

# NMNC 3110 Introduction to Nursing Concepts Exam 1 Practice (Sample)

## Study Guide



**Everything you need from our exam experts!**

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# Introduction

Preparing for a certification exam can feel overwhelming, but with the right tools, it becomes an opportunity to build confidence, sharpen your skills, and move one step closer to your goals. At Examzify, we believe that effective exam preparation isn't just about memorization, it's about understanding the material, identifying knowledge gaps, and building the test-taking strategies that lead to success.

This guide was designed to help you do exactly that.

Whether you're preparing for a licensing exam, professional certification, or entry-level qualification, this book offers structured practice to reinforce key concepts. You'll find a wide range of multiple-choice questions, each followed by clear explanations to help you understand not just the right answer, but why it's correct.

The content in this guide is based on real-world exam objectives and aligned with the types of questions and topics commonly found on official tests. It's ideal for learners who want to:

- Practice answering questions under realistic conditions,
- Improve accuracy and speed,
- Review explanations to strengthen weak areas, and
- Approach the exam with greater confidence.

We recommend using this book not as a stand-alone study tool, but alongside other resources like flashcards, textbooks, or hands-on training. For best results, we recommend working through each question, reflecting on the explanation provided, and revisiting the topics that challenge you most.

**Remember:** successful test preparation isn't about getting every question right the first time, it's about learning from your mistakes and improving over time. Stay focused, trust the process, and know that every page you turn brings you closer to success.

Let's begin.

# How to Use This Guide

**This guide is designed to help you study more effectively and approach your exam with confidence. Whether you're reviewing for the first time or doing a final refresh, here's how to get the most out of your Examzify study guide:**

## **1. Start with a Diagnostic Review**

**Skim through the questions to get a sense of what you know and what you need to focus on. Your goal is to identify knowledge gaps early.**

## **2. Study in Short, Focused Sessions**

**Break your study time into manageable blocks (e.g. 30 - 45 minutes). Review a handful of questions, reflect on the explanations.**

## **3. Learn from the Explanations**

**After answering a question, always read the explanation, even if you got it right. It reinforces key points, corrects misunderstandings, and teaches subtle distinctions between similar answers.**

## **4. Track Your Progress**

**Use bookmarks or notes (if reading digitally) to mark difficult questions. Revisit these regularly and track improvements over time.**

## **5. Simulate the Real Exam**

**Once you're comfortable, try taking a full set of questions without pausing. Set a timer and simulate test-day conditions to build confidence and time management skills.**

## **6. Repeat and Review**

**Don't just study once, repetition builds retention. Re-attempt questions after a few days and revisit explanations to reinforce learning. Pair this guide with other Examzify tools like flashcards, and digital practice tests to strengthen your preparation across formats.**

**There's no single right way to study, but consistent, thoughtful effort always wins. Use this guide flexibly, adapt the tips above to fit your pace and learning style. You've got this!**

## Questions

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- 1. Clinical reasoning is described as what?**
  - A. The thinking process by which a nurse reaches a clinical judgement**
  - B. The process of obtaining informed consent**
  - C. The act of performing clinical procedures**
  - D. The documentation of clinical data**
  
- 2. Which nurse is associated with founding the American Red Cross?**
  - A. Clara Barton**
  - B. Florence Nightingale**
  - C. Lillian Wald**
  - D. Mary Nutting**
  
- 3. Data for Nursing Assessment come from which sources?**
  - A. Primary sources only**
  - B. Secondary sources only**
  - C. Both primary and secondary sources**
  - D. Only family members**
  
- 4. Which concept explicitly includes the possibility to improvise new approaches based on patient response?**
  - A. Autonomy**
  - B. Clinical decision making**
  - C. Clinical judgement**
  - D. Reflection**
  
- 5. Which description best defines a comprehensive assessment?**
  - A. Focused on a single problem**
  - B. A broad, all-inclusive appraisal of the patient**
  - C. Only regarding chief complaint**
  - D. Only gathering demographic data**

- 6. In the scenario where a patient undergoing abdominal radiation has liquid stool and clean, intact skin, the error in the selected nursing diagnosis is best described as which of the following?**
- A. Incorrect clustering of data**
  - B. Wrong diagnosis**
  - C. Condition is a collaborative problem**
  - D. Premature ending assessment**
- 7. Which assessment approach is best to collect data about a patient's self-esteem?**
- A. Conducting a structured interview with direct questions**
  - B. Completing an entire head-to-toe assessment first**
  - C. Interviewing the patient in an unstructured format**
  - D. Disregard any nonverbal clues from the patient**
- 8. Which assessment activity is typically performed at hospital admission?**
- A. A problem-focused assessment**
  - B. A comprehensive assessment**
  - C. A shift assessment**
  - D. A discharge assessment**
- 9. Which statement best describes the ANA Code of Ethics?**
- A. A statement of philosophical principles that guide ethical practice.**
  - B. A legal mandate for nursing practice.**
  - C. A fixed medical protocol for every patient.**
  - D. A set of hospital policies on patient safety.**

**10. Florence Nightingale is associated with which definition of nursing?**

- A. Human beings are interacting in continuous motion as energy fields.**
- B. The nurse needs to focus on interpersonal processes between nurse and patient.**
- C. The imbalance between the patient and the environment decreases the capacity for health.**
- D. The nurse assists the patient with essential functions toward independence.**

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## Answers

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

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## **Explanations**

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**1. Clinical reasoning is described as what?**

- A. The thinking process by which a nurse reaches a clinical judgement**
- B. The process of obtaining informed consent**
- C. The act of performing clinical procedures**
- D. The documentation of clinical data**

Clinical reasoning is the thinking process by which a nurse reaches a clinical judgement. It involves actively gathering patient data, interpreting that information, weighing possible problems, and using knowledge and experience to form hypotheses, prioritize issues, and select appropriate interventions. This process aligns with the nursing process—assessment, diagnosis, planning, implementation, and evaluation—and relies on critical thinking and reflection to tailor care to the individual patient. It leads to a nursing diagnosis and an organized plan of care that promotes safety and effectiveness. The other activities—obtaining informed consent, performing procedures, and documenting data—are separate components: informed consent is an ethical-legal process, performing procedures is hands-on skill, and documenting data is recording findings.

**2. Which nurse is associated with founding the American Red Cross?**

- A. Clara Barton**
- B. Florence Nightingale**
- C. Lillian Wald**
- D. Mary Nutting**

The main idea here is knowing who established the American Red Cross and how that shaped disaster relief in the U.S. Clara Barton is the nurse who founded the American Red Cross in 1881, after her prominent Civil War-era work delivering care, collecting supplies, and advocating for federal disaster relief. She led the organization as its first president and helped build a lasting framework for civilian humanitarian aid. Florence Nightingale is recognized for transforming nursing and battlefield care during the Crimean War and for advancing nursing education and statistics, not for founding the Red Cross. Lillian Wald pioneered public health nursing and established the Henry Street Settlement to serve urban communities. Mary Nutting contributed to nursing education as a pioneering professor.

### 3. Data for Nursing Assessment come from which sources?

- A. Primary sources only
- B. Secondary sources only
- C. Both primary and secondary sources**
- D. Only family members

Data for a nursing assessment come from both primary and secondary sources. The primary source is the patient themselves, offering subjective data about symptoms, feelings, and health history, along with any information the patient can report directly. Secondary sources include the patient's medical records, test results, and information from family members, caregivers, or other health professionals who know the patient and can provide context or fill in gaps. Using both types gives a complete, accurate picture, especially when the patient can't communicate fully. For example, a patient may report pain and fatigue, while lab results and clinician notes help clarify the underlying condition and prior history. Relying on only one type can miss important details or lead to incomplete assessment.

### 4. Which concept explicitly includes the possibility to improvise new approaches based on patient response?

- A. Autonomy
- B. Clinical decision making
- C. Clinical judgement**
- D. Reflection

Clinical judgement is the ability to integrate knowledge, patient data, and real-time responses to adapt care as a situation evolves. It explicitly includes improvising new approaches based on how the patient responds, such as modifying the plan, trying alternative interventions, or escalating care when the initial action isn't effective. This ongoing, adaptive process relies on noticing changes, interpreting data, and deciding how to act in the moment, followed by reflection to refine future actions. Autonomy centers on respecting a patient's right to make their own decisions, not on how the nurse adapts care in response to changing conditions. Clinical decision making is the stepwise process of selecting among options and applying guidelines; while it guides actions, it does not inherently emphasize improvisation in response to patient feedback. Reflection involves thinking back on actions after care is delivered to learn and improve, rather than live, in-the-moment adaptation of care.

**5. Which description best defines a comprehensive assessment?**

- A. Focused on a single problem**
- B. A broad, all-inclusive appraisal of the patient**
- C. Only regarding chief complaint**
- D. Only gathering demographic data**

A comprehensive assessment means gathering information from many aspects of a patient's health and life to create a complete picture. It goes beyond the presenting issue to include medical history, current symptoms, a full physical exam, functional status and daily activities, mental and emotional health, social supports, cultural and spiritual beliefs, lifestyle, safety, and the living environment. This broad view helps identify risks and needs that might be missed if you only focus on one problem, the chief complaint, or just demographics. By establishing a baseline across multiple domains, it also informs the care plan and helps tailor interventions to the whole person.

**6. In the scenario where a patient undergoing abdominal radiation has liquid stool and clean, intact skin, the error in the selected nursing diagnosis is best described as which of the following?**

- A. Incorrect clustering of data**
- B. Wrong diagnosis**
- C. Condition is a collaborative problem**
- D. Premature ending assessment**

A nursing diagnosis must reflect what you actually assessed in the patient. In this scenario, the patient has liquid stool, which points to diarrhea, while the skin is clean and intact, showing no current skin breakdown. If the chosen nursing diagnosis claimed impaired skin integrity or a skin-related problem, that label doesn't fit the observed data. That mismatch is what makes the error a wrong diagnosis: the diagnosis does not align with the actual findings. It's not about finishing the assessment too early, nor about clustering data incorrectly or labeling it as a collaborative problem. The important step is to match the diagnosis to what the data show, so a diarrhea-related diagnosis would be more appropriate than one describing skin impairment.

**7. Which assessment approach is best to collect data about a patient's self-esteem?**

- A. Conducting a structured interview with direct questions**
- B. Completing an entire head-to-toe assessment first**
- C. Interviewing the patient in an unstructured format**
- D. Disregard any nonverbal clues from the patient**

Self-esteem is best explored through a patient-led conversation that invites personal meaning and feelings, rather than through rigid questions or physical checklists. An unstructured interview lets the patient describe what self-worth means to them, share sources of confidence or hurt, and discuss how they view themselves in relationships and daily life. This open format helps reveal nuances that standardized questions might miss and supports building trust so the patient feels safe discussing sensitive topics like self-acceptance, vulnerabilities, and coping styles. While observing how the patient communicates—tone, posture, eye contact—can add depth, the core data come from the patient's own words and self-perception, which an unstructured interview facilitates. In contrast, a full head-to-toe physical assessment focuses on bodily systems, not inner sense of self, and disregard for nonverbal cues would miss important signals about self-esteem. Hence, interviewing the patient in an unstructured format is the most effective way to gather data on self-esteem.

**8. Which assessment activity is typically performed at hospital admission?**

- A. A problem-focused assessment**
- B. A comprehensive assessment**
- C. A shift assessment**
- D. A discharge assessment**

When a patient is admitted to the hospital, a comprehensive assessment is performed to establish a complete baseline of health status. This broad intake evaluation gathers medical history, current symptoms, past illnesses, medications and allergies, vital signs, a head-to-toe physical examination, functional status, mental and emotional health, nutritional status, and psychosocial and cultural considerations, as well as living situation and support systems. It also identifies risk factors such as fall risk or infection risk. The goal is to uncover all health problems and needs on arrival so the initial care plan can be accurately prioritized and coordinated. In contrast, a problem-focused assessment targets a specific complaint or symptom, a shift assessment is a quicker check to monitor ongoing status during a shift, and a discharge assessment occurs when preparing for transition home to summarize progress and plan follow-up.

**9. Which statement best describes the ANA Code of Ethics?**

- A. A statement of philosophical principles that guide ethical practice.**
- B. A legal mandate for nursing practice.**
- C. A fixed medical protocol for every patient.**
- D. A set of hospital policies on patient safety.**

The ANA Code of Ethics provides a set of philosophical principles that guide ethical practice for nurses. It lays out the ideals and responsibilities that shape professional conduct, such as respecting patient autonomy, maintaining confidentiality, advocating for patients, and promoting justice. This code serves as a framework for ethical decision-making across diverse clinical situations, helping nurses reason through dilemmas and uphold professional identity. It is not a legal mandate that commands behavior in every circumstance, nor does it prescribe fixed medical protocols or hospital policies. Those come from laws, regulations, and institution-specific guidelines. The Code informs how nurses act within those boundaries, offering a standard for accountability and moral deliberation.

**10. Florence Nightingale is associated with which definition of nursing?**

- A. Human beings are interacting in continuous motion as energy fields.**
- B. The nurse needs to focus on interpersonal processes between nurse and patient.**
- C. The imbalance between the patient and the environment decreases the capacity for health.**
- D. The nurse assists the patient with essential functions toward independence.**

Florence Nightingale's view emphasizes how the environment influences healing. She believed health results when the person and their surroundings are in balance, and nursing should modify environmental factors—such as cleanliness, ventilation, light, noise, nutrition, and comfort—to support recovery. When there is an imbalance between the patient and the environment, the capacity for health is reduced, which is why this option best fits Nightingale's concept. The other ideas align with different nursing theories focused on interpersonal processes, energy fields, or enabling self-care, rather than Nightingale's environmental focus.

## Next Steps

**Congratulations on reaching the final section of this guide. You've taken a meaningful step toward passing your certification exam and advancing your career.**

**As you continue preparing, remember that consistent practice, review, and self-reflection are key to success. Make time to revisit difficult topics, simulate exam conditions, and track your progress along the way.**

**If you need help, have suggestions, or want to share feedback, we'd love to hear from you. Reach out to our team at [hello@examzify.com](mailto:hello@examzify.com).**

**Or visit your dedicated course page for more study tools and resources:**

**<https://nmnc3110introtonursing1.examzify.com>**

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

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