

NMNC 3110 INTRODUCTION TO NURSING CONCEPTS EXAM 1 PRACTICE (SAMPLE) STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

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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. Name two nonpharmacologic methods to relieve pain.**
 - A. Positioning and relaxation techniques
 - B. Distraction
 - C. Heat/cold therapy
 - D. Guided imagery
- 2. In nursing, problem solving is defined as**
 - A. Problem resolution
 - B. Decision making
 - C. Data collection
 - D. Outcome evaluation
- 3. Tanner's Noticing is best described as**
 - A. Similar to assessment, involving collection of data used to make effective judgments
 - B. The same as diagnosing
 - C. The same as planning
 - D. The same as evaluating
- 4. Apical pulse usage is for which patient group?**
 - A. Infants or during emergency assessment
 - B. Routine checks in adults
 - C. In CPR only
 - D. For BP measurement only
- 5. A PES statement in nursing diagnoses includes which elements?**
 - A. Plan, Evaluation, Status
 - B. Problem, Etiology, Symptoms
 - C. Potential problem, Expected outcome, Safety
 - D. Problem, Evaluation, Severity

6. What is PROM and when is it indicated?

- A. Passive range of motion performed by a caregiver; indicated for immobilized or postoperative patients to preserve joint flexibility.
- B. Passive range of motion performed by patient; indicated for active exercise only.
- C. PROM involves joint movement performed by a caregiver when the patient cannot move their joints themselves; indicated for immobilized or post-operative patients to preserve joint flexibility and prevent contractures.
- D. PROM is supposed to be done only by the patient with no assistance.

7. What is the typical normal range for systolic and diastolic blood pressure?

- A. Systolic 100-140 mmHg; Diastolic 70-90 mmHg
- B. Systolic 110-130 mmHg; Diastolic 50-70 mmHg
- C. Systolic 80-110 mmHg; Diastolic 40-60 mmHg
- D. Systolic 90-120 mmHg; Diastolic 60-80 mmHg

8. During the assessment phase, essential data collection is primarily accomplished through which activity?

- A. Interviewing the patient and family
- B. Administering medications
- C. Performing laboratory tests
- D. Documenting in the chart

9. Which statement best defines cultural humility?

- A. Learned knowledge of all cultures to avoid mistakes
- B. Avoid asking about beliefs to prevent offense
- C. A lifelong commitment to self-evaluation and self-critique regarding cultural biases
- D. Treating all patients the same

10. Which statement best reflects evidence-based practice in nursing?

- A. EBP is the process of applying hospital policy without considering research.
- B. EBP relies solely on tradition and clinician opinion.
- C. EBP blends the best available research with clinical expertise and patient values; for example, using a validated pain assessment tool to guide analgesia.
- D. EBP ignores patient preferences and values.

Answers

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

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Explanations

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1. Name two nonpharmacologic methods to relieve pain.

A. Positioning and relaxation techniques

B. Distraction

C. Heat/cold therapy

D. Guided imagery

Nonpharmacologic pain relief can come from strategies that improve comfort and calm the body. Positioning helps by reducing pressure, preventing awkward alignment, and supporting joints and muscles, which often lowers pain intensity. Relaxation techniques reduce muscle tension and nervous system arousal, making pain easier to tolerate by shifting focus and releasing endorphins through slower breathing, progressive muscle relaxation, or similar practices. While other nonpharmacologic approaches like distraction or heat/cold therapy are also useful, they each represent a single method. The choice that combines two distinct methods—positioning and relaxation techniques—best meets the prompt to name two approaches, illustrating how complementary strategies can enhance pain relief.

2. In nursing, problem solving is defined as

A. Problem resolution

B. Decision making

C. Data collection

D. Outcome evaluation

Problem solving in nursing means guiding the patient from recognizing a problem to a resolved state by planning and carrying out actions that address the issue and aim for a desired outcome. It involves defining the problem, considering options, selecting and implementing interventions, and then evaluating whether the problem has been resolved. Data collection and decision making are parts of the process—data collection informs understanding, and decision making helps choose strategies—but the essence of problem solving is achieving problem resolution. Outcome evaluation comes after actions to see whether the intended resolution occurred and to determine if further steps are needed.

3. Tanner's Noticing is best described as

A. Similar to assessment, involving collection of data used to make effective judgments

B. The same as diagnosing

C. The same as planning

D. The same as evaluating

Noticing in Tanner's Clinical Judgment Model is about picking up meaningful cues from the patient and the care environment and collecting the data needed to understand the patient's status. It mirrors the assessment process because both involve gathering information, observing patterns, and focusing on what matters for the patient's health. This step sets the stage for interpretation, where the nurse analyzes the data to form clinical judgments. It's not about diagnosing, planning, or evaluating—those come after data is gathered and interpreted. By paying attention to salient cues early, the nurse can detect subtle changes and prioritize actions.

4. Apical pulse usage is for which patient group?

A. Infants or during emergency assessment

B. Routine checks in adults

C. In CPR only

D. For BP measurement only

Apical pulse assessment uses listening to the heart with a stethoscope at the apex, which gives the most accurate heart rate when peripheral pulses are unreliable or in patients with very fast heart rates. In infants, the heart rate is high and the chest size and peripheral pulses can be hard to palpate, so auscultating at the apex provides a clear measure of rhythm and rate. In emergency assessment, rapid apex auscultation lets you quickly determine the heart rate when other measurements may be difficult or delayed. For adults in routine care, we usually rely on peripheral pulses like the radial pulse, and blood pressure is obtained with a cuff and auscultation over the brachial artery rather than the apical site. Apical assessment isn't limited to CPR and isn't used for BP measurement.

5. A PES statement in nursing diagnoses includes which elements?

A. Plan, Evaluation, Status

B. Problem, Etiology, Symptoms

C. Potential problem, Expected outcome, Safety

D. Problem, Evaluation, Severity

The main idea being tested is how a nursing diagnosis is structured in the PES format. A PES statement combines three parts: the Problem (the nursing diagnosis label that describes what the patient is experiencing), the Etiology (the cause or contributing factors behind that problem), and the Symptoms (the defining characteristics or cues that support the diagnosis). Together, they create a concise statement that links the patient's issue to its cause and the observable evidence. In practice, you'd see something like: Problem related to Etiology as evidenced by Symptoms. This format helps guide planning and interventions by making clear what is wrong, why it's happening, and what data confirm it. The other options mix in planning terms (like plan or evaluation) or outcomes or safety notions that aren't part of the PES structure, so they don't fit as the PES elements.

6. What is PROM and when is it indicated?

A. Passive range of motion performed by a caregiver; indicated for immobilized or postoperative patients to preserve joint flexibility.

B. Passive range of motion performed by patient; indicated for active exercise only.

C. PROM involves joint movement performed by a caregiver when the patient cannot move their joints themselves; indicated for immobilized or post-operative patients to preserve joint flexibility and prevent contractures.

D. PROM is supposed to be done only by the patient with no assistance.

PROM stands for passive range of motion. It is the movement of a joint performed by another person, usually a nurse or therapist, when the patient cannot move the joint on their own. It is indicated for immobilized or postoperative patients to keep the joint flexible and to prevent contractures, while also promoting circulation. This differs from active range of motion, where the patient moves the joint themselves.

7. What is the typical normal range for systolic and diastolic blood pressure?

- A. Systolic 100-140 mmHg; Diastolic 70-90 mmHg
- B. Systolic 110-130 mmHg; Diastolic 50-70 mmHg
- C. Systolic 80-110 mmHg; Diastolic 40-60 mmHg
- D. Systolic 90-120 mmHg; Diastolic 60-80 mmHg**

Normal blood pressure reflects enough force to perfuse organs without causing damage to blood vessels. The typical reference range used in introductory nursing is about systolic 90–120 mmHg and diastolic 60–80 mmHg. This range represents adequate cardiac output with vessels at a healthy tone. Readings consistently above this range can indicate elevated blood pressure or hypertension, while readings below may signal hypotension and possible inadequate perfusion. The option describing 90–120 systolic and 60–80 diastolic matches the common normal range used in practice.

8. During the assessment phase, essential data collection is primarily accomplished through which activity?

- A. Interviewing the patient and family**
- B. Administering medications
- C. Performing laboratory tests
- D. Documenting in the chart

Gathering essential data in the assessment phase hinges on talking with the patient and family. The interview provides subjective information about symptoms, medical history, daily functioning, beliefs, and psychosocial factors that the patient might not reveal through other means. Building rapport during this conversation helps ensure accuracy and completeness, forming the foundation for a comprehensive assessment and subsequent care planning. While a physical exam and observations supply objective data and other sources like records or tests add detail, the firsthand patient-and-family narrative obtained in the interview is the primary way to capture the personal health story that drives nursing care. Administering medications is an intervention, not a data-collection method, and while labs or chart entries contribute data, they are not the main means by which essential assessment information is first gathered.

9. Which statement best defines cultural humility?

- A. Learned knowledge of all cultures to avoid mistakes
- B. Avoid asking about beliefs to prevent offense
- C. A lifelong commitment to self-evaluation and self-critique regarding cultural biases**
- D. Treating all patients the same

Cultural humility means continually examining your own beliefs and biases and how they shape care, with a lifelong commitment to self-reflection and critique. This mindset fits best because it emphasizes ongoing self-evaluation rather than pretending to know everything about all cultures. Since no one can master every cultural nuance, the approach is to ask patients about their values, beliefs, and health practices and to adapt care to fit their unique context. It also involves acknowledging power dynamics in the nurse-patient relationship and inviting patients to participate as experts on their own experiences. Other descriptions miss the mark because mastering all cultures is unrealistic, avoiding questions about beliefs blocks true understanding, and treating everyone the same ignores individual differences and needs.

10. Which statement best reflects evidence-based practice in nursing?

- A. EBP is the process of applying hospital policy without considering research.
- B. EBP relies solely on tradition and clinician opinion.
- C. EBP blends the best available research with clinical expertise and patient values; for example, using a validated pain assessment tool to guide analgesia.**
- D. EBP ignores patient preferences and values.

Evidence-based practice in nursing means combining the best available research evidence with clinical expertise and the patient's values and preferences to guide care. This approach ensures decisions are informed by high-quality data, but also tailored to what a clinician knows works in practice and what matters to the patient. Using a validated pain assessment tool to guide analgesia exemplifies this because the tool provides reliable, standardized information about a patient's pain experience, which then informs treatment decisions in collaboration with the patient's goals and tolerances. Applying hospital policy without considering research ignores up-to-date evidence; relying solely on tradition or clinician opinion omits current data and patient context; and ignoring patient preferences contradicts the collaborative nature of care.

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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.

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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