Nursing Process Practice Test (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.

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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!

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Questions

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1. **Which sequence correctly lists Maslow's needs from basic to highest?**
   - A. Physiological needs; Safety needs; Love and belonging needs; Self-esteem needs; Self-actualization needs
   - B. Safety needs; Physiological needs; Love and belonging needs; Self-actualization needs; Self-esteem needs
   - C. Physiological needs; Safety needs; Love and belonging needs; Self-actualization needs; Self-esteem needs
   - D. Physiological needs; Safety needs; Self-esteem needs; Love and belonging needs; Self-actualization needs

2. **Which statement about goals in the nursing plan is true?**
   - A. They should be client-centered and measurable.
   - B. They must be written by the physician
   - C. They are optional in planning
   - D. They do not require evaluation

3. **Which action completes the evaluation phase?**
   - A. Terminating, continuing or revising the care plan
   - B. Initiating a new nursing process
   - C. Implementing new interventions
   - D. Conducting initial patient assessment

4. **Which statement best describes the nursing process?**
   - A. A one-time activity
   - B. Only used for acute care
   - C. Disregards client preferences
   - D. Interdependent

5. **How many data sources are used in nursing assessment?**
   - A. Two: primary and secondary
   - B. Four: patient, family, records, and labs
   - C. One
   - D. Three: primary, secondary, and tertiary

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6. Which senses should be included when collecting objective data?

- **A. Hearing, sight, and taste**
- **B. Smell, hearing, touch and sight**
- **C. Taste, sight, hearing, and balance**
- **D. Smell, taste, touch, and sight**

7. Which of the following is part of the implementation process activities?

- **A. Discharging the patient**
- **B. Prescribing therapy**
- **C. Reassessing**
- **D. Conducting a community survey**

8. Which statement best describes a medical diagnosis?

- **A. Identification of a disease condition based on specific findings such as diagnostic tests and procedures**
- **B. A clinical judgment in response to actual or potential health problems**
- **C. Changes possibly from day to day as the patient's response changes**
- **D. Focuses on coping strategies of the patient**

9. What is the purpose of the scientific rationale for student nurses?

- **A. To document patient complaints.**
- **B. The reason for choosing the particular intervention based on supportive evidence from textbooks, journals, and online nursing references.**
- **C. To list hospital policies.**
- **D. To assign an due date for care.**

10. Which step emphasizes prioritizing identified problems?

- **A. Step 7**
- **B. Step 1**
- **C. Step 3**
- **D. Step 4**

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Answers

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

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Explanations

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1. Which sequence correctly lists Maslow's needs from basic to highest?

A. Physiological needs; Safety needs; Love and belonging needs; Self-esteem needs; Self-actualization needs

B. Safety needs; Physiological needs; Love and belonging needs; Self-actualization needs; Self-esteem needs

C. Physiological needs; Safety needs; Love and belonging needs; Self-actualization needs; Self-esteem needs

D. Physiological needs; Safety needs; Self-esteem needs; Love and belonging needs; Self-actualization needs

Maslow’s hierarchy of needs is tested here, showing the progression from basic survival to higher personal growth. The correct sequence starts with physiological needs—those essential for life such as food, water, warmth, and rest. Once those are met, safety needs come next, meaning physical and emotional security and stability. After safety, the need for love and belonging arises, reflecting social connections and relationships. Following that is self-esteem, which involves respect, recognition, and a sense of competence. At the top is self-actualization, the realization of one’s full potential. So the order physiologic -> safety -> love/belonging -> self-esteem -> self-actualization is correct. Alternatives that begin with safety rather than physiological ignore the most fundamental needs; ones that place self-actualization before esteem or swap the placement of love/belonging and esteem disrupt the established hierarchy. In nursing practice, this helps prioritize care: ensure basics are addressed first—pain relief, nutrition, safety—before focusing on social supports or personal growth goals.

2. Which statement about goals in the nursing plan is true?

A. They should be client-centered and measurable.

B. They must be written by the physician

C. They are optional in planning

D. They do not require evaluation

Goals in the nursing plan should be client-centered and measurable. This means the target is defined in terms of what the patient values and can actually achieve, and there is an objective way to determine whether it has been met. When goals are client-centered, they reflect the patient’s needs, preferences, and functional abilities, rather than what others assume is best. When they are measurable, they include clear criteria for success, such as specific actions, amounts, or timeframes—for example, “The patient will ambulate 50 feet with a cane with supervision by end of shift,” or “The patient will self-administer insulin with zero hypoglycemia events for 24 hours.” Planning is an interprofessional process driven by assessment findings, with the nurse leading the development of goals in collaboration with the patient. Goals are not written only by physicians, and they are not optional. They require ongoing evaluation to determine progress, guide interventions, and decide whether to continue, modify, or discontinue the plan. Evaluation checks whether the patient met the goal, partially met it, or did not meet it, and it informs any necessary adjustments to care.

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3. Which action completes the evaluation phase?

- **A. Terminating, continuing or revising the care plan**
- B. Initiating a new nursing process
- C. Implementing new interventions
- D. Conducting initial patient assessment

The evaluation phase is about judging progress toward the patient's outcomes and deciding what to do next. After measuring and comparing actual results with the expected outcomes, you determine whether goals were met and what action is required. If outcomes are achieved, you terminate the plan; if progress is ongoing, you continue the plan; if goals aren't met or new information arises, you revise the plan. This is why terminating, continuing, or revising the care plan best completes the evaluation. Initiating a new nursing process would occur after closing a cycle, not during evaluation; implementing new interventions happens during the implementation phase; conducting the initial patient assessment occurs during the assessment phase.

4. Which statement best describes the nursing process?

- A. A one-time activity
- B. Only used for acute care
- C. Disregards client preferences
- **D. Interdependent**

The nursing process is an interdependent, collaborative cycle in which the nurse, patient, family, and other health professionals work together through assessment, diagnosis, planning, implementation, and evaluation. It isn't a one-time activity; it requires ongoing data gathering, clinical reasoning, and adjustments as the patient's condition and preferences change. It isn't limited to acute care, since this process guides care in any setting. It also honors the patient's values and choices, using them to set goals and choose interventions. Because care is shared and continually informed by feedback from the patient and the team, interdependence best describes how the nursing process functions.

5. How many data sources are used in nursing assessment?

- **A. Two: primary and secondary**
- B. Four: patient, family, records, and labs
- C. One
- D. Three: primary, secondary, and tertiary

Data gathered in a nursing assessment comes from two types of sources: primary and secondary. The primary source is the patient, who provides firsthand information about symptoms, history, and current status. Secondary sources include other people or documents that supplement the patient's information—such as family members, medical records, laboratory data, and notes from other health professionals. Although you can identify many individual sources, they are grouped into these two categories. The two-category framework is what this question is addressing.

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6. Which senses should be included when collecting objective data?

A. Hearing, sight, and taste

B. Smell, hearing, touch and sight

C. Taste, sight, hearing, and balance

D. Smell, taste, touch, and sight

Objective data collection relies on what you can observe with the senses: sight, hearing, smell, and touch. These four senses let you gather observable signs such as color, symmetry, odors, sounds, temperature, moisture, and texture, which are all measurable or observable in the physical exam. Taste is not routinely used to collect objective data because taste perception is subjective and varies with individual factors like recent meals or medications, making it unreliable as a standard data point. Balance isn't typically part of the standard objective assessment either; while it relates to the vestibular system, it's not a primary source of observable findings during a general survey. So including smell, hearing, touch, and sight covers the primary senses used for objective data.

7. Which of the following is part of the implementation process activities?

A. Discharging the patient

B. Prescribing therapy

C. Reassessing

D. Conducting a community survey

During the implementation phase, you carry out the planned interventions and monitor how the patient responds. Reassessing fits here because it provides real-time information about whether the interventions are working, if goals are being met, and whether adjustments are needed. This ongoing check is essential to adapt the care plan to the patient's changing condition and ensure safe, effective care. Discharging the patient is part of discharge planning and happens after evaluating readiness to leave care. Prescribing therapy is typically done by the prescriber, with nurses administering therapies rather than creating the plan itself. Conducting a community survey is a public health activity aimed at populations, not the day-to-day implementation of an individual patient's plan. So reassessing during implementation ensures the plan remains appropriate and effective as conditions evolve.

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8. Which statement best describes a medical diagnosis?

- **A. Identification of a disease condition based on specific findings such as diagnostic tests and procedures**
- **B. A clinical judgment in response to actual or potential health problems**
- **C. Changes possibly from day to day as the patient's response changes**
- **D. Focuses on coping strategies of the patient**

Medical diagnosis means identifying a disease or medical condition based on specific findings from testing and procedures. It relies on objective data—history, physical exam, lab results, imaging—to determine exactly what condition is present. That's why describing identification of a disease condition based on diagnostic tests and procedures best fits the concept of a medical diagnosis. The other statements describe nursing-related assessments or care planning rather than the physician-determined condition itself: a clinical judgment about actual or potential health problems aligns with a nursing diagnosis; changes day to day reflect shifting patient status rather than the definition of diagnosis; and focusing on coping strategies pertains to how a patient handles illness, again more in the realm of nursing care planning.

9. What is the purpose of the scientific rationale for student nurses?

- **A. To document patient complaints.**
- **B. The reason for choosing the particular intervention based on supportive evidence from textbooks, journals, and online nursing references.**
- **C. To list hospital policies.**
- **D. To assign an due date for care.**

The purpose of a scientific rationale is to explain why a nursing intervention is chosen, using evidence to support the plan. For student nurses, this means showing how assessment findings lead to a specific action that is backed by current information from textbooks, journals, and reputable online resources. This demonstrates critical thinking and ensures care is grounded in evidence, which supports patient safety and quality of outcomes. It's not about documenting patient complaints, listing hospital policies, or simply setting a due date for care; those tasks involve data collection, policy reference, or scheduling, rather than giving evidence-based justification for a chosen intervention.

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10. Which step emphasizes prioritizing identified problems?

- **A. Step 7**
- B. Step 1
- C. Step 3
- D. Step 4

Prioritizing identified problems means ranking what needs attention first based on urgency and safety. After problems are identified, you determine the order of interventions so the most critical issues—like threats to airway, breathing, or circulation—are addressed before less urgent concerns. This step guides the planning process, ensuring patient safety and the most effective use of interventions and resources. That's why the emphasis on prioritization is the best fit for this item.

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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://nursingprocess.examzify.com

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

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