90 practice questions for Gulf nursing licensing exams, with answers

For DHA, DOH (HAAD), MOHAP, SCFHS (Saudi Prometric), QCHP, OMSB, Kuwait MOH and NHRA nursing exams. Single best answer, the same style as the computer-based exams.

These are **original** questions written for practice by Gulf Health Exam. They are not recalled or real exam questions: those are often wrong, out of date, and using them can put a licence application at risk. Answers and full explanations are at the back.

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Questions

1. A community nurse runs a clinic for adults with type 2 diabetes and established peripheral neuropathy. The nurse teaches daily foot inspection, correct footwear and when to seek care for blisters. What is the main aim at this level of prevention?

A. To detect diabetes early in people who have no symptoms
B. To prevent ulceration and amputation in people who already have complications
C. To prevent healthy adults from developing type 2 diabetes
D. To reduce population sugar intake through public policy

Community and public health

2. A nurse finds a 58-year-old man unresponsive in his hospital bed. He is not breathing normally. The scene is safe and there is no response to shouting or shaking his shoulders. Which action should the nurse take next?

A. Shout for help, activate the emergency team and get the defibrillator, checking a pulse for no more than 10 seconds
B. Give two rescue breaths with a pocket mask, then go to call the emergency team
C. Insert an oropharyngeal airway and attach a pulse oximeter before calling for help
D. Check the medical record for the resuscitation status before starting any action

Critical care and emergency

3. A 46-year-old man is admitted with a 4-week cough with blood-streaked sputum, night sweats and weight loss. His chest X-ray shows an upper-lobe cavity and pulmonary tuberculosis is suspected. Which precaution is most appropriate while results are awaited?

A. Single room with the door left open for observation, and staff wearing a surgical mask
B. Positive-pressure single room with the door closed, and staff wearing a gown and gloves
C. Standard precautions only, with the patient wearing a surgical mask in a shared bay
D. Negative-pressure single room, door closed, staff in fit-tested N95 (FFP2) respirators

Fundamentals of nursing

4. The nurse in an emergency observation unit is caring for four patients. Which patient needs to be seen first?

A. A 62-year-old with a stable venous leg ulcer whose routine dressing change is due
B. A 55-year-old with long-standing back pain who is asking for the usual analgesia
C. A 70-year-old with slurred speech and right arm weakness that began 40 minutes ago
D. A 48-year-old with type 2 diabetes, fasting glucose 9.4 mmol/L and no symptoms

Leadership, ethics and law

5. During a magnesium sulfate infusion a woman with severe pre-eclampsia is drowsy, her respiratory rate is 8 breaths/min and her patellar reflexes are absent. What should the nurse do first?

A. Stop the infusion, call for help and prepare calcium gluconate
B. Reduce the infusion rate by half and recheck her reflexes in one hour
C. Give oxygen by face mask and continue the infusion at the same rate
D. Prepare naloxone and give it intravenously to reverse the sedation

Maternal and newborn care

6. A 74-year-old woman with chronic heart failure takes furosemide 40 mg orally each morning. At a clinic visit she reports a 2.5 kg weight gain over 3 days, swollen ankles and needing three pillows to sleep. What is the most appropriate nurse action?

A. Advise her to take an extra furosemide tablet when she feels breathless
B. Reassure her that a weight change of up to 3 kg is normal day to day
C. Report the weight gain and symptoms to the prescriber the same day
D. Encourage her to drink 2.5 to 3 L of fluid daily to protect her kidneys

Medical-surgical nursing

7. A 34-year-old woman with major depression says to the nurse, 'Everyone on this ward hates me. They talk about me when I leave the room.' Which response is most therapeutic?

A. 'That isn't true. All of the staff and patients on this ward like you very much.'
B. 'Why do you think that everyone here hates you? What have you done to upset them?'
C. 'It sounds as though you feel rejected here. Tell me what happened today.'
D. 'Let's not talk about that now. Shall we look at what is on the activity programme?'

Mental health nursing

8. A nurse is completing a routine developmental check on a healthy 9-month-old boy who was born at term. Which finding should the nurse report for further evaluation?

A. He makes no babbling sounds and does not turn when his name is called
B. He is not yet walking independently
C. He cries and clings when a stranger approaches
D. He picks up cereal pieces with a raking motion of the whole hand

Paediatric nursing

9. A nurse must infuse 500 mL of sodium chloride 0.9% over 6 hours using an infusion pump. At what rate should the pump be set? Round to the nearest whole number.

A. 100 mL/h
B. 50 mL/h
C. 167 mL/h
D. 83 mL/h

Pharmacology and medication safety

10. A 46-year-old man with a family history of heart disease says, "My father had it, but I feel fine and I'm not the type to get it." Using the Health Belief Model, which nurse intervention best addresses his barrier?

A. Give him a leaflet describing the benefits of regular exercise
B. Tell him that heart disease is the leading cause of death in the region
C. Review his own blood pressure, cholesterol and risk score with him
D. Arrange a cooking class and reassure him the cost is low

Community and public health

11. A nurse begins chest compressions on an adult in cardiac arrest who is lying on a firm surface. Which technique is correct?

A. Compress 4 cm at 80 per minute to reduce the risk of rib fractures
B. Compress 5 to 6 cm at 100 to 120 per minute, with full recoil
C. Compress 5 to 6 cm at 140 per minute to maximise cardiac output
D. Compress 2 to 3 cm, leaning on the chest between compressions

Critical care and emergency

12. A nurse sustains a needlestick injury from a hollow-bore needle used to draw blood from a patient known to have chronic hepatitis C. Which action should the nurse take first?

A. Squeeze the wound firmly to express blood, then cover it
B. Scrub the wound with a brush and a bleach solution
C. Report to occupational health before cleaning the site
D. Wash the site thoroughly with soap and running water

Fundamentals of nursing

13. A registered nurse delegates the morning hygiene care of a stable patient to a nursing assistant. Which responsibility remains with the registered nurse?

A. Performing the same task again to be certain it was done
B. Supervising the task and evaluating the outcome
C. Documenting the care as if personally performed
D. Transferring accountability to the nursing assistant

Leadership, ethics and law

14. On postpartum day 4 a breastfeeding woman has firm, warm and tender breasts, and the baby is struggling to latch. Which advice is most appropriate?

A. Stop breastfeeding for 24 hours to let the breasts rest and recover
B. Bind her breasts tightly with a firm bra and restrict her fluids
C. Limit feeds to a strict schedule of every 4 hours, day and night
D. Feed frequently and express a little milk beforehand to soften the areola

Maternal and newborn care

15. A 66-year-old man on a telemetry ward reports sudden palpitations and chest pain. The monitor shows an irregularly irregular narrow-complex rhythm at 156/min. BP 78/42 mmHg, he is drowsy and his skin is cold and clammy. Which action is most appropriate?

A. Give the prescribed oral metoprolol and recheck the rhythm in 30 minutes
B. Obtain a 12-lead ECG and wait for cardiology review before intervening
C. Prepare for unsynchronised defibrillation at the highest energy setting
D. Call the emergency team and prepare for synchronised electrical cardioversion

Medical-surgical nursing

16. Four patients are admitted after crisis presentations. Which statement is most indicative of a high risk of an imminent suicide attempt?

A. 'Sometimes I wish I would not wake up in the morning.'
B. 'I have thought about it, but I could never do that to my children.'
C. 'I scratch my arm when I am upset; it helps me cope, not die.'
D. 'I have been saving my tablets and I will take them on Saturday when my family is away.'

Mental health nursing

17. A 4-year-old boy is to receive an intramuscular injection. He tells the nurse, 'I got a needle because I was bad.' Which approach is most appropriate?

A. Explain in detail how the medicine is absorbed and works in his body
B. Explain simply that it is not a punishment, and let him play with a doll
C. Reassure him that the injection will not hurt at all if he keeps still
D. Give the injection without warning so he has less time to worry

Paediatric nursing

18. A nurse is to infuse 1000 mL of IV fluid by gravity over 10 hours. The administration set delivers 20 drops per mL. How many drops per minute should the nurse set? Round to the nearest whole number.

A. 33 drops/min
B. 100 drops/min
C. 25 drops/min
D. 50 drops/min

Pharmacology and medication safety

19. A new rapid test is used to screen 1000 people. Of 200 people who truly have the disease, 170 test positive. Of 800 people without the disease, 760 test negative. What is the sensitivity of the test?

A. 95%
B. 15%
C. 81%
D. 85%

Community and public health

20. During a cardiac arrest on a medical ward, compressions are in progress. The monitor shows ventricular fibrillation and the defibrillator has been attached. The team leader is charging the pads. What should the nurse do?

A. Stop compressions when the rhythm is seen and wait for the charge
B. Give adrenaline 1 mg first and delay the shock until it circulates
C. Continue compressions during charging, pause briefly to shock, then resume
D. Check for a pulse for 30 seconds after the shock before resuming CPR

Critical care and emergency

21. A 79-year-old man, one day after a hip hemiarthroplasty, is prescribed an opioid analgesic. He has nocturia and keeps trying to get out of bed unaided at night. His falls risk score is high. Which intervention is most likely to reduce his risk of falling?

A. Offer scheduled toileting, keep the bed low and the call bell within reach
B. Raise all four bed rails and remind him to wait for staff before getting up
C. Apply a waist restraint while he is in bed at night to stop him getting up
D. Withhold the opioid overnight so that he stays more alert when he gets up

Fundamentals of nursing

22. The charge nurse is assigning four patients to an enrolled (practical) nurse working under supervision of a registered nurse. Which patient is most appropriate for that assignment?

A. A 64-year-old, day 4 after hip replacement, stable, needing oral medications and a simple dressing
B. A 58-year-old who returned from cardiac catheterisation 2 hours ago and needs frequent monitoring
C. A 72-year-old admitted this morning who needs an admission assessment and care plan
D. A 40-year-old with new confusion and a rising respiratory rate

Leadership, ethics and law

23. Ten minutes after delivery a woman has heavy vaginal bleeding. The uterine fundus is soft, boggy and above the umbilicus. What should the nurse do first?

A. Place a cold pack on the abdomen
B. Encourage her to void and ambulate
C. Take her temperature
D. Massage the fundus until it is firm

Maternal and newborn care

24. A 70 kg patient with a pulmonary embolism is prescribed an unfractionated heparin infusion at 18 units/kg/h. The pharmacy supplies 25 000 units in 500 mL of 0.9% sodium chloride. At what rate should the infusion pump be set? Round to one decimal place.

A. 12.6 mL/h
B. 18.0 mL/h
C. 25.2 mL/h
D. 50.4 mL/h

Medical-surgical nursing

25. A 58-year-old man with severe treatment-resistant depression is scheduled for electroconvulsive therapy (ECT) at 08:00. Consent has been documented. Which nursing action is appropriate before ECT?

A. Allow a light breakfast with tea so he does not become hypoglycaemic
B. Confirm that he has fasted, ask him to empty his bladder, and remove dentures and jewellery
C. Give his usual morning dose of lorazepam to reduce anxiety before the procedure
D. Apply soft wrist restraints to prevent injury during the seizure

Mental health nursing

26. A 9-kg, 14-month-old boy has had watery diarrhoea for two days. He is irritable, has sunken eyes, dry mucous membranes, a slow skin pinch that returns within 2 seconds, and drinks eagerly. The unit follows the WHO Plan B protocol (75 mL/kg of oral rehydration solution over 4 hours). What volume should the nurse plan to give over the 4 hours?

A. 450 mL
B. 900 mL
C. 225 mL
D. 675 mL

Paediatric nursing

27. A child weighing 18 kg is prescribed paracetamol (acetaminophen) 15 mg/kg orally. The suspension contains 120 mg per 5 mL. How many mL should the nurse give? Round to one decimal place.

A. 9.0 mL
B. 2.3 mL
C. 11.3 mL
D. 22.5 mL

Pharmacology and medication safety

28. Four adults arrive together at the emergency department triage desk. Which patient should the nurse mask and move to an isolation room first?

A. A 45-year-old smoker with a chronic morning cough and no fever
B. A 30-year-old with vomiting and diarrhoea after a restaurant meal
C. A 58-year-old farm worker with fever 38.9 °C and dry cough who helps care for sick camels
D. A 70-year-old with a swollen red calf after a long flight

Community and public health

29. During CPR, the monitor shows a flat line in two leads and the leads are confirmed to be connected. IV access is established. Which action is most appropriate?

A. Deliver a 200 J biphasic shock immediately
B. Give atropine 3 mg IV and start transcutaneous pacing
C. Give amiodarone 300 mg IV as a rapid bolus
D. Give adrenaline 1 mg IV now and continue high-quality CPR

Critical care and emergency

30. A drowsy 68-year-old patient arrives on the ward from theatre without an identification wristband. A prescribed IV antibiotic dose is due. Which action is most appropriate?

A. Give the antibiotic after checking the bed number matches the medication chart
B. Verify identity from records with a second nurse and apply a new wristband first
C. Ask the drowsy patient to state their name, and give the dose if it matches
D. Give the dose now and apply the new wristband at the next ward round

Fundamentals of nursing

31. A 36-year-old school-bus driver admitted with uncontrolled seizures tells the nurse he will go back to work when discharged and asks her to keep this secret. Which action by the nurse is most appropriate?

A. Keep the information confidential, as the patient has asked
B. Telephone the school director to warn of the risk to the children
C. Refuse discharge until the patient promises not to drive the bus
D. Inform the treating physician and follow policy on disclosing risk to others

Leadership, ethics and law

32. A woman has just given birth vaginally to a healthy baby at term. There is no sign of a second baby. According to WHO recommendations, what should the midwife or nurse do within one minute of birth?

A. Clamp and cut the cord immediately and begin cord traction
B. Give oxytocin 10 IU intramuscularly
C. Massage the uterus to encourage the placenta to separate
D. Wait for signs of placental separation, then give oxytocin

Maternal and newborn care

33. A 24-year-old woman admitted with an acute asthma attack was audibly wheezing 20 minutes ago. Now her chest is almost silent, she is drowsy, SpO2 is 89% on high-flow oxygen and she cannot complete a sentence. What should the nurse do?

A. Stay with her, call the emergency team and continue nebulised salbutamol with oxygen
B. Record that the wheeze has resolved and reduce nebuliser frequency
C. Lay her flat to rest and reassess in one hour
D. Give another nebuliser and reassess in one hour before calling anyone

Medical-surgical nursing

34. A patient taking lithium for bipolar disorder has a blood sample taken 12 hours after the last dose. Which serum lithium result is within the usual maintenance therapeutic range?

A. 0.3 mmol/L
B. 1.6 mmol/L
C. 0.7 mmol/L
D. 2.4 mmol/L

Mental health nursing

35. A nurse is to give a liquid oral medication to a conscious 6-month-old infant. Which technique is safest?

A. Give small amounts slowly by oral syringe into the side of the cheek
B. Mix the dose into a full bottle of formula milk
C. Lay the infant flat and squirt the dose to the back of the throat
D. Pinch the infant's nostrils so that the infant swallows

Paediatric nursing

36. A patient is prescribed an unfractionated heparin infusion at 1,200 units/h. The pharmacy bag contains 25,000 units in 500 mL. At what rate should the pump be set?

A. 12 mL/h
B. 24 mL/h
C. 2.4 mL/h
D. 48 mL/h

Pharmacology and medication safety

37. Which storage practice is correct in a domestic-style vaccine refrigerator?

A. Store vaccines in the door shelves for easy access
B. Place vaccines on the middle shelves, with space around the boxes for air flow
C. Keep vaccines in the bottom drawer against the back wall
D. Store vaccines beside the freezer compartment to keep them cold

Community and public health

38. A patient remains in ventricular fibrillation after three shocks and 1 mg of adrenaline. Which medication does the nurse prepare next?

A. Adenosine 6 mg rapid IV push
B. Amiodarone 300 mg IV bolus
C. Atropine 1 mg IV
D. Calcium chloride 10% 10 mL routinely

Critical care and emergency

39. A 76-year-old woman on bed rest after a stroke has non-blanchable redness on both heels. Which intervention is best for protecting her heels?

A. Place a ring-shaped (donut) cushion under each heel
B. Place a pillow lengthwise under the calves so the heels are free of the mattress
C. Massage the reddened heels firmly twice each shift
D. Wrap the heels in a tight elastic bandage

Fundamentals of nursing

40. A nurse is floated from the medical ward to the ICU and is asked to manage a ventilated patient and titrate vasoactive infusions, which she has never done. What is the best action?

A. Accept the full assignment to avoid appearing unhelpful to the team
B. Refuse to work on the unit because it is not her usual area
C. Tell the charge nurse her limits and accept only tasks within her competence
D. Accept the patient and ask for help if problems arise during the shift

Leadership, ethics and law

41. A woman taking a combined oral contraceptive pill realises she forgot one pill yesterday, in week 2 of the pack. What advice is correct?

A. Skip the missed pill and continue as normal
B. Stop the pack and start a new one tomorrow
C. Take the missed pill now and take the next one at the usual time
D. Use condoms for the next 7 days and double the next dose

Maternal and newborn care

42. A 68-year-old man with long-standing COPD has an arterial blood gas result: pH 7.36, PaCO2 7.6 kPa (normal 4.7 to 6.0), HCO3 32 mmol/L (normal 22 to 26), PaO2 8.4 kPa. How should the nurse interpret this result?

A. Fully compensated respiratory acidosis
B. Normal arterial blood gas
C. Acute uncompensated respiratory acidosis
D. Primary metabolic alkalosis with respiratory compensation

Medical-surgical nursing

43. A 56-year-old malnourished man with alcohol dependence is confused and ataxic and has abnormal eye movements. Capillary glucose is 5.4 mmol/L. The prescriber orders both IV dextrose 5% and IV thiamine. What should the nurse do?

A. Start the dextrose first, then give thiamine when the infusion finishes
B. Give oral folic acid before any other treatment
C. Give the IV thiamine before or at the same time as the dextrose infusion
D. Give the thiamine after breakfast as a routine multivitamin

Mental health nursing

44. A 5-month-old received the first dose of a multi-dose vaccine series at 2 months and missed the second dose due at 4 months. His mother asks whether the series must start again. What is the nurse's best response?

A. The series must restart because the recommended interval has been exceeded
B. The series does not restart; the missed dose is given now and the schedule continues
C. The first dose no longer counts, so three new doses are needed
D. No more doses are needed because the first dose gives lasting protection

Paediatric nursing

45. A patient with rheumatoid arthritis has a new order: 'methotrexate 10 mg orally daily'. The patient is stable and has taken this medicine at home. What is the nurse's best action?

A. Withhold the dose and clarify the frequency with the prescriber
B. Give the dose, because 10 mg is a low dose
C. Give half the dose and monitor blood counts
D. Give the dose with folic acid from the patient's own supply

Pharmacology and medication safety

46. Which activity falls in the preparedness phase of the disaster management cycle?

A. Treating casualties at a field hospital
B. Rebuilding damaged health facilities
C. Counselling survivors after the event
D. Conducting evacuation drills and stocking emergency supplies

Community and public health

47. A 35-year-old woman develops generalised urticaria, stridor, wheeze and blood pressure 78/40 mmHg five minutes into an IV antibiotic infusion. The infusion is stopped. What is the next priority drug and route?

A. Adrenaline (epinephrine) 0.5 mg intramuscularly into the anterolateral mid-thigh
B. Chlorphenamine 10 mg IV
C. Hydrocortisone 200 mg IV
D. Salbutamol 5 mg nebulised

Critical care and emergency

48. A nurse needs to move a 95 kg patient who cannot assist up in the bed. Which action best protects both the patient and the nurse?

A. Lift the patient under the arms, bending the knees and keeping the back straight
B. Ask the patient's relative to help lift him up the bed with a draw sheet
C. Ask the patient to pull himself up using the overhead trapeze
D. Use a slide sheet with enough trained staff, as set out in the handling plan

Fundamentals of nursing

49. A patient with severe pain after surgery tells the nurse she is worried about her family finances. According to Maslow's hierarchy of needs, what should the nurse address first?

A. Her worry, by arranging a visit from the social worker today
B. Her need to belong, by inviting her family to visit
C. Her pain, by assessing it and giving prescribed analgesia
D. Her self-esteem, by praising her progress with exercises

Leadership, ethics and law

50. A woman has just given birth vaginally and the baby is skin-to-skin. The nurse is waiting for the placenta to separate. Which finding indicates that the placenta has separated?

A. The uterus becomes soft and flat on palpation
B. The woman has sudden severe lower abdominal pain with collapse
C. The cord retracts back into the vagina
D. The umbilical cord lengthens at the vulva with a small gush of blood

Maternal and newborn care

51. A patient with DKA is on a fixed-rate IV insulin infusion at 0.1 units/kg/hour with 0.9% sodium chloride. Blood glucose has fallen to 13.6 mmol/L, ketones are 3.4 mmol/L and pH is 7.21. Which action should the nurse anticipate?

A. Stopping the insulin infusion as glucose is near target
B. Changing to subcutaneous insulin now
C. Adding an IV glucose infusion while continuing the insulin
D. Changing the fluid from 0.9% to 0.45% sodium chloride

Medical-surgical nursing

52. A 16-year-old girl with anorexia nervosa is on an inpatient programme. Which nursing intervention is most appropriate at mealtimes?

A. Let her eat alone in her room so that she is less anxious
B. Negotiate the calorie content of each meal with her each day
C. Discuss her weight and body shape in detail during the meal
D. Stay with her during and after meals in a supportive, neutral way

Mental health nursing

53. An infant with gastroenteritis weighed 8.0 kg two days ago when well. Her weight on admission today is 7.2 kg. Assuming the weight loss is fluid, what percentage dehydration does this represent? Round to the nearest whole number.

A. 8%
B. 11%
C. 10%
D. 1%

Paediatric nursing

54. A 70-year-old patient is on day 5 of IV gentamicin. Which finding should the nurse report to the prescriber first?

A. Mild nausea after meals
B. New ringing in the ears and urine output of 20 mL/h
C. Slight redness at the cannula site
D. Temperature falling from 38.5 to 37.8 degrees Celsius

Pharmacology and medication safety

55. A nurse teaches a patient to measure blood pressure at home. Which instruction is correct?

A. Measure immediately after climbing the stairs
B. Measure standing with the arm hanging at the side
C. Sit quietly for 5 minutes with the back supported and the arm at heart level
D. Drink a coffee beforehand to be alert

Community and public health

56. A 40-year-old man is found unresponsive with pinpoint pupils, respiratory rate 6/min, SpO2 82% and a palpable pulse. An empty patch packet is nearby. What is the nurse's first priority?

A. Support ventilation with a bag-valve-mask and oxygen while naloxone is prepared
B. Perform gastric lavage
C. Give flumazenil 0.5 mg IV
D. Give a large naloxone bolus before any ventilation

Critical care and emergency

57. A nurse is assessing a surgical wound that is healing by secondary intention. Which finding indicates healthy healing?

A. Yellow, stringy tissue adhering to the base
B. Moist, bright red, bumpy tissue at the base
C. Green, foul-smelling drainage
D. Black, hard tissue at the edges

Fundamentals of nursing

58. A nurse is giving handover about a patient's HIV status. Which location is most appropriate?

A. A closed room, away from visitors and other patients
B. The ward corridor near the lifts
C. The nurses' station when visitors are waiting
D. The hospital cafeteria during the break

Leadership, ethics and law

59. Four women attend their first antenatal visit. Which woman should the nurse prioritise for early glucose tolerance testing?

A. A 24-year-old with a body mass index of 22 kg/m² in her first pregnancy
B. A 28-year-old with a body mass index of 24 kg/m² and one previous miscarriage
C. A 33-year-old with a body mass index of 26 kg/m² who follows a vegetarian diet
D. A 30-year-old with a body mass index of 38 kg/m² and a previous baby weighing 4.6 kg

Maternal and newborn care

60. A 55-year-old man has been prescribed atenolol for hypertension. He tells the nurse he plans to stop the tablets as soon as his BP is normal. Which instruction should the nurse give?

A. Stop the tablets if your pulse is ever below 80 beats per minute
B. Skip the tablets for a few days if you feel dizzy and then restart
C. Do not stop it suddenly because rebound tachycardia and high BP can occur
D. Take an extra tablet on days when your home BP reading is high

Medical-surgical nursing

61. A 34-year-old woman admitted with major depression has been sitting quietly with the nurse for several minutes after being asked how she felt about her family visit. She looks tearful but has not spoken. Which nurse response is most therapeutic?

A. Ask a new question about her sleep to move the interview along
B. Tell her that she should not be sad about a family visit
C. Remain with her quietly and wait for her to speak when she is ready
D. Leave the room to give her privacy and return in an hour

Mental health nursing

62. A 14-month-old with severe diarrhoea is irritable, has doughy skin and a serum sodium of 168 mmol/L. After resuscitation the prescriber orders rehydration over 48 hours so that sodium falls by no more than 0.5 mmol/L per hour. The mother asks why correction is so slow. Which explanation is best?

A. A rapid fall in sodium moves water into brain cells and can cause cerebral oedema and seizures
B. Slow correction stops potassium from rising too quickly in the blood
C. The kidneys cannot excrete sodium faster than this rate
D. Fast rehydration causes heart failure in every dehydrated child

Paediatric nursing

63. One hour after 5 mg of IV morphine, a postoperative patient is rousable only to pain, with a respiratory rate of 7 breaths/min and SpO2 of 89%. Which action should the nurse take first?

A. Allow the patient to sleep and recheck in 30 minutes
B. Apply oxygen by face mask only and reassess in 30 minutes
C. Stimulate the patient, support ventilation with oxygen and call for help, and give naloxone in small increments as prescribed
D. Give flumazenil

Pharmacology and medication safety

64. A nurse was exposed without adequate PPE to a patient later confirmed to have MERS-CoV. For how long should the nurse monitor for symptoms after the last exposure?

A. 48 hours, since most infections appear within two days
B. 14 days, reporting fever, cough or breathlessness immediately
C. 7 days, then stop if there are no symptoms
D. 28 days, because symptoms can occur after a month

Community and public health

65. After cooling for exertional heat stroke, a 28-year-old man passes dark brown urine, 20 mL/h. His creatine kinase is 48,000 U/L. Which nursing action is most appropriate?

A. Restrict fluids because of oliguria
B. Give IV isotonic crystalloid as ordered and monitor hourly urine output and potassium
C. Give ibuprofen for muscle pain
D. Give potassium supplements to replace losses

Critical care and emergency

66. A patient is found on the floor beside the bed. Which nursing entry is best?

A. 0215: Patient clumsy and uncooperative again, fell out of bed during the night.
B. 0215: Patient seems to have been drunk and careless, found on the floor.
C. 0215: Fell because night staff did not answer the call bell in time.
D. 0215: Found sitting on floor beside bed. States 'I slipped.' No visible injury. Doctor informed.

Fundamentals of nursing

67. A nurse realises she gave a patient 10 units of insulin instead of the prescribed 1 unit. Which action should she take first?

A. Complete the incident report
B. Assess the patient and notify the doctor immediately
C. Tell the patient's family about the error
D. Correct the entry in the medication chart

Leadership, ethics and law

68. A woman has just given birth vaginally without complications. How often should the nurse check her fundus, lochia, pulse and blood pressure in the first hour?

A. Every 2 hours
B. Every 4 hours
C. Every 15 minutes
D. Once at the end of the hour

Maternal and newborn care

69. On day 7 of an unfractionated heparin infusion for deep vein thrombosis, a 66-year-old man's platelet count falls from 280 to 105 x10^9/L. He has a new painful dusky area on his abdominal wall where heparin was injected earlier. Which action should the nurse take?

A. Continue the infusion and repeat the platelet count the next morning
B. Halve the infusion rate until the platelet count recovers
C. Stop the heparin infusion and report suspected heparin-induced thrombocytopenia urgently
D. Ask for enoxaparin to replace the infusion

Medical-surgical nursing

70. A patient taking lithium carbonate asks if he can follow a low-salt diet to lose weight. What should the nurse advise?

A. Cut out salt completely, as this reduces lithium side effects
B. Keep salt and fluid intake steady, as low salt raises lithium levels
C. Limit fluids to 1 litre a day to keep levels stable
D. Take an extra lithium dose on days of heavy sweating

Mental health nursing

71. Which description of a burn in a 14-month-old most strongly raises concern for non-accidental injury?

A. Symmetrical burns of both feet and buttocks with sharp borders and no splash marks
B. Scattered small splash burns on the chest after pulling a cup of hot tea off a table
C. A burn on the palm after touching a hot oven door
D. Sunburn on the shoulders after an afternoon outdoors

Paediatric nursing

72. A 22-year-old ingested thirty 500 mg paracetamol (acetaminophen) tablets 4 hours ago. The 4-hour plasma paracetamol level is above the treatment line. Which antidote should the nurse expect to administer?

A. Naloxone
B. Flumazenil
C. Acetylcysteine
D. Protamine sulfate

Pharmacology and medication safety

73. At a bus collision, a nurse using START triage assesses an adult who cannot walk. Respirations are 22/min, capillary refill is 4 seconds, and the patient obeys commands. Which category applies?

A. Delayed (yellow)
B. Minor (green)
C. Immediate (red)
D. Expectant (black)

Community and public health

74. A 40-year-old man fell 5 metres from scaffolding. He has pelvic pain, BP 84/50 mmHg and a heart rate of 128/min. A pelvic fracture is suspected. What is the best action?

A. Rock the iliac crests to confirm that the pelvis is unstable
B. Apply a pelvic binder at the level of the iliac crests
C. Log-roll the patient repeatedly to inspect the back and pelvis
D. Apply a pelvic binder centred on the greater trochanters

Critical care and emergency

75. A nurse prepares to transport a patient to radiology with a portable oxygen cylinder. How should the cylinder be transported?

A. Upright and secured in a stand or trolley, with the patient's oxygen flow checked
B. Lying flat on the bed between the patient's legs
C. Hanging from the intravenous pole by its regulator
D. Carried by hand in the nurse's arm with the valve open

Fundamentals of nursing

76. A nurse wants to know whether chlorhexidine bathing reduces bloodstream infections in adult intensive care patients compared with soap and water. In the PICO format, what is the "comparison"?

A. Adult intensive care patients
B. Chlorhexidine bathing
C. Rate of bloodstream infections
D. Bathing with soap and water

Leadership, ethics and law

77. A Rh-negative woman at 7 weeks is admitted for surgical management of an ectopic pregnancy. Which action is most appropriate?

A. Withhold anti-D because there is no viable fetus
B. Give anti-D immunoglobulin within 72 hours
C. Give anti-D only if the tube has ruptured
D. Give anti-D only if she conceives again

Maternal and newborn care

78. A nurse is about to begin transfusing a unit of red cells to an adult with anaemia. Which action is correct?

A. Run the first unit at maximum rate to complete it within 1 hour
B. Record vital signs only before and after the transfusion
C. Prime the line with 5% glucose to prevent clotting
D. Start slowly, stay with the patient and check vital signs at 15 minutes

Medical-surgical nursing

79. A patient admitted to the psychiatric unit wants to stop smoking. Which intervention is most appropriate?

A. Advise him to wait until discharge before trying to quit
B. Allow supervised cigarette breaks as a reward for progress
C. Advise him to stop abruptly without other support
D. Offer nicotine replacement as ordered plus counselling

Mental health nursing

80. A nurse teaches parents of a curious 18-month-old about preventing poisoning. Which advice is best?

A. Keep medicines in a low drawer, as the bottles have child-resistant caps
B. Keep syrup of ipecac at home to make the child vomit after an ingestion
C. Lock medicines and cleaning products away in their original containers
D. Tell the child the medicines are sweets that only an adult may give

Paediatric nursing

81. A patient receiving noradrenaline (norepinephrine) via a peripheral cannula has pain, a cool pale area and swelling around the site. Which action should the nurse take first?

A. Flush the cannula with saline to clear the line
B. Remove the cannula immediately and apply a warm compress
C. Stop the infusion, leave the cannula in place, attempt to aspirate and notify the prescriber for antidote per protocol
D. Slow the infusion rate and elevate the arm

Pharmacology and medication safety

82. A man whose personal best peak expiratory flow is 500 L/min reads 225 L/min with chest tightness. His action plan uses green 80–100%, yellow 50–79% and red below 50%. What should he do?

A. Take extra preventer doses and recheck tomorrow
B. Rest and recheck in 4 hours
C. Use the reliever only if wheeze appears
D. Use his reliever inhaler at once and seek urgent medical help

Community and public health

83. A rapid response call has been made for a 68-year-old man with acute shortness of breath, SpO2 86% and a respiratory rate of 30/min. What should the nurse do while waiting for the team?

A. Stay with him, apply oxygen and monitoring, and gather current observations, charts and code status
B. Leave to look for the senior doctor and return when they arrive
C. Transfer him to the radiology department to speed up diagnosis
D. Hold oxygen until the doctor prescribes it

Critical care and emergency

84. A patient has negative pressure wound therapy over an abdominal wound. Within 15 minutes, 250 mL of bright red blood collects in the canister. The patient's heart rate rises to 118/min and BP falls to 92/56 mmHg. What should the nurse do first?

A. Replace the canister and restart therapy at a lower pressure setting
B. Stop the therapy, leave the dressing in place, apply direct pressure and call for urgent medical help
C. Remove the foam dressing to find the source of the bleeding
D. Clamp the tubing and review the patient at the next ward round

Fundamentals of nursing

85. A confused patient repeatedly pulls at an intravenous cannula. Which action should the nurse take first?

A. Apply wrist restraints straight away to protect the line
B. Ask a relative to hold his hands throughout the night
C. Remove the cannula without consulting the doctor
D. Look for the cause and try less restrictive measures first

Leadership, ethics and law

86. A woman in labour has her membranes ruptured. Immediately she has fresh painless vaginal bleeding and the fetal heart rate falls to 90 beats/min while her own vital signs are normal. What should the nurse do first?

A. Perform a digital examination to find the source of bleeding
B. Place her left lateral and observe for 30 minutes
C. Apply a fetal scalp electrode and continue labour
D. Call for immediate obstetric help and prepare for emergency caesarean section

Maternal and newborn care

87. During surgery under sevoflurane and suxamethonium, a patient's end-tidal CO2 rises steadily, heart rate is 140/min, the jaw is rigid and temperature is 39.5 C. Which management is the priority?

A. Give intravenous paracetamol and apply surface cooling first
B. Stop the volatile agent, hyperventilate with 100% oxygen and give dantrolene
C. Deepen the volatile agent because the patient is too light
D. Give neostigmine to reverse the muscle rigidity

Medical-surgical nursing

88. An 82-year-old woman with mild dementia has become acutely confused over 24 hours, is drowsy at times and then agitated. Temperature is 38.3°C, urine is cloudy and foul-smelling. Which action should the nurse take first?

A. Record that her dementia has progressed
B. Give a PRN sedative to settle the agitation
C. Report the acute change and fever to the prescriber
D. Move her to a quiet room and review in the morning

Mental health nursing

89. A mother asks to give aspirin for her 7-year-old's fever and aches during influenza. What should the nurse advise?

A. Avoid aspirin because of Reye syndrome; use paracetamol
B. Aspirin is safe for children if it is given with food
C. Aspirin is acceptable at half of the usual adult dose
D. Use aspirin only if paracetamol has not reduced the fever

Paediatric nursing

90. Ibuprofen 400 mg is prescribed for four patients. Which patient should the nurse question about this order?

A. A patient with tension headache
B. A patient admitted yesterday with bleeding from a gastric ulcer
C. A patient with a sprained ankle
D. A patient with dental pain after extraction

Pharmacology and medication safety

Answers and explanations

1. Answer: B

These patients already have neuropathy, so the aim is to reduce disability and limb loss. This is tertiary prevention, which limits complications and supports rehabilitation in established disease.

Why the others are wrong: A. Detecting undiagnosed disease is secondary prevention; these patients are already diagnosed. **C.** Preventing onset in healthy adults is primary prevention. **D.** Policy change on sugar intake is a population-level primary or primordial measure.

Key point: Tertiary prevention reduces complications and disability in established disease.

Based on: IDF Clinical Practice Recommendations on the Diabetic Foot; Stanhope & Lancaster, Public Health Nursing, 10th ed.

2. Answer: A

After confirming unresponsiveness and absent or abnormal breathing, the rescuer shouts for help and activates the emergency response system so that a defibrillator and team arrive quickly. A pulse check of up to 10 seconds is done at the same time, and compressions start immediately if no definite pulse is felt.

Why the others are wrong: B. Starting with breaths delays recognition of arrest and activation of the team; compressions take priority in adults. **C.** Equipment and monitoring are secondary and delay help and compressions. **D.** Code status should be known by the team, but a delay to check the chart is not appropriate in an unresponsive, non-breathing patient unless a valid DNAR is already known.

Key point: Activate the emergency response and get the defibrillator early; start compressions without delay if there is no definite pulse.

Based on: AHA 2025 Guidelines for CPR and ECC

3. Answer: D

Tuberculosis is spread by small airborne droplet nuclei, so the patient needs an airborne infection isolation room (negative pressure, door closed) and staff need a fit-tested particulate respirator. Isolation starts on suspicion, before confirmation.

Why the others are wrong: A. Surgical masks do not filter airborne droplet nuclei and the door must stay closed. **B.** Positive pressure would push contaminated air out into the corridor; gown and gloves do not protect against inhalation. **C.** Standard precautions are not enough for suspected TB; a bay shares air with other patients.

Key point: Suspected TB, measles or varicella: airborne precautions, negative-pressure room and N95 respirator.

Based on: CDC Guideline for Isolation Precautions (2007, updated); WHO guidelines on TB infection prevention and control (2019)

4. Answer: C

Sudden focal neurological deficit within the thrombolysis window suggests acute stroke, where each minute of delay causes loss of brain tissue. Acute, new, potentially life- or function-threatening problems outrank stable chronic ones.

Why the others are wrong: A. A stable chronic wound can wait until the acute problem has been assessed. **B.** Chronic pain with a known pattern is less urgent than a new neurological deficit. **D.** An isolated, asymptomatic mildly raised glucose is not an emergency.

Key point: Acute and unstable problems take priority over chronic and stable ones, and time-critical conditions such as stroke come first.

Based on: Marquis & Huston, Leadership Roles and Management Functions in Nursing, 10th ed.

5. Answer: A

Respiratory rate under 12 breaths/min with absent reflexes signals toxicity. The infusion is stopped, senior help is called, airway and breathing are supported, and 10% calcium gluconate (1 g, 10 mL) is given by slow intravenous injection if ordered.

Why the others are wrong: B. Halving the rate is inadequate when respiratory depression is already present. **C.** Oxygen helps but continuing the drug allows toxicity to worsen. **D.** Naloxone reverses opioids; the antidote for magnesium is calcium gluconate.

Key point: Respiratory depression on magnesium: stop the drug, get help, calcium gluconate is the antidote.

Based on: ACOG Practice Bulletin 222 (2020); WHO recommendations for pre-eclampsia and eclampsia (2011)

6. Answer: C

A gain of more than 2 kg in 3 days, new oedema and orthopnoea indicate worsening congestion. The prescriber needs to review her diuretic dose and look for a cause. Self-adjusting diuretics without advice is unsafe.

Why the others are wrong: A. Changing the dose without prescriber advice risks electrolyte disturbance and kidney injury. **B.** Rapid gain over days is fluid, not normal fluctuation; ignoring it delays treatment. **D.** Increasing fluid intake would worsen congestion in a patient who is already overloaded.

Key point: A weight gain above 2 kg in 3 days in heart failure should be reported promptly.

Based on: ESC 2021 Guidelines for Acute and Chronic Heart Failure

7. Answer: C

Reflecting the feeling and inviting the patient to describe the situation shows acceptance and encourages exploration without confirming or arguing with the perception. It builds trust and gives the nurse the information needed to assess for low mood, paranoia or real conflict.

Why the others are wrong: A. Flatly disagreeing and giving false reassurance dismisses her feelings and makes her feel unheard. **B.** 'Why' questions can feel accusatory and invite defensiveness rather than exploration. **D.** Changing the subject blocks communication and tells the patient her concern is unimportant.

Key point: Reflect feelings and use open exploration; avoid false reassurance, 'why' questions and changing the subject.

Based on: Videbeck, Psychiatric-Mental Health Nursing, therapeutic communication techniques chapter

8. Answer: A

By 9 months an infant normally babbles with consonant sounds (for example 'ba-ba') and turns toward familiar voices. Absence of both suggests a possible hearing or language problem and needs audiology and developmental referral. The other findings are within normal limits.

Why the others are wrong: B. Independent walking is expected at about 12–15 months, so this is normal at 9 months. **C.** Stranger anxiety is a typical social milestone from about 6–9 months. **D.** A raking grasp is typical at this age; the pincer grasp develops at about 9–12 months.

Key point: Lack of babbling and of response to name at 9 months is a red flag for hearing or developmental delay.

Based on: CDC/AAP 'Learn the Signs. Act Early.' developmental milestones (2022 revision); Hockenberry & Wilson, Wong's Nursing Care of Infants and Children, 11th ed.

9. Answer: D

Rate (mL/h) = total volume / time in hours = 500 / 6 = 83.3, which rounds to 83 mL/h.

Why the others are wrong: A. This would finish the infusion in 5 hours. **B.** This would take 10 hours. **C.** This would finish in 3 hours.

Key point: mL/h = total volume divided by hours.

Based on: Potter & Perry Fundamentals of Nursing, IV therapy chapter

10. Answer: C

His statement shows low perceived susceptibility. Personalised data on his own risk factors makes the threat concrete and relevant. The Health Belief Model says action needs perceived susceptibility and severity that outweigh barriers.

Why the others are wrong: A. Benefits information targets perceived benefits; his main barrier is that he does not see himself at risk. **B.** General statistics are impersonal and do not change perceived personal susceptibility. **D.** Cost and cooking skill are perceived barriers to action, which he has not raised.

Key point: Match the intervention to the Health Belief Model construct that is lacking.

Based on: Glanz, Rimer & Viswanath, Health Behavior: Theory, Research, and Practice, 5th ed.

11. Answer: B

For adults, the target is a depth of at least 5 cm but not more than 6 cm, a rate of 100 to 120 per minute, full recoil, and minimal interruptions. Leaning on the chest stops the heart refilling between compressions.

Why the others are wrong: A. This is too shallow and too slow to generate adequate coronary and cerebral perfusion. **C.** The depth is right but rates above 120 per minute reduce filling time and compression quality. **D.** This depth is too shallow for an adult, and leaning on the chest prevents full recoil and reduces venous return.

Key point: Adult CPR: 5 to 6 cm, 100 to 120/min, full recoil, minimal pauses.

Based on: AHA 2025 Guidelines for CPR and ECC

12. Answer: D

Immediate first aid is to wash the puncture wound with soap and water without scrubbing or squeezing; mucous membranes are flushed with water. The nurse should then report the incident promptly so source and baseline testing, follow-up and any post-exposure prophylaxis can be arranged.

Why the others are wrong: A. Squeezing or milking the wound can damage tissue and is not recommended. **B.** Scrubbing or using bleach or strong antiseptics damages the skin and does not reduce risk. **C.** Reporting is essential but follows immediate first aid of the wound.

Key point: After a sharps injury: wash with soap and water first, then report immediately.

Based on: WHO Guidelines on post-exposure prophylaxis and occupational exposure; CDC guidance on occupational exposure to bloodborne pathogens

13. Answer: B

Delegation transfers the task but not accountability. The nurse must choose an appropriate person, give clear instructions, supervise, and evaluate the outcome and the patient's response.

Why the others are wrong: A. Repeating the task wastes resources and signals lack of trust; supervision and follow-up are sufficient. **C.** Documentation must show who performed the care; recording it as one's own is inaccurate. **D.** The nurse delegates the task but remains accountable for the decision to delegate and for outcomes.

Key point: You can delegate the task, but you remain accountable for the decision to delegate and for supervising the result.

Based on: Marquis & Huston, Leadership Roles and Management Functions in Nursing, 10th ed.

14. Answer: D

Engorgement is relieved by frequent, effective milk removal. Softening the areola by hand expression or reverse pressure helps the baby attach, and cold compresses after feeds ease discomfort.

Why the others are wrong: A. Stopping milk removal worsens engorgement and risks mastitis. **B.** Tight binding and fluid restriction are not recommended. **C.** Restricting feeds increases engorgement.

Key point: Engorgement: keep removing milk frequently.

Based on: WHO Infant and young child feeding counselling; Academy of Breastfeeding Medicine Protocol 36 (2022)

15. Answer: D

Tachycardia with hypotension, reduced consciousness and chest pain is haemodynamic instability (adverse features). Unstable tachyarrhythmia is treated with synchronised cardioversion under sedation, so help must be called and equipment prepared at once.

Why the others are wrong: A. An oral beta-blocker acts too slowly and may worsen hypotension in an unstable patient. **B.** Delaying treatment for review is unsafe when adverse features are present. **C.** Unsynchronised shocks are for pulseless VT/VF; shocking a conscious patient with a pulse must be synchronised.

Key point: Unstable tachycardia with a pulse needs synchronised cardioversion, not drugs and delay.

Based on: ERC Guidelines 2021 and AHA Adult Tachycardia with a Pulse algorithm (ACLS)

16. Answer: D

A specific plan, access to the means, a chosen time and preparation (saving tablets, arranging for others to be absent) indicate imminent risk. These elements move a patient from ideation to intent and require immediate protective action.

Why the others are wrong: A. This is passive ideation without plan or intent, which needs assessment but is lower risk. **B.** A strong protective factor is described, so risk is lower. **C.** This describes self-harm used to cope, without suicidal intent.

Key point: A specific plan, available means and a set time signal high imminent risk.

Based on: Videbeck, Psychiatric-Mental Health Nursing, suicide chapter

17. Answer: B

Preschoolers use magical thinking and often believe that illness or procedures are punishment. The nurse should correct this misconception in short concrete terms, be honest about brief discomfort, and use play with real equipment. This reduces fear and supports cooperation.

Why the others are wrong: A. Detailed physiological explanation suits school-age children; a preschooler cannot process it and is likely to be more frightened. **C.** This is dishonest and destroys trust when he feels pain; honesty about brief discomfort is recommended. **D.** Preschoolers need a short, honest explanation just before the procedure; giving none increases fear and fantasies.

Key point: Preschoolers think magically; reassure that procedures are not punishment and use play with a doll or equipment.

Based on: Wong's Nursing Care of Infants and Children, 11th ed., chapters on cognitive development and preparation for procedures

18. Answer: A

Drops/min = (volume x drop factor) / time in minutes = (1000 x 20) / 600 = 33.3, rounded to 33 drops/min.

Why the others are wrong: B. 100 is the rate in mL/h, not drops per minute. **C.** This uses a 15 drops/mL set. **D.** This uses a 30 drops/mL set.

Key point: Convert hours to minutes and use the drop factor printed on the set.

Based on: Potter & Perry Fundamentals of Nursing, IV therapy chapter

19. Answer: D

Sensitivity = true positives ÷ all with disease = 170 ÷ (170 + 30) = 170 ÷ 200 = 85%. It describes how well the test finds people who have the disease.

Why the others are wrong: A. 95% is the specificity (760 ÷ 800), the ability to identify people without disease. **B.** 15% is the false-negative proportion (30 ÷ 200), the opposite of sensitivity. **C.** 81% is the positive predictive value (170 ÷ 210), which depends on prevalence.

Key point: Sensitivity = TP ÷ (TP + FN); specificity = TN ÷ (TN + FP).

Based on: Gordis Epidemiology, 6th ed., screening and test validity

20. Answer: C

Ventricular fibrillation and pulseless ventricular tachycardia are shockable. Early defibrillation with the shortest possible peri-shock pause gives the best chance of survival, so compressions continue during charging and restart immediately after the shock.

Why the others are wrong: A. Pausing during charging increases hands-off time and lowers the chance of a successful shock. **B.** In a shockable rhythm, defibrillation is the priority; drugs do not replace the shock. **D.** Compressions resume at once after the shock; the rhythm and pulse are reassessed after two minutes of CPR.

Key point: Minimise hands-off time: compress while charging, shock, restart compressions at once.

Based on: AHA 2025 Guidelines for CPR and ECC

21. Answer: A

Falls prevention targets the cause: he is getting up to void. Scheduled toileting, a low bed and an accessible call bell address the need and lessen the injury risk. Interventions should be individualised, and restraints or bed rails are not appropriate falls prevention measures.

Why the others are wrong: B. Full rails raise the height of a fall and he may climb over them; they do not meet his toileting need. **C.** Restraints increase agitation and injury and do not address the cause. **D.** Untreated pain causes restlessness and harms recovery; the dose should be reviewed, not withheld.

Key point: Prevent falls by meeting the patient's need (toileting, pain, mobility) rather than restricting movement.

Based on: WHO Step Safely: Strategies for preventing and managing falls (2007); Joint Commission/JCI National Patient Safety Goals; Potter & Perry Fundamentals of Nursing, safety chapter

22. Answer: A

Stable patients with predictable needs and routine tasks are suited to practical nurses. Unstable patients, new admissions needing assessment, and patients needing frequent judgement-based monitoring are assigned to the registered nurse.

Why the others are wrong: B. A recently post-procedure patient needs ongoing assessment for bleeding and arrhythmias by the registered nurse. **C.** Initial assessment and care planning are registered nurse responsibilities. **D.** A patient with new, unexplained changes is unstable and needs registered nurse assessment.

Key point: Match assignments to scope and competence: stable and predictable for the practical nurse, unstable or undiagnosed for the registered nurse.

Based on: Marquis & Huston, Leadership Roles and Management Functions in Nursing, 10th ed.

23. Answer: D

A boggy fundus is uterine atony, the leading cause of PPH. Firm massage with a hand cupped over the fundus stimulates contraction while uterotonics are arranged.

Why the others are wrong: A. A cold pack does not contract the uterus. **B.** Ambulation is unsafe during active bleeding. **C.** Temperature is not the priority during haemorrhage.

Key point: Boggy uterus and bleeding: massage the fundus first.

Based on: WHO recommendations on postpartum haemorrhage (2012); Williams Obstetrics, postpartum haemorrhage chapter

24. Answer: C

Dose = 18 units/kg/h x 70 kg = 1260 units/h. Concentration = 25 000 units / 500 mL = 50 units/mL. Rate = 1260 / 50 = 25.2 mL/h. Always check the calculation independently with a second nurse because heparin is a high-alert medicine.

Why the others are wrong: A. Halves the correct rate; this results from using 100 units/mL. **B.** 18.0 mL/h delivers only 900 units/h (about 12.9 units/kg/h); it comes from entering the dose figure as the pump rate. **D.** Doubles the correct rate; this results from using 25 units/mL.

Key point: Dose per hour divided by concentration per mL gives the pump rate.

Based on: Institute for Safe Medication Practices (ISMP) List of High-Alert Medications; Lewis's Medical-Surgical Nursing, 12th ed.

25. Answer: B

ECT is performed under brief general anaesthesia with a muscle relaxant, so preparation follows pre-anaesthetic principles: fasting, an empty bladder, removal of dentures and jewellery, and checking consent and prescribed medicine instructions.

Why the others are wrong: A. Food before general anaesthesia increases the risk of aspiration. **C.** Benzodiazepines raise the seizure threshold and can reduce seizure quality, so the prescriber decides whether they are held. **D.** A muscle relaxant is given with the anaesthetic, so restraints are not used.

Key point: Prepare for ECT as for anaesthesia: fasting, empty bladder and no dentures or jewellery.

Based on: Videbeck, Psychiatric-Mental Health Nursing; Royal College of Psychiatrists ECT Handbook

26. Answer: D

The findings classify him as having some dehydration (irritable, sunken eyes, thirsty, slow skin pinch). Working: 75 mL/kg × 9 kg = 675 mL over 4 hours, about 170 mL per hour, given in small frequent sips, then reassess.

Why the others are wrong: A. This uses 50 mL/kg, which is not the volume specified by the protocol. **B.** This uses 100 mL/kg, the Plan C IV volume for severe dehydration, which is too high for Plan B. **C.** This is only 25 mL/kg and would under-treat his deficit.

Key point: Some dehydration: WHO Plan B is 75 mL/kg ORS over 4 hours, then reassess.

Based on: WHO The Treatment of Diarrhoea: A Manual for Physicians and Other Senior Health Workers

27. Answer: C

Dose = 18 kg x 15 mg/kg = 270 mg. Volume = (270 / 120) x 5 mL = 11.25 mL, which rounds to 11.3 mL. This is within the usual paediatric single-dose limits.

Why the others are wrong: A. This uses 12 mg/kg (216 mg) instead of the ordered 15 mg/kg. **B.** This forgets to multiply by the 5 mL volume. **D.** This multiplies by 10 mL rather than 5 mL.

Key point: Calculate the mg dose from weight first, then the volume from the concentration.

Based on: BNF for Children, paracetamol monograph / Harriet Lane Handbook

28. Answer: C

Fever and respiratory symptoms with animal exposure to camels match the MERS-CoV case definition. Early masking and isolation at triage prevents spread to other patients and staff. The others do not fit the respiratory-exposure profile.

Why the others are wrong: A. Chronic cough without fever and exposure suggests a chronic cause, so this is lower risk. **B.** Gastroenteritis needs contact precautions but not a respiratory case definition. **D.** Possible deep vein thrombosis needs assessment but is not infectious.

Key point: Screen for fever, respiratory symptoms and exposure at triage, and isolate before assessment.

Based on: WHO Case Definition for MERS-CoV; WHO IPC for MERS-CoV

29. Answer: D

For non-shockable rhythms such as asystole and PEA, adrenaline 1 mg should be given as early as possible, followed by every 3 to 5 minutes, together with continuous high-quality CPR and treatment of reversible causes.

Why the others are wrong: A. Asystole is a non-shockable rhythm; a shock does not help and wastes time. **B.** Atropine is no longer recommended in asystole or pulseless electrical activity. **C.** Amiodarone is used for shock-refractory VF or pulseless VT, not asystole.

Key point: Non-shockable rhythm: CPR plus early adrenaline, no shock.

Based on: AHA 2025 Guidelines for CPR and ECC

30. Answer: B

Medication should not be given until the patient's identity is reliably verified. The nurse should check the theatre handover and notes with a second nurse as per policy, apply a new wristband with the correct identifiers, and then give the dose.

Why the others are wrong: A. Bed number is not a patient identifier and a mismatch of patients is possible. **C.** A drowsy patient may answer incorrectly, so self-report alone is unreliable. **D.** Giving the drug before identity is verified and banded defeats the purpose of identification.

Key point: No band, no drug: verify identity with a second person and re-band before giving medicines.

Based on: Joint Commission International Patient Safety Goal 1; WHO High 5s Patient Identification SOP

31. Answer: D

Confidentiality yields when there is serious risk to identifiable others, but disclosure must follow law and policy rather than individual decision. The nurse escalates to the physician, who counsels the patient and, if needed, makes any permitted or required report.

Why the others are wrong: A. Confidentiality is not absolute when a serious, foreseeable risk to others exists. **B.** Disclosing to an employer on the nurse's own initiative bypasses the physician and the lawful disclosure process. **C.** Nurses cannot make discharge conditional on a promise or detain a competent patient.

Key point: Confidentiality has limits for serious risk to others, but disclosure goes through the team and policy, not unilateral action.

Based on: ICN Code of Ethics for Nurses (2021); Beauchamp & Childress, Principles of Biomedical Ethics, 8th ed.

32. Answer: B

Oxytocin 10 IU IM is the uterotonic of choice for preventing postpartum haemorrhage. It is given within one minute of birth, once a second baby is excluded, followed by delayed cord clamping and controlled cord traction by a trained provider.

Why the others are wrong: A. Early cord clamping is not advised, and cord traction is done only after a uterotonic is given. **C.** Uterine massage is not a substitute for a uterotonic in prevention. **D.** Oxytocin should not wait for placental signs.

Key point: Give oxytocin 10 IU IM within one minute of birth to prevent postpartum haemorrhage.

Based on: WHO recommendations for the prevention and treatment of postpartum haemorrhage (2012, updated 2018)

33. Answer: A

A silent chest with drowsiness and hypoxia despite oxygen signals life-threatening asthma: airflow is so low that wheeze disappears. She needs immediate senior or critical care help while bronchodilator and oxygen continue.

Why the others are wrong: B. Loss of wheeze here means minimal airflow, not improvement. **C.** Lying flat worsens breathing; she needs upright positioning and urgent help. **D.** Delaying escalation for an hour is unsafe in life-threatening asthma.

Key point: A silent chest in a severe asthmatic is an ominous sign; escalate immediately.

Based on: GINA Global Strategy for Asthma Management and Prevention, 2024; BTS/NICE/SIGN Asthma Guideline, 2024

34. Answer: C

Maintenance lithium levels are usually 0.4 to 1.0 mmol/L, with 0.6 to 0.8 mmol/L the common target, measured about 12 hours after the last dose. Levels above about 1.5 mmol/L are associated with toxicity.

Why the others are wrong: A. This level is subtherapeutic. **B.** This level is above the therapeutic range and may be associated with toxicity. **D.** This level is in the range of serious toxicity.

Key point: Maintenance lithium range is about 0.6 to 0.8 mmol/L taken 12 hours after the dose.

Based on: NICE CG185 Bipolar disorder; Maudsley Prescribing Guidelines in Psychiatry

35. Answer: A

Small volumes directed along the inside of the cheek with the infant held semi-upright allow the infant to swallow safely and reduce choking. Using a syringe also ensures an accurate dose, and the infant should be praised and comforted afterwards.

Why the others are wrong: B. The infant may not finish the feed and so receive an incomplete dose. **C.** Lying flat and squirting to the back of the throat increases the risk of aspiration and choking. **D.** This risks aspiration and distress and is not an acceptable technique.

Key point: Give oral liquids slowly into the cheek pocket with the infant semi-upright; never mix a whole dose in a full feed.

Based on: Wong's Nursing Care of Infants and Children, 11th ed., administration of medication

36. Answer: B

Concentration = 25,000 / 500 = 50 units/mL. Rate = 1,200 units/h / 50 units/mL = 24 mL/h.

Why the others are wrong: A. This assumes 100 units/mL instead of 50 units/mL. **C.** This is a decimal error. **D.** This assumes 25 units/mL.

Key point: Work out units per mL first, then divide the hourly dose by it.

Based on: ISMP high-alert medication guidance / Gahart's Intravenous Medications

37. Answer: B

Central shelves keep the most stable 2 to 8 °C range. Boxes should be spaced for circulation, and no food, drink or specimens should be stored in the same unit.

Why the others are wrong: A. The door has the greatest temperature variation each time it opens. **C.** The back wall and bottom can be too cold or hold moisture, and packing against walls blocks air flow. **D.** Proximity to the freezer compartment risks freezing.

Key point: Store vaccines centrally, spaced apart, never in the door or near the freezer.

Based on: WHO Vaccine Management Handbook; CDC Vaccine Storage and Handling Toolkit

38. Answer: B

Amiodarone 300 mg is the first-line antiarrhythmic for VF or pulseless VT that persists after defibrillation, followed by 150 mg if needed. Lidocaine is an accepted alternative if amiodarone is unavailable.

Why the others are wrong: A. Adenosine treats supraventricular tachycardia with a pulse, not VF. **C.** Atropine is for symptomatic bradycardia, not VF. **D.** Calcium is not given routinely in arrest; it is reserved for specific causes such as hyperkalaemia.

Key point: Refractory VF/pVT: amiodarone 300 mg, then 150 mg.

Based on: AHA 2025 Guidelines for CPR and ECC

39. Answer: B

Floating the heels removes pressure completely, with the knee slightly flexed to avoid popliteal vein pressure. It is the recommended technique for preventing and treating heel pressure injury.

Why the others are wrong: A. Ring cushions concentrate pressure on surrounding tissue and reduce blood flow. **C.** Massage of reddened skin can damage already compromised capillaries and is not recommended. **D.** A tight bandage adds pressure and can reduce circulation.

Key point: Offload the heels by floating them, not by ring cushions or massage.

Based on: NPIAP/EPUAP/PPPIA International Guideline: Prevention and Treatment of Pressure Ulcers/Injuries (2019)

40. Answer: C

Nurses are accountable for working within their competence. They should communicate limits, accept appropriate assignments, and request orientation or supervision for others.

Why the others are wrong: A. Accepting beyond competence endangers patients and breaches professional standards. **B.** Refusing all work is unnecessary when appropriate tasks can be assigned. **D.** Asking for help after the fact is too late for unsafe acts.

Key point: Work within your competence and speak up before accepting an unsafe assignment.

Based on: ICN Code of Ethics for Nurses (2021); Marquis & Huston, Leadership Roles and Management Functions in Nursing, 10th ed.

41. Answer: C

One missed combined pill (less than 48 hours late) needs no extra precautions as long as the pill is taken as soon as remembered and the rest are taken on time.

Why the others are wrong: A. Skipping a pill without taking the missed tablet reduces protection. **B.** Stopping the pack is unnecessary and creates a gap. **D.** Condoms for 7 days are needed only when two or more pills are missed, and doubling future doses is not a recommended regimen.

Key point: One missed pill: take it now and continue; extra protection is for two or more.

Based on: FSRH Combined Hormonal Contraception guideline (2019, amended 2023); WHO Family Planning Handbook

42. Answer: A

Raised PaCO2 with a pH on the acid side of 7.40 indicates a primary respiratory acidosis. The raised bicarbonate shows renal compensation over days, bringing the pH back to the low-normal range, so it is chronic and fully compensated.

Why the others are wrong: B. PaCO2 and HCO3 are both markedly abnormal; only the pH has normalised through compensation. **C.** If acute and uncompensated, the pH would be low and the bicarbonate near normal. **D.** pH below 7.40 points to an acid primary problem; high bicarbonate is the compensation, not the cause.

Key point: Compare the pH with 7.40 to decide the primary disorder; the opposite change is compensation.

Based on: Lewis's Medical-Surgical Nursing, 12th ed., acid-base imbalances

43. Answer: C

Ataxia, confusion and ophthalmoplegia suggest Wernicke encephalopathy. Glucose metabolism depends on thiamine, so thiamine must be given first or with glucose to avoid precipitating or worsening the condition.

Why the others are wrong: A. Glucose given before thiamine can worsen Wernicke encephalopathy by consuming remaining thiamine. **B.** Folic acid does not treat the suspected condition and should not delay thiamine. **D.** Delay and oral administration risk irreversible brain injury; high-dose parenteral thiamine is required.

Key point: Give IV thiamine before or with glucose in alcohol-dependent, malnourished patients.

Based on: NICE CG100 Alcohol-use disorders: physical complications; EFNS guidelines for diagnosis, therapy and prevention of Wernicke encephalopathy (Galvin et al., 2010)

44. Answer: B

Immunisation schedules do not restart after a delay. Previous valid doses count, the missed dose is given as soon as possible, and later doses follow at the minimum intervals.

Why the others are wrong: A. Extending the interval does not reduce the effect of earlier doses. **C.** Valid earlier doses are never discarded because of a delay. **D.** One dose of a multi-dose series does not give full or lasting protection.

Key point: Never restart a vaccine series because of a delay; continue from where it stopped.

Based on: WHO Immunization in Practice; CDC catch-up immunization principles

45. Answer: A

Methotrexate for rheumatoid arthritis is given once weekly. Daily administration has caused fatal bone marrow suppression, so the nurse must stop and clarify.

Why the others are wrong: B. Daily dosing can cause fatal toxicity even at small doses. **C.** Altering the dose without prescriber clarification is outside nursing practice. **D.** Folic acid does not make daily dosing safe.

Key point: Query any daily methotrexate order for non-cancer use.

Based on: ISMP high-alert medications list / BNF methotrexate monograph

46. Answer: D

Preparedness covers planning, training, drills and stockpiling before an event. Response happens during and immediately after, and recovery follows.

Why the others are wrong: A. Treating casualties belongs to the response phase. **B.** Rebuilding is part of the recovery phase. **C.** Counselling survivors belongs to recovery.

Key point: Preparedness is what you do before the event.

Based on: WHO Health Emergency and Disaster Risk Management Framework (2019); ICN Core Competencies in Disaster Nursing v2.0

47. Answer: A

Intramuscular adrenaline 0.5 mg (0.5 mL of 1 mg/mL) in the adult mid-outer thigh is the first-line treatment and should not be delayed. Antihistamines and corticosteroids are adjuncts only.

Why the others are wrong: B. Antihistamines treat skin symptoms but do not reverse airway obstruction or shock. **C.** Corticosteroids act too slowly to treat acute anaphylaxis. **D.** Salbutamol treats bronchospasm only and does not address airway oedema or hypotension.

Key point: Anaphylaxis: IM adrenaline first, in the mid-thigh.

Based on: World Allergy Organization Anaphylaxis Guidance 2020; Resuscitation Council UK anaphylaxis guideline

48. Answer: D

Manual lifting of dependent patients causes musculoskeletal injury to staff and shear to the patient. Slide sheets, hoists and enough staff make the move safe, and the assessment guides the equipment.

Why the others are wrong: A. Even with good posture, manually lifting a dependent patient risks staff injury, and lifting under the arms can injure the patient's shoulders. **B.** Relatives are not trained in safe handling, and a draw-sheet lift still means manually lifting the patient's weight. **C.** The patient cannot assist, so the nurse would end up taking the weight.

Key point: Use equipment and a handling plan instead of lifting dependent patients.

Based on: WHO Patient Safety Curriculum Guide; Potter & Perry, Fundamentals of Nursing, 10th ed., safe patient handling

49. Answer: C

Physiological needs such as pain relief, oxygen, food and fluid must be met before higher needs. Pain relief also allows the patient to take part in discussing her concerns later.

Why the others are wrong: A. Safety and security needs are higher than physiological needs, so they follow. **B.** Belonging needs are higher in the hierarchy. **D.** Self-esteem is a higher-level need.

Key point: Meet physiological needs first, then safety, belonging, esteem and self-actualisation.

Based on: Maslow's hierarchy of needs as applied in Potter & Perry, Fundamentals of Nursing

50. Answer: D

Classic signs of placental separation are a small gush of blood, lengthening of the cord at the vulva, and the fundus becoming firm, rounded and rising in the abdomen as the placenta enters the lower segment.

Why the others are wrong: A. After separation the fundus becomes firm and globular and rises; a soft, flat uterus suggests atony. **B.** Sudden severe pain with collapse suggests uterine inversion or rupture, not separation. **C.** The cord lengthens as the placenta descends; it does not retract.

Key point: Placenta separated: cord lengthens, gush of blood, uterus firm and globular.

Based on: Myles Textbook for Midwives, third stage of labour; WHO recommendations on postpartum haemorrhage (2012)

51. Answer: C

Insulin must continue until ketones clear and acidosis resolves, even though glucose is falling. When glucose falls below about 14 mmol/L, a glucose infusion (10% in UK JBDS guidance, 5% in the ADA consensus) is added alongside the sodium chloride so that insulin can keep suppressing ketone production without causing hypoglycaemia.

Why the others are wrong: A. Stopping insulin allows ketosis to continue. **B.** Subcutaneous insulin is for after ketones have resolved and the patient is eating. **D.** Isotonic fluid is continued to maintain circulation.

Key point: In DKA, continue insulin and add glucose when glucose falls below 14 mmol/L.

Based on: JBDS-IP Management of DKA in Adults 2023; ADA/EASD/JBDS/AACE consensus report on hyperglycaemic crises in adults 2024

52. Answer: D

Supervision during and after meals prevents food avoidance, hiding food and purging while providing support. The nurse stays matter-of-fact and neutral and avoids bargaining about food.

Why the others are wrong: A. Eating alone allows hiding, discarding food and later purging. **B.** Negotiating meals reinforces control over food; the plan should be consistent. **C.** Discussing weight and shape during meals increases anxiety and focuses on the illness.

Key point: Supervise meals and the period afterwards calmly and consistently.

Based on: NICE NG69 Eating disorders; Videbeck, Psychiatric-Mental Health Nursing

53. Answer: C

Weight loss = 8.0 - 7.2 = 0.8 kg. Percentage dehydration = loss divided by pre-illness weight: 0.8 / 8.0 x 100 = 10%. A deficit of about 10% (about 100 mL/kg) is at the severe end of dehydration and needs urgent clinical assessment.

Why the others are wrong: A. 8% results from using the loss in kilograms as a percentage. **B.** 11% results from dividing by the current weight (0.8 / 7.2) instead of the pre-illness weight. **D.** 1% is a decimal-place error.

Key point: Percentage dehydration = (pre-illness weight - current weight) / pre-illness weight x 100.

Based on: WHO Pocket Book of Hospital Care for Children, 2nd ed., dehydration; Nelson Textbook of Pediatrics

54. Answer: B

Tinnitus suggests ototoxicity and low urine output suggests nephrotoxicity, both serious dose-related adverse effects of gentamicin requiring review of the dose and drug levels.

Why the others are wrong: A. Mild nausea is common and not specific to aminoglycoside toxicity. **C.** A minor site reaction needs monitoring but is not urgent here. **D.** This suggests a response to treatment.

Key point: Monitor renal function, hearing and drug levels with aminoglycosides.

Based on: BNF gentamicin monograph / Lewis Medical-Surgical Nursing

55. Answer: C

Accurate readings need rest, a supported back, the arm at heart level and no caffeine, smoking or exercise within 30 minutes. Two readings a minute apart are usually recorded.

Why the others are wrong: A. Exertion raises the reading. **B.** The arm should be supported at heart level; hanging gives a falsely high reading. **D.** Caffeine raises blood pressure for 30 minutes or more.

Key point: Rest 5 minutes, back supported, arm at heart level, no caffeine beforehand.

Based on: ESH 2023 Guidelines for the Management of Arterial Hypertension; WHO Hypertension Guideline (2021)

56. Answer: A

Opioid toxicity kills through hypoventilation. Oxygenation and ventilation come first; naloxone is then titrated in small doses to restore adequate breathing rather than full consciousness. Transdermal patches should be removed.

Why the others are wrong: B. Gastric lavage is not indicated and risks aspiration in an unprotected airway. **C.** Flumazenil is a benzodiazepine antagonist and can precipitate seizures. **D.** Hypoxia must be corrected first; large bolus doses can cause severe withdrawal and pulmonary oedema.

Key point: Opioid poisoning: ventilate first, then titrate naloxone.

Based on: AHA 2025 Guidelines for CPR and ECC (opioid-associated emergencies)

57. Answer: B

Granulation tissue is made of new capillaries and connective tissue and appears beefy red, moist and granular. It fills the wound from the base up.

Why the others are wrong: A. This is slough, a sign of devitalised tissue that needs removal. **C.** This indicates likely infection. **D.** This is eschar, dead tissue that delays healing.

Key point: Healthy granulation tissue is moist, red and bumpy.

Based on: Wound, Ostomy and Continence Nurses Society wound care guidance; Potter & Perry, Fundamentals of Nursing, 10th ed.

58. Answer: A

Sensitive health information should be shared only with those who need it and in settings where it cannot be overheard. A private room is the safest option.

Why the others are wrong: B. Others may overhear in the corridor. **C.** Visitors could overhear the information. **D.** Public places are unsuitable for any identifiable patient information.

Key point: Discuss patient information only in private and with those who need to know.

Based on: International Council of Nurses, Code of Ethics for Nurses (2021)

59. Answer: D

Obesity (body mass index above 30 kg/m²) and a previous macrosomic baby (4.5 kg or more) are major risk factors for gestational diabetes, so she is the priority for early testing. A previous miscarriage, a vegetarian diet and a body mass index of 22 to 26 kg/m² without other risk factors do not place a woman in the high-risk group.

Why the others are wrong: A. A normal body mass index in a first pregnancy carries no major risk factor. **B.** A previous miscarriage does not raise the risk of gestational diabetes. **C.** A body mass index of 26 kg/m² with no other risk factor and a vegetarian diet carry much lower risk than option D.

Key point: Previous macrosomia and obesity prompt early screening for gestational diabetes.

Based on: NICE guideline NG3: Diabetes in pregnancy (2015, updated 2020); ADA Standards of Care in Diabetes, Management of diabetes in pregnancy (2026)

60. Answer: C

Abrupt withdrawal of a beta-blocker can cause rebound tachycardia, hypertension and angina or MI because of receptor up-regulation. Hypertension is often symptom-free, so the patient must continue treatment and any change should be tapered by the prescriber.

Why the others are wrong: A. A resting pulse of 70 to 80 is normal on a beta-blocker; the threshold for contacting the team is much lower (about 50 to 60), and stopping is not the patient's decision. **B.** Intermittent use gives unstable BP control and repeated withdrawal effects. **D.** Self-adjusting the dose risks bradycardia and hypotension.

Key point: Never stop a beta-blocker suddenly: rebound tachycardia, hypertension and angina can follow.

Based on: Lewis Medical-Surgical Nursing, 12th ed., hypertension drug therapy

61. Answer: C

Therapeutic silence gives the patient time to gather thoughts and feel accepted. Staying present shows respect and lets her lead when she is ready.

Why the others are wrong: A. Changing the subject interrupts her processing and signals discomfort with her feelings. **B.** Telling her not to feel sad dismisses her emotions and is non-therapeutic. **D.** Leaving for an hour abandons a distressed patient who needs presence.

Key point: Comfortable silence with the nurse present is a therapeutic communication technique.

Based on: Stuart, Principles and Practice of Psychiatric Nursing, 11th ed., therapeutic communication chapter

62. Answer: A

In hypernatraemia, brain cells adapt by increasing their solute content. If plasma sodium falls too fast, water is drawn into the cells, leading to cerebral oedema, seizures and possible death. Slow, controlled correction avoids this.

Why the others are wrong: B. Potassium is not the concern in this correction rate. **C.** Renal excretion is not the limiting factor; brain osmotic shifts are. **D.** Heart failure is not a universal risk and is not the reason for the slow rate.

Key point: Correct hypernatraemia slowly to avoid cerebral oedema.

Based on: Nelson Textbook of Pediatrics, hypernatraemic dehydration; APLS: The Pediatric Emergency Medicine Course

63. Answer: C

Opioid-induced respiratory depression is life-threatening. Stimulate, support airway and breathing, call for help and give naloxone titrated to restore breathing.

Why the others are wrong: A. This delays treatment of respiratory depression. **B.** Oxygen alone does not reverse hypoventilation. **D.** Flumazenil reverses benzodiazepines, not opioids.

Key point: Reversal is by naloxone titrated in small doses, with continuous monitoring.

Based on: Lewis Medical-Surgical Nursing / ISMP opioid safety guidance

64. Answer: B

The incubation period of MERS-CoV is up to 14 days, so contacts are monitored for 14 days after the last unprotected exposure and must report symptoms promptly to occupational health or infection control.

Why the others are wrong: A. The incubation period can be up to 14 days. **C.** This is shorter than the incubation period. **D.** This exceeds the recommended period of 14 days.

Key point: MERS-CoV contacts are monitored for 14 days after last exposure.

Based on: WHO MERS-CoV infection prevention and control guidance

65. Answer: B

Dark urine with very high creatine kinase indicates rhabdomyolysis. Early high-volume isotonic fluids maintain urine output and protect the kidneys; potassium, calcium and renal function are monitored closely.

Why the others are wrong: A. Rhabdomyolysis needs aggressive fluids to prevent pigment-induced kidney injury. **C.** NSAIDs are nephrotoxic and should be avoided in rhabdomyolysis. **D.** Potassium is released from damaged muscle; hyperkalaemia is the risk.

Key point: Rhabdomyolysis: fluids, avoid nephrotoxins, monitor potassium.

Based on: Wilderness Medical Society Clinical Practice Guidelines: Heat Illness; KDIGO AKI guideline

66. Answer: D

Documentation should be factual, objective, timed and include the patient's own words, observations and the actions taken. It should avoid opinion, labels and blame.

Why the others are wrong: A. This is subjective, judgemental, and does not include assessment. **B.** This is an assumption not based on assessment. **C.** Blame and speculation do not belong in the record; incident reporting is separate.

Key point: Chart facts, observations and actions, not opinions.

Based on: Potter & Perry, Fundamentals of Nursing, 10th ed., documentation; JCI Accreditation Standards for Hospitals, management of information

67. Answer: B

Patient safety comes first: check the glucose, monitor for hypoglycaemia and obtain medical orders. Then disclose the error honestly and complete an incident report with facts only.

Why the others are wrong: A. The report is required but follows the patient's care. **C.** Disclosure is required, but treatment comes first and is led with the team. **D.** Altering the record is inappropriate; any correction must be a transparent addendum after care.

Key point: Care for the patient first, then report and disclose honestly.

Based on: WHO Patient Safety Curriculum Guide (2011), reporting and learning

68. Answer: C

The first hour after birth is the period of highest risk for postpartum haemorrhage. Frequent checks of uterine tone, bleeding and vital signs at about 15-minute intervals detect early haemorrhage, with later intervals extended if stable.

Why the others are wrong: A. Two-hour gaps would miss rapid blood loss. **B.** Four-hourly checks suit later postnatal care, not the first hour. **D.** A single check does not detect developing bleeding.

Key point: Monitor the mother every 15 minutes in the first hour after birth.

Based on: WHO recommendations on prevention and treatment of postpartum haemorrhage (2012); Myles Textbook for Midwives, 17th ed.

69. Answer: C

A platelet fall of more than 50% between days 5 and 10 of heparin, with skin necrosis, strongly suggests HIT, a prothrombotic immune reaction. All heparin including flushes and LMWH must be stopped and a non-heparin anticoagulant started on medical order.

Why the others are wrong: A. Continuing heparin in suspected HIT greatly increases the risk of arterial and venous thrombosis. **B.** Reducing the dose still exposes the patient to heparin and the immune reaction continues. **D.** Low molecular weight heparin cross-reacts and is also contraindicated in HIT.

Key point: Platelets falling after 5 to 10 days of heparin: suspect HIT, stop all heparin and escalate.

Based on: ASH 2018 Guidelines for Heparin-Induced Thrombocytopenia

70. Answer: B

Lithium is handled by the kidney like sodium. Low sodium or dehydration makes the kidney retain lithium, raising levels toward toxicity. Intake should remain consistent.

Why the others are wrong: A. Salt restriction raises lithium levels. **C.** Fluid restriction risks dehydration and toxicity. **D.** Patients must not self-adjust doses; with heavy sweating they should drink more fluid and tell the team.

Key point: Keep sodium and fluids steady while on lithium.

Based on: Stahl's Essential Psychopharmacology; Videbeck, Psychiatric-Mental Health Nursing, 9th ed.

71. Answer: A

Symmetrical, sharply demarcated burns with spared flexed areas indicate forced immersion in hot water and are not consistent with accidental splashes. The nurse should report the concern to the child protection team.

Why the others are wrong: B. Splash burns on the upper body match a plausible accident history. **C.** Palm burns from a hot door match a plausible mechanism. **D.** Sunburn is explained by exposure and is a neglect issue at most.

Key point: Symmetrical immersion-type burns with clear borders are red flags for abuse.

Based on: WHO Preventing Child Maltreatment guide; RCPCH child protection evidence review on burns

72. Answer: C

Acetylcysteine replenishes glutathione and prevents hepatotoxicity in paracetamol overdose, and is most effective when given early.

Why the others are wrong: A. Naloxone reverses opioids. **B.** Flumazenil reverses benzodiazepines. **D.** Protamine reverses heparin.

Key point: Paracetamol overdose: acetylcysteine.

Based on: Lewis Medical-Surgical Nursing / BNF paracetamol poisoning guidance

73. Answer: C

In START, perfusion is checked after respiratory rate. Capillary refill over 2 seconds or absent radial pulse indicates shock and places the patient in the immediate category.

Why the others are wrong: A. Delayed is for patients with normal perfusion and mental status. **B.** Green applies to patients able to walk. **D.** The patient is breathing, so expectant does not apply.

Key point: START: breathing, perfusion, mental status; delayed refill means immediate.

Based on: START Triage (Newport Beach); WHO mass casualty management

74. Answer: D

Pelvic fractures can bleed many litres. A binder or sheet placed at the level of the greater trochanters reduces pelvic volume and tamponades venous bleeding. Examination by manipulation of the pelvis is avoided because it can disturb clots.

Why the others are wrong: A. Springing or rocking the pelvis can dislodge clots and worsen bleeding. **B.** A binder placed too high does not close the pelvic ring and is less effective. **C.** Repeated movement can worsen bleeding; a single controlled log roll is done only when necessary.

Key point: Pelvic binder at the greater trochanters; do not spring the pelvis.

Based on: ATLS 10th ed., ACS Committee on Trauma

75. Answer: A

Cylinders must be secured upright in a holder or trolley to prevent falling, valve damage and sudden gas release. The nurse should also check there is enough content for the journey.

Why the others are wrong: B. A loose cylinder can roll, fall or be knocked, and may injure the patient. **C.** The regulator is not designed to bear the weight and the pole may become unstable. **D.** Hand carrying risks dropping the cylinder, and valve damage can cause a violent gas release.

Key point: Always secure oxygen cylinders upright in a holder; never leave them loose or carry them by the regulator.

Based on: BTS Guideline for Oxygen Use in Adults (2017); WHO Oxygen Therapy for Children manual

76. Answer: D

PICO stands for Population, Intervention, Comparison and Outcome. The comparison is the alternative to the intervention, here the standard soap and water bath.

Why the others are wrong: A. This is the population. **B.** This is the intervention. **C.** This is the outcome.

Key point: PICO: Population, Intervention, Comparison, Outcome.

Based on: Melnyk & Fineout-Overholt, Evidence-Based Practice in Nursing & Healthcare, 4th ed.

77. Answer: B

Rh-negative women with an ectopic pregnancy can be sensitised by fetal cells entering the maternal blood during bleeding or surgery. Anti-D is given within 72 hours of the sensitising event.

Why the others are wrong: A. A non-viable pregnancy can still sensitise. **C.** Rupture is not required; surgery and bleeding can sensitise. **D.** Waiting for a future pregnancy leaves the risk of sensitisation unaddressed.

Key point: Rh-negative women need anti-D after ectopic pregnancy.

Based on: NICE guideline NG126: Ectopic pregnancy and miscarriage (2019, updated 2023); RCOG Green-top Guideline 21 (2016)

78. Answer: D

Most serious reactions, such as ABO incompatibility, occur early. Starting slowly with close observation limits harm if a reaction occurs. Each unit should be completed within 4 hours of leaving controlled storage.

Why the others are wrong: A. Running it fast removes the chance to recognise an early reaction; the 4 hour limit does not require 1 hour. **B.** Reactions can start within minutes, so interval observations during the transfusion are essential. **C.** Glucose causes red cell clumping and haemolysis; only 0.9% sodium chloride is used.

Key point: Start the transfusion slowly and observe closely for the first 15 minutes.

Based on: BSH Guideline on the Administration of Blood Components / WHO Clinical Transfusion Practice

79. Answer: D

Nicotine replacement with behavioural support improves quit success and manages withdrawal in hospitalised patients.

Why the others are wrong: A. Admission is a good opportunity to quit with support; delaying misses it. **B.** Using smoking as a reward reinforces dependence and undermines quitting. **C.** Unsupported abrupt cessation has lower success.

Key point: Combine nicotine replacement with counselling.

Based on: WHO Clinical treatment guideline for tobacco cessation in adults (2024)

80. Answer: C

Locking up medicines and chemicals in original labelled containers is the most effective prevention. Child-resistant caps slow but do not stop children.

Why the others are wrong: A. Caps are not child-proof and a low drawer is accessible. **B.** Ipecac is no longer recommended and can cause harm. **D.** Calling medicine sweets encourages children to take it.

Key point: Lock away medicines and chemicals; know the poison centre number.

Based on: Hockenberry & Wilson, Wong's Essentials of Pediatric Nursing, 11th ed.

81. Answer: C

Stopping the infusion limits further tissue injury. The cannula is left in place briefly so residual drug can be aspirated before removal, and the prescriber is notified so the antidote (phentolamine, infiltrated subcutaneously around the site) can be given per protocol.

Why the others are wrong: A. Flushing pushes more drug into the tissue. **B.** Removing the cannula first loses the chance to aspirate residual drug from the tissue. **D.** Continuing the infusion worsens tissue damage.

Key point: On suspected extravasation: stop, aspirate, do not flush.

Based on: Infusion Nurses Society, Infusion Therapy Standards of Practice (2024)

82. Answer: D

225 / 500 = 45%, which is in the red zone. Red zone indicates severe airway narrowing and needs reliever and urgent help.

Why the others are wrong: A. This is too slow for red-zone readings. **B.** Delay is unsafe. **C.** Red-zone readings need action now.

Key point: Calculate peak flow as a percentage of personal best.

Based on: GINA Global Strategy for Asthma Management and Prevention

83. Answer: A

The nurse stays with the patient, starts oxygen per protocol titrated to the target saturation, attaches monitoring and prepares an SBAR with the latest observations, medicines, results, allergies and resuscitation status.

Why the others are wrong: B. Leaving a deteriorating patient is unsafe. **C.** Transferring an unstable patient is risky and should follow stabilisation. **D.** Oxygen can be started as an emergency intervention under protocols.

Key point: Stay, support and prepare SBAR information.

Based on: Australian Commission on Safety and Quality in Health Care, Recognising and Responding to Acute Deterioration; British Thoracic Society Oxygen Guideline 2017

84. Answer: B

Active bleeding with haemodynamic changes is an emergency, and continuing suction will increase blood loss. The device is stopped, the dressing is left in place and pressure applied while urgent help is summoned.

Why the others are wrong: A. Restarting suction, even at a lower pressure, can worsen haemorrhage. **C.** Removing the dressing in the ward can increase bleeding and delay the emergency response. **D.** A delay until the next round is unsafe for a patient showing signs of shock.

Key point: Stop negative pressure therapy at once for brisk bleeding and call for urgent help.

Based on: FDA Safety Communication on NPWT (2011); manufacturer instructions for use

85. Answer: D

Patients have the right to be free from unnecessary restraint. The nurse assesses causes such as pain, hypoxia, infection or a full bladder, and uses the least restrictive alternatives first.

Why the others are wrong: A. Restraint is a last resort and requires an order and assessment. **B.** This is unsafe, unreliable and may be unsuitable for the family. **C.** Stopping prescribed therapy needs the doctor's decision.

Key point: Use the least restrictive measure and treat the cause of confusion.

Based on: Joint Commission International Accreditation Standards, Patient and Family Rights

86. Answer: D

Sudden bleeding at membrane rupture with fetal bradycardia and a stable mother suggests ruptured vasa praevia, in which fetal vessels bleed. The fetus loses blood rapidly, so immediate delivery is required.

Why the others are wrong: A. Examination wastes time and may disrupt vessels further. **B.** Observation allows fetal exsanguination. **C.** Continuing labour risks fetal death.

Key point: Bleeding at rupture with fetal bradycardia: suspect vasa praevia and deliver immediately.

Based on: RCOG Green-top Guideline 27b: Placenta praevia, placenta accreta and vasa praevia (2018)

87. Answer: B

Rising end-tidal CO2 with tachycardia, masseter rigidity and fever suggests malignant hyperthermia, a hypermetabolic crisis triggered by volatile agents and suxamethonium. Dantrolene stops the calcium release.

Why the others are wrong: A. Cooling helps later, but the trigger must be stopped and dantrolene given first. **C.** Deepening the volatile agent worsens the crisis because the agent is the trigger. **D.** Neostigmine does not treat this condition and can cause bradycardia.

Key point: Malignant hyperthermia: stop triggers, 100% oxygen, dantrolene, then cool.

Based on: MHAUS Emergency Therapy / AAGBI Malignant Hyperthermia Guideline

88. Answer: C

Acute fluctuating confusion is delirium, a medical emergency with an underlying cause, here probably a urinary tract infection. Prompt medical assessment is required.

Why the others are wrong: A. Dementia progresses over months to years, not hours. **B.** Sedation masks the cause and can worsen delirium. **D.** Observation alone delays treatment.

Key point: Sudden change in cognition in an older adult is delirium until proven otherwise.

Based on: NICE CG103 Delirium; Lewis, Medical-Surgical Nursing, 12th ed.

89. Answer: A

Aspirin in viral illnesses like influenza or varicella is linked with Reye syndrome, a serious liver and brain disease.

Why the others are wrong: B. Food does not remove the risk. **C.** Reduced dose does not remove the risk. **D.** Aspirin should not be used as a second option.

Key point: Avoid aspirin for children with viral illness.

Based on: WHO and AAP guidance on Reye syndrome

90. Answer: B

NSAIDs inhibit gastric prostaglandins and platelet function, so they are contraindicated in active peptic ulcer and gastrointestinal bleeding.

Why the others are wrong: A. A tension headache is a standard indication. **C.** Musculoskeletal pain is a standard indication. **D.** Dental pain is a standard indication.

Key point: Avoid NSAIDs in active GI bleeding.

Based on: BNF ibuprofen monograph / Lewis Medical-Surgical Nursing

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