1.Which of the following is not a method of data collection?
A.Interview
B.Biographic data
C.Social media
D.Health history

2. Wellness Nursing Diagnosis
A.Absence of illness
B.Not strictly a diagnosis
C.Human responses to levels of good health in an individual, family or community
D.All of the above

3. Which of the following is not considered a standardized language in nursing?
A.NIC
B.ANA
C.NOC
D.NANDA

5. Match the Nursing Process on the left with its description on the right
A. Assess
A.

B. Diagnose
B.

C. Plan and Identify Outcome
C.

D. Implement
D.

E. Evaluate
E.

6. A reflective reasoning process that guides a nurse in generating, implementing and evaluating approaches for dealing with client care and professional concerns
A.Nursing process
B.Critical thinking
C.Nursing care plan
D.Nursing logic

7. After establishing a database and before the identification of nursing diagnosis, what does a nurse do?
A.Documentation of database
B.Analysis of database
C.Filing of database
D.Acquiring a database of information

8. Which of the following is not a Physician Prescribed intervention?
A.Ordering diagnostic tests
B.Drug administration
C.Performing wound care
D.Elevating an edematous leg

9. Clinical judgment
A.Diagnosis
B.Job description of a clinical nurse
C.Data collection
D.Health intervention

10. Documentation is a vital component of which phase of the nursing process?
A.Assessment
B.Diagnosis
C.Planning
D.Implementation
E.Evaluation

11. Which of the following are functions of managed care? Select all that apply.
A.Provides control over health care services
B.Standardized diagnosis and treatment
C.Control Cost
D.Primary resource for patient advocacy

12. Risk factors
A.Description of a problem
B.Analysis of a health issue
C.Possible illness
D.Circumstances that increase the susceptibility of a patient to a problem

13. How many parts does a RISK NURSING DIAGNOSIS have?
A.1
B.3
C.2
D.None

14. A common framework that helps guide the prioritization of nursing tasks during the process of planning
A.Ericsson's psychosocial development
B.Maslow's hierarchy
C.Glasgow Scale
D.Bernoulli principle

15. Secondary Source of Data. (Select all that apply)
A.Diagnostic procedures
B.Medical record
C.Personal interview
D.Significant other

16. Clinical cues, signs, symptoms that furnish evidence that the problem exists.
A.Risk factors
B.Defining characteristics
C.Description of a problem
D.Nursing diagnosis

17. Syndrome Nursing Diagnosis
A.An isolated disease with numerous symptoms
B.Numerous symptoms describing a single disease
C.Used when a cluster of actual or risk nursing diagnosis are predicted to be present
D.Numerous symptoms leading to an idiopathic disorder

18. Components of a Nursing Diagnosis. Select all that apply
A.Nursing diagnosis title or label
B.Definition of the title or label
C.Data clustering
D.Contributing, etiologic or related factors
E.Defining characteristics

19. Difference between a goal statement and an outcome statement
A.A good outcome statement is specific to the patient
B.Goals are general deadlines that are to be met
C.An outcome statement refers to what the nurse will do
D.Goals and Statements are practically the same

20. Data Clustering
A.Analyzing signs and symptoms
B.Identifying patient statements
C.Grouping related cues together
D.Entering patient data in the computer

21. What is the "Nursing Process"? Select all that apply
A.Organizational framework for the practice of Nursing
B.Systematic method by which nurses plan and provide care for patients
C.The application of the nursing process only applies to RN's and not LPN's
D.The Nursing Scope and Standards of Practice of the ANA outlines the steps of the nursing process

22. Which of the following is a Risk Nursing Diagnosis statement?
A.Risk for falls related to unstable balance
B.Constipated because of fecal impaction
C.Risk for Diarrhea
D.Constipation related to dehydration

23. A synonym for significant data that usually demonstrate an unhealthy response.
A.Cue
B.Objective
C.Subjective
D.Interpretative

24. Validation of patient outcome and goals
A.Assessment
B.Planning
C.Intervention

D.Evaluation

25. Which of the following is not true about Focused ASSESSMENT
A.When patient is critically ill or disoriented
B.When patient is unable to respond
C.Preferably early in the morning before breakfast.
D.When drastic changes are happening to a patient.

26. Certain Physiologic complications that nurses monitor to detect their onset or changes in the patient's status.
A.Variance
B.Collaborative problems
C.Clustered Syndrome
D.Signs of death

27. If the first method of data collection is to conduct an interview, what is the second method?
A.Laboratory work
B.Diagnostic Tests
C.Evaluation
D.Performance of a physical examination

28. Evidence based practice
A.Past educational knowledge
B.Theoretical research
C.Expertise of specialists
D.Integration of research and clinical experience

29. Difference between Medical and Nursing Diagnoses
A.Medical is etiology; Nursing is human response
B.Medical is disease; Nursing is the cause of disease
C.Medical is illness; Nursing is illness too
D.Medical is to heal the disease: Nursing is to discover the disease

30. Which of the following refers to the definition of a Nursing Problem?
A.Nurse overload and nurse burnout
B.When the nurse calls in sick
C.Any health care condition that requires diagnostic, therapeutic, or educational actions.
D.Lose of employment

31. How cues, signs and symptoms identified in patient's assessment are written
A.Diagnosed by
B.Explained by
C.Manifested by
D.Caused by

32. What is RISK NURSING DIAGNOSIS as described by NANDA-I? Select all that apply
A.Human responses to health conditions/life processes that may develop in a vulnerable individual/family
B.Describes the symptoms of the disease
C.Supported by risk factors that contribute to increased vulnerability
D.Proof that the person is suffering from an illness

33. ANA defines it as a"systematic dynamic process by which the nurse, through interaction with the client, significant others and health care providers collect and analyzes data about the client

A.Physical Check-up
B.Hospital evaluation
C.Assessment
D.Analysis

34. Nursing interventions
A.Depend on the tasks delegated by the nursing supervisor
B.A sequence of prioritized tasks that describe a nurse's job
C.Activities that promote the achievement of the desired patient outcome
D.An act of taking care of the sick

35. Clear, precise description of a problem
A.Definition
B.Intervention
C.Etiology
D.Diagnosis

36. Which of the following statements about the nursing process is true.
A.A nursing process is written together with a nursing care plan
B.A nursing care plan is a product of the nursing process
C.Both the nursing process and the nursing care plan are purely critical thinking strategies
D.The nursing process is not an accurate clinical theory

37. Which of the following is not the role of the LPN/LVN in the nursing process?
A.Suggest interventions
B.Gather further data to confirm problems
C.Discuss details of the disease as part of patient education
D.Observe and report signficant cues

38. Headache, itchiness, warmth
A.Symptoms
B.Signs
C.Feelings
D.Emotions

39. Identification of a disease or condition by a scientific evaluation of physical signs, symptoms, history, laboratory test and procedures.
A.Health Analysis
B.Nursing Problem
C.Medical Diagnosis
D.All of the above

40. Prioritization of tasks belongs to which phase of the Nursing Process?
A.Assessment
B.Diagnosis
C.Planning
D.Implementation
E.Evaluation

41. Which of the following statements describe a well-written patient outcome statement? Select all that apply.
A.Uses a measurable verb
B.Focuses on the completion of nursing interventions
C.Does not interfere with the medical care plan
D.Includes a time frame for patient reevaluation

42. "Constipation related to insufficient fluid intake manifested by increased abdominal pressure". What is the defining characteristic?

A.Constipation
B.Insufficient fluid
C.Increased abdominal pressure
D.Related to

43. Which of the following are true regarding nursing diagnosis?

A.A nursing diagnosis is any problem related to the health of a patient
B.When writing a nursing diagnosis, place the adjective before the noun modified
C.A nursing diagnosis is usually the etiology of the disease
D.Both medical and nursing diagnosis can be converted into a nursing intervention.

44. IN which of the following scenarios would a standardized nursing care plan be appropriate?

A.Trauma center
B.Center for infection control
C.Intensive care unit
D.Maternity floor without a single Cesarean delivery

45. Clinical pathway

A.Nursing career development plan
B.Multidisciplinary action
C.A concept map for care plans
D.Specific location in a healthcare facility

46. The purpose to which an effort is directed

A.Goal
B.Outcome
C.Intervention
D.Evaluation

47. Variance

A.A research method
B.Patient does not achieve expected outcome
C.Similar to zoning
D.Not the same

48. Potential complications: hypoglycemia. This is a sample of what?

A.Syndromatic pathology
B.Definite Variance
C.Collaborative problem
D.Idiopathic etiology

49. Which of the following is not a nurse-prescribed intervention?

A.Turning the patient every two hours
B.Providing a back massage
C.Offering a vitamin supplement
D.Monitoring a patient for complications