurses should attempt to use a client’s preferred sensory style during communications.
Reference: www.wps.prenhall.com
Location on Site: Home > Therapeutic Communication > NCLEX Review

53. Answer 2. Tangential responses disregard important content and are related to incidental aspects of the conversation.
Reference: www.wps.prenhall.com
Location on Site: Home > Therapeutic Communication > NCLEX Review

54. Answer 2. Intrapersonal communication occurs when people communicate within themselves.
Reference: www.wps.prenhall.com
Location on Site: Home > Therapeutic Communication > NCLEX Review

55. Answer 1. The communication needs to be efficient, appropriate, flexible, and include feedback.
Reference: www.wps.prenhall.com
Location on Site: Chapter 10 > NCLEX® Review Questions

56. Answer 4. Facial expressions
Reference: www.wps.prenhall.com
Location on Site: Chapter 10 > NCLEX® Review Questions

57. Answer 2. The client processing auditory information
Rationale:
1. The client responding to auditory hallucinations. Eye movement side to side is an example of eyes accessing cues to an individual’s thinking process and is not necessarily indicative of auditory hallucination.
2. The client processing auditory information. An individual processing auditory information usually moves the eyes from side to side.
3. The client being bored with the interaction. Rolling of the eyes is typically observed in an individual who is bored with a situation.
4. The client engaging in intrapersonal communication. A person engaging in intrapersonal communication usually focuses the eyes down in the direction of the nondominant hand.
Reference: www.wps.prenhall.com
Location on Site: Chapter 10 > NCLEX® Review Questions

58. Answer 1. The present and not the past
Rationale:
1. The client responding to auditory hallucinations. Eye movement side to side is an example of eyes accessing cues to an individual’s thinking process and is not necessarily indicative of auditory hallucination.
2. The client processing auditory information. An individual processing auditory information usually moves the eyes from side to side.
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4. The client engaging in intrapersonal communication. A person engaging in intrapersonal communication usually focuses the eyes down in the direction of the nondominant hand.
Reference: www.wps.prenhall.com
Location on Site: Chapter 10 > NCLEX® Review Questions

Reference: www.wps.prenhall.com
Location on Site: Chapter 15 > NCLEX Multiple Choice Questions

60. Answer 4. Explain that his father has died and give him the option of attending the funeral.
Reference: www.wps.prenhall.com
Location on Site: Chapter 15 > NCLEX Multiple Choice Questions
63. Answer 3. suggest she take a few days off
Reference: www.wps.prenhall.com

64. Answer 2. for the family to gain support from each other
Reference: www.wps.prenhall.com

65. Answer 4. provide support, compassion, and love
Reference: www.wps.prenhall.com

66. Answer 4. Reverse triage works on the principle of the greatest good for the greatest number.
Rationale: During a disaster, nurses may be expected to perform triage. Triage means sorting. # 1 is incorrect because a mass casualty is an event with more than 100 victims. # 2 is incorrect because it describes basic triage and not reverse triage. # 3 is incorrect because victims least likely to survive or are already dead are color-coded as black.
Reference: www.wps.prenhall.com

67. Answer 3. The nurse should be someone the patient can turn to for guidance
Reference: ques no. 27, pg no. 659, NCLEX -RN review, 5th edition, NSNA

68. ANS: 4
The nurse is using the therapeutic communication technique of making observations when noting that the client smiles when talking about physical violence. The technique of making observations encourages the client to compare personal perceptions with those of the nurse.
Reference: www.quizlet.com
2204 therapeutic communication

69. ANS: 1
The nurse is using the therapeutic communication technique of restatement. Restatement involves repeating the main idea of what the client has said. The nurse uses this technique to communicate that the client’s statement has been heard and understood.
Reference: www.quizlet.com
2204 therapeutic communication

70. ANS: 3
The nurse is using the therapeutic communication technique of formulating a plan of action to help the client explore alternatives to drinking alcohol. The use of this technique, rather than direct confrontation regarding the client’s poor coping choice, may serve to prevent anger or anxiety from escalating.
Reference: www.quizlet.com
2204 therapeutic communication

71. ANS: 3
The nurse’s statement, “Yes, I see. Go on.” is an example of the therapeutic communication technique of a general lead. Offering a general lead encourages the client to continue sharing information.
Reference: www.quizlet.com
2204 therapeutic communication

72. ANS: 2
The nurse should identify that maintaining an uncrossed arm and leg posture is nonverbal behavior that reflects the “O” in the active-listening acronym SOLER. The acronym SOLER includes sitting squarely facing the client (S), open posture when interacting with the client (O), leaning forward toward the client (L), establishing eye contact (E), and relaxing (R).

73. ANS: 4
The purpose of providing appropriate feedback is to give the client critical information. Feedback should not be used to give advice or evaluate behaviors.
Reference: www.quizlet.com
2204 therapeutic communication

74. ANS: 1
This is an example of the therapeutic communication technique of formulating a plan of action. By the use of this technique, the nurse can help the client plan in advance to deal with a stressful situation which may prevent anger and/or anxiety from escalating to an unmanageable level.
Reference: www.quizlet.com
2204 therapeutic communication
This nursing statement is an example of the nontherapeutic communication block of belittling feelings. Belittling feelings occur when the nurse misjudges the degree of the client’s discomfort, thus a lack of empathy and understanding may be conveyed.

Reference: www.quizlet.com
2204 therapeutic communication

1. A young woman has suffered fractured pelvis in an accident, she has been hospitalized for 3 days, when she tells her primary nurse that she has something to tell her but she does not want the nurse to tell anyone. She says that she had tried to donate blood & tested positive for HIV. What is best action of the nurse to take?
   1) Document this information on the patient’s chart
   2) Tell the patient’s physician
   3) Inform the healthcare team who will come in contact with the patient
   4) Encourage the patient to disclose this information to her physician

2. A young woman who has tested positive for HIV tells her nurse that she has had many sexual partners. She has been on an oral contraceptive & frequently had not requested that her partners use condoms. She denies IV drug use. She tells her nurse that she believes that she will die soon. What would be the best response for the nurse to make.
   1) “Where there is life there is hope”
   2) “Would you like to talk to the nurse who works with HIV-positive patient’s?”
   3) “You are a long way from dying”
   4) “Not everyone who is HIV positive will develop AIDS & die”

3. An adult is offered the opportunity to participate in research on a new therapy. The researcher asks the nurse to obtain the patient’s consent. What is most appropriate for the nurse to take?
   1) Be sure the patient understands the project before signing the consent form
   2) Read the consent form to the patient & give him or her an opportunity to ask questions
   3) Refuse to be the one to obtain the patient’s consent
   4) Give the form to the patient & tell him or her to read it carefully before signing it.

4. An adult has signed the consent form for a research study but has changed her mind. The nurse tells the patient that she has the right to change her mind based upon which of the following principles.
   1) Paternalism & justice
   2) Autonomy & informed consent
   3) Beneficence & double effect
   4) Competence & right to know

5. The nurse is preparing to move an adult who has right sided paralysis from the bed into a wheelchair. Which statement describes the best action for the nurse to take.
   1) Position the wheelchair on the left side of the bed
   2) Keep the head of the bed elevated 10 degrees
   3) Protect the client’s left arm with a sling during the transfer
   4) Bend at the waist while helping the client into a standing position

6. An adult has experienced a CVA that has resulted in right side weakness. The nurse is preparing to move the patient right side of the bed so that he may then be turned to his left side. The nurse knows that an important principle when moving the patient is.
   1) To keep the feet close together
   2) To bend from waist
   3) To use body weight when moving objects
   4) A twisting motion will save steps

7. An adult has just returned to the unit from surgery. The nurse transferred him to his bed but did not put up the side rails. The client fell and was injured. What kind of liability does the nurse have?
   1) None
   2) Negligence
   3) Intentional tort
   4) Assault & battery

8. The nurse is in the hospital’s public cafeteria & hears two nursing assistants talking about the patient in 406. They are using her name & discussing intimate details about her illness which of the following actions is best for the nurse to take?
   1) Go over & tell the nursing assistants that their actions are inappropriate especially in a public place
   2) Wait & tell the assistants later that they were overheard discussing the patient otherwise they might be embarrassed
   3) Tell the nursing assistant’s supervisor about the incident. It is
the supervisor’s responsibility to address the issue

4) Say nothing. It is not the nurse’s job, he or she is not responsible for the assistant’s action

9. Which of the following client should the nurse deal with first
   1) A client who needs her dressing changed
   2) A client who needs to be suctioned
   3) A client who needs to be medicated for incisional pain
   4) A client who is incontinent & needs to be cleaned

10. A client on your medical surgical unit has a cousin who is a physician & wants to see the chart. Which of the following is the best response for the nurse to take?
   1) Hand the cousin the client chart to review
   2) Ask the client to sign an authorization & have someone review the chart with cousin
   3) Call the attending physician & have the doctor speak with the cousin
   4) Tell the cousin that the request cannot be granted

11. An adolescent male being treated for depression arrives with his family at the Adolescent Day Treatment Center for an initial therapy meeting with the staff. The nurse explains that one of the goals of the family meeting is to encourage the adolescent to:
   (A) Trust the nurse who will solve his problem.
   (B) Learn to live with anxiety and tension
   (C) Accept responsibility for his actions and choices.
   (D) Use the members of the therapeutic milieu to solve his problems.

12. A 23-year-old woman comes to the emergency room stating that she had been raped. Which of the following statements BEST describes the nurse’s responsibility concerning written consent?
   (A) The nurse should explain the procedure to the patient and ask her to sign the consent form.
   (B) The nurse should verify that the consent form has been signed by the patient and that it is attached to her chart.
   (C) The nurse should tell the physician that the patient agrees to have the examination.
   (D) The nurse should verify that the patient or a family member has signed the consent form.

13. The nurse cares for an elderly patient with moderate hearing loss. The nurse should teach the patient’s family to use which of the following approaches when speaking to the patient?
   (A) Raise your voice until the patient is able to hear you.
   (B) Face the patient and speak quickly using a high voice.
   (C) Face the patient and speak slowly using a slightly lowered voice.
   (D) Use facial expressions and speak as you would formally

14. A 52-year-old man is admitted to a hospital after sustaining a severe head injury in an automobile accident. When the patient dies, the nurse observes the patient’s wife comforting other family members. Which of the following interpretations of this behavior is MOST justifiable?
   (A) She has already moved through the stages of the grieving process.
   (B) She is repressing anger related to her husband’s death.
   (C) She is experiencing shock and disbelief related to her husband’s death.
   (D) She is demonstrating resolution of her husband’s death.

15. After two weeks of receiving lithium therapy, a patient in the psychiatric unit becomes depressed. Which of the following evaluations of the patient’s behavior by the nurse would be MOST accurate?
   (A) The treatment plan is not effective; the patient requires a larger dose of lithium.
   (B) This is a normal response to lithium therapy; the patient should continue with the current treatment plan.
16. The nurse works on a medical/surgical unit that has a shift with an unusually high number of admissions, discharges, and call bells ringing. A nurse's aide, who looks increasingly flustered and overwhelmed with the workload, finally announces “This is impossible! I quit!” and stumps toward the break room. Which of the following statements, if made by the nurse to the nurse's aide, is BEST?

A. Fine, we're better off without you anyway.
B. It seems to me that you feel frustrated. What can I help you with to care for our patients?
C. I can understand why you're upset, but I'm tired too and I'm not quitting.
D. Why don't you take a dinner break and come back? It will seem more manageable with a normal blood sugar.

17. A patient with a history of schizophrenia is admitted to the acute psychiatric care unit. He mutters to himself as the nurse attempts to take a history and yells, “I don't want to answer any more questions! There are too many voices in this room!” Which of the following assessment questions should the nurse ask NEXT?

A. Are the voices telling you to do things?
B. Do you feel as though you want to harm yourself or anyone else?
C. Who else is talking in this room? It's just you and me.
D. I don't hear any other voices

18. The nurse cares for a client diagnosed with conversion reaction. The nurse identifies the client is utilizing which of the following defense mechanisms?

A. Introjection
B. Displacement
C. Identification
D. Repression

19. A client comes to the local clinic complaining that sometimes his heart pounds and he has trouble sleeping. The physical exam is normal. The nurse learns that the client has recently started a new job with expanded responsibilities and is worried about succeeding. Which of the following responses by the nurse is BEST?

A. Have you talked to your family about your concerns?
B. You appear to have concerns about your ability to do your job
C. You could benefit from counseling.
D. It's normal to feel anxious when starting a new job.

20. Which of the following situations on a psychiatric unit are an example of a trusting patient-nurse relationship?

A. The patient tells the nurse that he feels suicidal
B. The nurse offers to contact the doctor if the patient has a headache.
C. The nurse gives the patient his daily medications right on schedule.
D. The nurse enforces rules strictly on the unit

24. The client is being involuntarily committed to the psychiatric unit after threatening to kill his spouse and children. The involuntary commitment is an example of what bioethical principle?

1) Fidelity
2) Veracity
3) Autonomy
4) Beneficence

21. A client expressed concern regarding the confidentiality of her medical information. The nurse assures the client that the nurse maintains client confidentiality by:

1) Sharing the information with all members of the health care team.
2) Limiting discussion about clients to the group room and hallways.
3) Summarizing the information the client provides during assessments and documenting this summary in the chart.
4) Explaining the exact limits of confidentiality in the exchanges between the client and the nurse.

22. When caring for clients with psychiatric diagnoses, the nurse recalls that the purpose of psychiatric diagnoses or psychiatric labeling is to:

1) Identify those individuals in need of more specialized care.
2) Identify those individuals who are at risk for harming others.
3) Enable the client's treatment team to plan appropriate and comprehensive care.
4) Define the nursing care for individuals with similar diagnoses.

23. The nurse restrains a client in a locked room for 3 hours until the client acknowledges who started a fight in the group room last evening. The nurse's behavior constitutes:
   1) False imprisonment.
   2) Duty of care.
   3) Standard of care practice.
   4) Contract of care

24. A client has been voluntarily admitted to the hospital. The nurse knows that which of the following statements is inconsistent with this type of hospitalization?
   1) The client retains all of his or her rights
   2) The client has a right to leave if not a danger to self or others
   3) The client can sign a written request for discharge
   4) The client cannot be released without medical advice

25. A nurse enters a patient's room & finds that the waste basket is on fire. The nurse immediately assists the patient out of the room. The next nursing action would be
   1) Confine the fire by closing the room door
   2) Activate the fire alarm
   3) Call for help
   4) Extinguish the fire

26. A nurse is preparing to initiate an IV line containing high dose of KCL & plans to use an IV infusion pump. The nurse brings the pump to the bedside prepares to plug the pump cord into the wall & notes that no receptacle is available in the wall socket. Which of the following is the most appropriate nursing action?
   1) Use an extension cord from nurses lounge for the pump plug
   2) Initiate the IV line without the use of a pump
   3) Plug in the pump cord in the available plug above the room's sink
   4) Contact the electrical maintenance deptt for assistance

27. A nurse obtains an order from a physician to restrain a client by using a jacket restraint. The nurse instructs nursing assistant to apply the restraint. Which of the following would indicate inappropriate application of the restraint by the nursing assistant?
   1) A safety knot in the restraint straps
   2) Restraint straps that are safely secured to the side rails
   3) The jacket restraint secured such that two fingers can slide easily between the restraints & the client skin
   4) Jacket restraint straps that do not tighten when force is applied against them

28. A mother calls the home care nurse & tells the nurse that her 3 year old child has ingested liquid furniture polish. The home care nurse would direct the mother immediately to
   1) Induce vomiting
   2) Bring the child to the ER
   3) Call an ambulance
   4) Call the poison control centre

29. A home care nurse performs a home safety assessment & discovers that a client is using a space heater to heat her apartment. Which of the following instructions would the nurse provide to the client regarding the use of the space heater?
   1) A space heater should not be used in an apartment
   2) Space heater to be placed at least 3 feet from anything that can burn
   3) The space heater should be placed in the hallway at night
   4) The space heater should be kept at a low setting at all times

30. An emergency room nurse receives a telephone call & is informed that a tsunami has hit a local residential area & that numerous casualties have occurred. The victims will be brought to the ER. The initial nursing action is which of the following?
   1) Prepare the triage room
   2) Obtain additional supplies from the central supply deptt
   3) Activate the agency disaster plan
   4) Obtain additional nursing staff to assist in treating the casualties

31. Ms. Jane is to have a pelvic exam, which of the following should the nurse do first?
   1) Have the client remove all her clothes, socks & shoes
   2) Have the client go to the bathroom & void saving a sample
   3) Place the client in lithotomy position on the exam table
   4) Assemble all the equipment needed for the examination

32. When prioritizing a client's plan of care based on Maslow's hierarchy of needs, the nurse Charles first priority would be:
   1) Allowing the family to see a newly admitted client
   2) Ambulating the client in the hallway
   3) Administering pain medication
   4) Placing wrist restraints on the client
33. Doctor’s Order: Tylenol supp 1 g pr q 6 hr prn temp > 101; Available: Tylenol supp 325 mg (scored). How many supp will you administer?
   A. 2 supp
   B. 1 supp
   C. 3 supp
   D. 5 supp

34. Doctor’s Order: Nafcillin 500 mg po pc; Available: Nafcillin 1 gm tab (scored). How many tab will you administer per day?
   A. 2.5 tabs
   B. 2 tabs
   C. 1.5 tabs
   D. 1 tab

35. Doctor’s Order: Synthroid 75 mcg po daily; Available: Synthroid 0.15 mg tab (scored). How many tab will you administer?
   A. 1 tab
   B. 0.5 tab
   C. 2 tabs
   D. 1.5 tabs

36. Doctor’s Order: Diuril 1.8 mg/kg po tid; Available: Diuril 12.5 mg caps. How many cap will you administer for each dose to a 31 lb child?
   A. 2 caps
   B. 2.5 caps
   C. 3 caps
   D. 1.5 caps

37. Doctor’s Order: Cleocin Oral Susp 600 mg po qid; Directions for mixing: Add 100 mL of water and shake vigorously. Each 2.5 mL will contain 100 mg of Cleocin. How many tsp of Cleocin will you administer?
   A. 3 tsp
   B. 5 tsp
   C. 3.5 tsp
   D. 1 tsp

38. Doctor’s Order: Sulfasalazine Oral Susp 500 mg q 6 hr; Directions for mixing: Add 125 mL of water and shake well. Each tbsp will yield 1.5 g of Sulfasalazine. How many mL will you give?
   A. 5 ml
   B. 3 ml
   C. 4 ml
   D. 2 ml

39. Your patient has had the following intake: 2 ½ cups of coffee (240 mL/cup), 11.5 oz of grape juice, ¾ qt of milk, 320 mL of diet coke, 1 ¼ L of D5W IV and 2 oz of grits. What will you record as the total intake in mL for this patient?
   A. 2,325 ml
   B. 3,265 ml
   C. 3,325 ml
   D. 2,235 ml

40. Your patient has had the following intake: 8 oz glasses of iced tea, 4 oz cartons of grape juice, ¾ pt of ice cream, 32 oz of juice, 1 ½ L of D5W IV and 6 oz of cottage cheese. What will you record as the total intake in mL for this patient?
   A. 3,357 ml
   B. 3,375 ml
   C. 3,915 ml
   D. 3,195 ml

41. Doctor’s Order: Kantamycin 7.5 mg/kg IM q 12 hr; Available: Kantamycin 0.35 Gm/mL. How many mL will you administer for each dose to a 157 lb patient?
   A. 2 ml
   B. 1 ml
   C. 2.5 ml
   D. 1.5 ml

42. Doctor’s Order: Heparin 7,855 units Sub Q bid; Available: Heparin 10,000 units per mL. How many mL will you administer?
   A. 0.79 ml
   B. 1.79 ml
   C. 0.17 ml
   D. 1.17 ml

43. Doctor’s Order: Demerol 50 mg IVP q 6 hr prn pain; Available: Demerol 75 mg/ 1.3mL. How many mL will you administer?
   A. 0.87 ml
   B. 1.87 ml
   C. 2 ml
   D. 2.87 ml

44. Doctor’s Order: Streptomycin 1.75 mg/ lb IM q 12 hr; Available: Streptomycin 0.35 g / 2.3 mL. How many mL will you administer a day to a 59 Kg patient?
   A. 1.5 ml
45. Doctor's Order: Bumex 0.8 mg IV bolus bid; Reconstitution instructions: Constitute to 1000 micrograms/3.1 mL with 4.8 mL of 5% Dextrose Water for Injection. How many mL will you administer?

A. 2 ml  
B. 3.5 ml  
C. 3 ml  
D. 2.5 ml

46. Doctor's Order: Tazidime 0.3 g IM tid; Reconstitution instructions: For IM solution add 1.5 mL of diluent. Shake to dissolve. Provides an approximate volume of 1.8 mL (280 mg/mL). How many mL will you give?

A. 1.9 mL  
B. 2 mL  
C. 3 mL  
D. 1.1 mL

47. Doctor’s Order: Infuse 50 mg of Amphotericin B in 250 mL NS over 4 hr 15 min; Drop factor: 12 gtt/mL. What flow rate (mL/hr) will you set on the IV infusion pump?

A. 11.8 mL/hr  
B. 58.8 mL/hr  
C. 14.1 mL/hr  
D. 60.2 mL/hr

48. Doctor’s Order: 1 ½ L of NS to be infused over 7 hours; Drop factor: 15 gtt/mL. What flow rate (mL/hr) will you set on the IV infusion pump?

A. 53.6 mL/hr  
B. 214.3 mL/hr  
C. 35.7 mL/hr  
D. 142.9 mL/hr

49. Doctor’s Order: Mandol 300 mg in 50 mL of D5W to infuse IVPB 15 minutes; Drop factor: 10 gtt/mL. How many mL/hr will you set on the IV infusion pump?

A. 200 mL/hr  
B. 87.5 mL/hr  
C. 33 mL/hr  
D. 50 mL/hr

50. Doctor’s Order: Infuse 1200 mL of 0.45% Normal Saline at 125 mL/hr; Drop Factor: 12 gtt/min. How many gtt/min will you regulate the IV?

A. 2 gtt/min  
B. 12 gtt/min  
C. 25 gtt/min  
D. 27 gtt/min

51. Doctor’s Order: Rocephin 0.5 grams in 250 mL of D5W to infuse
IVPB 45 minutes; Drop Factor: 12gt/min. How many gtt/min will you regulate the IVPB?

A. 6 gtt/min
B. 30 gtt/min
C. 67 gtt/min
D. 87 gtt/min

52. Doctor's Order: ¼ L of D5W to infuse over 2 hr 45 min; Drop factor: 60 gtt/mL. How many gtt/min will you regulate the IV?

A. 91 gtt/min
B. 96 gtt/min
C. 125 gtt/min
D. 142 gtt/min

54. The contingency theory of management moves the manager away from which of the following approaches?

1) No perfect solution
2) One size fits all
3) Interaction of the system with the environment
4) A method or combination of methods that will be most effective in a given situation

55. Transformational leadership is characterized by all of the following elements except:

1) Charisma
2) Inspirational leadership
3) Intellectual stimulation
4) Incentives to promote loyalty and performance.

56. The characteristics of an effective leader include:

1) Attention to detail
2) Financial motivation
3) Sound problem-solving skills and strong people skills
4) Emphasis on consistent job performance

57. Which nursing delivery model is based on a production and efficiency model and stresses a task-oriented approach?

1) Case management
2) Primary nursing
3) Differentiated practice
4) Functional method

58. What are essential competencies for today’s nurse manager?

1) A vision and goals
2) Communication and teamwork
3) Self- and group awareness
4) Strategic planning and design

59. What is the most important issue confronting nurse managers using situational leadership?

1) Leaders can choose one of the four leadership styles when faced with a new situation.
2) Personality traits and leader’s power base influence the leader’s choice of style.
3) Value is placed on the accomplishment of tasks and interpersonal
relationships between leader and group members and among group members.

4) Leadership style differs for a group whose members are at different levels of maturity.

60. When group members are unable and unwilling to participate in making a decision, which leadership style should the nurse manager use?
1) Participative
2) Authoritarian
3) Laissez-faire
4) Democratic

61. Ms. Castro is newly-promoted to a patient care manager position. She updates her knowledge on the theories in management and leadership in order to become effective in her new role. She learns that some managers have low concern for services and high concern for staff. Which style of management refers to this?
a. Organization Man
b. Impoverished Management
c. Country Club Management
d. Team Management

62. Her former manager demonstrated passion for serving her staff rather than being served. She takes time to listen, prefers to be a teacher first before being a leader, which is characteristic of
a. Transformational leader
b. Transactional leader
c. Servant leader
d. Charismatic leader

63. On the other hand, Ms. Castro notices that the Chief Nurse Executive has charismatic leadership style. Which of the following behaviors best describes this style?
a. Possesses inspirational quality that makes followers get attracted to him and regards him with reverence
b. Acts as he does because he expects that his behavior will yield positive results
c. Uses visioning as the core of his leadership
d. Matches his leadership style to the situation at hand.

64. Which of the following conclusions of Ms. Castro about leadership characteristics is TRUE?
a. There is a high correlation between the communication skills of a leader and the ability to get the job done.
b. A manager is effective when he has the ability to plan well.
c. Assessment of personal traits is a reliable tool for predicting a manager's potential
d. There is good evidence that certain personal qualities favor success in managerial role.

65. She reads about Path Goal theory. Which of the following behaviors is manifested by the leader who uses this theory?
a. Recognizes staff for going beyond expectations by giving them citations
b. Challenges the staff to take individual accountability for their own practice
c. Admonishes staff for being laggards.
d. Reminds staff about the sanctions for non performance.

66. One leadership theory states that “leaders are born and not made,” which refers to which of the following theories?
a. Trait
b. Charismatic
c. Great Man
d. Situational

67. She came across a theory which states that the leadership style is effective dependent on the situation. Which of the following styles best fits a situation when the followers are self-directed, experts and are matured individuals?
a. Democratic
b. Authoritarian
c. Laissez faire
d. Bureaucratic
68. She surfs the internet for more information about leadership styles. She reads about shared leadership as a practice in some magnet hospitals. Which of the following describes this style of leadership?

a. Leadership behavior is generally determined by the relationship between the leader’s personality and the specific situation  
b. Leaders believe that people are basically good and need not be closely controlled  
c. Leaders rely heavily on visioning and inspire members to achieve results  
d. Leadership is shared at the point of care.

69. Harry is a Unit Manager in the Medical Unit. He is not satisfied with the way things are going in his unit. Patient satisfaction rate is 60% for two consecutive months and staff morale is at its lowest. He decides to plan and initiate changes that will push for a turnaround in the condition of the unit. Which of the following actions is a priority for Harry?

a. Call for a staff meeting and take this up in the agenda.  
b. Seek help from her manager.  
c. Develop a strategic action on how to deal with these concerns.  
d. Ignore the issues since these will be resolved naturally

70. After discussing the possible effects of the low patient satisfaction rate, the staff started to list down possible strategies to solve the problems head-on. Should they decide to vote on the best change strategy, which of the following strategies is referred to this?

a. Collaboration  
b. Majority rule  
c. Dominance  
d. Compromise

1. Answer 4. Encourage the patient to disclose this information to her physician

   Rationale: a nurse is legally obliged to protect a client’s right to privacy

   Reference : Ques no. 1, pg no. 135, NCLEX –RN review, 5th edition, NSNA

2. Answer 2. “Would you like to talk to the nurse who works with HIV-positive patient’s?”

   Rationale: this provides the patient with expert care

   Reference : Ques no. 2, pg no. 135, NCLEX –RN review, 5th edition, NSNA

3. Answer 3. Refuse to be the one to obtain the patient’s consent

   Rationale: the nurse cannot obtain consent, they may legally witness consent to medical procedures. Research team is responsible for the consent.

   Reference : Ques no. 3, pg no. 135, NCLEX –RN review, 5th edition, NSNA

4. Answer 2. Autonomy & informed consent

   Rationale: autonomy is the ethical right to decide what treatment you will or will not receive. Informed consent can be withdrawn.

   Reference : Ques no. 4, pg no. 135, NCLEX –RN review, 5th edition, NSNA

5. Answer 1. Position the wheelchair on the left side of the bed

   Rationale: Place the wheelchair beside the bed on the patient’s strongest side, so that it faces the foot of the bed

   Reference : Ques no. 5, pg no. 135, NCLEX –RN review, 5th edition, NSNA

6. ANSWER 3. To use body weight when moving objects

   RATIONALE: OBJECT SHOULD BE pushed or pulled instead of lifted. It prevents strain to muscles & joints.

   Reference : Ques no. 6, pg no. 135, NCLEX –RN review, 5th edition, NSNA
7. Answer 2, Negligence
   Rationale: The nurse has been negligent & can be liable for malpractice
   Reference: Ques no. 18, pg no. 137, NCLEX – RN review, 5th edition, NSNA

8. Answer 1. Go over & tell the nursing assistants that their actions are inappropriate especially in a public place
   Rationale: The client has a right to confidentiality & her case should not be discussed in a public place
   Reference: Ques no. 19, pg no. 137, NCLEX – RN review, 5th edition, NSNA

9. Answer 2. A client who needs to be suctioned
   Rationale: Any client with a potential compromise of the airway should be dealt with first
   Reference: Ques no. 25, pg no. 137, NCLEX – RN review, 5th edition, NSNA

10. Answer 2. Ask the client to sign an authorization & have someone review the chart with cousin
   Rationale: The client must agree to & sign an authorization before others can review the chart
   Reference: Ques no. 21, pg no. 137, NCLEX – RN review, 5th edition, NSNA

11. The correct answer is C.

What is the goal of family therapy? Needed Info: Symptoms of depression: low self-esteem, obsessive thoughts, regressive behavior, unkempt appearance, lack of energy, weight loss, decreased concentration, withdrawn behavior.

(A) Trust the nurse who will solve his problem — not realistic
(B) Learn to live with anxiety and tension — minimizes concerns
(C) Accept responsibility for his actions and choices — CORRECT
(D) Use the members of the therapeutic milieu to solve his problems — must do it himself

REFERENCE: www.kaptest.com quest. 1

Sample NCLEX-RN® Quiz: Psychosocial Integrity A

12. The correct answer is B.

What is your responsibility concerning informed consent? Needed Info: Physician’s responsibility to obtain informed consent.

(A) The nurse should explain the procedure to the patient and ask her to sign the consent form — Physician should get patient to sign consent
(B) The nurse should verify that the consent form has been signed by the patient and that it is attached to her chart — CORRECT
(C) The nurse should tell the physician that the patient agrees to have the examination — Physician should explain procedure and get consent form signed
(D) The nurse should verify that the patient or a family member has signed the consent form — must be signed by patient, unless unable to do.

REFERENCE: www.kaptest.com quest. 2

Sample NCLEX-RN® Quiz: Psychosocial Integrity A

13. The correct answer is C.

What should you do to communicate with a person with a moderate hearing loss?

(A) Raise your voice until the patient is able to hear you — would result in high tones patient unable to hear
(B) Face the patient and speak quickly using a high voice — usually unable to hear high tones
(C) Face the patient and speak slowly using a slightly lowered voice — CORRECT: also decrease background noise; speak at a slow pace, use nonverbal cues helps but low tones
(D) Use facial expressions and speak as you would normally — nonverbal cues

REFERENCE: www.kaptest.com quest. 3

Sample NCLEX-RN® Quiz: Psychosocial Integrity A

14. The correct answer is C.

What is the reason for the wife’s behavior? Needed Info: Stages of grief:

1) shock and disbelief,
2) awareness of pain and loss,
3) restitution.
Acute period: 4-8 weeks, usual resolution: 1 year.
(A) She has already moved through the stages of the grieving process — takes one year
(B) She is repressing anger related to her husband’s death — not accurate; second stage: crying, regression
(C) She is experiencing shock and disbelief related to her husband’s death — CORRECT: denial first stage; inability to comprehend reality of situation
(D) She is demonstrating resolution of her husband’s death — too soon

REFERENCE: www.kaptest.com quest. 4

Sample NCLEX-RN® Quiz: Psychosocial Integrity A

15. The correct answer is C.
Is the depression normal, or something to be concerned about?
(A) The treatment plan is not effective; the patient requires a larger dose of lithium — not accurate
(B) This is a normal response to lithium therapy; the patient should continue with the current treatment plan — does not address safety needs
(C) This is a normal response to lithium therapy; the patient should be monitored for suicidal behavior — CORRECT: delay of 1-3 weeks before med benefits seen
(D) The treatment plan is not effective; the patient requires an antidepressant — normal response

REFERENCE: www.kaptest.com quest. 5

Sample NCLEX-RN® Quiz: Psychosocial Integrity A

16. Answer: 2 "It seems to me that you feel frustrated. What can I help you with to care for our patients?"
RATIONAL: This statement uses reflection and offers help to a fellow member of the patient care team. Do not refer back to yourself or offer a break. Offer to directly solve the cause of the problem.

REFERENCE: www.freenclexquestion.com quest no:1

17. ANSWER: 1 "Are the voices telling you to do things?
RATIONAL: We need to assess for command hallucinations to determine if this patient is at increased risk for harming himself or others.

REFERENCE: www.freenclexquestion.com quest no:2

18. ANSWER: 4 Repression
RATIONAL: The patient is repressing their stressful thoughts and converting them into a physical symptom (conversion reaction).

REFERENCE: www.freenclexquestion.com quest no:3

19. ANSWER: 2 You appear to have concerns about your ability to do your job
RATIONAL: Use reflection at them, to repeat the patient’s words back

REFERENCE: www.freenclexquestion.com quest no:4

20. ANSWER: 1 The patient tells the nurse that he feels suicidal
The trusting relationship between the patient and nurse means that the patient feels he can express his feelings in a safe environment.

REFERENCE: www.freenclexquestion.com quest no:5
21. **Answer 4, Beneficence**

**Rationale:**
1. Fidelity. Fidelity refers to the nurse’s loyalty and commitment to clients and remaining faithful to your duties, promises and obligations.
2. Beneficence. Protecting clients from harm because of their thoughts, feelings, and behaviors is an example of beneficence. An involuntary commitment is necessary to protect the client from harming self or others.
3. Veracity. Veracity implies the intention to tell the truth.
4. Autonomy. Autonomy is the freedom to choose a course of action and accept the consequences of the decision.

**Cognitive Level:** Application  
**Client Need:** Physical Integrity  
**Nursing Process:** Implementation  
**Learning Outcome:** Relate the five principles of bioethics to the practice of psychiatric–mental health nursing.

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**Location on Site:** Chapter 13 > NCLEX® Review Questions

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22. **Answer 4, Explaining the exact limits of confidentiality in the exchanges between the client and the nurse.**

**Rationale:**
1. Sharing the information with all members of the health care team. Nurses attempt to secure client confidentiality by sharing information with only those members of the health care team who have a need to know.
2. Explaining the exact limits of confidentiality in the exchange between the client and the nurse. Client education regarding the exact limits of confidentiality empowers the client.
3. Summarizing the information the client provides during assessments and documenting this summary in the chart. It is essential that the nurse documents information accurately and accurately represents the data the client has communicated. Summarizing the data increases the risk of the nurse losing objectivity.
4. Limiting discussion about clients to the group room and hallways. Discussions of client information should be restricted to private rather than public areas.

**Cognitive Level:** Application  
**Client Need:** Safe, Effective Care Environment  
**Nursing Process:** Implementation  
**Learning Outcome:** Discuss how ethical guidelines can be applied in reconciling crucial ethical dilemmas.

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23. **Answer 3, Enable the client’s treatment team to plan appropriate and comprehensive care.**

**Rationale:**
1. Standard of care practice. Standards of nursing care dictate that client care should be in the least restrictive environment. Restraining a client in a locked room violates this standard.
2. False imprisonment. False imprisonment is an example of a tort, a wrongful act. The nurse can be held liable for his or her actions.
3. Duty of care. The nurse acting in good faith for the client, with intentions to help the client, is exercising duty of care.
4. Contract of care. A contract of care is established between a client and a nurse once the nurse accepts the assignment.

**Cognitive Level:** Application  
**Client Need:** Safe, Effective Care Environment  
**Nursing Process:** Evaluation  
**Learning Outcome:** Identify the acts for which psychiatric–mental health nurses can be held legally liable.

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24. **Answer 1, False imprisonment.**

**Rationale:**
1. Standard of care practice. Standards of nursing care dictate that client care should be in the least restrictive environment. Restraining a client in a locked room violates this standard.
2. False imprisonment. False imprisonment is an example of a tort, a wrongful act. The nurse can be held liable for his or her actions.
3. Duty of care. The nurse acting in good faith for the client, with intentions to help the client, is exercising duty of care.
4. Contract of care. A contract of care is established between a client and a nurse once the nurse accepts the assignment.

**Cognitive Level:** Application  
**Client Need:** Safe, Effective Care Environment  
**Nursing Process:** Evaluation  
**Learning Outcome:** Identify the acts for which psychiatric–mental health nurses can be held legally liable.

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25. **Answer 4, the client cannot be released without medical advice**

**Rationale:** When a client is involuntarily admitted to the hospital, the client cannot be released without medical advice. The client does retain all of his rights, can sign a written request for discharge, and has a right to leave if not a danger to self or others.
26. **Answer 2** Activate the fire alarm  
**Rationale:** the order of priority in the event of a fire is to rescue the patient who are in danger the next step is to activate the fire alarm. The fire then is confined by closing all the doors & last the fire is extinguished  
**Reference:** ques no 1. Pg no. 183, saunders 3rd edition

27. **Answer 4.** Contact the electrical maintenance deptt for assistance  
**Rationale:** the nurse need to use hospital resources for assistance  
**Reference:** ques no 4. Pg no. 183, saunders 3rd edition

28. **Answer 2** Restraint straps that are safely secured to the side rails  
**Rationale:** half bow or safety knot should be used for applying a restraint because it does not tighten when force is applied against it & allows quick & easy removal of the restraint in case of emergency. the restraints straps are secured to the bed frame & never to the side rails to avoid accidental injury  
**Reference:** ques no 5. Pg no. 183, saunders 3rd edition

29. **Answer 4** Call the poison control centre  
**Rationale:** if poisoning occurs the poisoning control centre should be contacted immediately. vomiting should not be induced if the victim is unconscious & if the substance ingested is a strong corrosive  
**Reference:** ques no 8. Pg no. 183, saunders 3rd edition

30. **Answer 2.** Space heater to be placed at least 3 feet from anything that can burn  
**Rationale:** space heater need to be used appropriately because they present a great risk of fire  
**Reference:** ques no 3. Pg no. 183, saunders 3rd edition

31. **Answer 3** Activate the agency disaster plan  
**Rationale:** use the process of elimination to determine the priority action. Note the key word "initial"  
**Reference:** ques no 9. Pg no. 183, saunders 3rd edition

32. **Answer 2,** Have the client go to the bathroom & void saving a sample  
**Rationale:** the client should have an empty bladder before the examination  
**Reference:** ques no 26, pg no, 802, NCLEX RN review, 4th edition NSNA

33. **Answer C.** In Maslow’s hierarchy of needs, pain relief is on the first layer. Activity (option B) is on the second layer. Safety (option D) is on the third layer. Love and belonging (option A) are on the fourth layer.  
**Reference:** www.nclexreviewers.com

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**Safe and Effective Care Environment NCLEX Review Questions Answers and Rationale:**

**Answer:** C. 3 supp  
\[
1 \text{ g} = 1000 \text{ mg}  
\]

34. \[
\frac{1 \text{ g}}{325 \text{ mg}} \times \frac{1000 \text{ mg}}{1 \text{ g}} \times 1 \text{ supp} = 3.08 \text{ or } 3 \text{ supp}  
\]

35. **Answer:** C. 1.5 tabs  
\[
\frac{500 \text{ mg}}{1 \text{ g}} \times \frac{1 \text{ g}}{1,000 \text{ mg}} \times 3 \text{ meals} \times 1 \text{ tab} = 1.5 \text{ tabs}  
\]
36. Answer: B. 0.5 tab

\[
\frac{75 \, mcg}{0.15 \, mg} \times \frac{1 \, mg}{1,000 \, mcg} \times 1 \, tab = 0.5 \, tab
\]

37. Answer: A. 2 caps

31 lbs = 14 kg

\[
1.8 \, mg/kg \times 14 \, kg = 25.2 \, mg \text{ or } 25 \, mg \text{ (per dose)}
\]

\[
\frac{25 \, mg}{12.5 \, mg} \times 1 \, cap = 2 \, caps
\]

38. Answer: A. 3 tsp

\[
15 \, ml \times \frac{1 \, tsp}{5 \, ml} = 3 \, tsp
\]

39. Answer: A. 5 ml

1 tbsp = 15 ml

\[
\frac{500 \, mg}{1.5 \, g} \times \frac{1 \, g}{1,000 \, mg} \times 15 \, ml = 5 \, ml
\]

40. Answer: B. 3,265 ml

1 qt = 1,000 ml

1 oz = 30 ml

600 ml + 345 ml + 750 ml + 320 ml + 1,250 ml = 3,265 ml (Grits is not liquid at room temperature, so it is not included when calculating intake.)

41. Answer: D. 3,195 ml

1 pt = 500 ml

1 oz = 30 ml

240 ml + 120 ml + 375 ml + 960 ml + 1,500 ml = 3,195 ml (Cottage cheese is not liquid at room temperature, so it is not included when calculating intake.)

42. Answer: D. 1.5 ml

157 lbs = 71.36 kg or 71 kg
43. Answer: A. 0.79 ml
\[ \frac{7,855 \text{ units}}{10,000 \text{ units}} \times 1 \text{ ml} = 0.79 \text{ ml} \]

44. Answer: A. 0.87 ml
\[ \frac{50 \text{ mg}}{75 \text{ mg}} \times 1 \text{ ml} = 0.87 \text{ ml} \]

45. Answer: D. 3 ml
\[ \frac{59 \text{ kg}}{130 \text{ lbs}} = 0.45 \text{ kg/lb} \]
\[ 1.75 \text{ mg/lbs} \times 130 \text{ lbs} = 227.5 \text{ mg} \]
\[ \frac{227.5 \text{ mg}}{0.35 \text{ g}} \times \frac{1 \text{ g}}{1,000 \text{ mg}} \times 2.3 \text{ ml} = 1.5 \text{ ml} \]
\[ 1.5 \text{ ml} \times 2 = 3 \text{ ml} \]

46. Answer: D 2.5 ml
\[ 1 \text{ mg} = 1,000 \text{ mcg} \]
\[ \frac{0.8 \text{ mg}}{1,000 \text{ mcg}} \times \frac{1,000 \text{ mcg}}{1 \text{ mg}} \times 3.1 \text{ ml} = 2.5 \text{ ml} \]

47. Answer: D. 1.1 ml
\[ \frac{0.3 \text{ g}}{280 \text{ mg/ml}} \times \frac{1,000 \text{ mg}}{1 \text{ g}} \times 1 \text{ ml} = 1.1 \text{ ml} \]

48. Answer: B. 58.8 ml/hr
\[ 4 \text{ hr} 15 \text{ min} = 4.25 \text{ hrs} \]
\[ \frac{250 \text{ ml}}{4.25 \text{ hrs}} = 58.8 \text{ ml/hr} \]

49. Answer: B. 214.3 ml/hr
\[ \frac{1,500 \text{ ml}}{7 \text{ hrs}} = 214.3 \text{ ml/hr} \]

50. Answer: A. 200 ml/hr
\[ 15 \text{ min} = 0.25 \text{ hr} \]
\[
\frac{50\text{ ml}}{0.25\text{ hr}} = 200\text{ ml/hr}
\]

51. Answer: C. 25 gtt/min

\[
\frac{125\text{ ml}}{1\times60\text{ mins}} \times 12\text{ gtt/ml} = 25\text{ gtt/min}
\]

52. Answer: C. 67 gtt/min

\[
\frac{250\text{ ml}}{45\text{ mins}} \times 12\text{ gtt/ml} = 67\text{ gtt/min}
\]

53. Answer: A. 91 gtt/min

\[
\frac{250\text{ ml}}{2\text{ hrs} \times 60\text{ mins} + 45\text{ mins}} \times 60\text{ gtt/ml} = 91\text{ gtt/min}
\]

54. Answer 3, Conceptual and interpersonal skills
www.wps.prenhall.com

Location on Site: Chapter 9 > NCLEX Review Questions

55. Answer 2, One size fits all
www.wps.prenhall.com

Location on Site: Chapter 9 > NCLEX Review Questions

56. Answer 4, incentives to promote loyalty and performance
www.wps.prenhall.com

Location on Site: Chapter 9 > NCLEX Review Questions

57. Answer 3, sound problem-solving skills and strong people skills
www.wps.prenhall.com

Location on Site: Chapter 9 > NCLEX Review Questions

58. Answer 4, Functional method
www.wps.prenhall.com

Location on Site: Chapter 9 > NCLEX Review Questions

59. Answer 2, Communication and teamwork
www.wps.prenhall.com

Location on Site: Chapter 9 > NCLEX Review Questions

60. Answer 3, Value is placed on the accomplishment of tasks and on interpersonal relationships between leader and group members and among group members
www.wps.prenhall.com

Location on Site: Chapter 9 > NCLEX Review Questions

61. Answer 2, Authoritarian
www.wps.prenhall.com

Location on Site: Chapter 9 > NCLEX Review Questions
62. **Answer:** (C) Country Club Management  
**Rationale:** Country club management style puts concern for the staff as number one priority at the expense of the delivery of services. He/she runs the department just like a country club where everyone is happy including the manager.  
Reference: www.quizlets.com quest. no: 1

63. **Answer:** (C) Servant leader  
**Rationale:** Servant leaders are open-minded, listen deeply, try to fully understand others and not being judgmental  
Reference: www.quizlets.com quest. no: 2

64. **Answer:** (A) Possesses inspirational quality that makes followers gets attracted of him and regards him with reverence  
**Rationale:** Charismatic leaders make the followers feel at ease in their presence. They feel that they are in good hands whenever the leader is around.  
Reference: www.quizlets.com quest. no: 3

65. **Answer:** (C) Assessment of personal traits is a reliable tool for predicting a manager's potential.  
**Rationale:** It is not conclusive that certain qualities of a person would make him become a good manager. It can only predict a manager's potential of becoming a good one.  
Reference: www.quizlets.com quest. No 4

66. **Answer:** (A) Recognizes staff for going beyond expectations by giving them citations  
**Rationale:** Path Goal theory according to House and associates rewards good performance so that others would do the same  
Reference: www.quizlets.com quest. no: 5

67. **Answer:** (C) Great Man  
**Rationale:** Leaders become leaders because of their birth right. This is also called Genetic theory or the Aristotelian theory.  
Reference: www.quizlets.com quest. no: 6

68. **Answer:** (C) Laissez faire  
**RATIONALE:** Laissez faire leadership is preferred when the followers know what to do and are experts in the field. This leadership style is relationship-oriented rather than task-centered.  
Reference: www.quizlets.com quest. no: 7

69. **Answer:** (D) Leadership is shared at the point of care.  
**RATIONALE:** Shared governance allows the staff nurses to have the authority, responsibility and accountability for their own practice.  
Reference: www.quizlets.com quest. no: 8

70. **Answer:** (A) Call for a staff meeting and take this up in the agenda.  
**RATIONALE:** This will allow for the participation of every staff in the unit. If they contribute to the solutions of the problem, they will own the solutions; hence the chance for compliance would be greater.  
Reference: www.quizlets.com quest. no: 10

71. **Answer:** (B) Majority rule  
**RATIONALE:** Majority rule involves dividing the house and the highest vote wins. 1/2 + 1 is a majority.  
Reference: www.quizlets.com quest. no: 12
1. What should the nurse do when planning nursing care for a client with a different cultural background? The nurse should:

A. allow the family to provide care during the hospital stay so no rituals or customs are broken
B. identify how these cultural variables affect the health problem
C. speak slowly & show pictures to make sure the client always understands
D. explain how the client must adapt to hospital routines to be effectively cared for while in the hospital

2. You are assisting a doctor who is trying to assess and collect information from a child who does not seem to understand all that the doctor is telling and is restless. What will be your best response?

A. stay quiet and remain with the doctor
B. interrupt the doctor and ask the child the questions
C. remain with the doctor and try to gain the confidence of the child and politely assess the child’s level of understanding and help the doctor with the information he is looking for
D. make the child quiet & ask his mother to stay with him

3. What should be included in your initial assessment of your patient's respiratory status?

A. review the patient’s notes and charts, to obtain the patient’s history
B. review the results of routine investigations
C. observe the patient’s breathing for ease and comfort, rate and pattern
D. perform a systematic examination and ask the relatives for the patient’s history

4. What should be included in a prescription for oxygen therapy?

A. you don’t need a prescription for oxygen
B. the date it should commence, the doctor’s signature and bleep number
C. the type of oxygen delivery system, inspired oxygen percentage and duration of the therapy
D. you only need a prescription if the patient is going to have home oxygen

5. Accurate post-operative observations are key to assessing a patient's deterioration or recovery. The modified early warning score (MEWS) is a scoring system that supports that aim. What is the primary purpose of MEWS?

A. identifies patients at risk of deterioration
B. identifies potential respiratory distress
C. improves communication between nursing staff and doctors
D. assess the impact of pre-existing conditions on postoperative recovery.

6. Why is it important that the patients are effectively fasted prior to surgery?

A. to reduce the risk of vomiting
B. to reduce the risk of reflux and inhalation of gastric contents
C. to prevent vomiting and chest infections
D. to prevent the patient gagging

7. Why are anti-embolic stockings an effective means of reducing the potential of developing a deep vein thrombosis (DVT)?

A. they promote arterial blood flow
B. they promote venous blood flow
C. they reduce the risk of postoperative swelling
D. they promote lymphatic fluid flow, and drainage.

8. Which color card is used to report adverse drug reaction?

A. Green Card
B. Yellow Card
C. White Card
D. Blue Card

9. When will you disclose the identity of a patient under your care?

a. justified by public interest law and order
b. when media demands for it
c. when patient relatives wishes to
d. you can disclose it anytime you want
10. A client develops hyperpyrexia and flushing following after 15 min of starting a blood transfusion. Which of the following statements are true
   a) This a normal reaction to blood transfusion
   b) Adverse reaction to blood transfusion
   c) Blood Transfusion has nothing to do with hyperpyrexia
   d) None of the above

11. 500 mg of Amoxicillin is prescribed to a patient three times a day. 250 mg tablets are available. How many tablets for single dose?
   a. 4
   b. 2
   c. 6

12. What is the preferred position for Abdominal Parecentesis?
   a. Supine with headend elevated
   b. Prone
   c. Left side lateral
   d. Supine with knee bent

12. The nurse is functioning as a patient advocate. Which of the following would be the first step the nurse should take when functioning in this role?
   A. Ensure that the nursing process is complete and includes active participation by the patient and family
   B. Become creative in meeting patient needs.
   C. Empower the patient by providing needed information and support
   D. Help the patient understand the need for preventive health care.

13. *Essence of Care* benchmarking is a process of ------?
   A. Comparing, sharing and developing practice in order to achieve and sustain best practice.
   B. Assess clinical area against best practice
   C. Review achievement towards best practice
   D. Consultation and patient involvement

14. What are the principles of gaining informed consent prior to plan surgery?
   A. Gaining permission for an imminent procedure by providing information in medical terms, ensuring a patient knows the potential risks and intended benefits
   B. Gaining permission from a patient who is competent to give it, by providing information, both verbally and with written material, relating to the planned procedure, for them to read on the day of planned surgery
   C. Gaining permission from a patient who is competent to give it, by informing them about the procedure and highlighting risks if the procedure is not carried out
   D. Gaining permission from a patient who is competent to give it, by providing information in understandable terms prior to surgery, allowing time for answering questions, and inviting voluntary participation

15. What factors are essential in demonstrating supportive communication to patients?
   A. Listening, clarifying the concerns & feelings of the patient using open questions
   B. Listening, clarifying the physical needs of the patient using open questions
   C. Listening, clarifying the physical needs of the patient using open questions
   D. Listening, reflecting back the patient’s concerns & providing a solution

16. Which behaviors will encourage a patient to talk about their concerns?
   A. Giving reassurance & telling them not to worry
   B. Asking the patient about their family & friends
   C. Tell the patient you are interested in what is concerning them & that you are available to listen
   D. Tell the patient you are interested in what is concerning them if they tell you, they will feel better

17. What are the principles of communicating with a patient with delirium?
   A. *Use short statements & closed questions in a well – lit, quiet, familiar environment*
   B. *Use short statements & open questions in a well lit, quiet, familiar environment*
C. Write down all questions for the patient to refer back to
D. Communicate only through the family using short statements & closed questions

18. If you were told by a nurse at handover to take “standard precautions” what would you expect to be doing?
   A. Taking precautions when handling blood & ‘high risk’ body fluids sp that you don’t pass on any infection to the patient.
   B. Wearing gloves, aprons & mask when caring for someone in protective isolation to protect yourself from infection
   C. Asking relatives to wash their hands when visiting patients in the clinical setting
   D. Using appropriate hand hygiene, wearing gloves & aprons when necessary, disposing of used sharp instruments safely & providing care in a suitably clean environment to protect yourself & the patients

19. What steps would you take if you had sustained a needlestick injury?
   A. Ask for advice from the emergency department, report to occupational health & fill in an incident form.
   B. Gently make the wound bleed, place under running water & wash thoroughly with soap & water. Complete an incident form & inform your manager. Co-operate with any action to test yourself or the patient for infection with a bloodborne virus but do not obtain blood or consent for testing from the patient yourself; this should be done by someone not involved in the incident.
   C. Take blood from patient & self for Hep B screening & take samples & form to bacteriology. Call your union representative for support. Make an appointment with your GP for a sickness certificate to take time off until the wound site has healed so you don’t contaminate any other patients.
   D. Wash the wound with soap & water. Cover any wound with a waterproof dressing to prevent entry of any other foreign material. Wear gloves while working until the wound has healed to prevent contaminating any other patients. Take any steps to have the patient or yourself tested for the presence of a bloodborne virus.

20. What functions should a dressing fulfill for effective wound healing?
   A. High humidity, insulation, gaseous exchange, absorbent
   B. Anaerobic, impermeable, conformable, low humidity
   C. Insulation, low humidity, sterile, high adherence
   D. Absorbent, low adherence, anaerobic, high humidity

21. When would it be beneficial to use a wound care plan?
   A. On all chronic wounds
   B. On all infected wounds
   C. On all complex wounds
   D. On every wound

22. Dehydration is of particular concern in ill health. If a patient is receiving IV fluid replacement and is having their fluid balance recorded, which of the following statements is true of someone said to be in “positive fluid balance”?
   A. The fluid output has exceeded the input
   B. The doctor may consider increasing the IV drip rate
   C. The fluid balance chart can be stopped as “positive” means “good”
   D. The fluid input has exceeded the output

23. What is the best way to prevent who is receiving an enteral feed from aspirating?
   A. Lie them flat
   B. Sit them at least 45 degree angle
   C. Tell them to lie in their side
   D. Check their oxygen saturations

24. Which check do you need to carry out before setting up an enteral feed via nasogastric tube?
   A. That when flushed with red juice, the red juice can be seen when the tube is aspirated
   B. That air cannot be heard rushing into the lungs by doing the WHOOSH TEST
   C. That the pH of gastric aspirate is below 5.5 and the measurements on the NG tube is the same length as the time insertion.
   D. That the pH of gastric aspirate is above 6.6 and the measurements on the
NG tube is the same length as the time insertion.

25. Why are physiological scoring systems or early warning scoring systems used in clinical practice?

A. They help the nursing staff to accurately predict patient dependency on a shift by shift basis
B. The system provides an early accurate predictor of deterioration by identifying physiological criteria that alert the nursing staff to a patient at risk
C. These scoring systems are carried out as part of a national audit so we know how sick patients are in the united kingdom
D. They enable nurses to call for assistance from the outreach team or the doctors via an electronic communication system

26. Why would the intravenous route be used for the administration of medications?

A. It is a useful form of medication for patients who refuse to take tablets because they don't want to comply with treatment
B. It is cost effective because there is less waste as patients forget to take oral medication
C. The intravenous route reduces the risk of infection because the drugs are made in a sterile environment & kept in aseptic conditions
D. The intravenous route provides an immediate therapeutic effect & gives better control of the rate of administration as a more precise dose can be calculated so treatment can be more reliable

27. What are the professional responsibilities of the qualified nurse in medicines management?

A. Making sure that the group of patients that they are caring for receive their medications on time. If they are not competent to administer intravenous medications, they should ask a competent nursing colleague to do so on their behalf
B. The safe handling & administration of all medicines to patients in their care. This includes making sure that patients understand the medicines they are taking, the reason they are taking them & the likely side effects.
C. Making sure they know the names, actions, doses & side effects of all the medications used in their area of clinical practice
D. To liaise closely with pharmacy so that their knowledge is kept up to date.

28. What are the key reasons for administering medications to patients?

A. To provide relief from specific symptoms, for example pain, & managing side effects as well as therapeutic purposes.
B. As part of the process of diagnosing their illness, to prevent an illness, disease or side effect, to offer relief from symptoms or to treat a disease.
C. As part of the treatment of long-term diseases, for example heart failure, & the prevention of diseases such as asthma.
D. To treat acute illness, for example antibiotic therapy for a chest infection, & side effects such as nausea

29. Which of the following is a guiding principle for the nurse in distinguishing mental disorders from the expected changes associated with aging?

5) A competent clinician can readily distinguish mental disorders from the expected changes associated with aging.
6) Older people are believed to be more prone to mental illness than young people.
7) The clinical presentation of mental illness in older adults differs from that in other age groups.
8) When physical deterioration becomes a significant feature of an elder's life, the risk of comorbid psychiatric illness rises.

30. The wife of a recently deceased male is contacting individuals to inform them of her husband’s death. She decides, however, to drive to her parent’s home to tell them in person instead of using the telephone. Of what benefit did this communication approach serve?

5) She needed to get out of the house
6) For the family to gain support from each other
7) No benefit
8) She was having a pathological grief response

31. A client is ambulating with a walker. The nurse corrects the walking pattern of the patient if he does which of the following?

A. The patient walks first & then lifts the walker
B. The walker is held on the hand grips for stability
C. The patient's body weight is supported by the hands when advancing his weaker leg.
32. The nurse should adjust the walker at which level to promote safety & stability?
   A. Knee  
   B. Hip  
   C. Chest  
   D. Armpit

33. The nurse is assigned to care for a group of patients. On review of the patient’s medical records the nurse determines that which patient is at risk for fluid volume excess?
   E. The patient taking diuretics
   F. The patient with kidney disease
   G. The patient with an ileostomy
   H. The patient who requires gastrointestinal suctioning

34. What specifically do you need to monitor to avoid complications & ensure optimal nutritional status in patients being enterally fed?
   A. Blood glucose levels, full blood count, stoma site and body weight
   B. Eye sight, hearing, full blood count, lung function and stoma site
   C. Assess swallowing, patient choice, fluid balance, capillary refill time
   D. Daily urinalysis, ECG, Protein levels and arterial pressure

35. A patient needs weighing, as he is due a drug that is calculated on bodyweight. He experiences a lot of pain on movement so is reluctant to move, particularly stand up. What would you do?
   A. Document clearly in the patient’s notes that a weight cannot be obtained
   B. Offer the patient pain relief and either use bed scales or a hoist with scales built in
   C. Discuss the case with your colleagues and agree to guess his body weight until he agrees to stand and use the chair scales
   D. Omit the drugs as it is not safe to give it without this information; inform the doctor and document your actions

36. What is the best way to prevent who is receiving an enteral feed from aspirating?
   E. Lie them flat
   F. Sit them at least 45 degree angle
   G. Tell them to lie in their side
   H. Check their oxygen saturations

37. Which check do you need to carry out before setting up an enteral feed via nasogastric tube?
   E. That when flushed with red juice, the red juice can be seen when the tube is aspirated
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   G. That the pH of gastric aspirate is below 5.5 and the measurements on the NG tube is the same length as the time insertion.
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38. A nurse is caring for a patient with end-stage lung disease. The patient wants to go home on oxygen and be comfortable. The family wants the patient to have a new surgical procedure. The nurse explains the risk and benefits of the surgery to the family and discusses the patient’s wishes with the family. The nurse is acting as the patient’s:
   A. Educator
   B. Advocate
   C. Care giver
   D. Case manager

39. Which of the following is a specific benefit to an organization when delegation is carried out effectively?
   A. Delegates gain new skills facilitating upward mobility
   B. The client feels more of their needs are met.
   C. Managers devote more time to tasks that cannot be delegated.
   D. The organization benefits by achieving its goals more efficiently

40. Clinical bench-marking is
   a) to improve standards in health care
   b) a new initiate in health care system
   c) A new set of rule for health care professionals
   d) To provide a holistic approach to the patient
41. What statement, made in the morning shift report, would help an effective manager develop trust on the nursing unit?  
A. “I know I told you that you could have the weekend off, but I really need you to work.”  
B. “The others work many extra shifts, why can’t you?”  
C. “I’m sorry, but I do not have a nurse to spare today to help on your unit. I cannot make a change now, but we should talk further about schedules and needs.”  
D. “I can’t believe you need help with such a simple task. Didn’t you learn that in school.”

42. What factors are essential in demonstrating supportive communication to patients?  
E. Listening, clarifying the concerns & feelings of the patient using open questions  
F. Listening, clarifying the physical needs of the patient using open questions  
G. Listening, reflecting back the patient’s concerns & providing a solution

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G. Write down all questions for the patient to refer back to  
H. Communicate only through the family using short statements & closed questions

45. The code is concerned about focusing on which of the following criteria  
A – Clinical expertise  
B – Conduct, behavior, ethics & professionalism  
C – Hospital policies  
D – Disciplinary actions

46. Nurses who seek to enhance their cultural-competency skills and apply sensitivity toward others are committed to which professional nursing value?  
E. Autonomy  
F. Strong commitment to service  
G. Belief in the dignity and worth of each person  
H. Commitment to education

47. The nurse is assigned to care for a group of patients. On review of the patient’s medical records the nurse determines that which patient is at risk for fluid volume excess?  
I. The patient taking diuretics  
J. The patient with kidney disease  
K. The patient with an ileostomy  
L. The patient who requires gastrointestinal suctioning

48. Knowing the difference between normal age-related changes & pathologic findings, which finding should the nurse identify as pathologic in a 74 year old patient?  
5) Increase in residual lung volume  
6) Decrease in sphincter control of the bladder  
7) Increase in diastolic BP  
8) Decreased response to touch, heat & pain.

49. Which of the following is a specific benefit to an organization when delegation is carried out effectively?  
5) Delegates gain new skills facilitating upward mobility  
6) The client feels more of their needs are met.  
7) Managers devote more time to tasks that cannot be delegated.  
8) The organization benefits by achieving its goals more efficiently

50. A critically ill client asks the nurse to help him die. Which of the following would be an appropriate response for the nurse to give this client?  
5) Tell me why you feel death is your only option  
6) How would you like to do this  
7) Everyone dies sooner or later  
8) Assisted suicide is illegal in this state

1. Last sense lost of a dying pt?  
ans. hearing
51. Adverse reaction reporting
   - Yellow card

52. A COPD patient is recently discharged from the hospital and is on 2 ltr of oxygen, when a nurse visits the patient she see the patient is dysonea, anxious and frighten. What will be your response?
   - Call the emergency service

53. A nurse is administering a controlled drug at home, what precaution does she need to take?
   - Strict to local policies and guidelines

54. A nurse and colleague found a discrepancy of controlled drug. How to report?
   - Inform police
   - Inform pharmacy
   - Recheck, inform incharge, if not found inform senior nurse

55. While mentoring a final year student dispensing medication, nurse role?
   - Direct supervision
   - Before delegating find out he is competent
   - Ask him to tell after the administration is complete

56. Electronic data transfer is more these days, which of the report is not suitable to sent to a discharged client?
   - Confusing blood report
   - Smoking cessation policy

57. Not a sign of ectopic pregnancy?
   - Vaginal bleed
   - Shoulder pain
   - Dysuria
   - Positive pregnancy test

58. In a canteen queue pt collapses in front of you, what will be your response?
   - Run to bring AED
   - Shout for help
   - Assess for response
   - Assess for danger before approaching

59. Primary care?
   - Care provided in acute settings
   - First hand care approach made by pt

60. Why old people afebrile even if they are infected?
   - Immature mast T- lymphocytes
   - Interruption of non adrenaline activity

61. Intermediate care?
   - Care given to patient for rehabilitation before returning to home.

62. Pt suspected of UTI, what will you do?

63. A pt who is depressed for few days suddenly seems to be happy on a particular day. What does the Nurse assume?
   - He has a suicidal plan
64. You saw a pt with leg ulcer unhappy, who has been admitted in hospital for more than one week, you ask him whether he is ok, he answers he is ok. You response?
- As compared to last few days, today you seem to be weak, are you sure you're ok?
- You don't seem to be ok. Are you sure you are?

65. Clostridium difficile which measures is ineffective?
- Alcohol hand rub usage

66. Diarrhoea, which condition does not show this as a sign?
- Hashimotos syndrome
- Ulcerative colitis

67. Dehydration in old adult?
- Decreased turgour
- Elasticity

68. Which drug causes fall in elderly?
- Loop diuretics
- Beta blockers
- NSAIDs
- Hypnotics

69. 1 gm paracetamol advised. 500 mg tab available?
- Ans 2

70. 40 mg advised. 2.5 mg available?
- Ans 16

71. 125 mg available in 5 ml, 50 mg to be given?

72. 25 year old girl with learning disabilities is admitted for a minor surgery, she is very restless and agitated and wants her mother to stay with her, what will be your response?
- Advise the mother to stay till she settles.
- Tell her visiting hour is over

73. Removing plaster cast of a child who is not co-operating?
- Explain to him according to his own understanding in age appropriate language
- Force fully remove

74. When can you disclose information of pt?
- Justified by public interest and law and order

75. When confidentiality can be revealed?
- Protection and safety over rides the needs for confidentiality

76. NMC stands for?
- NMC stands Code and conduct for nurses

34. Steps in nursing process?
- Assessment, planning, implementation, evaluation
- Assessment, planning, audit

77. After completion of nursing notes, nurse should?
- Sign, printed name, designation, time, date
- Sign, designation, time, date
- sign, time, date of birth

78. During shift change nurse gets over from incharge to follow standard precautions
- Follow hand hygiene, wear apron and gloves whenever necessary, discard the needles properly and keep the environment clean and protect yourself and patient
- Using PPE <standard precautions>

79. Correct procedure to get informed consent from pt scheduled for surgery?
ans. Explain to him details of everything and makes sure his participation in the process
- Get consent on the day of surgery

80. Registered RN role while administering medicine?
- Should know about all medications
- Should know about medicines, explain to pt to make them understand why they are taking them
- For giving IV medicines get help of other nurse

81. While putting IV line doctor leaves to emergency, you have not done it before
- Don't insert as you are incompetent

82. You noticed medical equipment not working while you joined a new team and the team members are not using it. Your role?
- During audit raise your concern
- Inform in written to management
- Inform NMC
- Take photograph

83. Bio hazard label on a bottle in nursing counter?
- Double bag it, Sealing bag and wear gloves while handling specimen

84. How to check position of enteric tube?
ans. Aspirate and check pH

85. National early warning score?
ans. Helps nurses to early assess any deterioration of physiological features in pts

86. Heart rate below 50?
ans. Bradycardia

90. Proper technique to use walker<zimmers frame>?
- Move 10 feet, take small steps
- Move 10 feet, take large wide steps
- Move 12 feet
- Transform weight to walker and walk

91. Disorganised atrial ECG waves
ans. Atrial fibrillation

92. An old admitted patient comes up with a new confusion?
- Alzheimers
- Dementia
- Normal ageing
- Infection

93. Advice for a dementia patient while giving discharge teaching?
- predictable environment

94. While IV administration finds swelling and redness
   ans. Resite the cannula

100. Old dysphagic pt. Orders by doctors and therapist does not include?
   - giving water to drink

101. Why pts kept on NPO
   - prevent reflux and inhalation of gastric content
   - prevent vomiting

102. Proper way to remove vacuum drainage?
   - release vacuum and remove
   - pullout
   - get doctor to do it

103. Why double clamp applied to remove chest drainage?
   ans. Prevent pneumothorax

104. Leg stockings used. Why?
   ans. Promote venous return

105. When to keep pts privacy and dignity?
   - under all circumstances
   - not in emergency

106. Proliferative phase in wound healing, how long?
   ans. 5 to 24 days

107. Ideal wound dressing characteristics?
   - Gaseous exchange, high humidity, absorbent
   - Adherence, insulation, low humidity, high humidity, anaerobic

108. Ideal site for IM INJECTIONS in buttocks region?
   ans. Upper outer quadrant

109. After abdominal surgery, pt complains of pain even after administration of analgesics little ago?
   - apply heat
   - position to reclined position
   - Call the doctor
   - Read minister analgesic

110. Pt bring own medication to hospital and wants to self administer, your role?
   - allow him
   - give medications back to relatives to take back to home
   - keep it in locker, use from medication trolley
   - Explain to pt about medication before he administer it

111. After LP pt becomes unconscious. Reason?
   - CSF leakage
   - Headache
   - Herniation

112. Not a policy in palliative care?
   - Pain relief
113. Pt frequently urinates in night
   Ans: Nocturia

114. Accountability means?
   - Responsible
   - Responsive

115. Tibia, fibula fracture correction done, which sign and symptom leads to the suspicion that it is leading to compartment syndrome?
   - Pain not relieved by analgesics
   - Numbness and tingling sensation

116. A pt’s relative is seen praying in a dark place, your role?
   - Complaint to security that the chaplin is not open
   - Provide him a peaceful place
   - Tell him it is against the rule

117. After laminectomy how to turn patient?
   - Turned as a unit

118. While formulating and giving advices nurse is performing which role?
   - Advocate
   - Educator (Ans)
   - Healthcare
   - Researcher

119. Advocacy means?
   - Supporting and mediating on behalf of the pt
   - Act as a liaison between pt and health care team
   - Help pt to make informed decisions

120. Pt states “I hate cancer” according to kohler theory this is
   - Anger
   - Denial
   - Acceptance
   - Bargaining

121. Proper method to collect urine sample?
   Ans: Clean meatus and collect midstream

80. A nurse is advised one hour vital charting of a pt, how frequently it should be recorded?
   - Every one hour
   - Whenever the vital signs shows deviation from normal

122. When discharge should be planned?
   Ans: Within 24 hours of admission

123. Oxygen administration order should include?
   Ans: Initiation time, device, route, litre, how long etc.
   - No need to write order

123. One the day of discharge spouse of a pt is tensed about discharge?
   - Cancel discharge
123. Explain the pt to express his fears and fix time for consultation

124. Movement away from midline?
- abduction

125. Where to assess edema?
- ankles

126. In which type of wound, wound care plan to be implemented?
- all type of wounds

127. How to assess respiratory status?
- ease, rate, rhythm, pattern

128. After IV dose pt develops rash, itching, flushed skin
- septicemia
- adverse reaction

129. Indication of chest tube drainage
- pneumothorax

130. Health care assistant task delegation criteria?
- make sure he is competent
- make sure he is experienced
- confirm that he is a staff having same designation
- he is an employee of the same institution

131. A patient had complained several times, now that patient register a new complaint about your colleague, What will be your role?
- tell staff members to be careful to avoid mistakes in future
- be honest and impartial and complete investigation

132. Acute illness?
- sudden onset which is curable

133. Positive fluid balance?
- intake greater than output

134. When can we perform LP?
- ICP normal

135. How can we identify health problems of a patient?
- lifestyle
- medical notes
- discussion
- talking to their friends

136. While dealing with a pt, sexuality against nurses belief?
- acceptance to cultural diversity

137. Haemorrhoids risk factor?
- straining of stools
- veg diet
- fibre rich food
- non-processed food
138. When can we realize actual and potential problems of a pt?
- Assessment

140. Pt comes to emergency in shock, signs?
- Tachycardia, Hypotension
- Bradycardia, Hypotension

141. Pt centred care, who is the centre of approach?
- Pt Centered

142. Signs of infection?
- WBC raised, blood sugar low
- Tachycardia, shivering, temp 38.6°C
- Temp 36°C

143. Nursing home bill does not include?
- Laundry
- Food
- Social activities

145. Head injury, pt unequal pupils?
- Consider this as an emergency, follow ABCDE approach

146. IV administration benefit?
- Fast acting

147. While in outside setup what care will you give if exposed to a situation?
- Provide care which is at expected level
- Keeping up to professional standards
- Above what is expected
- No involvement

148. Measures to prevent fall in an unconscious pt in bed

149. Revising of care comes under which nursing process?
- Implementation
- Evaluation
- Assessment
- Planning

150. How to ensure your care was effective?
- By communicating effectively
- Therapeutic Techniques
- Understand Support and ensure pt comfort

151. A Jewish patient is admitted to a ward, what type of diet should be served considering cultural diversity?
1) Do not make assumptions, ask about any preference during assessment
2) Obtain the advice of Jewish raffi.
3) Instruct dietary department

152. Nurse working in a community observes that the residents have problems with nutrition
and hydration. The staff is very busy. What would you do?

1) Keep a trained staff to attend to the residents having problems.
2) Keep two HCA to assist with people who are slow eater.
3) Ask the chef to serve food that is cold so that they can eat fast.

153. You are working in a busy department and the staff is complaining that they are not able to complete prioritised duties of client. What would you do?

1) Ask the staff to skip the lunch to do duties.
2) Ask the staff to do duties within their limits and left the remaining duties to next shift.
3) Reassess and repriorities patient and ask for some more qualified staff.

154. You are appointed as an incharge of a unit and two staff informed that they will be on leave. What will you do?

1) Reject the duty
2) Inform the manager to make qualified staff nurses to stay until sufficient staff is available.
3) Ask the remaining staff to be extracareful while rendering care.

155. In a care setting you find that PPE’s are short of supply who will you inform?

1) Your immediate senior manager
2) Care quality commission
3) Hospital manager

156. A patient develop hemorrhage 48hrs after delivery this is?

1) Primery PPH
2) Secondary PPH
3) Tertiary PPH

157. 15 mins after blood transfusion patient developed high temperature and less pain this is

1) Common adverse reaction
2) Serious adverse reaction
3) Allergy

158. 6C’S – care, competence, courage, compassion, commitment

159. While administering digoxin you should check?

1) Heart rate
2) Urine output
3) Blood pressure

160. Important sign of fluid deficit

1) Hypotension
2) Full bound pulse
3) Increased urine output
161. Important sign of shock?
1) Cool moist cyanosed nailbed
2) Cool dry pink nail bed
3) warm pink nail bed.

1. In which part of nursing process, the nurse identifies the actual and potential health problems?
2. Which among the following is not a clinical sign of meconium aspiration?
   a. mottled skin
   b. presence of cry
   c. floppy newborn
   d. apnea

3. Intermediate care unit is for
   a. the patient who needs rehabilitation before going home.
   b. patients who needs care from nursing homes.

4. In cafeteria, patient collapsed what will you do first?
   a. check response
   b. shout for help
   c. go to collect AED

5. You need to give 40mg tablet available is 2.5mg tablets. How much tablets will you give?

6. 1000lt to be infused in 8 hours. How much ml will you give in one hour through infusion pump?

7. The patient and relatives paid for social care. This payment does not include which of the following?
   a. nursing care
   b. social activities
   c. laundary
   d. food

8. For which patient LP is safe?
   a. patient with a lesion at puncture site.
   b. patient with normal ICP
   c. patient on anticoagulant

9. What all things will you include in a handwritten nurses note?
   a. full name, designation, date and time of entry
   b. signature, print the name, date and time of entry
1. A 43-year-old African American male is admitted with sickle cell anemia. The nurse plans to assess circulation in the lower extremities every two hours. Which of the following outcome criteria would the nurse use?

- A. Body temperature of 99°F or less
- B. Toes moved in active range of motion
- C. Sensation reported when soles of feet are touched
- D. Capillary refill of < 3 seconds

2. A 30-year-old male from Haiti is brought to the emergency department in sickle cell crisis. What is the best position for this client?

- A. Side-lying with knees flexed
- B. Knee-chest
- C. High Fowler’s with knees flexed
- D. Semi-Fowler’s with legs extended on the bed

3. A 25-year-old male is admitted in sickle cell crisis. Which of the following interventions would be of highest priority for this client?

- A. Taking hourly blood pressures with mechanical cuff
- B. Encouraging fluid intake of at least 200mL per hour
- C. Position in high Fowler’s with knee gatch raised
- D. Administering Tylenol as ordered

4. Which of the following foods would the nurse encourage the client in sickle cell crisis to eat?

- A. Steak
- B. Cottage cheese
- C. Popsicle
- D. Lima beans

5. A newly admitted client has sickle cell crisis. He is complaining of pain in his feet and hands. The nurse’s assessment findings include a pulse oximetry of 92. Assuming that all the following interventions are ordered, which should be done first?

- A. Adjust the room temperature
- B. Give a bolus of IV fluids
- C. Start O₂
- D. Administer meperidine (Demerol) 75mg IV push

6. The nurse is instructing a client with iron-deficiency anemia. Which of the following meal plans would the nurse expect the client to select?

- A. Roast beef, gelatin salad, green beans, and peach pie
- B. Chicken salad sandwich, coleslaw, French fries, ice cream
- C. Egg salad on wheat bread, carrot sticks, lettuce salad, raisin pie
- D. Pork chop, creamed potatoes, corn, and coconut cake

7. Clients with sickle cell anemia are taught to avoid activities that cause hypoxia and hypoxemia. Which of the following activities would the nurse recommend?

- A. A family vacation in the Rocky Mountains
- B. Chaperoning the local boys club on a snow-skiing trip
- C. Traveling by airplane for business trips
- D. A bus trip to the Museum of Natural History

8. The nurse is conducting an admission assessment of a client with vitamin B12 deficiency. Which finding reinforces the diagnosis of B12 deficiency?

- A. Enlarged spleen
- B. Elevated blood pressure
- C. Bradycardia
- D. Beefy tongue

9. The body part that would most likely display jaundice in the dark-skinned individual is the:

- A. Conjunctiva of the eye
- B. Soles of the feet
- C. Roof of the mouth
- D. Shins

10. The nurse is conducting a physical assessment on a client with anemia. Which of the following clinical manifestations would be most indicative of the anemia?

- A. BP 146/88
11. The nurse is teaching the client with polycythemia vera about prevention of complications of the disease. Which of the following statements by the client indicates a need for further teaching?

- A. “I will drink 500mL of fluid or less each day.”
- B. “I will wear support hose.”
- C. “I will check my blood pressure regularly.”
- D. “I will report ankle edema.”

12. A 33-year-old male is being evaluated for possible acute leukemia. Which of the following findings is most likely related to the diagnosis of leukemia?

- A. The client collects stamps as a hobby.
- B. The client recently lost his job as a postal worker.
- C. The client had radiation for treatment of Hodgkin’s disease as a teenager.
- D. The client’s brother had leukemia as a child.

13. Where is the best site for examining for the presence of petechiae in an African American client?

- A. The abdomen
- B. The thorax
- C. The earlobes
- D. The soles of the feet

14. The client is being evaluated for possible acute leukemia. Which inquiry by the nurse is most important?

- A. “Have you noticed a change in sleeping habits recently?”
- B. “Have you had a respiratory infection in the last six months?”
- C. “Have you lost weight recently?”
- D. “Have you noticed changes in your alertness?”

15. Which of the following would be the priority nursing diagnosis for the adult client with acute leukemia?

- A. Oral mucous membrane, altered related to chemotherapy
- B. Risk for injury related to thrombocytopenia
- C. Fatigue related to the disease process
- D. Interrupted family processes related to life-threatening illness of a family member

16. A 21-year-old male with Hodgkin’s lymphoma is a senior at the local university. He is engaged to be married and is to begin a new job upon graduation. Which of the following diagnoses would be a priority for this client?

- A. Sexual dysfunction related to radiation therapy
- B. Anticipatory grieving related to terminal illness
- C. Tissue integrity related to prolonged bed rest
- D. Fatigue related to chemotherapy

17. A client has autoimmune thrombocytopenic purpura. To determine the client’s response to treatment, the nurse would monitor:

- A. Platelet count
- B. White blood cell count
- C. Potassium levels
- D. Partial prothrombin time (PTT)

18. The home health nurse is visiting a client with autoimmune thrombocytopenic purpura (ATP). The client’s platelet count currently is 80,000. It will be most important to teach the client and family about:

- A. Bleeding precautions
- B. Prevention of falls
- C. Oxygen therapy
- D. Conservation of energy

19. The client has surgery for removal of a Prolactinoma. Which of the following interventions would be appropriate for this client?

- A. Place the client in Trendelenburg position for postural drainage.
- B. Encourage coughing and deep breathing every two hours.
C. Elevate the head of the bed 30°.
D. Encourage the Valsalva maneuver for bowel movements.

20. The client with a history of diabetes insipidus is admitted with polyuria, polydipsia, and mental confusion. The priority intervention for this client is:

A. Measure the urinary output.
B. Check the vital signs.
C. Encourage increased fluid intake.
D. Weigh the client.

21. A client with hemophilia has a nosebleed. Which nursing action is most appropriate to control the bleeding?

A. Place the client in a sitting position.
B. Administer acetaminophen (Tylenol).
C. Pinch the soft lower part of the nose.
D. Apply ice packs to the forehead.

22. A client has had a unilateral adrenalectomy to remove a tumor. The most important measurement in the immediate post-operative period for the nurse to take is:

A. The blood pressure
B. The temperature
C. The urinary output
D. The specific gravity of the urine

23. A client with Addison’s disease has been admitted with a history of nausea and vomiting for the past three days. The client is receiving IV glucocorticoids (Solu-Medrol). Which of the following interventions would the nurse implement?

A. Glucometer readings as ordered
B. Intake/output measurements
C. Evaluating the sodium and potassium levels
D. Daily weights

24. A client had a total thyroidectomy yesterday. The client is complaining of tingling around the mouth and in the fingers and toes. What would the nurses’ next action be?

A. Obtain a crash cart.
B. Check the calcium level.
C. Assess the dressing for drainage.
D. Assess the blood pressure for hypertension.

25. A 32-year-old mother of three is brought to the clinic. Her pulse is 52, there is a weight gain of 30 pounds in four months, and the client is wearing two sweaters. The client is diagnosed with hypothyroidism. Which of the following nursing diagnoses is of highest priority?

A. Impaired physical mobility related to decreased endurance
B. Hypothermia r/t decreased metabolic rate
C. Disturbed thought processes r/t interstitial edema
D. Decreased cardiac output r/t bradycardia

26. The client presents to the clinic with a serum cholesterol of 275mg/dL and is placed on rosuvastatin (Crestor). Which instruction should be given to the client taking rosuvastatin (Crestor)?

A. Report muscle weakness to the physician.
B. Allow six months for the drug to take effect.
C. Take the medication with fruit juice.
D. Report difficulty sleeping.

27. The client is admitted to the hospital with hypertensive crises. Diazoxide (Hyperstat) is ordered. During administration, the nurse should:

A. Utilize an infusion pump.
B. Check the blood glucose level.
C. Place the client in Trendelenburg position.
D. Cover the solution with foil.

28. The six-month-old client with a ventral septal defect is receiving Digitalis for regulation of his heart rate. Which finding should be reported to the doctor?

A. Blood pressure of 126/80
B. Blood glucose of 110mg/dL
C. Heart rate of 60bpm
D. Respiratory rate of 30 per minute
29. The client admitted with angina is given a prescription for nitroglycerine. The client should be instructed to:

- Replenish his supply every three months.
- Take one every 15 minutes if pain occurs.
- Leave the medication in the brown bottle.
- Crush the medication and take with water.

30. The client is instructed regarding foods that are low in fat and cholesterol. Which diet selection is lowest in saturated fats?

- Macaroni and cheese
- Shrimp with rice
- Turkey breast
- Spaghetti with meat sauce

31. The client is admitted with left-sided congestive heart failure. In assessing the client for edema, the nurse should check the:

- Feet
- Neck
- Hands
- Sacrum

32. The nurse is checking the client's central venous pressure. The nurse should place the zero of the manometer at the:

- Phlebostatic axis
- PMI
- Erb's point
- Tail of Spence

33. The physician orders lisinopril (Zestril) and furosemide (Lasix) to be administered concomitantly to the client with hypertension. The nurse should:

- Question the order.
- Administer the medications.
- Administer separately.
- Contact the pharmacy.

34. The best method of evaluating the amount of peripheral edema is:

- Weighing the client daily
- Measuring the extremity
- Measuring the intake and output
- Checking for pitting

35. A client with vaginal cancer is being treated with a radioactive vaginal implant. The client’s husband asks the nurse if he can spend the night with his wife. The nurse should explain that:

- Overnight stays by family members is against hospital policy.
- There is no need for him to stay because staffing is adequate.
- His wife will rest much better knowing that he is at home.
- Visitation is limited to 30 minutes when the implant is in place.

36. The nurse is caring for a client hospitalized with a facial stroke. Which diet selection would be suited to the client?

- Roast beef sandwich, potato chips, pickle spear, iced tea
- Split pea soup, mashed potatoes, pudding, milk
- Tomato soup, cheese toast, Jello, coffee
- Hamburger, baked beans, fruit cup, iced tea

37. The physician has prescribed Novalog insulin for a client with diabetes mellitus. Which statement indicates that the client knows when the peak action of the insulin occurs?

- "I will make sure I eat breakfast within 10 minutes of taking my insulin."
- "I will need to carry candy or some form of sugar with me all the time."
- "I will eat a snack around three o'clock each afternoon."
- "I can save my dessert from supper for a bedtime snack."

38. The nurse is teaching basic infant care to a group of first-time parents. The nurse should explain that a sponge bath is recommended for the first two weeks of life because:

- New parents need time to learn how to hold the baby.
B. The umbilical cord needs time to separate.
C. Newborn skin is easily traumatized by washing.
D. The chance of chilling the baby outweighs the benefits of bathing.

39. A client with leukemia is receiving Trimetrexate. After reviewing the client's chart, the physician orders Wellcovorin (leucovorin calcium). The rationale for administering leucovorin calcium to a client receiving Trimetrexate is to:

A. Treat iron-deficiency anemia caused by chemotherapeutic agents
B. Create a synergistic effect that shortens treatment time
C. Increase the number of circulating neutrophils
D. Reverse drug toxicity and prevent tissue damage

40. A four-month-old is brought to the well-baby clinic for immunization. In addition to the DPT and polio vaccines, the baby should receive:

A. Hib titer
B. Mumps vaccine
C. Hepatitis B vaccine
D. MMR

41. The physician has prescribed Nexium (esomeprazole) for a client with erosive gastritis. The nurse should administer the medication:

A. 30 minutes before a meal
B. With each meal
C. In a single dose at bedtime
D. 30 minutes after meals

42. A client on the psychiatric unit is in an uncontrolled rage and is threatening other clients and staff. What is the most appropriate action for the nurse to take?

A. Call security for assistance and prepare to sedate the client.
B. Tell the client to calm down and ask him if he would like to play cards.
C. Tell the client that if he continues his behavior he will be punished.
D. Leave the client alone until he calms down.

43. When the nurse checks the fundus of a client on the first postpartum day, she notes that the fundus is firm, is at the level of the umbilicus, and is displaced to the right. The next action the nurse should take is to:

A. Check the client for bladder distention.
B. Assess the blood pressure for hypotension.
C. Determine whether an oxytocic drug was given.
D. Check for the expulsion of small clots.

44. A client is admitted to the hospital with a temperature of 99.8°F, complaints of blood-tinged hemoptysis, fatigue, and night sweats. The client’s symptoms are consistent with a diagnosis of:

A. Pneumonia
B. Reaction to antiviral medication
C. Tuberculosis
D. Superinfection due to low CD4 count

45. The client is seen in the clinic for treatment of migraine headaches. The drug Imitrex (sumatriptan succinate) is prescribed for the client. Which of the following in the client’s history should be reported to the doctor?

A. Diabetes
B. Prinzmetal’s angina
C. Cancer
D. Cluster headaches

46. The client with suspected meningitis is admitted to the unit. The doctor is performing an assessment to determine meningeal irritation and spinal nerve root inflammation. A positive Kernig’s sign is charted if the nurse notes:

A. Pain on flexion of the hip and knee
B. Nuchal rigidity on flexion of the neck
C. Pain when the head is turned to the left side
D. Dizziness when changing positions

47. The client with Alzheimer’s disease is being assisted with activities of daily living when the nurse notes that the client uses her toothbrush to brush her hair. The nurse is aware that the client is exhibiting:

A. Agnosia
48. The client with dementia is experiencing confusion late in the afternoon and before bedtime. The nurse is aware that the client is experiencing what is known as:

☐ A. Chronic fatigue syndrome
☐ B. Normal aging
☐ C. Sundowning
☐ D. Delusions

49. The client with confusion says to the nurse, “I haven’t had anything to eat all day long. When are they going to bring breakfast?” The nurse saw the client in the day room eating breakfast with other clients 30 minutes before this conversation. Which response would be best for the nurse to make?

☐ A. “You know you had breakfast 30 minutes ago.”
☐ B. “I am so sorry that they didn’t get you breakfast. I’ll report it to the charge nurse.”
☐ C. “I’ll get you some juice and toast. Would you like something else?”
☐ D. “You will have to wait a while; lunch will be here in a little while.”

50. The doctor has prescribed Exelon (rivastigmine) for the client with Alzheimer’s disease. Which side effect is most often associated with this drug?

☐ A. Urinary incontinence
☐ B. Headaches
☐ C. Confusion
☐ D. Nausea

52. A client with a diagnosis of HPV is at risk for which of the following?

☐ A. Hodgkin’s lymphoma
☐ B. Cervical cancer
☐ C. Multiple myeloma
☐ D. Ovarian cancer

53. During the initial interview, the client reports that she has a lesion on the perineum. Further investigation reveals a small blister on the vulva that is painful to touch. The nurse is aware that the most likely source of the lesion is:

☐ A. Syphilis
☐ B. Herpes
☐ C. Gonorrhea
☐ D. Condylomata

54. A client visiting a family planning clinic is suspected of having an STI. The best diagnostic test for treponema pallidum is:

☐ A. Venereal Disease Research Lab (VDRL)
☐ B. Rapid plasma reagin (RPR)
☐ C. Florescent treponemal antibody (FTA)
☐ D. Thayer-Martin culture (TMC)

55. A 15-year-old primigravida is admitted with a tentative diagnosis of HELLP syndrome. Which laboratory finding is associated with HELLP syndrome?

☐ A. Elevated blood glucose
☐ B. Elevated platelet count
☐ C. Elevated creatinine clearance
☐ D. Elevated hepatic enzymes

56. The nurse is assessing the deep tendon reflexes of a client with preeclampsia. Which method is used to elicit the biceps reflex?

☐ A. The nurse places her thumb on the muscle inset in the antecubital space and taps the thumb briskly with the reflex hammer.
☐ B. The nurse loosely suspends the client’s arm in an open hand while tapping the back of the client’s elbow.
C. The nurse instructs the client to dangle her legs as the nurse strikes the area below the patella with the blunt side of the reflex hammer.

D. The nurse instructs the client to place her arms loosely at her side as the nurse strikes the muscle insert just above the wrist.

57. A primigravida with diabetes is admitted to the labor and delivery unit at 34 weeks gestation. Which doctor’s order should the nurse question?

A. Magnesium sulfate 4gm (25%) IV

B. Brethine 10mcg IV

C. Stadol 1mg IV push every 4 hours as needed prn for pain

D. Ancef 2gm IVPB every 6 hours

58. A diabetic multigravida is scheduled for an amniocentesis at 32 weeks gestation to determine the L/S ratio and phosphatidyl glycerol level. The L/S ratio is 1:1 and the presence of phosphatidylglycerol is noted. The nurse’s assessment of this data is:

A. The infant is at low risk for congenital anomalies.

B. The infant is at high risk for intrauterine growth retardation.

C. The infant is at high risk for respiratory distress syndrome.

D. The infant is at high risk for birth trauma.

59. Which observation in the newborn of a diabetic mother would require immediate nursing intervention?

A. Crying

B. Wakefulness

C. Jitteriness

D. Yawning

60. The nurse caring for a client receiving intravenous magnesium sulfate must closely observe for side effects associated with drug therapy. An expected side effect of magnesium sulfate is:

A. Decreased urinary output

B. Hypersomnolence

C. Absence of knee jerk reflex

D. Decreased respiratory rate

61. The client has elected to have epidural anesthesia to relieve labor pain. If the client experiences hypotension, the nurse would:

A. Place her in Trendelenburg position.

B. Decrease the rate of IV infusion.

C. Administer oxygen per nasal cannula.

D. Increase the rate of the IV infusion.

62. A client has cancer of the pancreas. The nurse should be most concerned about which nursing diagnosis?

A. Alteration in nutrition

B. Alteration in bowel elimination

C. Alteration in skin integrity

D. Ineffective individual coping

63. The nurse is caring for a client with uremic frost. The nurse is aware that uremic frost is often seen in clients with:

A. Severe anemia

B. Arteriosclerosis

C. Liver failure

D. Parathyroid disorder

64. The client arrives in the emergency department after a motor vehicle accident. Nursing assessment findings include BP 80/34, pulse rate 120, and respirations 20. Which is the client’s most appropriate priority nursing diagnosis?

A. Alteration in cerebral tissue perfusion

B. Fluid volume deficit

C. Ineffective airway clearance

D. Alteration in sensory perception

65. The home health nurse is visiting an 18-year-old with osteogenesis imperfecta. Which information obtained on the visit would cause the most concern? The client:

A. Likes to play football

B. Drinks carbonated drinks

C. Has two sisters
66. The nurse working the organ transplant unit is caring for a client with a white blood cell count of 450. During evening visitation, a visitor brings a basket of fruit. What action should the nurse take?

- A. Allow the client to keep the fruit.
- B. Place the fruit next to the bed for easy access by the client.
- C. Offer to wash the fruit for the client.
- D. Ask the family members to take the fruit home.

67. The nurse is caring for the client following a laryngectomy when suddenly the client becomes nonresponsive and pale, with a BP of 90/40. The initial nurse’s action should be to:

- A. Place the client in Trendelenburg position.
- B. Increase the infusion of normal saline.
- C. Administer atropine intravenously.
- D. Move the emergency cart to the bedside.

68. The client admitted two days earlier with a lung resection accidentally pulls out the chest tube. Which action by the nurse indicates understanding of the management of chest tubes?

- A. Order a chest x-ray.
- B. Reinsert the tube.
- C. Cover the insertion site with a Vaseline gauze.
- D. Call the doctor.

69. A client being treated with sodium warfarin (Coumadin) has a Protime of 120 seconds. Which intervention would be most important to include in the nursing care plan?

- A. Assess for signs of abnormal bleeding.
- B. Anticipate an increase in the Coumadin dosage.
- C. Instruct the client regarding the drug therapy.
- D. Increase the frequency of neurological assessments.

70. Which selection would provide the most calcium for the client who is four months pregnant?

- A. A granola bar
- B. A bran muffin
- C. A cup of yogurt
- D. A glass of fruit juice

71. The client with preeclampsia is admitted to the unit with an order for magnesium sulfate. Which action by the nurse indicates the understanding of magnesium toxicity?

- A. The nurse performs a vaginal exam every 30 minutes.
- B. The nurse places a padded tongue blade at the bedside.
- C. The nurse inserts a Foley catheter.
- D. The nurse darkens the room.

72. The best size catheter for administration of a blood transfusion to a six-year-old is:

- A. 18 gauge
- B. 19 gauge
- C. 22 gauge
- D. 20 gauge

73. A client is admitted to the unit two hours after an explosion causes burns to the face. The nurse would be most concerned with the client developing which of the following?

- A. Hypovolemia
- B. Laryngeal edema
- C. Hypernatremia
- D. Hyperkalemia

74. The client has recently been diagnosed with diabetes. Which of the following indicates understanding of the management of diabetes?

- A. The client selects a balanced diet from the menu.
- B. The client can tell the nurse the normal blood glucose level.
- C. The client asks for brochures on the subject of diabetes.
- D. The client demonstrates correct insulin injection technique.

75. The client is admitted following cast application for a fractured ulna. Which finding should be reported to the doctor?
76. The client with AIDS should be taught to:

- A. Avoid warm climates.
- B. Refrain from taking herbals.
- C. Avoid exercising.
- D. Report any changes in skin color.

77. Which action by the healthcare worker indicates a need for further teaching?

- A. The nursing assistant ambulates the elderly client using a gait belt.
- B. The nurse wears goggles while performing a venipuncture.
- C. The nurse washes his hands after changing a dressing.
- D. The nurse wears gloves to monitor the IV infusion rate.

78. The client is having electroconvulsive therapy for treatment of severe depression. Prior to the ECT the nurse should:

- A. Apply a tourniquet to the client's arm.
- B. Administer an anticonvulsant medication.
- C. Ask the client if he is allergic to shell fish.
- D. Apply a blood pressure cuff to the arm.

79. The five-year-old is being tested for enterobiasis (pinworms). Which symptom is associated with enterobiasis?

- A. Rectal itching
- B. Nausea
- C. Oral ulcerations
- D. Scalp itching

80. The nurse is teaching the mother regarding treatment for pediculosis capitis. Which instruction should be given regarding the medication?

- A. Treatment is not recommended for children less than 10 years of age.
- B. Bed linens should be washed in hot water.
- C. Medication therapy will continue for one year.
- D. Intravenous antibiotic therapy will be ordered.

81. The registered nurse is making assignments for the day. Which client should be assigned to the pregnant nurse?

- A. The client with HIV
- B. The client with a radium implant for cervical cancer
- C. The client with RSV (respiratory syncytial virus)
- D. The client with cytomegalovirus

82. The nurse is planning room assignments for the day. Which client should be assigned to a private room if only one is available?

- A. The client with methicillin resistant-staphylococcus aureus (MRSA)
- B. The client with diabetes
- C. The client with pancreatitis
- D. The client with Addison's disease

83. The doctor accidentally cuts the bowel during surgery. As a result of this action, the client develops an infection and suffers brain damage. The doctor can be charged with:

- A. Negligence
- B. Tort
- C. Assault
- D. Malpractice

84. Which assignment should not be performed by the nursing assistant?

- A. Feeding the client
- B. Bathing the client
- C. Obtaining a stool
- D. Administering a fleet enema

85. The mother calls the clinic to report that her newborn has a rash on his forehead and face. Which action is most appropriate?
A. Tell the mother to wash the face with soap and apply powder.
B. Tell her that 30% of newborns have a rash that will go away by one month of life.
C. Report the rash to the doctor immediately.
D. Ask the mother if anyone else in the family has had a rash in the last six months.

86. Which nurse should not be assigned to care for the client with a radium implant for vaginal cancer?

A. The LPN who is six months postpartum
B. The RN who is pregnant
C. The RN who is allergic to iodine
D. The RN with a three-year-old at home

87. Which information should be reported to the state Board of Nursing?

A. The facility fails to provide literature in both Spanish and English.
B. The narcotic count has been incorrect on the unit for the past three days.
C. The client fails to receive an itemized account of his bills and services received during his hospital stay.
D. The nursing assistant assigned to the client with hepatitis fails to feed the client and give the bath.

88. The nurse is suspected of charting medication administration that he did not give. After talking to the nurse, the charge nurse should:

A. Call the Board of Nursing.
B. File a formal reprimand.
C. Terminate the nurse.
D. Charge the nurse with a tort.

89. The home health nurse is planning for the day’s visits. Which client should be seen first?

A. The 78-year-old who had a gastrectomy three weeks ago and has a PEG tube
B. The five-month-old discharged one week ago with pneumonia who is being treated with amoxicillin liquid suspension
C. The 50-year-old with MRSA being treated with Vancomycin via a PICC line
D. The 30-year-old with an exacerbation of multiple sclerosis being treated with cortisone via a centrally placed venous catheter

90. The emergency room is flooded with clients injured in a tornado. Which clients can be assigned to share a room in the emergency department during the disaster?

A. A client having auditory hallucinations and the client with ulcerative colitis
B. The client who is pregnant and the client with a broken arm
C. A child who is cyanotic with severe dyspnea and a client with a frontal head injury
D. The client who arrives with a large puncture wound to the abdomen and the client with chest pain

91. Before administering eardrops to a toddler, the nurse should recognize that it is essential to consider which of the following?

A. The age of the child
B. The child’s weight
C. The developmental level of the child
D. The IQ of the child

92. The nurse is discussing meal planning with the mother of a two-year-old. Which of the following statements, if made by the mother, would require a need for further instruction?

A. ”It is okay to give my child white grape juice for breakfast.”
B. ”My child can have a grilled cheese sandwich for lunch.”
C. ”We are going on a camping trip this weekend, and I have bought hot dogs to grill for his lunch.”
D. ”For a snack, my child can have ice cream.”

93. A client with AIDS has a viral load of 200 copies per ml. The nurse should interpret this finding as:

A. The client is at risk for opportunistic diseases.
B. The client is no longer communicable.
C. The client’s viral load is extremely low so he is relatively free of circulating virus.
D. The client’s T-cell count is extremely low.
94. The client has an order for sliding scale insulin at 1900 hours and Lantus insulin at the same hour. The nurse should:

- A. Administer the two medications together.
- B. Administer the medications in two injections.
- C. Draw up the Lantus insulin and then the regular insulin and administer them together.
- D. Contact the doctor because these medications should not be given to the same client.

95. A priority nursing diagnosis for a child being admitted from surgery following a tonsillectomy is:

- A. Altered nutrition
- B. Impaired communication
- C. Risk for injury/aspiration
- D. Altered urinary elimination

96. What would the nurse expect the admitting assessment to reveal in a client with glomerulonephritis?

- A. Hypertension
- B. Lassitude
- C. Fatigue
- D. Vomiting and diarrhea

97. Which action is contraindicated in the client with epiglottis?

- A. Ambulation
- B. Oral airway assessment using a tongue blade
- C. Placing a blood pressure cuff on the arm
- D. Checking the deep tendon reflexes.

98. A 25-year-old client with a goiter is admitted to the unit. What would the nurse expect the admitting assessment to reveal?

- A. Slow pulse
- B. Anorexia
- C. Bulging eyes
- D. Weight gain

99. Which of the following foods, if selected by the mother with a child with celiac, would indicate her understanding of the dietary instructions?

- A. Whole-wheat toast
- B. Angel hair pasta
- C. Reuben on rye
- D. Rice cereal

100. The first action that the nurse should take if she finds the client has an O₂ saturation of 68% is:

- A. Elevate the head.
- B. Recheck the O₂ saturation in 30 minutes.
- C. Apply oxygen by mask.
- D. Assess the heart rate.

101. Which observation would the nurse expect to make after an amniotomy?

- A. Dark yellow amniotic fluid
- B. Clear amniotic fluid
- C. Greenish amniotic fluid
- D. Red amniotic fluid

102. The client taking Glyburide (Diabeta) should be cautioned to:

- A. Avoid eating sweets.
- B. Report changes in urinary pattern.
- C. Allow three hours for onset.
- D. Check the glucose daily.

103. The obstetric client's fetal heart rate is 80–90 during the contractions. The first action the nurse should take is:

- A. Reposition the monitor.
- B. Turn the client to her left side.
- C. Ask the client to ambulate.
104. Arterial ulcers are best described as ulcers that:

- A. Are smooth in texture
- B. Have irregular borders
- C. Are cool to touch
- D. Are painful to touch

105. A vaginal exam reveals a footling breech presentation. The nurse should take which of the following actions at this time?

- A. Anticipate the need for a Caesarean section.
- B. Apply an internal fetal monitor.
- C. Place the client in Genu Pectoral position.
- D. Perform an ultrasound.

106. A vaginal exam reveals that the cervix is 4 cm dilated, with intact membranes and a fetal heart tone rate of 160–170 bpm. The nurse decides to apply an external fetal monitor. The rationale for this implementation is:

- A. The cervix is closed.
- B. The membranes are still intact.
- C. The fetal heart tones are within normal limits.
- D. The contractions are intense enough for insertion of an internal monitor.

107. The following are all nursing diagnoses appropriate for a gravida 1 para 0 in labor. Which one would be most appropriate for the primagravida as she completes the early phase of labor?

- A. Impaired gas exchange related to hyperventilation
- B. Alteration in placental perfusion related to maternal position
- C. Impaired physical mobility related to fetal-monitoring equipment
- D. Potential fluid volume deficit related to decreased fluid intake

108. As the client reaches 6 cm dilation, the nurse notes late decelerations on the fetal monitor. What is the most likely explanation of this pattern?

- A. The baby is sleeping.
- B. The umbilical cord is compressed.
- C. There is head compression.
- D. There is uteroplacental insufficiency.

109. The nurse notes variable decelerations on the fetal monitor strip. The most appropriate initial action would be to:

- A. Notify her doctor.
- B. Start an IV.
- C. Reposition the client.
- D. Readjust the monitor.

110. Which of the following is a characteristic of an ominous periodic change in the fetal heart rate?

- A. A fetal heart rate of 120–130 bpm
- B. A baseline variability of 6–10 bpm
- C. Accelerations in FHR with fetal movement
- D. A recurrent rate of 90–100 bpm at the end of the contractions

111. The rationale for inserting a French catheter every hour for the client with epidural anesthesia is:

- A. The bladder fills more rapidly because of the medication used for the epidural.
- B. Her level of consciousness is such that she is in a trancelike state.
- C. The sensation of the bladder filling is diminished or lost.
- D. She is embarrassed to ask for the bedpan that frequently.

112. A client in the family planning clinic asks the nurse about the most likely time for her to conceive. The nurse explains that conception is most likely to occur when:

- A. Estrogen levels are low
- B. Lutenizing hormone is high
- C. The endometrial lining is thin
- D. The progesterone level is low

113. A client tells the nurse that she plans to use the rhythm method of birth control. The nurse is aware that the success of the rhythm method depends on the:
114. A client with diabetes asks the nurse for advice regarding methods of birth control. Which method of birth control is most suitable for the client with diabetes?

- A. Intrauterine device
- B. Oral contraceptives
- C. Diaphragm
- D. Contraceptive sponge

115. The doctor suspects that the client has an ectopic pregnancy. Which symptom is consistent with a diagnosis of a ruptured ectopic pregnancy?

- A. Painless vaginal bleeding
- B. Abdominal cramping
- C. Throbbing pain in the upper quadrant
- D. Sudden, stabbing pain in the lower quadrant

116. The nurse is teaching a pregnant client about nutritional needs during pregnancy. Which menu selection will best meet the nutritional needs of the pregnant client?

- A. Hamburger patty, green beans, French fries, and iced tea
- B. Roast beef sandwich, potato chips, baked beans, and cola
- C. Baked chicken, fruit cup, potato salad, coleslaw, yogurt, and iced tea
- D. Fish sandwich, gelatin with fruit, and coffee

117. The client with hyperemesis gravidarum is at risk for developing:

- A. Respiratory alkalosis without dehydration
- B. Metabolic acidosis with dehydration
- C. Respiratory acidosis without dehydration
- D. Metabolic alkalosis with dehydration

118. A client tells the doctor that she is about 20 weeks pregnant. The most definitive sign of pregnancy is:

- A. Elevated human chorionic gonadotropin
- B. The presence of fetal heart tones
- C. Uterine enlargement
- D. Breast enlargement and tenderness

119. The nurse is caring for a neonate whose mother is diabetic. The nurse will expect the neonate to be:

- A. Hypoglycemic, small for gestational age
- B. Hyperglycemic, large for gestational age
- C. Hypoglycemic, large for gestational age
- D. Hyperglycemic, small for gestational age

120. Which of the following instructions should be included in the nurse’s teaching regarding oral contraceptives?

- A. Weight gain should be reported to the physician.
- B. An alternate method of birth control is needed when taking antibiotics.
- C. If the client misses one or more pills, two pills should be taken per day for one week.
- D. Changes in the menstrual flow should be reported to the physician.

121. The nurse is discussing breastfeeding with a postpartum client. Breastfeeding is contraindicated in the postpartum client with:

- A. Diabetes
- B. HIV
- C. Hypertension
- D. Thyroid disease

122. A client is admitted to the labor and delivery unit complaining of vaginal bleeding with very little discomfort. The nurse’s first action should be to:

- A. Assess the fetal heart tones.
- B. Check for cervical dilation.
- C. Check for firmness of the uterus.
- D. Obtain a detailed history.
123. A client telephones the emergency room stating that she thinks that she is in labor. The nurse should tell the client that labor has probably begun when:

- A. Her contractions are two minutes apart.
- B. She has back pain and a bloody discharge.
- C. She experiences abdominal pain and frequent urination.
- D. Her contractions are five minutes apart.

124. The nurse is teaching a group of prenatal clients about the effects of cigarette smoke on fetal development. Which characteristic is associated with babies born to mothers who smoked during pregnancy?

- A. Low birth weight
- B. Large for gestational age
- C. Preterm birth, but appropriate size for gestation
- D. Growth retardation in weight and length

125. The physician has ordered an injection of RhoGam for the postpartum client whose blood type is A negative but whose baby is O positive. To provide postpartum prophylaxis, RhoGam should be administered:

- A. Within 72 hours of delivery
- B. Within one week of delivery
- C. Within two weeks of delivery
- D. Within one month of delivery

126. After the physician performs an amniotomy, the nurse’s first action should be to assess the:

- A. Degree of cervical dilation
- B. Fetal heart tones
- C. Client’s vital signs
- D. Client’s level of discomfort

127. A client is admitted to the labor and delivery unit. The nurse performs a vaginal exam and determines that the client’s cervix is 5cm dilated with 75% effacement. Based on the nurse’s assessment the client is in which phase of labor?

- A. Active
133. A two-year-old is admitted for repair of a fractured femur and is placed in Bryant’s traction. Which finding by the nurse indicates that the traction is working properly?

- A. The infant no longer complains of pain.
- B. The buttocks are 15° off the bed.
- C. The legs are suspended in the traction.
- D. The pins are secured within the pulley.

134. Which statement is true regarding balanced skeletal traction? Balanced skeletal traction:

- A. Utilizes a Steinman pin
- B. Requires that both legs be secured
- C. Utilizes Kirschner wires
- D. Is used primarily to heal the fractured hips

135. The client is admitted for an open reduction internal fixation of a fractured hip. Immediately following surgery, the nurse should give priority to assessing the:

- A. Serum collection (Davol) drain
- B. Client’s pain
- C. Nutritional status
- D. Immobilizer

136. Which statement made by the family member caring for the client with a percutaneous gastrostomy tube indicates understanding of the nurse’s teaching?

- A. “I must flush the tube with water after feedings and clamp the tube.”
- B. “I must check placement four times per day.”
- C. “I will report to the doctor any signs of indigestion.”
- D. “If my father is unable to swallow, I will discontinue the feeding and call the clinic.”

137. The nurse is assessing the client with a total knee replacement two hours post-operative. Which information requires notification of the doctor?

- A. Scant bleeding on the dressing
- B. Low-grade temperature
- C. Hemoglobin of 7gm
- D. The urinary output has been 120ml during the last hour

138. The nurse is caring for the client with a five-year-old diagnosis of plumbism. Which information in the health history is most likely related to the development of plumbism?

- A. The client has traveled out of the country in the last six months.
- B. The client’s parents are skilled stained-glass artists.
- C. The client lives in a house built in 1990.
- D. The client has several brothers and sisters.

139. A client with a total hip replacement requires special equipment. Which equipment would assist the client with a total hip replacement with activities of daily living?

- A. High-seat commode
- B. Recliner
- C. TENS unit
- D. Abduction pillow

140. An elderly client with an abdominal surgery is admitted to the unit following surgery. In anticipation of complications of anesthesia and narcotic administration, the nurse should:

- A. Administer oxygen via nasal cannula.
- B. Have narcan (naloxane) available.
- C. Prepare to administer blood products.
- D. Prepare to do cardioresuscitation.

141. Which roommate would be most suitable for the six-year-old male with a fractured femur in Russell’s traction?

- A. 16-year-old female with scoliosis
- B. 12-year-old male with a fractured femur
C. 10-year-old male with sarcoma
D. 6-year-old male with osteomyelitis

142. A client with osteoarthritis has a prescription for Celebrex (celecoxib). Which instruction should be included in the discharge teaching?

- A. Take the medication with milk.
- B. Report chest pain.
- C. Remain upright after taking for 30 minutes.
- D. Allow six weeks for optimal effects.

143. A client with a fractured tibia has a plaster-of-Paris cast applied to immobilize the fracture. Which action by the nurse indicates understanding of a plaster-of-Paris cast?

- A. Handles the cast with the fingertips
- B. Petals the cast
- C. Dries the cast with a hair dryer
- D. Allows 24 hours before bearing weight

144. The teenager with a fiberglass cast asks the nurse if it will be okay to allow his friends to autograph his cast. Which response would be best?

- A. "It will be alright for your friends to autograph the cast."
- B. "Because the cast is made of plaster, autographing can weaken the cast."
- C. "If they don’t use chalk to autograph, it is okay."
- D. "Autographing or writing on the cast in any form will harm the cast."

145. The nurse is assigned to care for the client with a Steinman pin. During pin care, she notes that the LPN uses sterile gloves and Q-tips to clean the pin. Which action should the nurse take at this time?

- A. Assisting the LPN with opening sterile packages and peroxide
- B. Telling the LPN that clean gloves are allowed
- C. Telling the LPN that the registered nurse should perform pin care
- D. Asking the LPN to clean the weights and pulleys with peroxide

146. A child with scoliosis has a spica cast applied. Which action specific to the spica cast should be taken?

- A. Check the bowel sounds.
- B. Assess the blood pressure.
- C. Offer pain medication.
- D. Check for swelling.

147. The client with a cervical fracture is placed in traction. Which type of traction will be utilized at the time of discharge?

- A. Russell’s traction
- B. Buck’s traction
- C. Halo traction
- D. Crutchfield tong traction

148. A client with a total knee replacement has a CPM (continuous passive motion device) applied during the post-operative period. Which statement made by the nurse indicates understanding of the CPM machine?

- A. "Use of the CPM will permit the client to ambulate during the therapy."
- B. "The CPM machine controls should be positioned distal to the site."
- C. "If the client complains of pain during the therapy, I will turn off the machine and call the doctor."
- D. "Use of the CPM machine will alleviate the need for physical therapy after the client is discharged."

149. A client with a fractured hip is being taught correct use of the walker. The nurse is aware that the correct use of the walker is achieved if the:

- A. Palms rest lightly on the handles
- B. Elbows are flexed 0°
- C. Client walks to the front of the walker
- D. Client carries the walker

150. When assessing a laboring client, the nurse finds a prolapsed cord. The nurse should:

- A. Attempt to replace the cord.
- B. Place the client on her left side.
- C. Elevate the client’s hips.
- D. Cover the cord with a dry, sterile gauze.
151. The nurse is caring for a 30-year-old male admitted with a stab wound. While in the emergency room, a chest tube is inserted. Which of the following explains the primary rationale for insertion of chest tubes?

○ A. The tube will allow for equalization of the lung expansion.
○ B. Chest tubes serve as a method of draining blood and serous fluid and assist in reinflating the lungs.
○ C. Chest tubes relieve pain associated with a collapsed lung.
○ D. Chest tubes assist with cardiac function by stabilizing lung expansion.

152. A client who delivered this morning tells the nurse that she plans to breastfeed her baby. The nurse is aware that successful breastfeeding is most dependent on the:

○ A. Mother’s educational level
○ B. Infant’s birth weight
○ C. Size of the mother’s breast
○ D. Mother’s desire to breastfeed

153. The nurse is monitoring the progress of a client in labor. Which finding should be reported to the physician immediately?

○ A. The presence of scant bloody discharge
○ B. Frequent urination
○ C. The presence of green-tinged amniotic fluid
○ D. Moderate uterine contractions

154. The nurse is measuring the duration of the client’s contractions. Which statement is true regarding the measurement of the duration of contractions?

○ A. Duration is measured by timing from the beginning of one contraction to the beginning of the next contraction.
○ B. Duration is measured by timing from the end of one contraction to the beginning of the next contraction.
○ C. Duration is measured by timing from the beginning of one contraction to the end of the same contraction.
○ D. Duration is measured by timing from the peak of one contraction to the end of the same contraction.

155. The physician has ordered an intravenous infusion of Pitocin for the induction of labor. When caring for the obstetric client receiving intravenous Pitocin, the nurse should monitor for:

○ A. Maternal hypoglycemia
○ B. Fetal bradycardia
○ C. Maternal hyperreflexia
○ D. Fetal movement

156. A client with diabetes visits the prenatal clinic at 28 weeks gestation. Which statement is true regarding insulin needs during pregnancy?

○ A. Insulin requirements moderate as the pregnancy progresses.
○ B. A decreased need for insulin occurs during the second trimester.
○ C. Elevations in human chorionic gonadotrophin decrease the need for insulin.
○ D. Fetal development depends on adequate insulin regulation.

157. A client in the prenatal clinic is assessed to have a blood pressure of 180/96. The nurse should give priority to:

○ A. Providing a calm environment
○ B. Obtaining a diet history
○ C. Administering an analgesic
○ D. Assessing fetal heart tones

158. A primigravida, age 42, is six weeks pregnant. Based on the client's age, her infant is at risk for:

○ A. Down syndrome
○ B. Respiratory distress syndrome
○ C. Turner’s syndrome
○ D. Pathological jaundice

159. A client with a missed abortion at 29 weeks gestation is admitted to the hospital. The client will most likely be treated with:

○ A. Magnesium sulfate
○ B. Calcium gluconate
○ C. Dinoprostone (Prostin E.)
○ D. Bromocrystine (Parlodol)
160. A client with preeclampsia has been receiving an infusion containing magnesium sulfate for a blood pressure that is 160/80; deep tendon reflexes are 1 plus, and the urinary output for the past hour is 100mL. The nurse should:

- A. Continue the infusion of magnesium sulfate while monitoring the client's blood pressure.
- B. Stop the infusion of magnesium sulfate and contact the physician.
- C. Slow the infusion rate and turn the client on her left side.
- D. Administer calcium gluconate IV push and continue to monitor the blood pressure.

161. Which statement made by the nurse describes the inheritance pattern of autosomal recessive disorders?

- A. An affected newborn has unaffected parents.
- B. An affected newborn has one affected parent.
- C. Affected parents have a one in four chance of passing on the defective gene.
- D. Affected parents have unaffected children who are carriers.

162. A pregnant client, age 32, asks the nurse why her doctor has recommended a serum alpha fetoprotein. The nurse should explain that the doctor has recommended the test:

- A. Because it is a state law
- B. To detect cardiovascular defects
- C. Because of her age
- D. To detect neurological defects

163. A client with hypothyroidism asks the nurse if she will still need to take thyroid medication during the pregnancy. The nurse's response is based on the knowledge that:

- A. There is no need to take thyroid medication because the fetus's thyroid produces a thyroid-stimulating hormone.
- B. Regulation of thyroid medication is more difficult because the thyroid gland increases in size during pregnancy.
- C. It is more difficult to maintain thyroid regulation during pregnancy due to a slowing of metabolism.
- D. Fetal growth is arrested if thyroid medication is continued during pregnancy.

164. The nurse is responsible for performing a neonatal assessment on a full-term infant. At one minute, the nurse could expect to find:

- A. An apical pulse of 100
- B. An absence of tonus
- C. Cyanosis of the feet and hands
- D. Jaundice of the skin and sclera

165. A client with sickle cell anemia is admitted to the labor and delivery unit during the first phase of labor. The nurse should anticipate the client's need for:

- A. Supplemental oxygen
- B. Fluid restriction
- C. Blood transfusion
- D. Delivery by Caesarean section

166. A client with diabetes has an order for ultrasonography. Preparation for an ultrasound includes:

- A. Increasing fluid intake
- B. Limiting ambulation
- C. Administering an enema
- D. Withholding food for eight hours

167. An infant who weighs 8 pounds at birth would be expected to weigh how many pounds at one year?

- A. 14 pounds
- B. 16 pounds
- C. 18 pounds
- D. 24 pounds

168. A pregnant client with a history of alcohol addiction is scheduled for a nonstress test. The nonstress test:

- A. Determines the lung maturity of the fetus
- B. Measures the activity of the fetus
- C. Shows the effect of contractions on the fetal heart rate
- D. Measures the neurological well-being of the fetus
169. A full-term male has hypospadias. Which statement describes hypospadias?

- A. The urethral opening is absent
- B. The urethra opens on the top side of the penis
- C. The urethral opening is enlarged
- D. The urethra opens on the under side of the penis

170. A gravida III para II is admitted to the labor unit. Vaginal exam reveals that the client's cervix is 8cm dilated, with complete effacement. The priority nursing diagnosis at this time is:

- A. Alteration in coping related to pain
- B. Potential for injury related to precipitate delivery
- C. Alteration in elimination related to anesthesia
- D. Potential for fluid volume deficit related to NPO status

171. The client with varicella will most likely have an order for which category of medication?

- A. Antibiotics
- B. Antipyretics
- C. Antivirals
- D. Anticoagulants

172. A client is admitted complaining of chest pain. Which of the following drug orders should the nurse question?

- A. Nitroglycerin
- B. Ampicillin
- C. Propranolol
- D. Verapamil

173. Which of the following instructions should be included in the teaching for the client with rheumatoid arthritis?

- A. Avoid exercise because it fatigues the joints.
- B. Take prescribed anti-inflammatory medications with meals.
- C. Alternate hot and cold packs to affected joints.
- D. Avoid weight-bearing activity.

174. A client with acute pancreatitis is experiencing severe abdominal pain. Which of the following orders should be questioned by the nurse?

- A. Meperidine 100mg IM m 4 hours PRN pain
- B. Mylanta 30 ccs m 4 hours via NG
- C. Cimetidine 300mg PO m.i.d.
- D. Morphine 8mg IM m 4 hours PRN pain

175. The client is admitted to the chemical dependence unit with an order for continuous observation. The nurse is aware that the doctor has ordered continuous observation because:

- A. Hallucinogenic drugs create both stimulant and depressant effects.
- B. Hallucinogenic drugs induce a state of altered perception.
- C. Hallucinogenic drugs produce severe respiratory depression.
- D. Hallucinogenic drugs induce rapid physical dependence.

176. A client with a history of abusing barbiturates abruptly stops taking the medication. The nurse should give priority to assessing the client for:

- A. Depression and suicidal ideation
- B. Tachycardia and diarrhea
- C. Muscle cramping and abdominal pain
- D. Tachycardia and euphoric mood

177. During the assessment of a laboring client, the nurse notes that the FHT are loudest in the upper-right quadrant. The infant is most likely in which position?

- A. Right breech presentation
- B. Right occipital anterior presentation
- C. Left sacral anterior presentation
- D. Left occipital transverse presentation

178. The primary physiological alteration in the development of asthma is:

- A. Bronchiolar inflammation and dyspnea
- B. Hypersecretion of abnormally viscous mucus
C. Infectious processes causing mucosal edema
D. Spasm of bronchiolar smooth muscle

179. A client with mania is unable to finish her dinner. To help her maintain sufficient nourishment, the nurse should:

A. Serve high-calorie foods she can carry with her.
B. Encourage her appetite by sending out for her favorite foods.
C. Serve her small, attractively arranged portions.
D. Allow her in the unit kitchen for extra food whenever she pleases.

180. To maintain Bryant’s traction, the nurse must make certain that the child’s:

A. Hips are resting on the bed, with the legs suspended at a right angle to the bed
B. Hips are slightly elevated above the bed and the legs are suspended at a right angle to the bed
C. Hips are elevated above the level of the body on a pillow and the legs are suspended parallel to the bed
D. Hips and legs are flat on the bed, with the traction positioned at the foot of the bed

181. Which action by the nurse indicates understanding of herpes zoster?

A. The nurse covers the lesions with a sterile dressing.
B. The nurse wears gloves when providing care.
C. The nurse administers a prescribed antibiotic.
D. The nurse administers oxygen.

182. There is an order for a trough to be drawn on the client receiving Vancomycin. The nurse is aware that he should contact the lab for them to collect the blood:

A. 15 minutes after the infusion
B. 30 minutes before the fourth infusion
C. one hour after the infusion
D. two hours after the infusion

183. The client using a diaphragm should be instructed to:

A. Refrain from keeping the diaphragm in longer than four hours
B. Keep the diaphragm in a cool location
C. Have the diaphragm resized if she gains five pounds
D. Have the diaphragm resized if she has any surgery

184. The nurse is providing postpartum teaching for a mother planning to breastfeed her infant. Which of the client’s statements indicates the need for additional teaching?

A. “I’m wearing a support bra.”
B. “I’m expressing milk from my breast.”
C. “I’m drinking four glasses of fluid during a 24-hour period.”
D. “While I’m in the shower, I’ll allow the water to run over my breasts.”

185. Damage to the VII cranial nerve results in:

A. Facial pain
B. Absence of ability to smell
C. Absence of eye movement
186. A client is receiving Pyridium (phenazopyridine hydrochloride) for a urinary tract infection. The client should be taught that the medication may:

A. Cause diarrhea
B. Change the color of her urine
C. Cause mental confusion
D. Cause changes in taste

187. Which of the following tests should be performed before beginning a prescription of Accutane?

A. Check the calcium level.
B. Perform a pregnancy test.
C. Monitor apical pulse.
D. Obtain a creatinine level.

188. A client with AIDS is taking Zovirax (acyclovir). Which nursing intervention is most critical during the administration of acyclovir?

A. Limit the client’s activity.
B. Encourage a high-carbohydrate diet.
C. Utilize an incentive spirometer to improve respiratory function.
D. Encourage fluids.

189. A client is admitted for an CAT scan. The nurse should question the client regarding:

A. Pregnancy
B. A titanium hip replacement
C. Allergies to antibiotics
D. Inability to move his feet

190. The nurse is caring for the client receiving Amphotericin B. Which of the following indicates that the client has experienced toxicity to this drug?

A. Changes in vision
B. Nausea
C. Urinary frequency
D. Changes in skin color

191. The nurse should visit which of the following clients first?

A. The client with diabetes with a blood glucose of 95mg/dL
B. The client with hypertension being maintained on Lisinopril
C. The client with chest pain and a history of angina

D. The client with Raynaud's disease

192. A client with cystic fibrosis is taking pancreatic enzymes. The nurse should administer this medication:

A. Once per day in the morning

B. Three times per day with meals

C. Once per day at bedtime

D. Four times per day

193. Cataracts result in opacity of the crystalline lens. Which of the following best explains the functions of the lens?

A. The lens controls stimulation of the retina.

B. The lens orchestrates eye movement.

C. The lens focuses light rays on the retina.

D. The lens magnifies small objects.

194. A client who has glaucoma is to have miotic eyedrops instilled in both eyes. The nurse knows that the purpose of the medication is to:

A. Anesthetize the cornea

195. A client with a severe corneal ulcer has an order for Gentamicin gtt. q 4 hours and Neomycin 1 gtt q 4 hours. Which of the following schedules should be used when administering the drops?

A. Allow five minutes between the two medications.

B. The medications may be used together.

C. The medications should be separated by a cycloplegic drug.

D. The medications should not be used in the same client.

196. The client with color blindness will most likely have problems distinguishing which of the following colors?

A. Orange

B. Violet

C. Red

D. White

197. The client with a pacemaker should be taught to:
A. Report ankle edema
B. Check his blood pressure daily
C. Refrain from using a microwave oven
D. Monitor his pulse rate

198. The client with enuresis is being taught regarding bladder retraining. The nurse should advise the client to refrain from drinking after:

A. 1900
B. 1200
C. 1000
D. 0700

199. Which of the following diet instructions should be given to the client with recurring urinary tract infections?

A. Increase intake of meats.
B. Avoid citrus fruits.
C. Perform pericare with hydrogen peroxide.
D. Drink a glass of cranberry juice every day.

200. The physician has prescribed NPH insulin for a client with diabetes mellitus. Which statement indicates that the client knows when the peak action of the insulin occurs?

A. "I will make sure I eat breakfast within two hours of taking my insulin."
B. "I will need to carry candy or some form of sugar with me all the time."
C. "I will eat a snack around three o'clock each afternoon."
D. "I can save my dessert from supper for a bedtime snack."

201. A client with pneumacystis carinii pneumonia is receiving Methotrexate. The rationale for administering leucovorin calcium to a client receiving Methotrexate is to:

A. Treat anemia
B. Create a synergistic effect
C. Increase the number of white blood cells
D. Reverse drug toxicity

202. A client tells the nurse that she is allergic to eggs, dogs, rabbits, and chicken feathers. Which order should the nurse question?

A. TB skin test
B. Rubella vaccine
C. ELISA test
D. Chest x-ray
203. The physician has prescribed ranitidine (Zantac) for a client with erosive gastritis. The nurse should administer the medication:

A. 30 minutes before meals
B. With each meal
C. In a single dose at bedtime
D. 60 minutes after meals

204. A temporary colostomy is performed on the client with colon cancer. The nurse is aware that the proximal end of a double barrel colostomy:

A. Is the opening on the client’s left side
B. Is the opening on the distal end on the client’s left side
C. Is the opening on the client’s right side
D. Is the opening on the distal right side

205. While assessing the postpartal client, the nurse notes that the fundus is displaced to the right. Based on this finding, the nurse should:

A. Ask the client to void.
B. Assess the blood pressure for hypotension.
C. Administer oxytocin.
D. Check for vaginal bleeding

206. The physician has ordered an MRI for a client with an orthopedic ailment. An MRI should not be done if the client has:

A. The need for oxygen therapy
B. A history of claustrophobia
C. A permanent pacemaker
D. Sensory deafness

207. A six-month-old client is placed on strict bed rest following a hernia repair. Which toy is best suited to the client?

A. Colorful crib mobile
B. Hand-held electronic games
C. Cars in a plastic container
D. 30-piece jigsaw puzzle

208. The nurse is preparing to discharge a client with a long history of polio. The nurse should tell the client that:

A. Taking a hot bath will decrease stiffness and spasticity.
B. A schedule of strenuous exercise will improve muscle strength.
C. Rest periods should be scheduled throughout the day.
D. Visual disturbances can be corrected with prescription glasses.
209. A client on the postpartum unit has a proctoepisiotomy. The nurse should anticipate administering which medication?

A. Dulcolax suppository  
B. Docusate sodium (Colace)  
C. Methyergonovine maleate (Methergine)  
D. Bromocriptine sulfate (Parlodel)

210. A client with pancreatic cancer has an infusion of TPN (Total Parenteral Nutrition). The doctor has ordered for sliding-scale insulin. The most likely explanation for this order is:

A. Total Parenteral Nutrition leads to negative nitrogen balance and elevated glucose levels.  
B. Total Parenteral Nutrition cannot be managed with oral hypoglycemics.  
C. Total Parenteral Nutrition is a high-glucose solution that often elevates the blood glucose levels.  
D. Total Parenteral Nutrition leads to further pancreatic disease.

211. An adolescent primigravida who is 10 weeks pregnant attends the antepartal clinic for a first check-up. To develop a teaching plan, the nurse should initially assess:

A. The client's knowledge of the signs of preterm labor  
B. The client's feelings about the pregnancy  
C. Whether the client was using a method of birth control

212. An obstetric client is admitted with dehydration. Which IV fluid would be most appropriate for the client?

A. 0.45 normal saline  
B. Dextrose 1% in water  
C. Lactated Ringer's  
D. Dextrose 5% in 0.45 normal saline

213. The physician has ordered a thyroid scan to confirm the diagnosis of a goiter. Before the procedure, the nurse should:

A. Assess the client for allergies.  
B. Bolus the client with IV fluid.  
C. Tell the client he will be asleep.  
D. Insert a urinary catheter.

214. The physician has ordered an injection of RhoGam for a client with blood type A negative. The nurse understands that RhoGam is given to:

A. Provide immunity against Rh isoenzymes  
B. Prevent the formation of Rh antibodies
C. Eliminate circulating Rh antibodies

D. Convert the Rh factor from negative to positive

215. The nurse is caring for a client admitted to the emergency room after a fall. X-rays reveal that the client has several fractured bones in the foot. Which treatment should the nurse anticipate for the fractured foot?

A. Application of a short inclusive spica cast

B. Stabilization with a plaster-of-Paris cast

C. Surgery with Kirschner wire implantation

D. A gauze dressing only

216. A client with bladder cancer is being treated with iridium seed implants. The nurse’s discharge teaching should include telling the client to:

A. Strain his urine

B. Increase his fluid intake

C. Report urinary frequency

D. Avoid prolonged sitting

217. Following a heart transplant, a client is started on medication to prevent organ rejection. Which category of medication prevents the formation of antibodies against the new organ?

A. Antivirals

B. Antibiotics

C. Immunosuppressants

D. Analgesics

218. The nurse is preparing a client for cataract surgery. The nurse is aware that the procedure will use:

A. Mydriatics to facilitate removal

B. Miotic medications such as Timoptic

C. A laser to smooth and reshape the lens

D. Silicone oil injections into the eyeball

219. A client with Alzheimer’s disease is awaiting placement in a skilled nursing facility. Which long-term plans would be most therapeutic for the client?

A. Placing mirrors in several locations in the home

B. Placing a picture of herself in her bedroom

C. Placing simple signs to indicate the location of the bedroom, bathroom, and so on

D. Alternating healthcare workers to prevent boredom

220. A client with an abdominal cholecystectomy returns from surgery with a Jackson-Pratt drain. The chief purpose of the Jackson-Pratt drain is to:
A. Prevent the need for dressing changes
B. Reduce edema at the incision
C. Provide for wound drainage
D. Keep the common bile duct open

221. The nurse is performing an initial assessment of a newborn Caucasian male delivered at 32 weeks gestation. The nurse can expect to find the presence of:

A. Mongolian spots
B. Scrotal rugae
C. Head lag
D. Polyhydramnios

222. The nurse is caring for a client admitted with multiple trauma. Fractures include the pelvis, femur, and ulna. Which finding should be reported to the physician immediately?

A. Hematuria
B. Muscle spasms
C. Dizziness
D. Nausea

223. A client is brought to the emergency room by the police. He is combative and yells, “I have to get out of here. They are trying to kill me.” Which assessment is most likely correct in relation to this statement?

A. The client is experiencing an auditory hallucination.
B. The client is having a delusion of grandeur.
C. The client is experiencing paranoid delusions.
D. The client is intoxicated.

224. The nurse is preparing to suction the client with a tracheotomy. The nurse notes a previously used bottle of normal saline on the client’s bedside table. There is no label to indicate the date or time of initial use. The nurse should:

A. Lip the bottle and use a pack of sterile 4×4 for the dressing.
B. Obtain a new bottle and label it with the date and time of first use.
C. Ask the ward secretary when the solution was requested.
D. Label the existing bottle with the current date and time.

225. An infant’s Apgar score is 9 at five minutes. The nurse is aware that the most likely cause for the deduction of one point is:

A. The baby is hypothermic.
B. The baby is experiencing bradycardia.
C. The baby’s hands and feet are blue.
D. The baby is lethargic.
226. The primary reason for rapid continuous rewarming of the area affected by frostbite is to:
   A. Lessen the amount of cellular damage
   B. Prevent the formation of blisters
   C. Promote movement
   D. Prevent pain and discomfort

227. A client recently started on hemodialysis wants to know how the dialysis will take the place of his kidneys. The nurse’s response is based on the knowledge that hemodialysis works by:
   A. Passing water through a dialyzing membrane
   B. Eliminating plasma proteins from the blood
   C. Lowering the pH by removing nonvolatile acids
   D. Filtering waste through a dialyzing membrane

228. During a home visit, a client with AIDS tells the nurse that he has been exposed to measles. Which action by the nurse is most appropriate?
   A. Administer an antibiotic.
   B. Contact the physician for an order for immune globulin.
   C. Administer an antiviral.
   D. Tell the client that he should remain in isolation for two weeks.

229. A client hospitalized with MRSA is placed on contact precautions. Which statement is true regarding precautions for infections spread by contact?
   A. The client should be placed in a room with negative pressure.
   B. Infection Requires close contact; therefore, the door may remain open.
   C. Transmission is highly likely, so the client should wear a mask at all times.
   D. Infection Requires skin-to-skin contact and is prevented by hand washing, gloves, and a gown.

230. A client who is admitted with an above-the-knee amputation tells the nurse that his foot hurts and itches. Which response by the nurse indicates understanding of phantom limb pain?
   A. “The pain will go away in a few days.”
   B. “The pain is due to peripheral nervous system interruptions. I will get you some pain medication.”
   C. “The pain is psychological because your foot is no longer there.”
   D. “The pain and itching are due to the infection you had before the surgery.”

231. A client with cancer of the pancreas has undergone a Whipple procedure. The nurse is aware that during the Whipple procedure, the doctor will remove the:
   A. Head of the pancreas
   B. Proximal third section of the small intestines
C. Stomach and duodenum
D. Esophagus and jejunum

232. The physician has ordered a minimal-bacteria diet for a client with neutropenia. The client should be taught to avoid eating:

A. Fruits
B. Salt
C. Pepper
D. Ketchup

233. A client is discharged home with a prescription for Coumadin (sodium warfarin). The client should be instructed to:

A. Have a Protime done monthly.
B. Eat more fruits and vegetables.
C. Drink more liquids.
D. Avoid crowds.

234. The nurse is assisting the physician with removal of a central venous catheter. To facilitate removal, the nurse should instruct the client to:

A. Perform the Valsalva maneuver as the catheter is advanced
B. Turn his head to the left side and hyperextend the neck
C. Take slow, deep breaths as the catheter is removed
D. Turn his head to the right while maintaining a sniffing position

235. A client has an order for streptokinase. Before administering the medication, the nurse should assess the client for:

A. Allergies to pineapples and bananas
B. A history of streptococcal infections
C. Prior therapy with phenytoin
D. A history of alcohol abuse

236. The nurse is providing discharge teaching for the client with leukemia. The client should be told to avoid:

A. Using oil- or cream-based soaps
B. Flossing between the teeth
C. The intake of salt
D. Using an electric razor

237. The nurse is changing the ties of the client with a tracheotomy. The safest method of changing the tracheotomy ties is to:
A. Apply the new tie before removing the old one.

B. Have a helper present.

C. Hold the tracheotomy with the nondominant hand while removing the old tie.

D. Ask the doctor to suture the tracheostomy in place.

238. The nurse is monitoring a client following a lung resection. The hourly output from the chest tube was 300mL. The nurse should give priority to:

A. Turning the client to the left side

B. Milking the tube to ensure patency

C. Slowing the intravenous infusion

D. Notifying the physician

239. The infant is admitted to the unit with tetralogy of Fallot. The nurse would anticipate an order for which medication?

A. Digoxin

B. Epinephrine

C. Aminophylline

D. Atropine

240. The nurse is educating the lady's club in self-breast exam. The nurse is aware that most malignant breast masses occur in the Tail of Spence. On the diagram, place an X on the Tail of Spence.

241. The toddler is admitted with a cardiac anomaly. The nurse is aware that the infant with a ventricular septal defect will:

A. Tire easily

B. Grow normally

C. Need more calories

D. Be more susceptible to viral infections

242. The nurse is monitoring a client with a history of stillborn infants. The nurse is aware that a nonstress test can be ordered for this client to:

A. Determine lung maturity

B. Measure the fetal activity

C. Show the effect of contractions on fetal heart rate

D. Measure the well-being of the fetus

243. The nurse is evaluating the client who was admitted eight hours ago for induction of labor. The following graph is noted on the monitor. Which action should be taken first by the nurse?
A. Instruct the client to push.

B. Perform a vaginal exam.

C. Turn off the Pitocin infusion.

D. Place the client in a semi-Fowler’s position.

244. The nurse notes the following on the ECG monitor. The nurse would evaluate the cardiac arrhythmia as:

A. Atrial flutter

B. A sinus rhythm

C. Ventricular tachycardia

D. Atrial fibrillation

245. A client with clotting disorder has an order to continue Lovenox (enoxaparin) injections after discharge. The nurse should teach the client that Lovenox injections should:

A. Be injected into the deltoid muscle

B. Be injected into the abdomen

C. Aspirate after the injection

D. Clear the air from the syringe before injections

246. The nurse has a preop order to administer Valium (diazepam) 10mg and Phenergan (promethazine) 25mg. The correct method of administering these medications is to:

A. Administer the medications together in one syringe

B. Administer the medication separately

C. Administer the Valium, wait five minutes, and then inject the Phenergan

D. Question the order because they cannot be given at the same time

247. A client with frequent urinary tract infections asks the nurse how she can prevent the reoccurrence. The nurse should teach the client to:

A. Douche after intercourse

B. Void every three hours

C. Obtain a urinalysis monthly

D. Wipe from back to front after voiding

248. Which task should be assigned to the nursing assistant?

A. Placing the client in seclusion

B. Emptying the Foley catheter of the preeclamptic client

C. Feeding the client with dementia

D. Ambulating the client with a fractured hip
249. The client has recently returned from having a thyroidectomy. The nurse should keep which of the following at the bedside?

A. A tracheotomy set
B. A padded tongue blade
C. An endotracheal tube
D. An airway

5. C
6. C
7. D
8. D
9. C
10. B

250. The physician has ordered a histoplasmosis test for the elderly client. The nurse is aware that histoplasmosis is transmitted to humans by:

A. Cats
B. Dogs
C. Turtles
D. Birds

11. A
12. C
13. D
14. B
15. B
16. A
17. A

Quick Answers

1. D
2. D
3. B
4. C
5. C
6. C
7. D
8. D
9. C
10. B
11. A
12. C
13. D
14. B
15. B
16. A
17. A
18. A
19. C
20. B
21. C
22. A
23. A
24. B
25. D
26. A
27. B
28. C
29. C
30. C
31. B
32. A
33. B
34. B
35. D
36. B
37. A
38. B
39. D
40. A
41. A
42. A
43. A
44. C
45. B
46. A
47. B
48. C
49. C
50. D
51. B
52. B
53. B
54. C
55. D
56. A
57. B
58. C
59. C  
60. B  
61. D  
62. A  
63. C  
64. B  
65. A  
66. D  
67. B  
68. C  
69. A  
70. C  
71. C  
72. D  
73. B  
74. D  
75. D  
76. B

77. D  
78. D  
79. A  
80. B  
81. A  
82. A  
83. D  
84. D  
85. B  
86. B  
87. B  
88. B  
89. D  
90. B  
91. A  
92. C  
93. C  
94. B
239. A

240. See diagram.

241. A

242. B

243. C

244. C

245. B

246. B

247. B

248. C

249. A

250. D

76. Nurses who seek to enhance their cultural-competency skills and apply sensitivity toward others are committed to which professional nursing value?
   I. Autonomy
   J. Strong commitment to service
   K. Belief in the dignity and worth of each person
   L. Commitment to education

77. When trying to make a responsible ethical decision, what should the nurse understand as the basis for ethical reasoning?
   E. Ethical principles & code
   F. The nurse's experience
   G. The nurse's emotional feelings
   H. The policies & practices of the institution

78. A fully alert & competent 89 year old client is in end stage liver disease. The client says, "I'm ready to die," & refuses to take food or fluids. The family urges the client to allow the nurse to insert a feeding tube. What is the nurse's moral responsibility?
   E. The nurse should obtain an order for a feeding tube
   F. The nurse should encourage the client to reconsider the decision
   G. The nurse should honor client's decision
   H. The nurse must consider that the hospital can be sued if she honors the client's request

79. A mentally competent client with end stage liver disease continues to consume alcohol after being informed of the consequences of this action. What action best illustrates the nurse's role as a client advocate?
   E. Asking the spouse to take all the alcohol out of the house
   F. Accepting the patient's choice & not intervening
   G. Reminding the client that the action may be an end-of-life decision
   H. Refusing to care for the client because of the client's noncompliance

80. A nurse demonstrates patient advocacy by becoming involved in which of the following activities?
   5) Taking a public stand on quality issues and educating the public on "public interest" issues
   6) Teaching in a school of nursing to help decrease the nursing shortage
   7) Engaging in nursing research to justify nursing care delivery
   8) Supporting the status quo when changes are pending

81. The nurse is functioning as a patient advocate. Which of the following would be the first step the nurse should take when functioning in this role?
   A. Ensure that the nursing process is complete and includes active participation by the patient and family
   B. Become creative in meeting patient needs.
   C. Empower the patient by providing needed information and support
   D. Help the patient understand the need for preventive health care.
82. A famous actress has had plastic surgery. The media contacts the nurse on the unit and asks for information about the surgery. The nurse knows:
   A. Any information released will bring publicity to the hospital.
   B. Nurses are obligated to respect client’s privacy and confidentiality.
   C. It does not matter what is disclosed, the media will find out any way.
   D. According to beneficence, the nurse has an obligation to implement actions that will benefit clients.

83. Essence of Care benchmarking is a process of ______?
   E. Comparing, sharing and developing practice in order to achieve and sustain best practice
   F. Assess clinical area against best practice
   G. Review achievement towards best practice
   H. Consultation and patient involvement

84. An adult is offered the opportunity to participate in research on a new therapy. The researcher asks the nurse to obtain the patient’s consent. What is most appropriate for the nurse to take?
   5) Be sure the patient understands the project before signing the consent form
   6) Read the consent form to the patient & give him or her an opportunity to ask questions
   7) Refuse to be the one to obtain the patient’s consent
   8) Give the form to the patient & tell him or her to read it carefully before signing it

85. An adult has just returned to the unit from surgery. The nurse transferred him to his bed but did not put up the side rail. The client fell and was injured. What kind of liability does the nurse have?
   5) None
   6) Negligence
   7) Intentional tort
   8) Assault & battery

86. A patient is admitted to the ward with symptoms of acute diarrhea. What should your initial management be?
   A. Assessment, protective isolation, universal precautions
   B. Assessment, source isolation, antibiotic therapy
   C. Assessment, protective isolation, antimotility medication
   D. Assessment, source isolation, universal precautions

87. Your patient has undergone a formation of a loop colostomy. What important considerations should be borne in mind when selecting an appropriate stoma appliance for your patient?
   A. Dexterity of the patient, consistency of effluent, type of stoma
   B. Patient preference, type of stoma, consistency of effluent, state of peristomal skin, dexterity of patient
   C. Patient preference, lifestyle, position of stoma, consistency of effluent, state of peristomal skin, dexterity of patient, type of stoma
   D. Cognitive ability, lifestyle, patient dexterity, position of stoma, state of peristomal skin, type of stoma, consistency of effluent, patient preference

88. What are the principles of gaining informed consent prior to plan surgery?
   E. Gaining permission for an imminent procedure by providing information in medical terms, ensuring a patient knows the potential risks and intended benefits
   F. Gaining permission from a patient who is competent to give it, by providing information, both verbally and with written material, relating to the planned procedure, for them to read on the day of planned surgery
   G. Gaining permission from a patient who is competent to give it, by informing them about the procedure and highlighting risks if the procedure is not carried out
   H. Gaining permission from a patient who is competent to give it, by providing information in understandable terms prior to surgery, allowing time for answering questions, and inviting voluntary participation

89. When should adult patients in acute hospital settings have observations taken?
A. When they are admitted or initially assessed. A plan should be clearly documented which identifies which observations should be taken & how frequently subsequent observations should be done.

B. When they are admitted & then once daily unless they deteriorate.

C. As indicated by the doctor.

D. Temperatures should be taken daily, respirations at night, pulse & blood pressure 4 hourly.

90. A patient is agitated and is unable to settle, she is also finding it difficult to sleep, reporting that she is in pain. What would you do at this point?

A. Ask her to score her pain, describe its intensity, duration, describe its intensity, duration, the site, any relieving measures and what makes it worse, looking for non-verbal clues, so you can determine the appropriate method of pain management.

B. Give her some sedatives so she goes to sleep.

C. Calculate a pain score, suggest that she takes deep breaths, reposition her pillows, return in 5min to gain a comparative pain score.

D. Give her any analgesia she is due. If she has not any, contact the doctor to get some prescribed. Also give her a warm milky drink and reposition her pillows. Document your action.

91. A patient in your care knocks their head on the bedside locker when reaching down to pick up something they have dropped. What do you do?

A. Let the patient's relatives know so that they don't make a complaint & write an incident report for yourself so you remember the details in case there are problems in the future.

B. Help the patient to a safe comfortable position, commence neurological observations & ask the patient's doctor to come & review them, checking the injury isn't serious. When this has taken place, write up what happened & any future care in the nursing notes.

C. Discuss the incident with the nurse in charge, & contact your union representative in case you get into trouble.

D. Help the patient to a safe comfortable position, take a set of observations & report the incident to the nurse in charge who may call a doctor. Complete an incident form. At an appropriate time, discuss the incident with the patient & if they wish, their relatives.

92. Which of the following client should the nurse deal with first?

5) A client who needs her dressing changed.

6) A client who needs to be suctioned.

7) A client who needs to be medicated for incisional pain.

8) A client who is incontinent & needs to be cleaned.

93. A client on your medical surgical unit has a cousin who is a physician & wants to see the chart. Which of the following is the best response for the nurse to take?

5) Hand the cousin the client chart to review.

6) Ask the client to sign an authorization & have someone review the chart with cousin.

7) Call the attending physician & have the doctor speak with the cousin.

8) Tell the cousin that the request cannot be granted.

94. Which professional organizations are responsible for establishing the code?

E. NHS

F. NMC

G. American Nurses Association, National League of Nursing, and American Association of Nurse Executives

H. State Boards of Nursing, state and national organizations, and specialty organizations.

95. The code is concerned about focusing on which of the following criteria?

A. Clinical expertise.

B. Conduct, behavior, ethics & professionalism.

C. Hospital policies.

D. Disciplinary actions.

96. What factors are essential in demonstrating supportive communication to patients?

I. Listening, clarifying the concerns & feelings of the patient using open questions.

J. Listening, clarifying the physical needs of the patient using open questions.

K. Listening, clarifying the physical needs of the patient using open questions.

L. Listening, reflecting back the patient's concerns & providing a solution.

97. Which behaviors will encourage a patient to talk about their concerns?

I. Giving reassurance & telling them not to worry.

J. Asking the patient about their family & friends.
K. Tell the patient you are interested in what is concerning them & that you are available to listen.

L. Tell the patient you are interested in what is concerning them if they tell you, they will feel better.

98. What is the difference between denial & collusion?
   A. Denial is when a healthcare professional refuses to tell a patient their diagnosis for the protection of the patient whereas collusion is when healthcare professionals & the patient agree on the information to be told to relatives & friends.
   
   B. Denial is when a patient refuses treatment & collusion is when a patient agrees to it.
   
   C. Denial is a coping mechanism used by an individual with the intention of protecting themselves from painful or distressing information whereas collusion is the withholding of information from the patient with the intention of protecting them.
   
   D. Denial is a normal acceptable response by a patient to a life-threatening diagnosis whereas collusion is not.

99. If you were explaining anxiety to a patient, what would be the main points to include?
   A. Signs of anxiety include behaviours such as muscle tension, palpitations, a dry mouth, fast shallow breathing, dizziness & an increased need to urinate or defaecate.
   
   B. Anxiety has three aspects: physical – bodily sensations related to fight & flight response, behavioural – such as avoiding the situation & cognitive (thinking) – such as imagining the worst.
   
   C. Anxiety is all in the mind, if they learn to think differently, it will go away.
   
   D. Anxiety has three aspects: physical – such as running away, behavioural – such as imagining the worse (catastrophizing) & cognitive (thinking) – such as needing to urinate.

100. What are the principles of communicating with a patient with delirium?
   E. Use short statements & closed questions in a well-lit, quiet, familiar environment.
   
   F. Use short statements & open questions in a well-lit, quiet, familiar environment.
   
   G. Write down all questions for the patient to refer back to.
   
   H. Communicate only through the family using short statements & closed questions.

101. Which of the following statements by a nurse would indicate an understanding of intrapersonal communications?
   5) "Intrapersonal communications occur between two or more people.
   
   6) "Intrapersonal communications occurs within a person.
   
   7) "Interpersonal communications is the same as intrapersonal communications.
   
   8) "Nurses should avoid using intrapersonal communications."

102. Which therapeutic communication technique is being used in this nurse-client interaction?
   Client: "When I get angry, I get into a fistfight with my wife or I take it out on the kids.
   Nurse: "I notice that you are smiling as you talk about this physical violence.

   5) Encouraging comparison
   
   6) Exploring
   
   7) Formulating a plan of action
   
   8) Making observations

103. Which nursing statement is a good example of the therapeutic communication technique of giving recognition?
   A. "You did not attend group today. Can we talk about that?"
   B. "I'll sit with you until it is time for your family session.
   C. "I notice you are wearing a new dress and you have washed your hair."
   D. "I'm happy that you are now taking your medications. They will really help."

104. The nurse asks a newly admitted client, "What can we do to help you?" What is the purpose of this therapeutic communication technique?
   A. To reframe the client's thoughts about mental health treatment
   B. To put the client at ease
   C. To explore a subject, idea, experience, or relationship
   D. To communicate that the nurse is listening to the conversation

105. Which nursing statement is a good example of the therapeutic communication technique of focusing?
   A. "Describe one of the best things that happened to you this week."
   B. "I'm having a difficult time understanding what you mean."
   C. "Your counseling session is in 30 minutes. I'll stay with you until then."
   D. "You mentioned your relationship with your father. Let's discuss that further."
106. Which nursing response is an example of the nontherapeutic communication block of requesting an explanation?

A. "Can you tell me why you said that?"
B. "Keep your chin up. I'll explain the procedure to you."
C. "There is always an explanation for both good and bad behaviors."
D. "Are you not understanding the explanation I provided?"

107. Which therapeutic communication technique should the nurse use when communicating with a client who is experiencing auditory hallucinations?

A. "My sister has the same diagnosis as you and she also hears voices."
B. "I understand that the voices seem real to you, but I do not hear any voices."
C. "Why not turn up the radio so that the voices are muted."
D. "I wouldn’t worry about these voices. The medication will make them disappear."

108. Which nursing statement is a good example of the therapeutic communication technique of offering self?

A. "I think it would be great if you talked about that problem during our next group session."
B. "Would you like me to accompany you to your electroconvulsive therapy treatment?"
C. "I notice that you are offering help to other peers in the milieu."
D. "After discharge, would you like to meet me for lunch to review your outpatient progress?"

34. On a psychiatric unit, the preferred milieu environment is BEST described as:

A. Providing an environment that is safe for the patient to express feelings.
B. Fostering a sense of well-being and independence in the patient.
C. Providing an environment that will support the patient in his or her therapeutic needs.
D. Fostering a therapeutic social, cultural, and physical environment.

35. A new mother is admitted to the acute psychiatric unit with severe postpartum depression. She is tearful and states, "I don't know why this happened to me! I was so excited for my baby to come, but now I don't know!" Which of the following responses by the nurse is MOST therapeutic?

A. "Having a new baby is wonderful, but the stress and different hormone levels don’t help. It happens to many new mothers and it can be treated.
B. "Maybe you weren’t ready for a child after all."
C. "What happened once you brought the baby home? Did you feel nervous?"
D. "Has your husband been helping you with the housework at all?"

36. A patient with antisocial personality disorder enters the private meeting room of a nursing unit as a nurse is meeting with a different patient. Which of the following statements by the nurse is BEST?

A. "I'm sorry, but HIPPA says that you can't be here. Do you mind leaving?"
B. "You may sit with us as long as you are quiet."
C. "I need you to leave us alone.
D. "Please leave and I will speak with you when I am done."

37. The wife of a client with PTSD (post traumatic stress disorder) communicates to the nurse that she is having trouble dealing with her husband’s condition at home. Which of the following suggestions made by the nurse is CORRECT?

A. "Discourage your husband from exercising, as this will worsen his condition."
B. "Encourage your husband to avoid regular contact with outside family members."
C. "Do not touch or speak to your husband during an active flashback. Wait until it is finished to give him support."
D. "Keep your cupboards free of high-sugar and high-fat foods."
38. A patient has just been told by the physician that she has stage III uterine cancer. The patient says to the nurse, “I don’t know what to do. How do I tell my husband?” and begins to cry. Which of the following responses by the nurse is the MOST therapeutic?
A. “It seems to be that this is a lot to handle. I’ll stay here with you.”
B. “How do you think would be best to tell your husband?”
C. “I think this will all be easier to deal with than you think.”
D. “Why do you think this is happening to you?”

39. A client expressed concern regarding the confidentiality of her medical information. The nurse assures the client that the nurse maintains client confidentiality by:
5) Sharing the information with all members of the health care team.
6) Limiting discussion about clients to the group room and hallways.
7) Summarizing the information the client provides during assessments and documenting this summary in the chart.
8) Explaining the exact limits of confidentiality in the exchanges between the client and the nurse.

40. When caring for clients with psychiatric diagnoses, the nurse recalls that the purpose of psychiatric diagnoses or psychiatric labeling is to:
5) Identify those individuals in need of more specialized care.
6) Identify those individuals who are at risk for harming others.
7) Enable the client’s treatment team to plan appropriate and comprehensive care.
8) Define the nursing care for individuals with similar diagnoses.

41. If you were told by a nurse at handover to take “standard precautions” what would you expect to be doing?
E. Taking precautions when handling blood & ‘high risk’ body fluids sp that you don’t pass on any infection to the patient.
F. Wearing gloves, aprons & mask when caring for someone in protective isolation to protect yourself from infection.
G. Asking relatives to wash their hands when visiting patients in the clinical setting.

42. You are told a patient is in “source isolation”. What would you do & why?
A. Isolating a patient so that they don’t catch any infections.
B. Nursing an individual who is regarded as being particularly vulnerable to infection in such a way as to minimize the transmission of potential pathogens to that person.
C. Nurse the patient in isolation, ensure that you wear appropriate personal protective equipment (PPE) & adhere to strict hand hygiene, for the purpose of preventing the spread of organisms from that patient to others.
D. Nursing a patient who is carrying an infectious agent that may be risk to others in such a way as to minimize the risk of the infection spreading elsewhere in their body.

43. What would make you suspect that a patient in your care had a urinary tract infection?
A. The doctor has requested a midstream urine specimen.
B. The patient has a urinary catheter in situ & the patient’s wife states that he seems more forgetful than usual.
C. The patient has spiked a temperature, has a raised white cell count (WCC), has new-onset confusion & the urine in the catheter bag is cloudy.
D. The patient has complained of frequency of faecal elimination & hasn’t been drinking enough.

44. You are caring for a patient in isolation with suspected clostridium difficile. What are the essential key actions to prevent the spread of infection?
A. Regular hand hygiene & the promotion of the infection prevention link nurse role.
B. Encourage the doctors to wear gloves & aprons, to be bare below the elbow & to wash hands with alcohol handrub. Ask for cleaning to be increased with soap-based products.
C. Ask the infection prevention team to review the patient’s medication chart & provide regular teaching sessions on the ‘5 moments of hand hygiene’. Provide the patient & family with adequate information.
D. Review antimicrobials daily, wash hands with soap & water before & after each contact with the patient, ask for enhanced cleaning with chlorine–based products & use gloves & aprons when disposing of body fluids.
45. What steps would you take if you had sustained a needlestick injury?
   E. Ask for advice from the emergency department, report to occupational health & fill in an incident form.
   F. Gently make the wound bleed, place under running water & wash thoroughly with soap & water. Complete an incident form & inform your manager. Co-operate with any action to test yourself or the patient for infection with a bloodborne virus but do not obtain blood or consent for testing from the patient yourself; this should be done by someone not involved in the incident.
   G. Take blood from patient & self for Hep B screening & take samples & form to bacteriology. Call your union representative for support. Make an appointment with your GP for a sickness certificate to take time off until the wound site has healed so you contaminate any other patients.
   H. Wash the wound with soap & water. Cover any wound with a waterproof dressing to prevent entry of any other foreign material. Wear gloves while working until the wound has healed to prevent contaminating any other patients. Take any steps to have the patient or yourself tested for the presence of a bloodborne virus.

46. What functions should a dressing fulfill for effective wound healing?
   E. High humidity, insulation, gaseous exchange, absorbent
   F. Anaerobic, impermeable, conformable, low humidity
   G. Insulation, low humidity, sterile, high adherence
   H. Absorbent, low adherence, anaerobic, high humidity

47. When would it be beneficial to use a wound care plan?
   E. On all chronic wounds
   F. On all infected wounds
   G. On all complex wounds
   H. On every wound

48. How would you care for a patient with necrotic wound?
   A. Systemic antibiotic therapy and apply a dry dressing
   B. Debride and apply a hydrogel dressing
   C. Debride and apply an antimicrobial dressing
   D. Apply a negative pressure dressing

49. A new postsurgical wound is assessed by the nurse and is found to be hot, tender and swollen. How could this wound be best described?
   A. In the inflammation phase of healing
   B. In the haemostasis phase of healing
   C. In the reconstructive phase of wound healing
   D. As an infected wound

50. What are the four stages of wound healing in the order they take place?
   A. Proliferative phase, inflammatory phase, remodeling phase, maturation phase
   B. Haemostasis, inflammation phase, proliferative phase, maturation phase
   C. Inflammatory phase, dynamic stage, neutrophil phase, maturation phase
   D. Haemostasis, proliferation phase, inflammation phase, remodeling phase
   E. Haemostasis, proliferation phase, inflammation phase, remodeling phase

51. If an elderly immobile patient had a “grade 3 pressure sore”, what would be your management?
   A. Hydrocolloid dressing, pressure-relieving mattress, nutritional support
   B. Dry dressing, pressure-relieving mattress, mobilization
   C. Film dressing, mobilization, positioning, nutritional support
   D. Foam dressing, pressure-relieving mattress, nutritional support

52. How can risks be reduced in the healthcare setting?
   A. By adopting a culture of openness & transparency & exploring the root causes of patient safety incidents.
   B. Healthcare will always involve risks so incidents will always occur. We need to accept this.
   C. Healthcare professionals should be encouraged to fill in incident forms; this will create a culture of “no blame”.
   D. By setting targets which measure quality.

53. A patient in your care knocks their head on the bedside locker when reaching down to pick up something they have dropped. What do you do?
   A. Let the patient’s relatives know so that they don’t make a complaint & write an incident report for yourself so you remember the details in case there are problems in the future.
   B. Help the patient to a safe comfortable position, commence neurological observations & ask the patient’s doctor to come & review them, checking the injury isn’t serious. When this has taken
place, write up what happened & any future care in the nursing notes
C. Discuss the incident with the nurse in charge, & contact your union representative in case you get into trouble
B. Help the patient to a safe comfortable position, take a set of observations & report the incident to the nurse in charge who may call a doctor. Complete an incident form. At an appropriate time discuss the incident with the patient & if they wish, their relatives.

54. You are looking after a 75 year old woman who had an abdominal hysterectomy 2 days ago. What would you do to reduce the risk of her developing a deep vein thrombosis (DVT)?
A. Give regular analgesia to ensure she has adequate pain relief so she can mobilize as soon as possible. Advise her not to cross her legs
B. Make sure that she is fitted with properly fitting antiembolic stockings & that are removed daily
C. Ensure that she is wearing antiembolic stockings & that she is prescribed prophylactic anticoagulation & is doing hourly limb exercises
D. Give adequate analgesia so she can mobilize to the chair with assistance. Give subcutaneous low molecular weight heparin as prescribed. Make sure that she is wearing antiembolic stockings

55. You are looking after an emaciated 80-year old man who has been admitted to your ward with acute exacerbation of chronic obstructive airways disease (COPD). He is currently so short of breath that it is difficult for him to mobilize. What are some of the actions you take to prevent him developing a pressure ulcer?
A. He will be at high risk of developing a pressure ulcer so place him on a pressure relieving mattress
B. Assess his risk of developing a pressure ulcer with a risk assessment tool. If indicated, procure an appropriate pressure-relieving mattress for him & sit him for his chair. Reasses the patient’s pressure areas at least twice a day & keep them clean & dry. Review his fluid & nutritional intake & support him to make changes as indicated.
C. Assess his risk of developing a pressure ulcer with a risk assessment tool & reassess every week. Reduce his fluid intake to avoid him becoming incontinent & the pressure areas becoming damp with urine
D. He is at high risk of developing a pressure ulcer because of his recent acute illness, poor nutritional intake & reduced mobility. By giving him his prescribed antibiotic therapy, referring him to the dietician & physiotherapist, the risk will be reduced.

56. You are looking after a 76-year old woman who has had a number of recent falls at home. What would you do to try & ensure her safety whilst she is in hospital?
A. Refer her to the physiotherapist & provide her with lots of reassurance as she has lost a lot of confidence recently
B. Make sure that the bed area is free of clutter. Place the patient in a bed near the nurse’s station so that you can keep an eye on her. Put her on an hourly toileting chart. Obtain lying & standing blood pressures as postural hypotension may be contributing to her falls
C. Make sure that the bed area is free of clutter & that the patient can reach everything she needs, including the call bell. Check regularly to see if the patient needs assistance mobilizing to the toilet. Ensure that she has properly fitting slippers & appropriate walking aids
D. Refer her to the community falls team who will assess her when she gets home

57. The client reports nausea and constipation. Which of the following would be the priority nursing action?
A. Collect a stool sample
B. Complete an abdominal assessment
C. Administer an anti-nausea medication
D. Notify the physician

58. The nurse suspects that a client is withholding health-related information out of fear of discovery and possible legal problems. The nurse formulates nursing diagnoses for the client carefully, being concerned about a diagnostic error resulting from which of the following?
A. Incomplete data
B. Generalize from experience
C. Identifying with the client
D. Lack of clinical experience
59. Which of the following descriptors is most appropriate to use when stating the “problem” part of a nursing diagnosis?

A. Grimacing  
B. Anxiety  
C. Oxygenation saturation 93%  
D. Output 500 mL in 8 hours

60. The rehabilitation nurse wishes to make the following entry into a client’s plan of care: “Client will reestablish a pattern of daily bowel movements without straining within two months.” The nurse would write this statement under which section of the plan of care?

A. Nursing diagnosis/problem list  
B. Nursing orders  
C. Short-term goals  
D. Long-term goals

61. The nurse has just been promoted to unit manager. Which advice, offered by a senior unit manager, will help this nurse become inspirational and motivational in this new role?

A. “If you make a mistake with your staff, admit it, apologize, and correct the error if possible.”  
B. “Don’t be too soft on the staff. If they make a mistake, be certain to reprimand them immediately.”  
C. “Give your best nurses extra attention and rewards for their help.”  
D. “Never gets into a disagreement with a staff member.”

62. The famous 14 Principles of Management was first defined by

A. Elton Mayo  
B. Henri Fayol  
C. Adam Smith  
D. James Watt

63. The nursing staff communicates that the new manager has a focus on the “bottom line,” and little concern for the quality of care. What is likely true of this nurse manager?

A. The manager is looking at the total care picture.  
B. The manager is communicating the importance of a caring environment.  
C. The manager understands the organization’s values and how they mesh with the manager’s values.  
D. The manager is unwilling to listen to staff concerns unless they have an impact on costs.

64. A very young nurse has been promoted to nurse manager of an inpatient surgical unit. The nurse is concerned that older nurses may not respect the manager’s authority because of the age difference. How can this nurse manager best exercise authority?

A. Use critical thinking to solve problems on the unit.  
B. Give assignments clearly, taking staff expertise into consideration.  
C. Understand complex health care environments.  
D. Maintain an autocratic approach to influence results.

65. What statement, made in the morning shift report, would help an effective manager develop trust on the nursing unit?

A. “I know I told you that you could have the weekend off, but I really need you to work.”  
B. “The others work many extra shifts, why can’t you?”  
C. “I’m sorry, but I do not have a nurse to spare today to help on your unit. I cannot make a change now, but we should talk further about schedules and needs.”  
D. “I can’t believe you need help with such a simple task. Didn’t you learn that in school?”

66. The nurse executive of a health care organization wishes to prepare and develop nurse managers for several new units that the organization will open next year. What should be the primary goal for this work?

A. Focus on rewarding current staff for doing a good job with their assigned tasks by selecting them for promotion.  
B. Prepare these managers so that they will focus on maintaining standards of care.  
C. Prepare these managers to oversee the entire health care organization.  
D. Prepare these managers to interact with hospital administration.

67. What are the key competencies and features for effective collaboration?

A. Effective communication skills, mutual respect, constructive feedback, and conflict management.
B. High level of trust and honesty, giving and receiving feedback, and decision making.
C. Mutual respect and open communication, critical feedback, cooperation, and willingness to share ideas and decisions.
D. Effective communication, cooperation, and decreased competition for scarce resources.

68. A registered nurse is a preceptor for a new nursing graduate and is describing critical paths and variance analysis to the new nursing graduate. The registered nurse instructs the new nursing graduate that a variance analysis is performed on all clients:
   a) continuously
   b) daily during hospitalization
   c) every third day of hospitalization
   d) every other day of hospitalization

69. A nurse manager is planning to implement a change in the method of the documentation system for the nursing unit. Many problems have occurred as a result of the present documentation system, and the nurse manager determines that a change is required. The initial step in the process of change for the nurse manager is which of the following?
   a) plan strategies to implement the change
   b) set goals and priorities regarding the change process
   c) identify inefficiency that needs improvement or correction
   d) identify potential solutions and strategies for the change process

70. Ms. Castro is newly-promoted to a patient care manager position. She updates her knowledge on the theories in management and leadership in order to become effective in her new role. She learns that some managers have low concern for services and high concern for staff. Which style of management refers to this?
   a. Organization Man
   b. Impoverished Management
   c. Country Club Management
   d. Team Management

71. What are essential competencies for today's nurse manager?
   5) A vision and goals
   6) Communication and teamwork
   7) Self- and group awareness
   8) Strategic planning and design

72. As a nurse manager achieves a higher management position in the organization, there is a need for what type of skills?
   5) Personal and communication skills
   6) Communication and technical skills
   7) Conceptual and interpersonal skills
   8) Visionary and interpersonal skills

73. The characteristics of an effective leader include:
   5) attention to detail
   6) financial motivation
   7) sound problem-solving skills and strong people skills
   8) emphasis on consistent job performance

74. What is the most important issue confronting nurse managers using situational leadership?
   5) Leaders can choose one of the four leadership styles when faced with a new situation.
   6) Personality traits and leader's power base influence the leader's choice of style.
   7) Value is placed on the accomplishment of tasks and on interpersonal relationships between leader and group members and among group members.
   8) Leadership style differs for a group whose members are at different levels of maturity.

75. A nurse case manager receives a referral to provide case management services for an adolescent mother who was recently diagnosed with HIV. Which statement indicates that the patient understands her illness?
A. "I can never have sex again, so I guess I will always be a single parent.”
B. "I will wear gloves when I’m caring for my baby, because I could infect my baby with AIDS.”
C. "My CD4 count is 200 and my T cells are less than 14%. I need to stay at these levels by eating and sleeping well and staying healthy.”
D. "My CD4 count is 800 and my T cells are greater than 14%. I need to stay at these levels by eating and sleeping well and staying healthy.”

76. When developing a program offering for patients who are newly diagnosed with diabetes, a nurse case manager demonstrates an understanding of learning styles by:
A. Administering a pre- and posttest assessment.
B. Allowing patient’s time to voice their opinions.
C. Providing a snack with a low glycemic index.
D. Utilizing a variety of educational materials.

77. There have been several patient complaints that the staff members of the unit are disorganized and that "no one seems to know what to do or when to do it.” The staff members concur that they don’t have a real sense of direction and guidance from their leader. Which type of leadership is this unit experiencing?
1. Autocratic.
2. Bureaucratic.
3. Laissez-faire.

78. Which strategy could the nurse use to avoid disparity in health care delivery?
A. Recognize the cultural issue related to patient care.
B. Request more health plan options.
C. Care for more patients even if quality suffers.
D. Campaign for fixed nurse-patient ratios.

79. Which option best illustrates a positive outcome for managed care?
A. Reshaping current policy.
B. Involvement in the political process.
C. Increase in preventative services.
D. Cost-benefit analysis.

80. The patient is being discharged from the hospital after having a coronary artery bypass graft (CABG). Which level of the health care system will best serve the needs of this patient at this point?
1. Primary care.
2. Secondary care.
3. Tertiary care.

81. Dehydration is of particular concern in ill health. If a patient is receiving IV fluid replacement and is having their fluid balance recorded, which of the following statements is true of someone said to be in “positive fluid balance”?
E. The fluid output has exceeded the input
F. The doctor may consider increasing the IV drip rate
G. The fluid balance chart can be stopped as “positive” means “good”
H. The fluid input has exceeded the output

82. What specifically do you need to monitor to avoid complications & ensure optimal nutritional status in patients being enterally fed?
E. Blood glucose levels, full blood count, stoma site and body weight
F. Eye sight, hearing, full blood count, lung function and stoma site
G. Assess swallowing, patient choice, fluid balance, capillary refill time
H. Daily urinalysis, ECG, Protein levels and arterial pressure

83. A patient needs weighing, as he is due a drug that is calculated on bodyweight. He experiences a lot of pain on movement so is reluctant to
move, particularly stand up. What would you do?
E. Document clearly in the patient’s notes that a weight cannot be obtained
C. Offer the patient pain relief and either use bed scales or a hoist with scales built in
G. Discuss the case with your colleagues and agree to guess his body weight until he agrees to stand and use the chair scales
H. Omit the drugs as it is not safe to give it without this information; inform the doctor and document your actions

84. If the prescribed volume is taken, which of the following types of feed will provide all protein, vitamins, minerals and trace elements to meet patient’s nutritional requirements?
   A. Protein shakes/supplements
   B. Sip feeds
   C. Energy drink
   D. Mixed fat and glucose polymer solutions/powder

85. A patient has been admitted for nutritional support and started receiving a hyperosmolar feed yesterday. He presents with diarrhea but no pyrexia. What is likely to be cause?
   A. The feed
   B. An infection
   C. Food poisoning
   D. Being in hospital

86. Your patient has a bulky oesophageal tumor and is waiting for surgery. When he tries to eat, food gets stuck and gives him heart burn. What is the most likely route that will be chosen to provide him with the nutritional support he needs?
   A. Nasogastric tube feeding
   B. Feeding via a Percutaneous Endoscopic Gastrostomy (PEG)
   C. Feeding via a Radiologically Inserted Gastostomy (RIG)
   D. Continue oral

87. What is the best way to prevent who is receiving an enteral feed from aspirating?
   I. Lie them flat
   J. Sit them at least 45 degree angle
   K. Tell them to lie in their side
   L. Check their oxygen saturations

88. Which of the following medications are safe to be administered via a nasogastric tube?
   A. Enteric-coated drugs to minimize the impact of gastric irritation
   B. A cocktail of all medications mixed together, to save time and prevent fluid over loading the patient
   C. Any drugs that can be crushed
   D. Drugs that can be absorbed via this route, can be crushed and given diluted or dissolved in 10-15ml of water

89. Which check do you need to carry out before setting up an enteral feed via nasogastric tube?
   I. That when flushed with red juice, the red juice can be seen when the tube is aspirated
   J. That air cannot be heard rushing into the lungs by doing the WHOOSH TEST
   K. That the pH of gastric aspirate is below 5.5 and the measurements on the NG tube is the same length as the time insertion
   L. That the pH of gastric aspirate is above 6.6 and the measurements on the NG tube is the same length as the time insertion.

90. Monica is going to receive blood transfusion. How frequently should we do her observation?
   A. Temperature and Pulse before the blood transfusion begins, then every hour, and at the end of bag/unit
   B. Temperature, pulse, blood pressure and respiration before the blood transfusion begins, then after 15 min, then as indicated in local guidelines, and finally at the end of bag/unit.
   C. Temperature, pulse, blood pressure and respiration and urinalysis before the blood transfusion, then at end of bag.
   D. Pulse, blood pressure and respiration every hour, and at the end of the bag

91. How do the structures of the human body work together to provide support and assist in movement?
   A. The skeleton provides a structural framework. This is moved by the muscles that contract or extend and in order to function, cross at least one joint and are attached to the articulating bones.
   B. The muscles provide a structural framework and are moved by bones to
which they are attached by ligaments.

C. The skeleton provides a structural framework; this is moved by ligaments that stretch and contract.

D. The muscles provide a structural framework, moving by contracting or extending, crossing at least one joint and attached to the articulating bones.

92. What are the most common effects of inactivity?
A. Pulmonary embolism, UTI, & fear of people
B. Deep arterial thrombosis, respiratory infection, fears of movement, loss of consciousness, de-conditioning of cardiovascular system leading to an increased risk of angina.
C. Loss of weight, frustration and deep vein thrombosis
D. Social isolation, loss of independence, exacerbation of symptoms, rapid loss of strength in leg muscles, de-conditioning of cardiovascular system leading to an increased risk of chest infection and pulmonary embolism.

93. What do you need to consider when helping a patient with shortness of breath sit out in a chair?
A. They should not sit out on a chair; lying flat is the only position for someone with shortness of breath so that there are no negative effects of gravity putting pressure in lungs.
B. Sitting in a reclining position with legs elevated to reduce the use of postural muscle oxygen requirements, increasing lung volumes and optimizing perfusion for the best V/Q ratio. The patient should also be kept in an environment that is quiet so they don’t expend any unnecessary energy.
C. The patient needs to be able to sit in a forward leaning position supported by pillows. They may also need access to a nebulizer and humidified oxygen so they must be in a position where this is accessible without being a risk to others.
D. There are two possible positions, either sitting upright or side lying. Which is used and is determined by the age of the patient. It is also important to remember that they will always need a nebulizer and oxygen and the air temperature must be below 20 degree Celsius.

94. Your patient has bronchitis and has difficulty in clearing his chest. What position would help to maximize the drainage of secretions?
A. Lying flat on his back while using a nebulizer
B. Sitting up leaning on pillows and inhaling humidified oxygen
C. Lying on his side with the area to be drained uppermost after the patient has had humidified air
D. Standing up in fresh air taking deep breaths

95. Mrs. Jones has had a cerebral vascular accident, so her left leg is increased in tone, very stiff and difficult to position comfortably when she is in bed. What would you do?
A. Give Mrs. Jones analgesia and suggest she sleeps in chair
B. Try to diminish increased tone by avoiding extra stimulation by ensuring her foot does not come into contact with the end of the bed; supporting with a pillow, her left leg in side lying and keeping the knee flexed
C. Give Mrs. Jones diazepam and tilt the bed
D. Suggest a warm bath before she lies on the bed. Then use pillows to support the stiff limb

96. When should adult patients in acute hospital settings have observations taken?
E. When they are admitted or initially assessed. A plan should be clearly documented which identifies which observations should be taken & how frequently subsequent observations should be done.
F. When they are admitted & then once daily unless they deteriorate.
G. As indicated by the doctor.
H. Temperature should be taken daily, respirations at night, pulse & blood pressure 4 hourly.

97. Why are physiological scoring systems or early warning scoring systems used in clinical practice?
E. They help the nursing staff to accurately predict patient dependency on a shift by shift basis.
F. The system provides an early accurate predictor of deterioration by identifying physiological criteria that alert the nursing staff to a patient at risk.
G. These scoring systems are carried out as part of a national audit so we know how sick patients are in the United Kingdom.
H. They enable nurses to call for assistance from the outreach team or the doctors via an electronic communication system.

98. Why would the intravenous route be used for the administration of medications?
E. It is a useful form of medication for patients who refuse to take tablets.
because they don't want to comply with treatment
F. It is cost effective because there is less waste as patients forget to take oral medication
G. The intravenous route reduces the risk of infection because the drugs are made in a sterile environment & kept in aseptic conditions
H. The intravenous route provides an immediate therapeutic effect & gives better control of the rate of administration. As a more precise dose can be calculated, so treatment can be more reliable.

99. You have been asked to give Mrs. Patel her Mid-day oral metronidazole. You have never met her before. What do you need to check on the drug chart before you administer it?
A. Her name & address, the date of the prescription & dose
B. Her name, date of birth, the ward, consultant, the dose & route, & that it is due at 12.00
C. Her name, date of birth, hospital number, if she has any known allergies, the prescription for metronidazole: dose, route, time, date & that it is signed by the doctor, & when it was last given.
D. Her name & address, date of birth, name of ward & consultant, if she has any known allergies specifically to penicillin that prescription is for metronidazole; dose, route, time, date & that it is signed by the doctor, when it was last given & who gave it so you can check with them how she reached.

100. As a newly qualified nurse, what would you do if a patient vomits when taking or immediately after taking tablets?
A. Comfort the patient, check to see if they have vomited the tablets, & ask the doctor to prescribe something different as these obviously don’t agree with the patient
B. Check to see if the patient has vomited the tablets & if so, document this on the prescription chart. If possible, the drugs may be given again after the administration of antiemetics or when the patient no longer feels nauseous. It may be necessary to discuss an alternative route of administration with the doctor.
C. In the future administer antiemetics prior to administration of all tablets
D. Discuss with pharmacy the availability of medication in a liquid form or hide the tablets in food to take the taste away.

1. Which of the steps is not involved in Tuckman’s group formation theory
a. Forming
b. Storming
c. Norming
d. Accepting

2. A patient was on morphine at hospital. On discharge doc prescribes fentanyl patches. At home patient should be observed for which signs of opiate toxicity?
   a. Shallow, slow respiration, drowsiness, difficulty to walk, speak and think
   b. Rapid, shallow respiration, drowsiness, difficulty to walk, speak and think
   c. Rapid, wheezy respiration, drowsiness, difficulty to walk, speak and think

3. When the doc will prescribe a broad spectrum antibiotic
   a. On admission
   b. When septicemia is suspected
   c. When the blood culture shows positive growth of organism

4. AVPU stands for
A. Alert, voice, pain, unresponsive

5. A patient got admitted to hospital with a head injury. Within 15 minutes, GCS was assessed and it was found to be 15. After initial assessment, a nurse should monitor neurological status
   a. Every 15 mts
   b. 30 mts
   c. 40 mts
   d. 60 mts

6. Sign of dehydration
   a. Bounding pulse
   b. Hypertension
   c. Jugular distension
   d. Hypotension

7. Precise indicator of anticoagulation status when on oral anticoagulants
   a. PTT
   b. aPTT
   c. CT
   d. INR

8. A patient, after screening tests, is diagnosed as having ca breast. While discussing the treatment options, she begins to cry. As RN ur role?
a. Tell family members to take the patient home
b. Give leaflets about breast cancer and ask patient and family to leave
c. Consider it as a normal reaction to chronic diseases like cancer. Do nothing and patient will accept reality sooner or later
d. Comprehending the importance of taking right decision, offer a quiet and peaceful room to the patient and explore concerns

9. U just joined in a new hospital. U see a senior nurse beating a child with learning disability. Ur role
   a. Neglect the situation as u r new to the scenario
   b. Intervene at the spot, speak directly to the senior in a non-confronting manner, and report to management in writing
   c. Inform the ward in-charge after the shift

10. During blood transfusion, a patient develops pyrexia, and loin pain. Rn interprets the situation as
    a. Common reaction to transfusion
    b. Adverse reaction to blood transfusion
    c. Patient has septicemia

11. Angel, 52 years old lose her husband due to some disease. 4 weeks later, she calls her mother and says that, yesterday my husband died…I didn't know that he was sick…I cant sleep and I see rats and mites in the kitchen. What is angel's condition?
   a. She cant adjust without her husband
   b. Late grievance with signs of dementia
   c. Alzheimers with delirium

12. 2.5 mg tablet. 5 mg to b given. How many tabs=
13. 100ml infusion to be given over half an hour. How many ml per hr=
14. 1000 mg dose to be given thrice a day.250 mg tabs available. No. of tabs in single dose=
15. A patients gum bleds when he brushes, which indicates
   a. Poor flossing
   b. Poor diet
   c. Loose denture

16. A patient who doesn't know English comes to hospital. Ur role?
   a. Use a professional interpreter
   b. Try to use non verbal communication techs
   c. Use the security who knows pt's language

17. A patient is on treatment5 for gout with allopurinol. You advice pt to
   a. Expose himself to sunlight for some hrs every day
   b. Drink plenty of water, 2-3 litres while taking tablet
   c. Monitor renal function carefully
   d. Dnt use common analgesics

18. MRSA- methicillin resistant staph aureus
19. A nurse notices a thin emaciated child among the family members of a patient. The child is weak and withdrawn. When nurse offers some food to child, mother says dnt give as he eats too much. Nurses response
   a. Mother needs to take care of her child. So neglect the situation
   b. Ask family members about child abuse
   c. Call the local police for help
   d. Inform the manager about suspected child neglect and seek support

20. A patient doesn't take a tablet which is prescribed by a doc. Nurse shud
   a. Inform the incident to senior nurse and ward inchargre
   b. Inform pharmacist
   c. Dnt inform anybody...routinely chart

21. Hypokalemia can occur in which situation
   a. Addissons disease
   b. When use spironolactone
   c. When use furosemide

22. A nurse delegates duties to a health assistant. What nmc standard she should keep in mind while doin this?
   a. She transfers the accountability to care assistant
   b. RN is accountable for care assistants actions
   c. No need to assess the competency, as the care assistant is expert in her care area

23. A registered nurse notices that one of the student nurses is addicted to using social networks. She is not at all interested in patient care and always chat in the media. What is the worst advice RN can give to student nurse?
   a. Don't upload the pics of patients even if they give consent
   b. Don't chat with the previous or current patients
   c. Use privacy settings for safety
   d. Never identify urself as a NURSE in any media

24. A nurse notices a bedsore. it's a shallow wound, red colored with no pus. Dermis is lost. At what stage this bedsore is?
   a. Stage1- non blanchable erythema
   b. Stage2- Partial thickness skin loss
   c. Stage3- full thickness skin loss
   d. Stage4- full thickness tissue lose

25. Prior to administering digoxin, our role
   a. Check the bp before administering
   b. Check the HR nd rhythm
   c. Make sure that patient had food
   d. Patient doesn't have any problems with urination
26. A youngster is getting discharged with antibiotics. Best advice that cud b give is
   a. Complete the course of antibiotics
   b. Once symptoms subside, u can stop takin
   c. Every day take antibiotics as prescribed , with food or just after food. Make sure u take all tablets
27. In the immediate post operative period, the priority is
   a. Taking care of the airway
   b. Watching for blood lose
   c. Monitoring urine output
28. Now the medical team encourages early ambulation in the post operative period. which complication is least prevented by this
   a. Tissue wasting
   b. Thrombophlebitis
   c. Wound infection
   d. pneunonia
29. a nurse has the role to protect the patient from clinical envt. Which of the following action wont necessarily protect him from envt??
   a. Arranging medicines properly
   b. Repairing medical eqpments
   c. Keepin floor non slippery
   d. Air conditioning the room
30. Which condition cause tissue edema
   a. Left sided hert failure
   b. Right sided HF
   c. Pulmonary embolism
   d. Pulmonary hypertension
31. When an oropharyngeal airway is inserted properly, what is the sign
   a. Airway obstruction
   b. Retching and bomiting
   c. Bradycardia
   d. Tachycardia
32. Nursing care should be
   a. Task oriented
   b. Caring medical and surgical patient
   c. Patient oriented, individualistic care
   d. All
33. Who is responsible for disposing te sharps??
   a. Doctor
   b. RN
   c. Care assistant
   d. One who used sharps
34. Before a gastric surgery, a nurse identifies that the patients BMI is too low. To whome s he should contact to improve the patients health before surgery
   a. Gastro enterologist
   b. Dietitian
   c. Family doc of pt
   d. Physio
35. A patient, after stroke has sustained dysphagia. Which member of the inter disciplinary team a nurse shud contact??
   a. Physiotherapist
   b. Speech therapist
   c. Neurophysiologist
   d. Dietitian
36. A patient is not able to read and speak after he sustained a stroke. This condition is termed
   a. Primary progressive aphasia
   b. Aphasia
   c. Dysphasia
   d. Dysphagia
37. Team members finds that one of the members is making constant errors In recording. The team is concerned because faulty recording can affect the continuity of care between the shifts and jeopardise patient care. What the nurse should have done before starting job??
   Ans. She shoud have identified her weakness and asked support from incharge to participate in continuous education and training in recording.
38. A nurse finds it very difficult to understand the needs of a child with learning disability. She goes to other nurses and professionals to seek help. How u interpret this action
   a. The nurse is short of self confidence
   b. A nurse, who is well aware of her limitations seeked help from others. She worked within her competency.
   c. She doesn't have the kind of courage a nurse should have
39. AnRN identifies a care assistant not washing hands hand before caring an immunocompromised client. Your response?
   a. Let her do the procedure. Corrrect her later
   b. Inform to ward incharge
   c. Interrupt the procedure, correct her politely, teach her 6 steps of handwashing and make sure she became competent
40. Before giving direct care to the patient, u should
a. Wear mask, aprons
b. Wash hands with alcohol rub
c. Handwashing using 6 steps
d. Take all standard precautions

41. A community health nurse, with second yr nursing students is collecting history in a home. Nurse notices that a student is not at all interested in what is going around and she is chatting in her phone. Ideal response?
   a. Ask the student to leave the group
   b. Warn her in public that such behaviours are not accepted
   c. Inform to the principal
   d. Talk to her in private and make her aware that such behaviours could actually belittle the profession

42. A sexually active female, who has been taking oral contraceptives develops diarrhoea. Best advice
   a. Advice her to refrain from sex till next periods
   b. Advice to switch to other measures like condoms, as diarrhoea may reduce the effect of oral contraceptives

43. Training of student nurses is the responsibility of
   a. Ward incharge
   b. Senior nurses
   c. Team leaders
   d. All RNS

44. A nurse who works with patients having complex needs should
   a. Collaborate with all nurses to give the best possible care
   b. Team up with other members of medical team to meet different needs
   c. She should take time and learn how to meet diverse needs

45. How to take an infected sheet for washing according to uk standard
   a. Take infected linen in yellow bag for disposal
   b. Take in red plastic bag, that disintegrates in high temperature
   c. Use red linen bag that allows washing in high temperature
   d. Use a white bag

46. A patient develops gingivitis after using an artificial denture. It is characterized by
   a. White patches on tongue
   b. Red shiny patches on tongue
   c. Red shiny patches around the palate of teeth
   d. White patches in the palate

47. 6 c’s in nursing
    Answer: care, compassion, competence, communication, courage, commitment.

48. The bystander of a muslim lady wishes that a lady doctor only should check the patient. Best response
    a. Just neglect the request
    b. Tell her that, only male doctor is available and he is taking care of many female staffs daily
    c. Respect the request, if possible arrange the consultation with a female doctor

49. A patient has sexual interest in u. what wud u do
    A. Just avoid it, because the problem can be the manifestation of the underlying disorder, nd it will be resolved by its own as he recovers
    B. Never attend that patient
    C. Try to re establish the therapeutic communication and relationship with patient. And inform manager for support
    D. Inform police

50. A patient under u developed shortness of breath while climbing stairs. U inform this to the doctor. This response is interpreted as
    a. Breaching of patients confidentiality
    b. Essential, as it is the matter of patient’s health
    c. Unlawful, because she didn’t get the consent from pt

51. U give the information about a patient to police when
    a. the police shows u the id
    b. past conviction
    c. serious threat for public safety

52. Bystander informs you that the patient is in severe pain. Ur response
    a. Tell him that he wud come as soon as possible
    b. Record in the chart and inform doc and incharge
    c. Tell that she wud give the nex dose of analgesic when it s time
    d. Go instantly to the patient and assess the condition

53. Being a student, observe the insertion of an icd in the clinical setting. This is
    a. Formal learning
    b. Informal learning

54. A patient develops shortness breath after administering 3rd dose of penicillin. The patient is unwell. Ur response
    a. Call for help, ensure anaphylaxis pack is available, assess ABC, dnt leave the patient until medical help comes
    b. Assess ABC, make patient lie flat, reassure and continue observing

55. A patient doesn’t sign the consent for mastectomy. But bystanders strongly feel that she needs surgery.
    a. Allow family members to take decision on behalf of pt
    b. Doc can proceed with surgery, since it is in line with the best interest and outcome
c. Respect patients decision. She has the right to accept or deny

A patient's gum bleeds when he brushes, which indicates
- Poor flossing
- Poor diet
- Loose denture

When an oropharyngeal airway is inserted properly, what is the sign
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- Retching and vomiting
- Bradycardia
- Tachycardia

A patient, after stroke has sustained dysphagia. Which member of the interdisciplinary team should a nurse contact??
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- Neurophysiologist
- Dietician

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- Warn her in public that such behaviours are not accepted
- Inform to the principal
- Talk to her in private and make her aware that such behaviours could actually belittle the profession
- ask her to leave phone and assist in what u do in polite language

When the doctor will prescribe a broad spectrum antibiotic
- on admission
- when septicaemia is suspected
- when the blood culture shows positive growth of organism
- after obtaining blood samples for culture

In the immediate post operative period, the priority is
- Taking care of the airway
- Watching for blood lose
- Monitoring urine output

How to take an infected sheet for washing according to the UK standard
- Take infected linen in yellow bag for disposal
- Take in red plastic bag, that disintegrates in high temperature
- Use red linen bag that allows washing in high temperature

You are nurse at the community care centre. An elderly complaints to you that his neighbour is stealing money from him. He spends it for his shopping and sometimes the neighbour does not shop and keeps the money with him. You will:
- Confront the neighbour when he visits you next time
- Remain quiet and ignore the complaint
- request the elderly to talk to the hospital Chaplin for further assistance
- Raise a complaint in the incident report form and investigate the matter and inform the concerned

A client wants to leave the hospital. The medical team is not happy with his clinical condition and judgment as per the mental health act. What will you do?
- let the client leave the hospital as he does not possess any threat to the public or is visibly ill
• inform the security to hold the patient and not let him go away
• inform the police
• counsel the patient to stay back in the hospital for his betterment

What is the purpose of clinical audit?
• it helps to understand the functioning and effectiveness of nursing activities
• helps to understand the outcomes and processes for medical and surgical procedures
• helps to identify areas of improvement in the system pertaining to Nursing and medical personnel
• helps to understand medical outcomes and processes only

While brushing the teeth the nurse observes bleeding gums in the client. The nurse understands that the probable cause for this gingivitis is:
• Poor diet
• Poor flossing
• Poor tarter removal
• Infection

Who among the list below are more prone to coronary artery disease?
• Hypotension, smoker, DM, obese women, non-sedentary lifestyle
• Hypotension, smoker, DM, obese men, non-sedentary lifestyle
• Hypertension, smoker, obese men, sedentary lifestyle

A client with CVA is found to have difficulty in swallowing. Whom do you think should be informed for further assessment:
• neurologist
• occupational physiotherapist

proper technique for eye instillation
• A supine
• B sit up and head tilt backwards
• C sit up and head tilt rightwards

while gaining consent nurse should assess
• capacity
• understanding
• emotions

Which position is given after abdominal paracentesis?
• Supine with knees bent
• Supine with head raised 40-50cm
• Right lateral
• Prone

What is the most serious complication after liver biopsy within 24hrs?
• Nausea and vomiting
• Pain at the site of biopsy
• Back pain

How will the nurse take vitals respiration of an unwell patient?
• Assess the ease of breathing, rate, pattern & sign of cyanosis
• Assess patient could speak a complete sentence, ease of breathing, rate, pattern & sign of cyanosis

An 18 yrs old female client who has learning disability is admitted for minor abdominal surgery. She is very restless and uncooperative. Her mother requests she wants to stay with the patient whole night. Nurse notices that the visiting time has got over. What is the appropriate action?
• Allow her to stay with patient and help the patient settle down.
• Ask the doctor regarding this.
- Ask the mother to leave as the visiting time got over.
- Assure her that you will manage the situation and ask her to leave.

Which of the following is an indication for intrapleural chest drain insertion?
- Pneumothorax
- Tuberculosis
- Asthma
- Malignancy of lungs

Which is the most suitable site for assessing edema?
- Foot/Ankle
- Clavicle
- C. Sternum

Which is the most common sign of dehydration in older patient?
- Reduced skin turgor
- Bruises
- Skin lesions
- Pale/ Cyanosis

Which type of drugs causes most of the falls in older patient?
- Hypnotics
- Loop diuretics
- Beta blockers
- Non steroidal anti-inflammatory drugs

Which condition is not a cause of diarrhea?
- Ulcerative colitis
- Intestinal obstruction
- Hashimotos disease
- Food allergy

Which among the following is a cause of Hemorrhoids?
- High fibre rich diet
- Non-processed food
- Straining while passing stools
- Unsaturated fats in the diet

When teaching a patient to use a standard frame which is not advisable?
- It is safe to use when you go out
- Push the arm of the chair while getting up
- Do not hold the frame until you are standing

While teaching a patient to walk in Z___ walker, which is the most appropriate advice?
- Lift the walker 10 inches forward then take 2 steps and come in the middle
- Slide the walker 10 inches forward then take small steps to maintain balance

Patient with clostridium difficile has stools with blood and mucus. due to which condition?
- Ulcerative colitis
- Chrons disease
- Inflammatory bowel disease

Patient is given penicillin. After 12 hrs he develops itching, rash and shortness of breath. what could be the reason?
- Speed shock
- Allergic reaction

After lumbar laminectomy, which the appropriate method to turn the patient?
- Patient holds at the side of the bed, with crossed knees try to turn by own
- Head is raised & knees bent, patient tries to make movement
- Patient is turned as a unit

For every patient admitted in ward, discharge planning should be done. When should the process start?
- Within 24 hrs of admission
- When patient tells he wants to leave
- When the family requests for a discharge.
- Immediately after the doctor’s order for discharge

When do the proliferation phase start in wound healing?
- 10-24 days
- minutes
- 1-2 days
25 days or more
Patient is in post operative period. Patient is crying as pain is not reducing even after analgesia. What is the nursing action?
- Call the doctor
- Give a semi-reclined position to the patient
- Give a heat pad for application
- Provide a glass of water.

Patient is getting discharge with continuing O2 therapy through nasal cannula 2lit. When you visit the patient you find patient is dyspeptic, anxious and frightened. What is the nurse's best action?
- Increase the level of O2
- Administer tab. oramorph which is prescribed whenever necessary
- Try to calm down the patient

You have just finished dressing a leg ulcer. You observe patient is depressed and withdrawn. You ask the patient whether everything is okay. She says yes. What is your next action?
- Say "I observe you don't seem as usual. Are you sure you are okay?"
- Say "Cheer up, shall I make a cup of tea for you?"
- Accept her answer & leave, attend to other patients
- Inform the doctor about the change of the behaviour.

Patient with suicidal tendency after 2 trials of suicidal attempt gets admitted in a psychiatric unit. After 2 days he seems cheerful and motivated. Which is the explanation a nurse can give?
- He has made new friends and is happy
- He has finalised a suicidal plan
- Treatment is working, now he is recovering
- He is happy. He is eating and drinking well

A young woman gets admitted with abdominal pain & vaginal bleeding. Nurse should consider an ectopic pregnancy. Which among the following is not a symptom of ectopic pregnancy?
- Pain at the shoulder tip
- Dysuria
- Positive pregnancy test

Patient complaints of getting up frequently at night to void. What is the condition?
- Hematuria
- Nocturia
- Polyuria
- Oliguria

Symptoms of dehydration
- Increased pulse rate and BP
- Decreased pulse rate and decreased BP
- Decreased pulse rate and BP

Patient says, "I hate this cancer". Nurse understands which stage patient is in according to Kubler Ross stages of death?
- Anger
- Denial
- Depression
- Bargaining

Nurse is about to give Tab. Digoxin to the patient. She notices patient’s heart rate 58 beats/min. What is the best action to do?
- Give the medication because it is prescribed
- Give the medication as patient says this is his normal range of heart rate
- Omit the dose and document it and report
- Omit the dose and bleep the doctor

Patient is in the end stage palliative care. Which among the following is not advisable?
- Giving analgesics and trying to relieve the symptoms
- Talk to family and friends to provide psychological support
- Resuscitation
- Make the patient sit outside and engage in the activities he likes.

Patient has tibia fibula fracture. Which one of the following is not a symptom of compartment
syndrome.

- Pain not subsiding even after giving epidural analgesia
- Nausea and vomiting
- Tingling and numbness of the lower limb
- Cold extremities

Nurse discloses patient's information to a third party when

- It is by the law/ order
- It is justified for public interest
- Media insists for disclosure
- It is by the law/ order and justified for public interest

What is the best nursing responsibility in the following regarding privacy?

- Privacy is only maintained in elderly patients
- Privacy is only maintained in mixed sex wards.
- Privacy should always maintained whatever the situation may be
- Privacy is only maintained in emergency situation

What is the concept of record keeping?

- It is any form of arrangements of records which gives relevant information about patient
- It has a record of nursing care given to the patient
- It has medical history of the patient and the ongoing treatment
- All of the above

Which is the best site for giving IM injection on buttocks

- Upper outer quadrant
- Upper inner quadrant
- Lower outer quadrant
- Lower inner quadrant

Nurse advises patient to move extremities away from midline. What is this movement called as

- adduction
- abduction

- Flexion
- Extension

Nurse is about to give usual enteral feed to the patient. How she will check for the correct position of feeding tube in the abdomen?

- Inject water or air to hear gastric gurgle
- Pull the tube slightly out and re-insert
- Take abdominal X-ray
- Aspirate gastric contents to check pH <4

Nurse is in contact with the patient after the discharge of the patient through mails and contacts. Which is the least option to send to the patient through mails?

- Health promotional events
- Positive reinforcement on smoking cessation
- Patient's abnormal blood results
- Content on healthy dietary habits

How should be the surrounding area of a patient with dementia?

- Increased stimuli
- Creative environment
- Restrict activities

What is the best method to give dignity and respect to the patient?

- By giving compassionate care, and speaking gently with patient.
- By behaving in professional manner all the time.
- By giving medications on time

Holistic care is

a) 

b) 

c) 

d) 

Compassionate care is

A. 

B. 

C. 

D. 

E. 

F. 

G. 

H. 

I. 

J. 

K. 

L. 

M. 

N. 

O. 

P. 

Q. 

R. 

S. 

T. 

U. 

V. 

W. 

X. 

Y. 

Z. 

55. Pyrexia is not a common symptom of elderly patients with acute infection. What may be the reason?
   - Thyroxine level reduces to adjust with cold
   - Production of immature T cells which does not allow pyrexic symptom to show

56. A person who display the defence mechanism of compensation
   - Refuse to hear unwanted information
   - Transfer feeling to someone else
   - Place blame on others for personal actions
   - Overemphasize behavior which accommodate for perceived weakness

A patient who refuses to believe a terminal diagnosis is exhibiting
   - Regression
   - Mourning
   - Denial
   - Rationalization

When teaching a patient to use the three point gait technique of crutch use
   - The injured leg moves along with both crutches
   - Move one crutch then followed by injured leg
   - Move both crutch ahead then followed by both legs

Which of the following tasks may be delegated to unlicensed assistive personal
   - Cleaning a wound with peroxide
   - Colostomy irrigation
   - Assisting with performing incentive spirometry
   - Removing saline lock IV

Which example best describe a nurse who exhibits moral courage?
   - A nurse feels angry when a parent refuses important treatment for child
   - A nurse considers seeking help for depression when she feels she cannot meet the needs of her client
   - A nurse contacts a physician for further orders when he fails to order comfort measures for a client with terminal illness
   - Courage involves taking action to do what is right even when there might be negative consequences

Which is the most appropriate phrase to communicate?
   - I’m sorry, your mother died.
   - I’m sorry, your mother gone to heaven
   - I’m sorry, your mother is no longer with us.
   - I’m sorry, your mother passed away.

14. The most common symptom in type I DM?
   - thirst
   - weight loss
   - Ketoacidosis

15. Common minor disorder in pregnancy?
   - abdominal pain
   - heart burn
   - headache

Community Hospital in the local place provides what services
   - Rehabilitation, physiotherapy, psychiatry, acute care
   - Rehabilitation, acute and primary care, occupational therapy, Step down care for discharged patients
   - Rehabilitation, Respite care, acute and primary care, physiotherapy, psychiatry, occupational therapy, palliative care, Step down care for discharged patients
   - Rehabilitation, Respite care, palliative care, Step down care for discharged patients

A patient with Lung cancer suffers from breathlessness, which would be the worst possible measure
   - Crystal therapy by Traditional therapist
• Educating to control the breath by chest physiotherapist
• Chest physiotherapy, by physiotherapist

A patient is on Inj. Fentanyl skin patch common side effect of the fentanyl overdose is
• Fast and deep breathing, dizziness, sleepiness
• Slow and shallow breathing, dizziness, sleepiness
• Noisy and shallow breathing, dizziness, sleepiness
• Wheeze and shallow breathing, dizziness, sleepiness

Common cause of airway obstruction in an unconscious patient
• Oropharyngeal tumor
• Laryngeal cyst
• Obstruction of foreign body
• Tongue falling back

Mr. XXX suffers from Cerebro vascular accident, he is unable to speak or verbalize anything, which medical term is more appropriate
• Dysphagia
• Aphasia
• Ataxia
• Dysphasia

Angle of Subcutaneous Insulin administration
• 45
• 90
• 25
• 40

A patient of COPD is discharged after treatment from the hospital, what advice should the nurse give to prevent exacerbation of the condition.

A patient with dehydration has severe fluid volume deficit, which following sign will indicate
• Hypotension
• A bounding pulse
• Increased urine output
• Increased respiratory rate

A relative of the patient talks to the nurse over the phone and asks permission to come and visit the patient in the hospital. She admits that she had few episodes of vomiting and diarrhea. What is the best response by the nurse.
• Don’t allow her to come and meet the patient.
• Ask her to come and visit after 48hrs of recovery from the symptoms
• Advice her to sanitize the hands with hand rub before e

Q1- A client is having diagnosed atrial activity. Identify the ECG
• Atrial fibrillation
• Cardiac arrest
• Ventricular tachycardia
• Asystole

Q2- A client is admitted to the psychiatric unit to monitor for depression and suicidal behavior. On the 3rd day he seems to be very happy and is interacting with others, what may be this
• He has finalized his plan for suicide
• Its improvement
• He had made new friends

A drug 75ml is to be infused over half an hour. Calculate ml/hr.
ANSWER: 150ml/hr
A drug 8.25mg is ordered, it is available as 2.75mg. Calculate the dose.
Paracetamol 1 gm is ordered. It is available as 500mg. How many tablets need to be administered?

**ANSWER: 2 tablets**

What should be taught to a client about use of zimmer frame

- move affected leg first
- move unaffected leg
- **move both legs together**

What a patient should not do when using zimmer frame

- it can be used outside
- don't carry any other thing with walker
- **push walker forward when using**
- slide walker forward

What is the best time for LP

- normal ICP
- raised ICP
- when there is skin infection in the area where LP is to be done

9. A client immediately following LP developed deterioration of consciousness, bradycardia, increased systolic BP. What is this

- normal reaction
- **client has brain stem herniation**
- spinal headache

A drug 150g is prescribed it is available as 5g tablets. How many tablets need to be administered.

**ANSWER: 30 tablets**

11. while changing tubing and cap change on a patient with central line on right subclavian what should the nurse do to prevent complication

- ask patient to breath normally
- **ask patient to hold the breath and bear down**

- inhale slowly
- exhale slowly

A new staff is careless about the documentation and reported by the colleague staff. What will be your action against this problem as a nurse manager.

- make her contact with the person dealing induction programme
- Advice the colleague staff to help her
- In private call the staff and enquire about the problems in the new job area and give clarifications as it is very important which affect the patient care

A nurse assistant dealing aggressively with an elderly patient what will be your action

- immediately block the staff and report in the authority & make sure that pt is safe.
- ignore the situation
- report in the authority
- enquire about the incident with the pt later

What will be the 1st action against an incident of anaphylactic shock of pt on the infusion of penicillin

- immediately stop the infusion, Call for help, see the anaphylactic kit is available and don't leave the pt alone

Initial signs of phlebitis

- hot and tender skin
- Signs of shock
- cold skin with cyanosed nail bed

A patient asks a RN, “can I tell u a secret?”. What is the RNs best response?

- Yes because it develops trust which is central to the NPR
- Yes and I will share it with the relevant medical team
- Yes I will share it with all the medical professionals who are supposed to know the secret
- **Yes I will keep the secret because it is confidential**

A Jewish patient refuses blood transfusion in a critical situation and states that his religion is against it. What should the nurse do?

- Ignore patients will and give him blood
A patient wants to leave hospital against medical advice. The doctors are concerned about patients' competence under the mental capacity act. What should the nurse do?

- Let the patient go, he is competent and in his full sense
- Call the police
- Restrain the patient
- Call the security and make the patient stay until the doctors complete their assessment

Which of the following cannot be seen in a depressed client?

- Inactivity
- Sad facial expression
- Slow monotonous speech
- Increased energy

Important advice that should be given to a gout patient taking medication (allopurinol)?

- Drink plenty of fluids
- Take analgesics

When should prescribed antibiotics be administered to a septicemic patient?

- Immediately after admission
- After getting blood culture result
- Immediately following blood drawn for culture

Why adjuvant therapies like anticonvulsants and antidepressants are prescribed to a patient receiving opioids for palliative care?

- Full form of MRSA

Dr ordered 2.5 mg tab __________ per hour. Amount required for one day full dose

A student nurse is supported by whom in terms of learning in clinical area

- All RN
- Clinical nurse only
- Nurse educator only

Sign of phlebitis

A client with a stoma asking for detailed education about it and also the way to prevent it from deteriorating.

Nurse will assess the site, check for inflammation, wet area before asking stoma nurse to come and explain to her about her all queries

100. Cause of oedema in tissue

- RT sided heart failure
- LT sided heart failure
- Pulmonary embolism

Nurses are having a lot of work to be done, went to RN stating they won't be able to finish all. What should she do?

- Goes to nurse manager telling it would cause compromise of care in terms of dignity and respect of pt, so please arrange some staff

Morning staff says to relieving nurse that you will be alone today at work as another evening nurse won't be coming because of her sickness. Additionally, the ward is very busy. What will you do?

- Go to nurse manager requesting her to keep morning staff retained until ward gets settled and she could arrange some staff

How a nurse transports CDs from pharmacy to a patient's home

- Shows badge to pharmacist, takes drugs, securely brings to pt home, gets the patient receive those, have a witness who will sign then along with you
1. A pt with impaired vision requires proper hydration. As a nurse, how will you demonstrate that their good hydration status of patient is maintained?
   - by asking the pt whether he needs assistance in eating
   - asking NAP to not fill the tea cup fully, as it may spill

2. In COPD patient, what we see:
   - CO2 high, PO2 low
   - CO2 low, PO2 high

3. NTG drug should be discarded after 8 weeks once it is opened. Why?

4. Angle of subcutaneous injection:
   - 90
   - 45

5. Who is responsible for pt's safeguarding?
   - all health personnel

6. Independent Mental Capacity Advocate, when will an IMCA make a decision for the client?
   - When there is a close family member
   - When there is a close friend present
   - When there is intermittent mental illness in patient
   - When there is no friend and family present to make a wish or take a decision for the client

7. There are two types of diabetes, type I and type II, which symptom is the most common in type I diabetes mellitus?
   - Blurred vision

8. Thirst
   - Weight loss
   - Ketoacidosis

9. As a registered nurse, how will you advise a new registrant who is confused about avoiding to make assumptions about patients and give effective care in accord to the Code 2005?
   - Promote professionalism and trust
   - Prioritise people
   - Practice effectively
   - Promote safety

10. What are the symptoms of compensated shock?
    - Tachycardia, vasoconstriction and confusion
    - Bradycardia, low blood pressure and drowsy
    - Circulatory collapse, cardiovascular dysfunction, brain stem damage

11. A nurse is performing covert administration of drugs to the client, which of the following is an appropriate explanation of this?
    - Covert administration of drugs to clients is ethically and professionally wrong
    - Assess the deprivation of liberty safeguards and mental capacity of the client and then administer in accordance with the multi-disciplinary team care plan
    - Covert administration of drugs can only be allowed if the client's next of kin advises so

12. Protective diets are full of anti-oxidants and are helpful in diseased conditions, what from the following can be included in protective diet?
- Tomatoes, carrots and broccoli
- Beef fish and chicken
- Eggs dairy and cheese
- Rice beans and pasta

115. You are caring for a Hindu client and it's time for drug administration; the client refuses to take the capsule referring to the animal product that might have been used in its making, what is the appropriate action for the nurse to perform?
- She will not administer and document the omissions in the patient's chart
- The nurse will ignore the client's request and administer forcefully
- The nurse will open the capsule and administer the powdered drug
- The nurse will establish with the pharmacist if the capsule is suitable for vegetarians

116. There is a Chinese client in your care and the relatives of the client insist upon bringing their own food for the client, what is appropriate for the nurse to do?
- Accept the wish under Western Foods and Cultural differences consideration
- Refuse the client's wish as the food might carry infection
- Ask the next of kin to bring in the food and hand it to the dietary department for necessary changes to be done in diet

117. The nurse is admitting a client, on initial assessment the nurse tries to inquire the patient if he has been taking alternative therapies and OTC drugs but the client becomes angry and refuses to answer saying the nurse is doing so because he belongs to an ethnic minority group, what is the nurse's best response?
- The nurse will stop asking questions as it is upsetting to the patient
- Wait and give some time for the client to get adjusted to modern ways of hospitalisation
- The nurse will politely explain to the patient about alternative therapies such as St. John's Wort which interact with drugs
- The nurse will assign another nurse to ask questions

118. There is a child you are taking care of at home who has a history of anaphylactic shock from certain foods, the nurse is feeding him lunch, he looks suddenly confused, breathless and acting different, the nurse has access to emergency drugs access and the mobile phone, what will she do?
- She will keep the child awake by talking to him and call 911 for help
- She will raise the child's legs and administer Inj. Adrenaline and call the emergency services
- The nurse will keep the child in standing position and try to reassure the child

119. Post-operatively the nurse finds the client producing gurgling sounds from the throat, the nurse knows.
- These sounds are normal due to anesthesia effect in immediate post-operative phase
- The nurse must immediately insert LMA (Laryngeal Mask Airway)
- The nurse knows that the client's airway is partially occluded

120. The nurse observes another colleague telling a patient harshly that you will not be allowed to go to bed until you finish your meal. As a newly registered nurse what will you do?
- Raise your concerns with the ward sister and let her investigate the incident
- Challenge the practice, as it is disrupting the dignity of the client and then talk to the line manager
• Ignore the happening as it is the other staff’s discretion as to how she does her work
• Let the nurse leave and inquire yourself about this happening with the patient

1. There were plenty of drug calculations, as many as 10-12. I don’t remember the exact digits but they were diverse, drug calculations according to body surface area too.

2. What is the min required hours for in service education in UK for 3 years?
   • 25
   • 35
   • 45
   • 55

3. Who is responsible for disposal of sharps?
   • Doctor
   • Nurse
   • HCA
   • Professional who uses the sharp

4. A patient asks a RN, “Can I tell u a secret?” What is the RNs best response?
   • Yes because it develops trust which is central to the NPR
   • Yes and I will share it with the relevant medical team
   • Yes I will share it with all the medical professionals who are supposed to know the secret
   • Yes I will keep the secret because it is confidential

5. A Jewish patient refuses blood transfusion in a critical situation and states that his religion is against it. What should the nurse do?
   • Ignore patients will and give him blood
   • Tell the patient relatives to take decision
   • Accept the clients will

6. Force the client to give consent

7. A patient wants to leave hospital against medical advice. The doctors are concerned about patients competence under the mental capacity act. What should the nurse do?
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    • Accept the clients will

21. Force the client to give consent

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    • Ignore patients will and give him blood
    • Tell the patient relatives to take decision
    • Accept the clients will

23. Force the client to give consent

24. A Jewish patient refuses blood transfusion in a critical situation and states that his religion is against it. What should the nurse do?
    • Ignore patients will and give him blood
    • Tell the patient relatives to take decision
    • Accept the clients will

25. Force the client to give consent
1. Which one of the following is not a symptom of ectopic pregnancy - shoulder tip pain
2. Which statement by the nurse will encourage the patient to express his feelings?
3. Normal pH of blood? 7.35-7.45
4. Protective meal time means?
5. Protective foods?
6. Broccoli, carrot, tomato
7. Decreased urine output is called? Oliguria
8. Signs and symptoms of anaemia.
10. The important responsibility of a nurse in PGD type medicine management?
   • A nurse cannot delegate her duties to others.
11. Unconditional positive regard means?
12. Nearly 15 questions on Drug calculations to find out no of tabs, drops/ minute and one question to calculate the time required for total infusion [given total volume of infusion, drops/ minute, and drops /ml]?
13. Protective meal time means?
14. Protective foods?
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29. Unconditional positive regard means?
30. Nearly 15 questions on Drug calculations to find out no of tabs, drops/ minute and one question to calculate the time required for total infusion [given total volume of infusion, drops/ minute, and drops /ml]?
5. clinical benchmarking?
- to improve standards in health care

6. a nurse is administering a controlled drug at home, what precaution does she need to take?
- stick to local policies and guidelines
- dont give rest of the medication to relatives
- dont leave balance of medication in home

7. nurse and colleague found a discrepancy of controlled drug. how to report?
- inform police
- inform pharmacy
- recheck. inform incharge if not found inform senior nurse

8. while mentoring a final year student dispensing medication, nurse role?
- direct supervision
- before delegating find out he is competent
- ask him to tell after administration is complete

9. electronic data transfer is more these days, which of the report is not suitable to send to a discharged client?
- confusing blood report
- smoking cessation policy

10. not a sign of ectopic pregnancy?
- vaginal bleed
- shoulder pain
- dysuria

11. not a sign of meconium aspiration syndrome?
- positive pregnancy test

12. in a canteen queue pt collapses in front of you, what will be ur response?
- run to bring AED
- shout for help
- assess for response
- assess for danger before approaching

13. compassionate care?
Ans: Deep awareness of the suffering of another coupled with the wish to relieve it.

14. primary care?
- care provided in acute settings
- first hand care approach made by pt

15. why old people afebrile even if they are infected?
- immature mast T- lymphocytes

16. postural hypotension? Hypotension when standing

17. intermediate care?
- care given to patient for rehabilitation before returning to home.
18. pt suspected of UTI?
- Hand hygiene and promotion of infection link nurse
- Ask doctors to wear gloves, gown
- Use PPE while dealing with body fluids
- Review antimicrobials daily and report health care team

19. a pt who is depressed for few days suddenly seems to be happy on a particular day. What does the Nurse assume?
- He has a suicidal plan

20. you saw a pt with leg ulcer unhappy, who has been admitted in hospital for more than one week, you ask him whether he is ok, he answers he is ok you response?
- As compared to last few days, today you seem to be weak, are u sure u r ok?
- you dont seem to be ok, are you sure you are ok

21. Which is not the complication of speed shock?
- Cardio vascular collapse
- Peripheral edema

22. Clostridium difficile which measures is ineffective?
- Alcohol hand rub usage

23. Diarrhoea, which condition does not show this as a sign?
- Hashimoto's syndrome
- Ulcerative colitis

24. Dehydration in old adult?
- Decreased turgour

25. Which drug causes fall in elderly?
- Loop diuretics
- Beta blockers
- NSAIDs

26. 1 gm paracetamol advised, 500 mg tab available?
- Ans: 2

27. 25 mg advised, 2.5 mg available?
- Ans: 16

28. 125 mg available in 5 ml, 50 mg to be given?
- Ans: 2 ml

29. 25 year old girl with learning disabilities is admitted for a minor surgery, she is very restless and agitated and wants her mother to stay with her, what will your response?
- Advise the mother to stay till she settles.
- Tell her visiting hour is over
- Tell her you will take care of the child

30. 25 year old girl with learning disabilities is admitted for a minor surgery, she is very restless and agitated and wants her mother to stay with her, what will your response?
- Advise the mother to stay till she settles.
- Tell her visiting hour is over
- Tell her you will take care of the child

31. Removing plaster cast of a child who is not co-operating?
- Explain to him according to his own understanding in age appropriate language
- Force fully remove

32. When can you disclose information of pt?
- Justified by public interest and law and order
-law and order

33. when confidentiality can be revealed

34. nmc stands for?

35. steps in nursing process?

36. during shift change nurse gets over from incharge to follow standard precautions

37. correct procedure to get informed consent from pt scheduled for surgery?

38. registered RN role while administering medicine?

39. national early warning score?

40. how to check position of enteric tube?

41. while putting iv line doctor leaves to emergency you have not done it before

42. you noticed medical equipment not working while you joined a new team and the team members are not using it your role?

43. bio hazard label on a bottle in nursing counter?

44. while using crutches where to give weight

45. heart rate below 50?

46. should know about medicines explain to pt to make them understand why they are taking them

- for giving iv medicines get help of other nurse

- dont insert as you are incompetent

- during audit raise your concern

- inform nmc

- take photograph

- double bag it. Sealing bag and wear gloves while handling specimen

- use gloves

- inform lab before transferring

- arms
48. Proper technique to use a walker or Zimmer frame?
- Move 10 feet, take small steps
- Move 10 feet, take large wide steps
- Move 12 feet
- Transfer weight to walker and walk

49. Which step is not right to follow while using a walker?
- Use outside
- Take small steps

50. When getting up from chair by pushing with palms on armrest:
- Inform doctor

51. Disorganised atrial ECG waves:
- Atrial fibrillation

52. An old admitted patient comes up with a new confusion?
- Alzheimers
- Dementia
- Normal ageing
- Infection

53. Advice for a dementia patient while giving discharge teaching?
- Predictable environment

54. While IV administration finds swelling and redness:
- Resite the cannula

55. Old dysphagic patient’s orders by doctors and therapist does not include?
- Giving water to drink

56. Why pts kept on NPO?
- Prevent reflux and inhalation of gastric content
- Prevent vomiting

57. Proper way to remove vacuum drainage?
- Release vacuum and remove
- Pull out
- Get doctor to do it

58. Why double clamp applied to remove chest drainage?
- Prevent pneumothoax

59. Leg stockings used why?
- Promote venous return

60. When to keep pts privacy and dignity?
- Under all circumstances
- Not in emergency

61. Proliferative phase in wound healing how long?
- 5 to 24 days

62. Ideal wound dressing characteristics?
63. Ideal site for IM INJECTIONS in buttocks region?

- upper outer quadrant

64. After abdominal surgery, pt complains of pain even after administration of analgesics. How to help?

- apply heat
- position to reclined position
- Call the doctor
- Read minister analgesic

65. Pt brings own medication to hospital and wants to self-administer. Your role?

- allow him
- give medications back to relatives to take back to home
- keep it in locker, use from medication trolley
- explain to pt about medication before he administer it

66. After LP pt becomes unconscious. Reason?

- CSF leakage
- headache
- herniation

67. Not a policy in palliative care?

- pain relief
- CPR

68. Pt frequently urinates in night

ans: Nocturia
- Polyuria

69. Accountability means?

- responsible
- responsive

70. Tibia fibula fracture correction done, which sign and symptom leads to the suspicion that it is leading to compartment syndrome?

- pain not relieved by analgesics
- numbness and tingling sensation

71. A pt’s relative is seen praying in a dark place. Your role?

- complaint to security that the chaplin is not open
- provide him a peaceful place
- tell him it is against the rule

72. After laminectomy, how to turn patient?

- Turned as a unit

73. How nurse should improve his practice?

- experience
- feedback
- reflection

ans: All of above
74. While formulating and giving advice, nurse is performing which role?
- advocate
- educator [Ans]
- health career
- researcher

75. Advocacy means?
- Supporting and mediating on behalf of the pt
- act as a liaison between pt and health care team
- help pt to make informed decisions

76. Pt states "I hate cancer" according to kubler theory this is?
- anger
- denial
- acceptance
- Bargaining

77. Proper method to collect urine sample?
Ans. Clean meatus and collect midstream

78. Needle stick injury?
Squeeze the finger and wash it under running water and report to ur manager

79. How frequent vitals must be recorded?
- While observing any changes in the vital and as required
- During admission and then plan is made how frequently it should be measured

80. A nurse is advised one hour vital charting of a pt, how frequently it should be recorded?
- every one hour
- whenever the vital signs show deviation from normal

81. When discharge should be planned?
Ans. Within 24 hours of admission

82. Oxygen administration order should include?
Ans. Initiation time, device, route, litre, how long etc
- No need to write order

83. One the day of discharge spouse of a pt is tensed about discharge?
- Cancel discharge
- Explain the pt to express his fears and fix time for consultation

84. Cancer pt scheduled for CT. Worried, your role?
Ans. Encouraging him to tell about how he feels and about his fears

85. Movement away from midline?
- Abduction

86. Where to assess edema?
Ans. Ankles

87. In which type of wound, wound care plan to be implemented?
- All type of wounds

88. How to assess respiratory status?
- Ease, rate, rhythm, pattern
89. Potassium sparing diuretic
- Spirinolactone

90. After IV dose pt develops rashes, itching, flushed skin
- Septicemia

- Adverse reaction

91. Indication of chest tube drainage
- Pneumothorax

92. Health care assistant task delegation criteria?
- Make sure he is competent
- Make sure he is experienced
- Confirm that he is a staff having same designation
- He is an employee of the same institution

93. A pt had complained several times, now that pt register a new complaint about your colleague, your role?
- Tell staff members to be careful to avoid mistakes in future
- Be honest and impartial and complete investigation

94. Acute illness?
- Sudden onset which is curable

95. Positive fluid balance?
- Intake greater than output

96. Abdominal paracentesis position, how to position client?
- Head elevation with pillows to 45 to 50 CM

97. When can we perform LP?
- ICP normal

98. How can we identify health problems of a patient?
- Lifestyle
- Medical notes
- Discussion
- Talking to their friends

99. How to collect details of a pt?
- Listening, clarifying and asking open ended questions
- Listen to their concerns
- Ask relatives

100. While dealing with a pt, sexuality against nurses belief?
- Acceptance to cultural diversity

101. When you provide care for a pt of different culture?
- Whenever possible provide sensible care

102. Haemorrhoids risk factor?
- Straining of stools
- Veg diet
- Fibre rich food
- non - processed food

103. comprehensive nursing care?

Critical nd advanced care

104. when can we realise actual and potential problems of a pt?

- assessment

105. pt comes to emergency in shock, signs?

- tachycardia, hypotension
- tachycardia, hypertension
- bradycardia, hypotension

106. pt centred care, who is the centre of approach?

- pt centered

107. signs of infection?

- WBC raised, blood sugar low
- tachycardia, shivering, temp 38.6 c
- temp 36 c

108. nursing home bill does not include?

- laundry
- food
- social activities

109. head injury pt, unequal pupils?

- consider this as an emergency, follow ABCDE approach

110. iv administration benefit?

- fast acting

111. after nj feeding how to position the client

- 45 degree
- head turned to side

112. criteria to base while giving care?

- all criteria emotional, spiritual, cultural...

113. while in outside setup what care will you give if exposed to a situation?

- provide care which is at expected level
- keeping up to professional standards
- above what is expected
- no involvement

114. measures to prevent fall in an unconscious pt in bed

- side rails
- call bell

115. how to act in an emergency

- according to our competence
- according to situation

116. Revising of care comes under which nursing process?

- implementation
- evaluation
Assessment

Planning

117 How to ensure your care was effective
- By communicating effectively

Therapeutic Techniques

Understand Support and ensure pt comfort

118 While giving Morphine to a immediate post-operative pt which is not recommended.
- Checking if all the controlled medicines are in stock

1. How to collect urine for examination of a patient who is admitted?
   a. With strip for test
   b. Clean the meatus and collect midstream urine
   c. Clean and collect first urine
   d. Take the last urine.

2. NMC stands for?
   a. Sets standards of practice, conduct, for nurses
   b. Is a labour organisation
   c. To make written complaints
   d. Keeps record of nurse salaries.

3. When you tell your 4th year student under your care to dispense medication to your patient what you will assess?
   a. Whether she is able to give medicine.
   b. Whether she is under your same employment
   c. You will assess her competency and skills

4. You are dealing with an infectious patient. What standard precautions will you take?
   a. Hand hygiene.
   b. Proper disposal of waste.
   c. Using self-protective device.

5. When will you disclose the informed consent?
   a. Media interest.
   b. On the request of the doctor.
   c. Justified by public interest AND law and order.
   d. On public interest.

6. If your patient is having positive balance, how will you find out dehydration is balanced?
   a. Input exceeds output.
   b. Output exceeds input.
   c. Optimally hydrated.
   d. Optimally dehydrated.

7. What is the meaning of accountability?
   a. Responsibility with authority.
   b. Discipline
   c. Respect
   d. Responsible and answerable

8. After lumbar puncture, the patient became unconscious. What will be the reason?
   a. Increased ICP.
   b. Headache.
   c. Side effect of medications.
   d. CSF leakage.

9. What is early warning signs?
   a. Early detection of deterioration of the patient vital signs.
   b. Nurse to take more care and responsibility.
   c. Nurse must learn more and educate.

10. How to move patient after laminectomy?
    a. Move as a unit.
    b. Logrolling with bed sheet.
    c. Ask the patient to drag/slide slowly by holding the side rails.
    d. Move the head first and then the body.

11. Leg stockings are used for DVT for what purpose?
    a. Arterial blood circulation increase.
    b. Venous blood return increase.

12. Why is orthostatic hypotension more common in elderly people?
    a. Adrenaline and epinephrine absorption is reduced.
    b. Venus plaques are more.

13. Why the temperature does not increase in elderly patients with infection?
    a. Increased immature T cell production.
    b. Adrenaline and epinephrine absorption is slow.
    c. Thyroxine slower to adjust in the cold.
14. For adverse drug reaction, in which colour will you mark?
   a. Red
   b. Yellow
   c. Blue
   d. Pink

15. An 8 year old child with cast on his hand has come and the nurse wants to remove the cast. But the child is not allowing to remove the cast. What will be your response?
   a. Talk to the boy in age appropriate language and make him understand.
   b. Advise the parents to talk to him and make him understand.
   c. Let the patient go without removing the cast.
   d. Inform the treating physician.

16. What is not the sign of meconium aspiration?
   a. Baby will cry.
   b. Apnoea
   c. Baby will be floppy
   d. Mottled skin

17. An 8 year old child with learning disability is admitted for a minor surgery. The mother wants to stay with the child after visiting hours. What will be your response?
   a. Allow the mother to stay.
   b. You will ask the treating physician.
   c. You will inform the mother that the official visiting hours are over.
   d. You will tell the mother that she can go and that you will take care of the child.

18. An elderly patient complains of some new confusion. What may be the cause?
   a. Dementia
   b. Old age
   c. Alzheimer

19. 40 mg medicine is to be given to the patient. However, 1.5 mg tablet is available in the ward. How many tablets will you administer?
   a. 10
   b. 4
   c. 16
   d. 12

20. A COPD patient is at home care. When you visit the patient, he is dyspnoeic, very anxious and frightened. What will you do? He is already on 2 lit oxygen ------
   a. Call the emergency service.
   b. Give Oramorph 5mg medications as prescribed.

21. How will you find out that your teaching was effective to the patient using crutches
   a. Lifting the walker ahead and taking small steps
   b. Put crutches 12 inches in front and keep small steps

22. What is the best way to walk using walker
   a. Lean and walk slowly

23. The nurse wants to move patients leg from the midline. What is it call
   a. Abduction
   b. Adduction
   c. Extension
   d. Flexion

24. If you notice that your patient is having suspected UTI, what precaution you will take
   a. Improve the infection control nurse role.
   b. Encourage the doctors to perform strict hand hygiene.
   c. Review the antimicrobials daily, follow standard precautions, proper disposal of body fluid waste.
   d. Inform infection control team to review medication, ask them to take class on five moments of hand hygiene and inform the patient and family with correct information.

25. You are ready in assisting a doctor in insertion of iv cannula. The doctor left for an emergency and ordered you for iv insertion. You are not trained in the particular procedure. You will,
   a. Complain that doctor left you alone.
   b. Ask your colleague to supervise you.
   c. Inform the head nurse.
   d. Not insert iv as you are not competent in the task.

26. S/s of dehydration in old age is
   a. Skin turgor
b. elasticity
c. wrinkles

27. Patient is posted for CT scan. Patient is afraid cancer will reveal during scan. Patient asked why this test. What will be your response

a. Tell the patient it is a normal procedure
b. understand her feelings and record.
c. tell her that you will arrange a meeting with doctor.

28. Which is not the sign of ectopic pregnancy

a. shoulder pain.
b. vaginal bleeding
c. dysuria
d. positive pregnancy test.
Back pain

29. Lumbar puncture can be done easily when

a. Increased ICP
b. When pt having lumbar infection.
c. normal ICP.

30. What the nurse should include when teaching a patient with altered sensorium

a. Safe environment
b. Fluid intake and output
c. Orienting patient with new situation.

31. Pt with clostridium difficile, what safety measures is not recommended.

a. using alcohol gel hand rub
b. use separate equipments
c. Isolation

32. If you see biohazard label on the specimen what do you do

- Double the bag, use self-sealing bag, use gloves when handling specimen.
- Use self-protective device
- Use gloves, inform the lab and send the sample.

33. If you are delegating one work to your coworker what is your responsibility

- A make sure that you know her name.
- B. make sure that she is an employee of your hospital.
- C. confirm that she is competent to perform the task.

34. Pt is taking controlled drug at home. What is your responsibility

a. drug should be locked.
b. assess for risk of drug addiction.
c. should follow local policy and guidelines.

35. When you are going to administer digoxin for a patient, you find the pulse rate is 58 bpm. What will you do next?

a. you will hold the medication.
b. Omit the dose, record and report to the physician.
c. omit the dose and bleep the physician urgently.

36. Outside hospital setting a registered nurse is supposed to act,

a. less than inside hospital settings.
b. a reasonable amount of care as required is anticipated.
c. according to the ability
37. You are posted as a charge nurse newly and you find that unjustified duties in the ward that put someone at risk of harm. What will be your next plan.
   a. raise your concern verbally when you get clinical supervision.
   b. write your concerns to the management.
   c. inform the nmc.

38. Narcotic drug missed from your ward. What will be your response?
   a. check the record book, order book and inform to the registered nurse or in charge of the clinical area. If the missed drug is not found inform any senior nurse on duty and write incident report.
   b. inform the nmc.
   c. call the pharmacy and inform the senior pharmacist.
   d. check the record book, call the pharmacy to resolve the issue, write incident report.

39. How will you assess sexuality in a non-judgemental way.
   a. acceptance and understanding of cultural diversity.
   b. therapeutic
   c. observation

40. Why two clamps are used when removing the ICD?
   a. to prevent introduction of infection.
   b. to prevent air entry and pneumothorax.

41. Which type of wound dressing will heal the wound soon?

42. While giving IV infusion, patient developed speed shock. Which is not the s/s?
   a. circulatory collapse.
   b. peripheraledema.
   c. facial flushing.
   d. headache.

43. If an equipment is not maintained what is your responsibility
   a. Complaint to supervisor
   b. Inform clinical audit
   c. Make written complaint

44. Case management

45. Patient with cast on legs, only the toes exposed. How will you find out the risk for compartmental syndrome?
   a. pain that is not alleviated by analgesics.
   b. numbness and tingling sensation.
   c. dusky toes.

46. Best way to take consent on preoperative day
   a. Give verbal and written form of information and should be read on the day of surgery.
   b. Patient should be informed about the treatment and risks in a language that he understands, given opportunity to ask questions

47. Advocacy means?
   a. liaison between patient and healthcare system.
   b. informs, supports and mediates patient decisions on behalf of the patient.

48. You are in the queue in the canteen for lunch and you see a person collapse in front of you, what will you do?
a. assess for responsiveness.
b. shout for help.
c. assess for any danger.
d. run for AED.

49. Intermediate Care means?
50. What should not be done while using walker?
   a. walk outside.
   b. Do not carry anything with you.
   c. while getting up from chair use sit ups.

60. Compassion means
   a. sympathetic, kind act giving care.
   b. nursing care that have empathy, dignity, respect and intelligent kindness.

61. Bradycardia means.
62. Primary Care means?
   a. Care given in the acute care settings.
   b. the first point of contact that the patient has in the health care system.

63. Which of the following can be a cause for blood and mucus in the stool,
   a. Ulcerative colitis.
   b. Crohn’s disease.
   c. food poisoning.
   d. pseudomembraneous colitis.

64. Diarrhoea not present in
   a. intestinal obstruction.
   b. Hashimoto’s disease.
   c. ulcerative colitis.
   d. needle stick injury protocol

Press the blood

Wash with soap & water

Incident report

66. holistic care.
67. palliative care.

68. How will you remove vacuum drain.
   a. pull the drain.
   b. let the doctor do it.
   c. remove the vacuum and then drain.

69. What is Clinical benchmarking?
   a. Reflective process.
   b. Clinical benchmarking.
   c. peer and patient response.
   d. All the above.

70. How will the nurse assess the quality of care given?
   a. Reflective process.
   b. Clinical benchmarking.
   c. peer and patient response.
   d. All the above.