1. The nurse is caring for a client admitted 2 days ago for a myocardial infarction. Upon assessment, the nurse notes a new systolic murmur at the cardiac apex. The nurse should assess for which of the following conditions?
(A) Ventricular aneurysm.           (B) Acute pericarditis.
(C) Papillary muscle dysfunction.    (D) Pulmonary embolism.

2. When administering a thrombolytic drug to the client experiencing a myocardial infarction, the nurse explains to him that the purpose of the drug is to:
(A) Help keep him well hydrated.
(B) Dissolve clots that he may have.
(C) Prevent kidney failure.
(D) Treat potential cardiac arrhythmias.

3. When teaching the client with myocardial infarction, the nurse explain that the pain associated with MI is caused by:
(A) Left ventricular overload.
(B) Impending circulatory collapse.
(C) Extracellular electrolyte imbalances.
(D) Insufficient oxygen reaching the heart muscle

4. Which of the following symptoms is the most common clinical finding associated with bladder cancer?
(A) Suprapubic pain                (B) Dysuria
(C) Painless hematuria             (D) Urine retention

5. In the oliguric phase of acute renal failure, the nurse should anticipate the development of which of the following complication?
(A) Pulmonary edema        (B) Metabolic alkalosis
(C) Hypotension              (D) Hypokalemia

6. The nurse teaches the client how to recognize signs and symptoms of infection in the shunt by telling the client to assess the shunt each day for:
(A) Absence of a bruit
(B) Sluggish capillary refill time
(C) Coolness of the involved extremity
(D) Swelling at the shunt site

7. A client has signs of increased intracranial pressure(ICP) .Which of the following is an early indicator of deterioration?
(A) Widening pulse pressure
(B) Decrease in the pulse rate
(C) Dilated, fixed pupils.
(D) Decrease in level of consciousness.

8. The nurse develops a teaching plan for a client newly diagnosed with Parkinson's disease. Which of the following topics that the nurse plans to discuss is the most important?
   (A) Maintaining a balanced nutritional diet
   (B) Enhancing the immune system
   (C) Maintaining a safe environment
   (D) Engaging in diversional activity

9. For the client who is experiencing expressive aphasia, which nursing intervention is most helpful in promoting communication?
   (A) Speaking loudly.
   (B) Using a picture board.
   (C) Writing directions so client can read them.
   (D) Speaking in short sentences.

10. The most common symptom of patients with scabies is:
    (A) Nausea
    (B) nocturnal pruritus
    (C) localized pain
    (D) skin paresthesia.

11. A patient has an inhalation burn injury. Which of the following is a medical emergency?
    (A) Singed facial hair
    (B) Neck or face burns
    (C) Pallor
    (D) Respiratory stridor.

12. Mr. Bell, a 58-year-old patient with colon cancer, is receiving combined radiation and chemotherapy. He is suffering from diarrhea, this is related to the:
    (A) Diagnosis of the patient
    (B) Patient's inability to eat and drink during treatment
    (C) Treatment's irritating effect on the mucosa of the GI tract
    (D) Fluid and electrolyte imbalance of the patient.

13. A clinical sign of gouty arthritis is:
    (A) Heberden's nodes
    (B) Tophi deposits
    (C) Homan's sign
    (D) Swan neck.

14. TB is spread by:
    (A) Inhaling the TB bacteria after a person coughs, speaks, or sneezes
    (B) Talking with an individual with TB
15. You suspect that 59-year-old Mary has a nutritional deficiency. Which of the following physical assessment findings indicates a nutritional problem?

(A) Decreased weight, erythematous iris, stuttering
(B) Missing teeth, enlarged gall bladder, sunken cheeks
(C) Hepatosplenomegaly, decreased muscle tone, dry hair
(D) Enlarged labia, recessed gums, xanthomas.

16. Ms. Hellen is being discharged following a prosthetic hip implant. She asks when she can begin to bear weight on the affected leg. Select the most appropriate response:

(A) You must not bear weight on your affected leg for 6 to 12 months
(B) Most patients bear weight in 5 days
(C) You must learn to use a gait enhancer and keep the majority of weight off the unaffected leg
(D) Most patients require some degree of non-weight bearing for 6 weeks to 3 months.

17. When caring for a patient with hepatic encephalopathy the nurse may give enemas, provide a low-protein diet, and limit physical activity. These measures are done to:

(A) Promote fluid loss
(B) Eliminate potassium ions
(C) Decrease portal pressure
(D) Decrease the production of ammonia.

18. In the treatment of asthma, peak-flow monitoring is important to help the patient manage the asthma. Peak-flow monitoring measures:

(A) The inspiratory capacity of the lungs
(B) How well air moves out of the lungs during forceful exhalation.
(C) The vital capacity of the lungs
(D) The residual volume of the lungs.

19. An intrapartum client tells the nurse her last period was Apr 28. The nurse uses Negele's rule to compute the client's expected date of birth. Based on this information, what would the nurse document as the expected date of birth?

(A) February 4 (of the next year)
(B) February 21 (of the next year)
(C) May 21 (of the next year)
(D) January 21 (of the next year)

20. Quickening in primagravidas usually can be detected during which of the following weeks of gestation?

(A) 10 to 14 weeks
(B) 15 to 17 weeks
(C) 18 to 20 weeks
(D) 20 to 22 weeks

21. According to ten steps by WHO, which was the right description?

(A) NOT show mothers how to breastfeed, if they should separated from their infants
(B) Give newborn infants food or drink, when they ask
22. Which is correct about fetal distress nursing interventions: Late decelerations or prolong variables, low or absent variability with bradycardia
   (A) Turn left side  (B) O₂ supply  
   (C) Discontinue oxytocin then notify Dr  (D) all of above are correct

23. Which would be normal physical response for newborn: 
   (1) respirations should be regular, abdominal, 40-50 per minute, deep; (2) respirations should be irregular, abdominal, 30-60 per minute, shallow; (3) heart rate may range 120-160; (4) heart rate may range 100-180
   (A) 1, 3  (B) 2, 4  (C) 1, 4  (D) 2, 3

24. The nurse assesses the fundus of a 12 hours postpartum client to be 1 cm above the umbilicus and deviated to the right. Which of the following nursing interventions would be appropriate?
   (A) assist client to voiding  
   (B) encourage client to breastfeed  
   (C) monitor for signs for infection  
   (D) call physician immediately

25. A 34-year-old woman, G₁P₀A₁ and at 28 week gestation, but this is her first prenatal visit after missing period. According to this situation, she should be taken which kind of special prenatal tests? 
   (1) MCV test (2) blood sample of Down syndrome screen (3) GBS (Group B streptococcus) (4) amniocentesis (5) GDM screen
   (A) 1, 2  (B) 1, 2, 3  (C) 1, 2, 4  (D) 1, 2, 4, 5

26. Which is not cause water baby first breath inhibitors
   (A) Dive reflex  (B) Osmotic pressure  (C) Mild hypoxia  (D) oxytocin

27. When obtaining consent for surgery, the nurse should initially:
   (A) Explain the risks involved in the surgery  
   (B) Explain that obtaining the signature is routine for any surgery  
   (C) Evaluate whether the client’s knowledge level is sufficient to give consent  
   (D) Witness the signature because this is what the nurse’s signature documents

28. The nursing process can be defined as the:
   (A) Implementation of client care by the nurse  
   (B) Steps the nurse employs to meet client needs  
   (C) Activities a nurse employs to identify a client’s problem  
   (D) Process the nurse uses to determine nursing goals for the client

29. The effectiveness of nurse-client communication is best validated by:
   (A) Client feedback  
   (B) Medical assessments  
   (C) Health care team conferences  
   (D) Client’s physiologic adaptations

30. When the nurse first talks with a client coming to the clinic, the type of interview that is
likely to be most productive is:
(A) Directive  (B) Exploratory  (C) Problem solving  (D) Information giving

31. When promoting affective learning (developing attitudes) in a client with a newly diagnosed disease, the nurse must first consider the influence of the:
(A) Client’s past experience  
(B) Total stress of the situation  
(C) Client’s personal resources  
(D) Type of onset of the disease

32. The nurse understand that symptoms occurring during an anaphylactic reaction are the result of:
(A) Increased cardiac output and hypertension  
(B) Respiratory depression and cardiac standstill  
(C) Constriction of capillaries and decreased cardiac output  
(D) Bronchial constriction and decreased peripheral resistance

33. To utilize the nursing process, the nurse must first:
(A) Identify goals for nursing care  
(B) State the client’s nursing needs  
(C) Obtain information about the client  
(D) Evaluate the effectiveness of nursing actions

34. The determining factor in the revision of a nursing care plan is the:
(A) Time available for care  
(B) Validity of the diagnoses  
(C) Method for providing care  
(D) Effectives of the interventions

35. Andy is a five-year boy. Which of following is not the right description for Andy’s development?
(A) He is not egocentric any more.  
(B) He is under the operative stage.  
(C) The developmental crisis of his social development is sham and doubt.  
(D) Having magic thought is normal for him.

36. Following above, in order to promote the social ability of Andy, which of following is the best play for him?
(A) riding bicycle   (B)drawing   (C)running   (D) doll play.

37. Amy is a eight-month-old girl. Based on Erikson’s and Piaget’s theories, which of following is correct?
(A) Amy’s task of social development is developing trust with her mother.  
(B) Amy will has a risk of developing doubt if her mother suffered from depression.  
(C) Amy has not developed the sense of object permanence.  
(D) She is under pre-operative stage.

38. 4-year-old who has a congenital heart defect develops hear failure and is exhibiting marked dyspnea at rest. The nurse is aware this finding can be attribute to
(A) Anemia    (B) Hypovolemia   (C) Pulmonary edema
(D) Metabolic acidosis.

39. When giving nursing care to a child with leukemia, the nurse notes blood on the pillowcase and several bloody tissues. The nurse should check the child’s laboratory report for
(A) platelet count   (B) uric acid level   (C) prothrombin time
(D) red blood cell toothbrush.

40. The nurse in the pediatric clinic taking a health history of a toddler with an exacerbation of eczema. The nurse should assess if the toddler has been
(A) Eating well and drink sufficient milk.
(B) Wearing new clothes or eating new foods.
(C) Near anyone with a streptococcus infection.
(D) In close contact with anyone with eczema recently.

41. When the nurse caring for an infant with meningitis extends the baby’s leg, the ham-string muscles go into spasm. The nurse recognizes that the baby is exhibiting a positive
(A) Cremasteric reflex   (B) Babinski reflex    (C) Chvostek’s sign
(D) Kernig’s sign

42. According to the mechanism of Hyperbilirubinemia, which of the following is not included?
(A) longer life span of RBC in infants
(B) actively enterhepatic circulation
(C) unconjugated bilirubin transfer into conjugated bilirubin by liver glucuronyl transferase
(D) excreted through feces

43. A novice nurse asks the mentor, “Not all patients present with blatant suicidal ideation. How will I know when to assess for suicide risk?” The best reply would be, “Nurses working with psychiatric patients should pursue assessment of suicide risk for individuals who display tendencies to be
(A) blaming, abusive, or confused.
(B) hostile, impulsive, or depressed.
(C) compulsive, obsessive, or weak.
(D) risk-taking, aggressive, or controlling.”

44. Which is the best indication that case management has been carried out successfully?
(A) The patient and family have access to all needed support services.
(B) The spiritual needs of the patient and family have been met.
(C) The patient is being monitored for any medication non-compliance.
(D) The emotional needs of the patient and family have been met.

45. Kelly, age 19, recently gave birth. Since bringing the baby home, she says she has felt apathetic, fatigued, and helpless. She cares adequately for the baby, but states, "I don't know what's expected of me." No cognitive impairment or thought disorder is noted. The nurse should consider the possibility that Kelly may benefit from
(A) crisis intervention.    (B) short hospitalization.
(C) neuroleptic medication.  (D) antidepressant medication.

46. The diagram above is a Johari window that a nurse thinks accurately represents her. If she wishes to be more successful in psychiatric nursing, the nurse should make it her initial goal to increase the size of

(A) quadrant 1.  (B) quadrant 2.  (C) quadrant 3.  (D) quadrant 4.

47. While completing the nursing admission of a patient admitted to the general hospital for surgery, the nurse observes that the patient is experiencing a narrowed perceptual field and seems to focus on immediate concerns. The patient is able to follow directions with assistance. The nurse can assess that the patient is experiencing anxiety at the

(A) mild level.  (B) panic level.  
(C) severe level.  (D) moderate level.

48. A fundamental (and very key) therapeutic tool the nurse uses to provide quality care to a psychiatric patient is

(A) context     (B) self-analysis  
(C) nonverbal behavior   (D) therapeutic self-disclosure

49. Mr. C. is being treated for severe depression. He evidences resistance to involvement in the nurse patient relationship by being withdrawn and unresponsive. He is preoccupied with guilt and hopelessness. When interacting with him, a highly therapeutic approach could be summarized as

(A) "Everything will work out."
(B) "Let's explore the origins of your pessimism."
(C) "You will feel better as your treatment continues."
(D) "You have to help yourself by getting rid of your negative thoughts."

50. Tim, 22, has schizophrenia. The nurse notes that he is often forgetful and seems uninterested in activities. Further he has difficulty completing tasks. The nurse planning care for Tim will select successful strategies if he or she understands these behaviors are due to

(A) a lack of self-esteem.  
(B) manipulative tendencies.
( C) shyness and embarrassment.  
(D) problems in cognitive functioning.