Nursing Process Practice Test (Sample)

Study Guide

BY EXAMZIFY

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

1. **What best defines a goal in the planning phase?**

    A. A broad statement describing the desired change in a client's condition or behavior.

    B. A list of nursing interventions

    C. A diagnostic label

    D. A legal consent form

2. **Which of the following is NOT one of the three guides used to prioritize patient needs?**

    A. Diet restrictions

    B. Maslow

    C. Pt preference

    D. Anticipation of future problems

3. **Which of the following is NOT a secondary source of data?**

    A. Information obtained from the patient

    B. Family members

    C. Past and current health records

    D. Laboratory tests

4. **In a nursing diagnosis, which phrase links the etiology to the problem?**

    A. related to

    B. as evidenced by

    C. due to

    D. connected to

5. **How do short-term and long-term goals differ in nursing planning?**

    A. A short-term goal is achieved in a short period of time; a long-term goal may take several days, weeks, or months.

    B. Short-term goals take months; long-term goals take hours

    C. Short-term goals are not measurable

    D. Short-term goals are for the nurse's convenience

6. **What does NANDA-I stand for?**

   A. National Association of Nursing Diagnosis and Assessment International

   B. North American Nursing and Diagnostic Association International

   C. North American Nursing Diagnosis Association International

   D. National Association of Nurses Diagnosing and Assessing

7. **The nursing process is appropriate for use in which settings?**

   A. All settings

   B. Hospitals only

   C. Long-term care only

   D. Pediatric clinics only

8. **In the planning phase of the nursing process, which outputs comprise the plan of care?**

   A. Data collection and assessment

   B. Implementing interventions

   C. Evaluating outcomes

   D. A plan of care with client-centered goals and expected outcomes

9. **Which statement best defines a risk diagnosis?**

   A. Describes human responses to health conditions that may develop in a vulnerable individual, family, or community and is supported by risk factors.

   B. Describes actual current health problems that require immediate intervention.

   C. Describes the health promotion goal for a patient.

   D. Describes wellness levels in relation to disease prevention.

10. **During clustering of data, which approach is used to analyze and synthesize the information that is collected?**

   A. Critical thinking is used to analyze and synthesize the information that is collected

   B. Guesswork helps identify client problems

   C. Data entry alone determines the nursing diagnosis

   D. Visual inspection of data is sufficient without analysis

Answers

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

Explanations

1. What best defines a goal in the planning phase?

A. A broad statement describing the desired change in a client's condition or behavior.

B. A list of nursing interventions

C. A diagnostic label

D. A legal consent form

In planning, the goal represents the desired outcome of care. It's a clear statement of the specific change in the patient's condition or behavior that nursing care aims to achieve. Goals are patient-centered, observable, and time-bound, providing a target for both the actions you'll take and the way you'll measure success. This distinguishes goals from the actions themselves—nursing interventions are the concrete steps you perform to reach the goal. It also separates goals from a diagnostic label, which identifies a problem, and from a legal consent form, which relates to agreeing to procedures and not to outcome targets. By setting a measurable goal, you can determine if the patient progressed toward the desired change within a defined timeframe and adjust the plan if needed. For example: "The patient will ambulate 100 feet with a walker without dizziness within three days."

2. Which of the following is NOT one of the three guides used to prioritize patient needs?

A. Diet restrictions

B. Maslow

C. Pt preference

D. Anticipation of future problems

Prioritizing patient needs in nursing relies on three guides: Maslow's hierarchy of needs to determine which needs must be met first (from physiological to self-actualization), patient preferences to ensure care respects the patient's values and choices, and anticipation of future problems to plan ahead and prevent potential complications. Diet restrictions are important for nutrition and treatment, but they do not serve as a framework for deciding which needs take priority. They fit within the plan as a necessary intervention rather than guiding the order in which needs are addressed. So the option that isn't a priority-setting guide is the dietary restrictions.

3. Which of the following is NOT a secondary source of data?

A. Information obtained from the patient

B. Family members

C. Past and current health records

D. Laboratory tests

Primary data are information collected directly from the patient through interview and physical assessment. Information obtained from the patient is therefore primary data, not a secondary data source. The other sources come from outside the patient: family members provide observations about the patient from someone else's perspective; past and current health records are documents compiled by clinicians; laboratory tests yield objective results generated by technicians. These are all considered secondary data because their origin is not the patient's own direct report. In practice, you gather primary data first from the patient, then supplement with secondary data to complete the assessment.

4. In a nursing diagnosis, which phrase links the etiology to the problem?

A. related to

B. as evidenced by

C. due to

D. connected to

In a nursing diagnosis, the phrase that links the problem to its underlying cause or contributing factors is the exact connector used to show how the etiology explains the problem. That connector is "related to." It sits between the diagnostic label (the problem) and the etiology, forming the Problem related to Etiology as evidenced by Signs/Symptoms structure. This standard phrasing communicates that the etiology is the reason the problem exists and guides interventions toward addressing that underlying cause. The other options don't serve this linking role in the formal PES format. "As evidenced by" is reserved for listing defining characteristics or objective findings that support the diagnosis. "Due to" and similar wording aren't the conventional linking phrase used to connect problem and etiology in this structured format, and can blur the intended relationship. For example: Impaired gas exchange related to alveolar hypoventilation as evidenced by shortness of breath and low oxygen saturation.

5. How do short-term and long-term goals differ in nursing planning?

A. A short-term goal is achieved in a short period of time; a long-term goal may take several days, weeks, or months.

B. Short-term goals take months; long-term goals take hours

C. Short-term goals are not measurable

D. Short-term goals are for the nurse's convenience

In nursing planning, goals are defined by the timeframe in which we expect to achieve them. Short-term goals are the stepping-stone outcomes that can be reached quickly, typically within hours to a few days. They help us monitor immediate progress and guide day-to-day care. Long-term goals require a longer horizon—several days, weeks, or even months—and reflect broader, sustained outcomes such as returning to full function or being discharge-ready. This distinction matters because it shapes what interventions we implement now and how we evaluate progress. For example, after surgery, a short-term goal might be to walk 20 feet with support by the end of the shift, while a long-term goal could be regaining full knee strength and range of motion over several weeks. The other options don't fit because they misstate the timing or purpose of goals. Saying short-term goals take months and long-term goals take hours reverses the reality of planning timelines. Claiming short-term goals aren't measurable ignores the practice of setting specific, observable targets. Suggesting short-term goals are for the nurse's convenience conflicts with patient-centered care and the purpose of nursing planning, which is to achieve meaningful patient outcomes.

6. What does NANDA-I stand for?

   A. National Association of Nursing Diagnosis and Assessment International

   B. North American Nursing and Diagnostic Association International

   C. North American Nursing Diagnosis Association International

   D. National Association of Nurses Diagnosing and Assessing

NANDA-I is the standardized language nurses use for describing patient problems that nursing care can address. The full name is North American Nursing Diagnosis Association International, with the I standing for International. This naming reflects the organization's role in creating and maintaining a widely used taxonomy of nursing diagnoses to improve communication, documentation, and care planning across the nursing process. The term emphasizes that these diagnoses are about nursing problems, defined with specific characteristics and factors, not medical diseases.

7. The nursing process is appropriate for use in which settings?

   A. All settings

   B. Hospitals only

   C. Long-term care only

   D. Pediatric clinics only

The nursing process is a versatile, patient-centered framework that guides care in any healthcare setting. Its stages—assessment, nursing diagnoses, planning, implementation, and evaluation—provide a structured approach that can be tailored to the specific environment, whether in hospitals, long-term care facilities, clinics, home health, or community and school settings. This adaptability means the same fundamental steps help nurses organize information, set priorities, implement interventions, and evaluate outcomes across all contexts, ensuring consistent, coordinated care regardless of where care occurs. Therefore, it applies everywhere, not just in one type of setting.

8. In the planning phase of the nursing process, which outputs comprise the plan of care?

   A. Data collection and assessment

   B. Implementing interventions

   C. Evaluating outcomes

   D. A plan of care with client-centered goals and expected outcomes

In planning, the outputs that form the plan of care are a document that specifies client-centered goals and the expected outcomes—together with the nursing interventions and how progress will be measured. This plan translates what was learned in assessment into concrete, forward-looking steps: what the patient aims to achieve, how success will be defined and measured, and what actions will be taken to reach those targets. It often includes timelines, who is responsible for each action, and criteria for evaluating progress. Data collection and assessment belong to the assessment phase, where you gather information and identify problems. Implementing interventions happens during the implementation phase, when you carry out the planned actions. Evaluating outcomes occurs in the evaluation phase, where you determine whether the goals were met and adjust the plan as needed.

9. Which statement best defines a risk diagnosis?

A. Describes human responses to health conditions that may develop in a vulnerable individual, family, or community and is supported by risk factors.

B. Describes actual current health problems that require immediate intervention.

C. Describes the health promotion goal for a patient.

D. Describes wellness levels in relation to disease prevention.

Risk diagnosis focuses on a potential problem that could develop because a person, family, or community is vulnerable and has identifiable risk factors. It describes human responses to health conditions that may develop, and it is supported by those risk factors rather than by current symptoms. This means the diagnosis is about what could happen in the future and guides preventive actions to reduce the likelihood of the problem occurring.   The other ideas describe something different: a statement about an actual health problem that already exists and needs immediate intervention; a health promotion goal aiming at desired outcomes rather than a potential problem; or wellness levels in relation to disease prevention, which reflect current wellness status rather than a probable future issue.

10. During clustering of data, which approach is used to analyze and synthesize the information that is collected?

A. Critical thinking is used to analyze and synthesize the information that is collected

B. Guesswork helps identify client problems

C. Data entry alone determines the nursing diagnosis

D. Visual inspection of data is sufficient without analysis

When assessing a client, organizing and interpreting what's been observed requires critical thinking to analyze and synthesize the information. Clustering data isn't just about recording facts; it's about interpreting cues, recognizing patterns, and linking them to potential problems. This thoughtful synthesis helps you generate accurate nursing diagnoses rather than jumping to conclusions or basing them on raw data alone. That's why using critical thinking is the best approach. Guessing won't reliably reveal true problems, data entry by itself doesn't determine a diagnosis, and simply visually inspecting data without analysis can miss important patterns or changes.

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://nursingprocess.examzify.com

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