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INTRODUCTION

How to use this PDF reviewer

This free PDF contains 50 board-style PNLE practice questions with correct answers and short rationales. Questions are grouped by subject area and cover all major nursing domains tested in the Philippine Nurse Licensure Examination.

Each question follows the PNLE board exam format: a patient scenario or clinical question with four answer choices (A-D). The correct answer is marked after the options, followed by a 2-3 sentence rationale explaining the reasoning.

This PDF is a study aid - not a guarantee of exam results. Use it as part of a broader review routine that includes structured lessons, repeated practice, and review of your weakest areas.

STUDY TIPS FOR BEST RESULTS

- Answer each question before reading the rationale.
- Understand why distractors (wrong answers) are incorrect.
- Track which topics you miss and review those subjects first.
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PRACTICE QUESTIONS

50 PNLE Questions with Answers and Rationales

Try to answer each question before reading the correct answer and rationale.

FUNDAMENTALS OF NURSING

Q1 Fundamentals of Nursing

A nurse is preparing to perform a sterile dressing change. After opening the sterile field, the nurse accidentally reaches over an item on the field to retrieve scissors. Which principle was violated?

- A. Medical asepsis
- B. Surgical asepsis - reaching over a sterile field contaminates it**
- C. Standard precautions
- D. Contact precautions

Correct Answer: B

RATIONALE

Reaching over a sterile field violates surgical asepsis because the area above the field is considered contaminated. Airborne particles, unsterile sleeves, or hands passing over the field can contaminate sterile items. Items should be positioned to avoid crossing the sterile zone before the procedure begins.

Q2 Fundamentals of Nursing

A nurse finds a partial-thickness wound with an intact serum-filled blister over a bony prominence. The surrounding skin is intact. Which pressure injury stage is this?

- A. Stage 1
- B. Stage 2**
- C. Stage 3
- D. Stage 4

Correct Answer: B

RATIONALE

Stage 2 pressure injuries present as partial-thickness dermal loss with a moist pink or red wound bed, or as an intact or open serum-filled blister. Stage 1 shows non-blanchable redness with intact skin. Stage 3 involves full-thickness tissue loss with visible subcutaneous fat. Stage 4 involves exposed bone, tendon, or muscle.

Q3 Fundamentals of Nursing

A nurse has just inserted a nasogastric tube. Which method is the gold standard to confirm placement before initiating a tube feeding?

- A. Aspirate contents and check pH below 5
- B. Inject air while auscultating the epigastrium
- C. Obtain a chest and abdominal x-ray**
- D. Submerge the distal end in water and observe for bubbles

Correct Answer: C

RATIONALE

Radiographic confirmation (x-ray) is the gold standard for verifying nasogastric tube placement. It provides definitive visualization of the tube's position. Aspirating and checking pH is an acceptable bedside method, but auscultation and water submersion tests are unreliable and no longer recommended as sole verification methods.

Q4 Fundamentals of Nursing

A patient reports 7/10 chest pain that 'spreads down to the left arm.' Which component of PQRST pain assessment does 'spreads to the left arm' represent?

- A. Quality
- B. Intensity
- C. Radiation**
- D. Timing

Correct Answer: C

RATIONALE

In the PQRST pain framework, R stands for Region and Radiation - describing where the pain originates and whether it spreads elsewhere. Radiation of chest pain to the left arm is a classic ischemic presentation. Quality describes the character (sharp, dull, burning), intensity uses the 0-10 scale, and timing addresses onset, duration, and pattern.

Q5 Fundamentals of Nursing

A nurse delivers oxygen via nasal cannula at 4 L/min. Approximately what fraction of inspired oxygen (FiO₂) is the patient receiving?

- A. 28%
- B. 32%
- C. 36%**
- D. 44%

Correct Answer: C

RATIONALE

With a nasal cannula, each liter per minute adds approximately 4% to the baseline FiO₂ of 21%. At 4 L/min: 21% + (4 x 4%) is approximately 37%, closest to 36%. Nasal cannulas are appropriate for low to moderate supplemental oxygen needs; flow rates above 6 L/min are poorly tolerated and ineffective.

Q6 Fundamentals of Nursing

According to the WHO 5 Moments of Hand Hygiene, when must the nurse perform hand hygiene before touching a patient's intact skin for a routine assessment?

- A. Only before an aseptic task
- B. Before patient contact**
- C. After body fluid exposure risk only
- D. After contact with patient surroundings

Correct Answer: B

RATIONALE

WHO Moment 1 is 'Before patient contact' - hand hygiene must be performed before touching the patient to protect them from pathogens on the nurse's hands. The five moments are: (1) before patient contact, (2) before aseptic task, (3) after body fluid exposure, (4) after patient contact, and (5) after contact with patient surroundings.

Q7 Fundamentals of Nursing

A nurse witnesses a patient fall in the hallway. After ensuring patient safety and notifying the physician, what should the nurse do next?

- A. Inform the family and then document in nursing notes only
- B. Document objectively in nursing notes and complete a separate incident report**
- C. Complete the incident report and file it in the medical record
- D. Notify the nursing supervisor and await further instructions before documenting

Correct Answer: B

RATIONALE

After a patient fall, the nurse must document objective findings in the nursing notes and complete a separate incident (variance) report per institutional policy. Incident reports are administrative quality-improvement tools and must never be filed inside the medical record or referenced within nursing notes. Documentation should be prompt, factual, and without assigning blame.

Q8 Fundamentals of Nursing

Before surgery, the surgeon explains the procedure, risks, benefits, and alternatives to the patient, who then signs the consent form. Which element of informed consent did the surgeon fulfill?

- A. Competency assessment
- B. Voluntariness

C. Disclosure of information

- D. Documentation only

Correct Answer: C

RATIONALE

Informed consent has three components: disclosure (physician explains procedure, risks, benefits, alternatives), competency (patient can understand and decide), and voluntariness (decision is free from coercion). The scenario describes the disclosure component. Nurses witness the signature and verify understanding but do not obtain the consent - that is the physician's responsibility.

Q9 Medical-Surgical Nursing

A nurse observes the water in the water-seal chamber of a chest tube drainage system fluctuating up with inspiration and down with expiration. How should the nurse interpret this finding?

- A. An air leak is present and the system should be replaced
- B. The drainage system is functioning normally (tidaling)**
- C. The lung has fully re-expanded and the tube can be removed
- D. The chest tube is kinked and requires repositioning

Correct Answer: B

RATIONALE

Tidaling - fluctuation of water level with respiration - in the water-seal chamber indicates normal function. The negative intrathoracic pressure during inspiration draws fluid up; expiration allows it to fall. Cessation of tidaling may indicate lung re-expansion or a tube obstruction. Continuous bubbling (not tidaling) indicates an air leak.

Q10 Medical-Surgical Nursing

A patient reports crushing chest pain radiating to the jaw, rated 9/10, diaphoresis, and nausea beginning 45 minutes ago. Which two nursing actions are the priority?

- A. Elevate the HOB and apply oxygen at 6 L/min
- B. Administer aspirin 325 mg and obtain a 12-lead ECG immediately**
- C. Obtain IV access and draw cardiac enzymes first
- D. Administer sublingual nitroglycerin and call the family

Correct Answer: B

RATIONALE

When acute MI is suspected, aspirin is given immediately to inhibit platelet aggregation, and a 12-lead ECG must be obtained within 10 minutes of symptom onset to identify the MI type and guide reperfusion therapy. These two actions are the highest priority, consistent with the MONA protocol and current ACLS guidelines for ACS management.

Q11 Medical-Surgical Nursing

A patient with COPD requires supplemental oxygen at a precise inspired oxygen concentration of 28% (FiO₂ 0.28). Which oxygen delivery device should the nurse select?

- A. Nasal cannula at 6 L/min
- B. Simple face mask at 5 L/min
- C. Venturi mask set to 28%**
- D. Partial rebreather mask at 8 L/min

Correct Answer: C

RATIONALE

The Venturi mask delivers a precise, consistent FiO₂ regardless of the patient's breathing pattern, making it the preferred device for patients with COPD who need controlled oxygen therapy. Patients with COPD may rely on hypoxic drive; excessive oxygen can suppress this drive. A nasal cannula at 6 L/min delivers approximately 44% FiO₂ - too high for this patient.

Q12 Medical-Surgical Nursing

A patient underwent a right parietal craniotomy. Which position should the nurse maintain in the immediate postoperative period to reduce intracranial pressure?

- A. Flat supine to promote venous return to the heart
- B. Trendelenburg to increase cerebral perfusion pressure
- C. Head of bed at 30 degrees to promote venous drainage from the brain**
- D. Left lateral to protect the operative site

Correct Answer: C

RATIONALE

Elevating the head of bed 30 degrees after craniotomy promotes venous drainage from the cerebral circulation, reducing cerebral edema and intracranial pressure. Trendelenburg position is contraindicated as it significantly increases ICP. The flat supine position does not adequately facilitate venous drainage. Lateral positioning may be appropriate in certain cases but is not the standard postoperative default.

Q13 Medical-Surgical Nursing

A 72-year-old patient presents with sudden, severe tearing back pain and a pulsatile abdominal mass. BP is 88/60 mmHg and HR is 116 bpm. Which nursing action is the priority?

- A. Perform a thorough abdominal assessment and document
- B. Establish large-bore IV access and prepare for emergency surgery**
- C. Administer the prescribed antihypertensive to control BP
- D. Obtain an abdominal ultrasound before initiating other interventions

Correct Answer: B

RATIONALE

Tearing back pain with a pulsatile abdominal mass and signs of hemorrhagic shock indicate a ruptured abdominal aortic aneurysm, a life-threatening emergency. The priority is large-bore IV access for aggressive fluid resuscitation and immediate surgical notification. Antihypertensives would worsen shock. The clinical presentation is diagnostic - awaiting imaging delays life-saving intervention.

Q14 Medical-Surgical Nursing

A patient weighing 70 kg has deep partial-thickness burns over 36% of the TBSA. Using the Parkland formula ($4 \text{ mL} \times \text{kg} \times \% \text{ TBSA}$), how much fluid should be given in the first 8 hours?

- A. 2,520 mL
- B. 5,040 mL**
- C. 7,560 mL
- D. 10,080 mL

Correct Answer: B

RATIONALE

Parkland formula: $4 \text{ mL} \times 70 \text{ kg} \times 36\% = 10,080 \text{ mL}$ total for the first 24 hours. Half (5,040 mL) is given in the first 8 hours from time of injury; the remaining 5,040 mL over the next 16 hours. Ringer's lactate is the fluid of choice. Timing is calculated from the time of injury, not time of admission.

Q15 Medical-Surgical Nursing

A patient with chronic kidney disease has a serum potassium of 6.2 mEq/L. The cardiac monitor shows peaked T-waves. Which physician order should the nurse implement first?

- A. Sodium polystyrene sulfonate (Kayexalate) orally
- B. Regular insulin IV with 50% dextrose
- C. Calcium gluconate 1 g IV over 2 to 3 minutes**
- D. Furosemide 40 mg IV push

Correct Answer: C

RATIONALE

When hyperkalemia is accompanied by ECG changes such as peaked T-waves, cardiac membrane stabilization with IV calcium gluconate is the immediate first priority to prevent life-threatening arrhythmias. Calcium gluconate does not lower serum potassium but protects the heart while other measures take effect. Insulin with dextrose and Kayexalate lower potassium over time and are initiated after membrane stabilization.

Q16 Medical-Surgical Nursing

A patient with liver cirrhosis has asterixis and elevated serum ammonia. Which prescribed treatment should the nurse administer?

- A. Furosemide IV for fluid overload
- B. Lactulose by mouth to reduce ammonia**
- C. Albumin infusion to restore oncotic pressure
- D. Neomycin enema as first-line therapy

Correct Answer: B

RATIONALE

Lactulose is the first-line treatment for hepatic encephalopathy. It acidifies the colon, converting ammonia (NH₃) to ammonium (NH₄⁺) which cannot be absorbed, and promotes its excretion in stool. Goal: 2-4 soft stools daily. Furosemide treats ascites, albumin treats SBP/hepatorenal syndrome, and neomycin is an alternative but carries toxicity risks.

Q17 Medical-Surgical Nursing

A nurse palpates the left lower quadrant of a patient with right lower quadrant pain, low-grade fever, and anorexia, and the patient reports pain in the right lower quadrant. Which sign has the nurse elicited?

- A. McBurney's point
- B. Psoas sign
- C. Rovsing's sign**
- D. Obturator sign

Correct Answer: C

RATIONALE

Rovsing's sign is positive when palpation of the left lower quadrant produces pain in the right lower quadrant, suggesting appendiceal inflammation. McBurney's point is direct tenderness at a specific anatomical point. The psoas sign is pain with right hip extension; the obturator sign is pain with internal rotation of the flexed right hip. All suggest appendicitis.

Q18 Medical-Surgical Nursing

A post-TURP patient's continuous bladder irrigation drainage becomes bright red. Which action should the nurse take first?

A. Increase the CBI flow rate to dilute the bleeding

- B. Stop CBI immediately and notify the physician
- C. Irrigate manually with 50 mL normal saline
- D. Document and reassess in 30 minutes

Correct Answer: A

RATIONALE

Bright red drainage after TURP may indicate increased bleeding. The initial response is to increase the CBI flow rate to dilute the blood and prevent clot formation that could obstruct the catheter. If bright red drainage persists or the patient shows signs of hemorrhage (hypotension, tachycardia), the physician must be notified immediately. Stopping CBI without physician guidance may allow clot retention.

Q19 Medical-Surgical Nursing

A patient on post-operative day 2 following total hip replacement reports right calf aching, warmth, and swelling. The right calf circumference is 3 cm greater than the left. Which nursing action is the priority?

- A. Apply knee-high compression stockings to both legs
- B. Elevate the right leg and apply a warm compress
- C. Assist the patient to ambulate to promote venous return
- D. Place the patient on bed rest and notify the physician immediately**

Correct Answer: D

RATIONALE

Unilateral calf swelling, warmth, and pain with measurable circumference asymmetry after major orthopedic surgery are classic warning signs of deep vein thrombosis (DVT). The immediate priority is bed rest to prevent thrombus dislodgement and potential pulmonary embolism, followed by prompt physician notification for anticoagulation orders and confirmatory imaging. Compression stockings and ambulation are contraindicated until DVT is ruled out or anticoagulation is established.

Q20 Medical-Surgical Nursing

A patient with bilateral pneumonia requires postural drainage of the right lower lobe. Which position should the nurse use?

- A. High Fowler's with head turned right
- B. Left lateral position with foot of bed elevated**
- C. Right lateral position with foot of bed elevated
- D. Prone with a pillow under the abdomen

Correct Answer: B

RATIONALE

To drain the right lower lobe, the patient is placed in the left lateral position with the foot of the bed elevated 18-20 inches. This positions the right lower lobe uppermost and allows gravity to drain secretions toward the larger airways. Right lateral would drain the left lower lobe. Postural drainage should be performed before meals or 2 hours after to reduce aspiration risk.

MATERNAL AND CHILD NURSING

Q21 Maternal and Child Nursing

A nurse monitors FHR decelerations that begin after the peak of contractions and return to baseline after the contraction ends. How should the nurse interpret this pattern?

- A. Early decelerations - benign head compression
- B. Variable decelerations - umbilical cord compression
- C. Late decelerations - uteroplacental insufficiency**
- D. Accelerations - normal fetal response

Correct Answer: C

RATIONALE

Late decelerations begin at or after the peak of contractions and return to baseline after the contraction ends, indicating uteroplacental insufficiency and fetal hypoxia - a nonreassuring pattern. Early decelerations mirror contractions and are benign (head compression). Variable decelerations have abrupt onset and variable timing (cord compression). All late decelerations require immediate nursing intervention.

Q22 Maternal and Child Nursing

A patient at 32 weeks presents with painless bright red vaginal bleeding. The uterus is soft and non-tender. Which condition does this most likely indicate?

A. Placental abruption

B. Placenta previa

C. Preterm labor

D. Uterine rupture

Correct Answer: B

RATIONALE

Painless bright red bleeding with a soft, non-tender uterus in the second or third trimester is the classic presentation of placenta previa, where the placenta partially or completely covers the cervical os. Placental abruption presents with painful dark bleeding and a rigid uterus. Uterine rupture involves severe pain and shock. Preterm labor involves regular contractions.

Q23 Maternal and Child Nursing

A patient on IV oxytocin for labor augmentation develops contractions every 1.5 minutes lasting 90 seconds with incomplete uterine relaxation. Which action should the nurse take first?

- A. Reduce the oxytocin rate by 50% and notify the physician
- B. Discontinue the oxytocin infusion and notify the physician**
- C. Continue infusion and provide reassurance
- D. Increase IV fluids and prepare for emergency cesarean section

Correct Answer: B

RATIONALE

Contractions every less than 2 minutes lasting more than 90 seconds with inadequate uterine relaxation represent uterine hyperstimulation (tachysystole), which compromises uteroplacental blood flow. The oxytocin infusion must be discontinued immediately. The patient should be repositioned to left lateral, oxygen applied, and the physician notified. Reducing the rate is insufficient when hyperstimulation with inadequate relaxation is present.

Q24 Maternal and Child Nursing

A patient 30 minutes postpartum has a boggy uterine fundus displaced to the right of midline and elevated above the umbilicus. Which action should the nurse take first?

- A. Perform fundal massage until the uterus firms
- B. Assess the bladder and assist the patient to void or catheterize**
- C. Administer oxytocin 10 units IM as prescribed
- D. Apply ice to the perineum and monitor vital signs

Correct Answer: B

RATIONALE

A boggy, displaced fundus in the immediate postpartum period most commonly indicates bladder distension - the full bladder displaces the uterus and prevents it from contracting. The priority is to empty the bladder. If the fundus remains boggy after voiding or catheterization, uterine massage and oxytocin are indicated. Proceeding directly to oxytocin without addressing the distended bladder delays the correct intervention.

Q25 Maternal and Child Nursing

A patient who just delivered is rubella non-immune and receives the MMR vaccine. Which is the most critical element of discharge teaching?

- A. Avoid breastfeeding for 4 weeks after vaccination
- B. Avoid pregnancy for at least 28 days after vaccination**
- C. Avoid contact with immunocompromised individuals for 3 months
- D. Return for a booster dose in 6 months

Correct Answer: B

RATIONALE

The MMR vaccine is a live attenuated vaccine contraindicated during pregnancy. After vaccination, women must avoid pregnancy for at least 28 days (4 weeks) due to the theoretical risk of congenital rubella syndrome from the vaccine strain. MMR is safe in breastfeeding. The 28-day pregnancy avoidance is the most critical - failure to follow it is the primary risk.

Q26 Maternal and Child Nursing

A newborn at 1 minute of life: HR 95 bpm, gasping respirations, some flexion, grimace only to stimulation, blue body with pink extremities. What is the Apgar score?

A. 4

B. 5

C. 6

D. 7

Correct Answer: B

RATIONALE

Apgar scoring: HR below 100 = 1; gasping = 1; some flexion = 1; grimace only = 1; blue body/pink extremities (acrocyanosis) = 1. Total = 5. A score of 7-10 is normal. Scores of 4-6 indicate moderate depression and require stimulation and possibly supplemental oxygen. Scores of 0-3 indicate severe depression requiring active resuscitation.

Q27 Maternal and Child Nursing

A new mother asks how she will know her breastfed newborn is getting enough milk. Which nurse response is most appropriate?

- A. Weigh the baby before and after each feeding to measure intake
- B. By day 4, the baby should have at least 6 wet diapers and 3-4 stools daily**
- C. Absence of crying between feedings confirms adequate intake
- D. A strong let-down reflex indicates sufficient milk supply

Correct Answer: B

RATIONALE

By day 4 of life, a well-nourished breastfed newborn produces at least 6 wet diapers and 3-4 stools per day - objective indicators of adequate hydration and intake. Weighing before and after feeds is impractical for home use and increases maternal anxiety. Absence of crying and perception of let-down are subjective and unreliable.

Q28 Maternal and Child Nursing

A patient at 9 weeks gestation has had no oral intake for 3 days due to vomiting and presents with orthostatic dizziness and dark urine. Which nursing intervention is the priority?

- A. Encourage small frequent meals and ginger supplements
- B. Establish IV access and administer prescribed IV fluids and antiemetics**
- C. Insert a nasogastric tube for enteral feeding immediately
- D. Teach the BRAT diet and oral hydration techniques

Correct Answer: B

RATIONALE

Hyperemesis gravidarum with 3 days of no oral intake and clinical dehydration (orthostatic symptoms, dark urine) requires IV fluid resuscitation as the immediate priority. IV antiemetics (e.g., ondansetron) break the vomiting cycle. Oral interventions are for mild nausea. Enteral feeding is considered only for cases failing IV management. IV access and fluids are the nursing priority.

PEDIATRIC NURSING

Q29 Pediatric Nursing

Parents report their 2-year-old had a generalized tonic-clonic seizure for 2 minutes with fever (39.2 degrees C) and is now drowsy but responsive. Which statement should the nurse include in teaching?

- A. This type of seizure significantly increases epilepsy risk
- B. Febrile seizures are common in young children and rarely cause brain damage**
- C. Aspirin should be given to prevent future febrile seizures
- D. Hospitalization is always required after a febrile seizure

Correct Answer: B

RATIONALE

Simple febrile seizures (duration less than 15 minutes, generalized, no recurrence within 24 hours) are common in children ages 6 months to 5 years and are generally benign, rarely causing neurological damage or significantly increasing epilepsy risk. Aspirin is contraindicated in children (Reye's syndrome risk). Not all febrile seizures require hospitalization. Parents should be taught injury prevention during seizures.

Q30 Pediatric Nursing

A 4-year-old with fever, severe headache, and photophobia resists neck flexion. The nurse cannot straighten the child's knee when the hip is flexed at 90 degrees, and the child reports pain. Which sign has been elicited?

A. Brudzinski's sign

B. Kernig's sign

C. Babinski's sign

D. Battle's sign

Correct Answer: B

RATIONALE

Kernig's sign is positive when a patient cannot fully extend the knee from a 90-degree hip flexion due to pain or resistance, indicating meningeal irritation. Combined with the other findings, this suggests bacterial meningitis requiring immediate evaluation. Brudzinski's sign is involuntary knee flexion on passive neck flexion. Babinski tests corticospinal tracts. Battle's sign indicates basilar skull fracture.

Q31 Pediatric Nursing

A 3-year-old presents with a barking cough, inspiratory stridor, and low-grade fever (38.0 degrees C). Symptoms are worse at night. The child is mildly anxious with a patent airway. Which intervention should the nurse prepare?

A. Position in high Fowler's and prepare for intubation

B. Provide cool mist humidification and administer prescribed racemic epinephrine

C. Administer ampicillin IV for bacterial infection

D. Obtain lateral neck x-ray before initiating any treatment

Correct Answer: B

RATIONALE

Barking cough, inspiratory stridor, and nocturnal worsening are classic signs of viral croup (laryngotracheobronchitis). Management includes cool mist humidification and racemic epinephrine nebulization for moderate-to-severe cases, along with corticosteroids (dexamethasone). Antibiotics are not indicated for viral croup. Treatment should not be delayed while awaiting imaging in a child with stridor.

Q32 Pediatric Nursing

An infant with RSV bronchiolitis has wheezing, subcostal retractions, and oxygen saturation (SpO₂) of 91% on room air. Which nursing position is most appropriate?

- A. Prone to maximize diaphragm excursion
- B. Supine with neck slightly hyperextended
- C. Semi-upright at 30-45 degrees**
- D. Left lateral to clear secretions

Correct Answer: C

RATIONALE

A semi-upright position at 30-45 degrees facilitates diaphragmatic movement and reduces the work of breathing for infants with bronchiolitis. Prone is contraindicated in infants (SIDS risk) except in monitored ICU settings. Supplemental oxygen should be applied to correct SpO₂. RSV bronchiolitis treatment is primarily supportive: oxygenation, hydration, and nasal suctioning.

Q33 Pediatric Nursing

Parents of a 5-year-old newly diagnosed with celiac disease ask which foods to eliminate. Which nurse response is correct?

- A. Rice and potatoes
- B. Wheat, barley, and rye**
- C. Cow's milk and dairy products
- D. Soy products and corn

Correct Answer: B

RATIONALE

Celiac disease is triggered by gluten found in wheat, barley, and rye. The only evidence-based treatment is strict, lifelong adherence to a gluten-free diet, allowing intestinal villi to heal and preventing complications. Rice, potatoes, soy, and corn are naturally gluten-free. Dairy avoidance is only needed if secondary lactose intolerance is present. Label reading is essential.

PSYCHIATRIC NURSING

Q34 Psychiatric Nursing

A patient admitted to an inpatient psychiatric unit has not spoken since arrival. Which therapeutic communication approach is most appropriate?

- A. Ask 'Why don't you want to talk to me today?'
- B. Sit quietly beside the patient and offer therapeutic presence**
- C. State 'I need you to tell me how you are feeling right now'
- D. Ask a series of closed-ended questions to gather objective data quickly

Correct Answer: B

RATIONALE

For a withdrawn patient, offering therapeutic presence - sitting quietly without demanding verbal responses - communicates safety and acceptance without pressure. The 'why' question can feel accusatory. Demanding disclosure violates autonomy. Closed-ended questions limit emotional expression. Therapeutic silence and presence signal the nurse's availability while respecting the patient's current state.

Q35 Psychiatric Nursing

A patient experiencing a panic attack is hyperventilating, gripping the bed rail, and saying 'I cannot breathe. I feel like I am dying.' Which nursing intervention should the nurse perform first?

- A. Leave the patient briefly to prepare a prescribed benzodiazepine
- B. Call the rapid response team and prepare for emergency intubation
- C. Remain with the patient, speak calmly, and guide slow controlled breathing**
- D. Ask the patient to describe what triggered the panic attack

Correct Answer: C

RATIONALE

During an acute panic attack, the nurse's immediate priority is to remain with the patient to reduce fear, speak in a calm and steady voice to decrease stimulation, and guide slow controlled breathing to reverse hyperventilation. Leaving the patient worsens anxiety. Intrusive questioning during acute panic is inappropriate. Pharmacological intervention may follow if non-pharmacological measures are insufficient.

Q36 Psychiatric Nursing

A patient with schizophrenia tells the nurse, 'The television is sending me coded messages that only I can understand.' Which symptom is the nurse documenting?

- A. Negative symptom - flat affect
- B. Negative symptom - alogia
- C. Positive symptom - delusion of reference**
- D. Positive symptom - disorganized speech

Correct Answer: C

RATIONALE

A delusion of reference is a positive symptom of schizophrenia in which the patient believes external events have special personal meaning directed at them. Positive symptoms are excesses or distortions of normal function (delusions, hallucinations, disorganized behavior). Negative symptoms are reductions (flat affect, alogia, avolition, anhedonia). Correct identification guides treatment planning.

Q37 Psychiatric Nursing

A patient is unresponsive after ingesting diazepam. Respirations are 8/min and BP is 90/60 mmHg. Which prescribed medication should the nurse prepare?

- A. Naloxone (Narcan) IV
- B. Flumazenil (Romazicon) IV**
- C. Activated charcoal via NG tube
- D. Physostigmine IV

Correct Answer: B

RATIONALE

Flumazenil is the antidote for benzodiazepine overdose, competitively blocking benzodiazepine receptors and reversing CNS and respiratory depression. Naloxone reverses opioid overdose. Activated charcoal is contraindicated in unresponsive patients due to aspiration risk. Physostigmine reverses anticholinergic toxicity. Flumazenil should be used cautiously in patients with benzodiazepine dependence (seizure risk).

Q38 Psychiatric Nursing

A patient with anorexia nervosa (BMI 13.5) begins refeeding. On day 3, the nurse notes muscle weakness, paresthesia, and irregular heart rhythm. Serum phosphate is critically low. Which complication is occurring?

- A. Hypercalcemia from malnutrition
- B. Refeeding syndrome**
- C. Electrolyte imbalance from laxative abuse
- D. Wernicke's encephalopathy

Correct Answer: B

RATIONALE

Refeeding syndrome occurs when malnourished patients resume nutritional intake, causing rapid intracellular shifts of phosphate, potassium, and magnesium. Hypophosphatemia is the hallmark and can cause cardiac arrhythmias, respiratory failure, muscle weakness, and neurological symptoms. It is potentially fatal. Prevention requires slow caloric reintroduction with close electrolyte monitoring.

COMMUNITY HEALTH NURSING

Q39 Community Health Nursing

A community health nurse plans a program distributing free measles vaccines to all children under 5 in a barangay. Which level of prevention does this represent?

- A. Primordial prevention
- B. Primary prevention**
- C. Secondary prevention
- D. Tertiary prevention

Correct Answer: B

RATIONALE

Primary prevention aims to prevent disease before it occurs by building immunity in healthy populations. Immunization is a classic example. Secondary prevention involves early detection (screening). Tertiary prevention focuses on rehabilitation and preventing complications in those already ill. Primordial prevention addresses underlying social and environmental determinants of risk.

Q40 Community Health Nursing

A community health nurse screens participants at a community fair and refers those with BP of 140/90 mmHg or higher to their physician. Which level of prevention is this?

- A. Primary
- B. Secondary**
- C. Tertiary
- D. Primordial

Correct Answer: B

RATIONALE

Secondary prevention involves early detection of disease through screening and prompt referral for treatment before disease progresses. Blood pressure screening identifies hypertension early, when intervention is most effective. Primary prevention involves reducing risk factors (e.g., diet counseling). Tertiary prevention manages established disease to reduce disability.

Q41 Community Health Nursing

A community health nurse learns a student was recently diagnosed with pulmonary TB. Which nursing action is the priority?

- A. Administer tuberculin skin tests to all students in the school
- B. Identify and assess all close contacts of the index case for symptoms and testing**
- C. Report the case and begin mass isoniazid prophylaxis immediately
- D. Isolate the student and restrict the school from operating for 2 weeks

Correct Answer: B

RATIONALE

Contact investigation is the priority when a new TB case is identified - identifying all close contacts (household members and those with prolonged exposure) and assessing them for symptoms and latent TB infection. The case must also be reported to local health authorities per disease surveillance protocols. Mass prophylaxis and school closure are not standard first-line responses.

Q42 Community Health Nursing

A community health nurse has four clients to visit. Which client should be prioritized first?

- A. 35-year-old with mild hypertension attending monthly clinic check-ups
- B. 24-year-old new mother discharged yesterday after an uncomplicated delivery
- C. 60-year-old with stable type 2 diabetes last seen 2 weeks ago
- D. 78-year-old with moderate dementia who lives alone and has not been seen in 3 months**

Correct Answer: D

RATIONALE

The 78-year-old with moderate dementia living alone and without contact for 3 months represents the highest vulnerability and safety risk. Dementia impairs self-care, judgment, and the ability to recognize or report emergencies. The prolonged contact gap raises concern for deterioration, medication non-adherence, or neglect. Community health nurses prioritize clients with the greatest safety risk.

Q43 Community Health Nursing

A nurse explains the epidemiological triangle to nursing students. The dengue virus is the agent; the susceptible person is the host. Which component does an Aedes mosquito represent?

- A. Host
- B. Agent
- C. Vector within the environment**
- D. Agent-host interaction

Correct Answer: C

RATIONALE

In the epidemiological triangle, the environment encompasses external factors that influence disease transmission, including biological vectors like the Aedes mosquito that carry and transmit the dengue virus from host to host. Disease occurs when an imbalance exists among agent, host, and environment. Understanding the triangle helps target interventions - e.g., vector control (environment) alongside host immunity (vaccination).

PROFESSIONAL ADJUSTMENT

Q44 Professional Adjustment

A patient's employer calls asking about the patient's medical condition and work restrictions. The patient is currently admitted. Which response is most appropriate?

- A. Provide information since the caller identified themselves as the employer
- B. Confirm only that the patient is admitted and refer the caller to the charge nurse
- C. Decline to share any information without the patient's written authorization**
- D. Share general information that does not include the diagnosis

Correct Answer: C

RATIONALE

Patient health information is protected under the Data Privacy Act of 2012 (Philippines) and confidentiality principles. A nurse may not release any patient information to third parties - including admission status or work restrictions - without explicit written authorization from the patient. Exceptions include legally mandated disease reporting, abuse reporting, and court orders.

Q45 Professional Adjustment

A nurse prepares to delegate vital sign collection for a stable patient to a nursing aide. Which framework guides whether this delegation is appropriate?

- A. Right patient, right medication, right dose, right route, right time
- B. Right task, right circumstance, right person, right direction, right supervision**
- C. Right task, right frequency, right person, right environment, right outcome
- D. Right nurse, right aide, right patient, right task, right outcome

Correct Answer: B

RATIONALE

The five rights of delegation are: (1) Right task - appropriate to delegate by policy; (2) Right circumstance - patient is stable; (3) Right person - delegatee has the skills; (4) Right direction - clear, specific instructions given; (5) Right supervision - the RN monitors outcomes. Vital signs for a stable patient is an appropriate delegation. The nurse retains accountability.

Q46 Professional Adjustment

A nurse's PRC license will expire at the end of the year. Which action is required to maintain licensure?

- A. Pass a licensure examination renewal
- B. Complete required CPD units and renew the license before expiration**
- C. Submit a letter of good standing from the employer to the PRC
- D. Wait until the license expires and then reapply

Correct Answer: B

RATIONALE

Philippine PRC licenses are renewed every 3 years. To renew, registered nurses must complete the required Continuing Professional Development (CPD) units within the renewal period as mandated by RA 10912, and submit the renewal application before expiration. There is no re-examination for renewal. Allowing the license to lapse incurs penalties and additional reinstatement requirements.

Q47 Professional Adjustment

A surgeon asks the operating room nurse to assist with a task outside the nurse's scope of practice. Which response is most appropriate?

- A. Perform the task since the surgeon directs all OR staff
- B. Perform the task to avoid conflict and report it afterward
- C. Decline the task, explain the scope limitation, and notify the nursing supervisor**
- D. Ask a senior nurse to perform it without notifying anyone

Correct Answer: C

RATIONALE

Nurses are legally and ethically bound to practice within their defined scope under RA 9173 (Philippine Nursing Act of 2002). Performing tasks outside scope of practice creates legal liability regardless of who directed the task. The nurse must respectfully decline, explain the limitation, and notify the nursing supervisor so the task can be appropriately reassigned. Compliance followed by after-the-fact reporting does not protect the patient.

Q48 Leadership / Research

A nurse witnesses a colleague administer medication to the wrong patient. The charge nurse dismisses the concern and says not to document it. Which action should the nurse take next?

- A. Accept the charge nurse's decision to avoid conflict
- B. Document the error in the patient's chart only
- C. Report the incident through the next level of the chain of command**
- D. Confront the colleague directly without further reporting

Correct Answer: C

RATIONALE

When a patient safety concern is dismissed at one level of the chain of command, the nurse has a professional and ethical obligation to escalate the report to the next level - nursing supervisor, nurse manager, patient safety officer, or risk management. Silence on a medication error that could harm a patient is not acceptable. Incident reports should also be completed per institutional policy.

Q49 Leadership / Research

Before enrolling participants in a wound care protocol study, the researcher explains the purpose, procedures, risks, benefits, and right to withdraw without penalty. Which research principle is being applied?

- A. Beneficence
- B. Justice

C. Respect for persons / Informed consent

- D. Fidelity

Correct Answer: C

RATIONALE

Informed consent in research embodies respect for persons (autonomy) - ensuring participants understand the study and voluntarily choose to participate. It requires disclosure of purpose, procedures, risks, benefits, and the unconditional right to withdraw. Beneficence maximizes benefit and minimizes harm; justice requires fair participant selection; fidelity refers to keeping commitments. Informed consent is mandatory under the National Ethical Guidelines for Health Research (Philippines).

Q50 Leadership / Research

A hospital quality committee reviews data showing higher-than-expected CLABSI rates in the ICU and identifies this as a 'never event.' Which statement best defines a never event?

- A. An adverse outcome that occurs despite appropriate nursing care
- B. A serious, largely preventable adverse event that should never occur in healthcare settings**
- C. A reportable event occurring less than once per year on the unit
- D. A minor complication requiring additional nursing intervention

Correct Answer: B

RATIONALE

Never events (serious reportable events) are serious, largely preventable patient safety incidents that should never occur with proper protocols in place - examples include wrong-site surgery, retained surgical items, and CLABSI from protocol deviation. Per institutional and regulatory policy, never events are expected to be reported and trigger formal root cause analysis and corrective action. The term reflects that these events are considered wholly preventable.

Answer Key

Q# Ans	Q# Ans	Q# Ans	Q# Ans	Q# Ans
1. B	11. C	21. C	31. B	41. B
2. B	12. C	22. B	32. C	42. D
3. C	13. B	23. B	33. B	43. C
4. C	14. B	24. B	34. B	44. C
5. C	15. C	25. B	35. C	45. B
6. B	16. B	26. B	36. C	46. B
7. B	17. C	27. B	37. B	47. C
8. C	18. A	28. B	38. B	48. C
9. B	19. D	29. B	39. B	49. C
10. B	20. B	30. B	40. B	50. B

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