AIIMS NORCET Mains Scenario Based Questions

Q1. A 65-year-old patient with a history of COPD is on oxygen therapy. He suddenly becomes confused and drowsy. What should the nurse do first?
(a) Increase the oxygen flow rate
(b) Assess the patient's respiratory rate and SpO_2
(c) Stop oxygen and call the physician
(d) Prepare for intubation

S1. Ans. (b)
Sol. Sudden confusion in a COPD patient on oxygen may indicate CO_2 retention. Assessing vitals helps determine if oxygen is contributing to hypoventilation. Increasing O_2 without assessment may worsen the condition.

Q2. A primigravida at 38 weeks presents with severe headache, blurred vision, and swelling of hands. Her BP is 160/110 mmHg. What is the priority nursing action?
(a) Check fetal heart rate
(b) Notify the physician immediately
(c) Administer antihypertensive as per prescription
(d) Recheck BP in 30 minutes

S2. Ans. (b)
Sol. These are classic signs of severe preeclampsia. Immediate notification is vital to prevent complications like eclampsia or placental abruption.

Q3. A patient post abdominal surgery reports sudden shortness of breath and sharp chest pain. What should the nurse do first?
(a) Administer analgesics
(b) Raise the head of the bed
(c) Call for a chest X-ray
(d) Encourage coughing and deep breathing

S3. Ans. (b)
Sol. These signs may indicate a pulmonary embolism. Raising the HOB improves oxygenation. Immediate assessment and reporting are essential.

Q4. During medication rounds, a nurse finds an IV drug not charted but patient insists it's prescribed. What should the nurse do?
(a) Give the medication
(b) Check with the physician or medical records
(c) Inform the patient it cannot be given
(d) Ask another nurse

S4. Ans. (b)
Sol. Always verify with the physician or medical order before administering any medication. Administering without a valid prescription is unsafe and unethical.

Q5. A psychiatric patient becomes increasingly agitated and clenches fists. What is the immediate response?
(a) Restrain the patient
(b) Call security
(c) Use a calm voice and talk in a quiet room
(d) Leave the patient alone

S5. Ans. (c)
Sol. Early signs of aggression should be de-escalated using therapeutic communication. Restraint and security are last resorts.

Q6. A postpartum mother has excessive bleeding and a boggy uterus. What is the priority intervention?
(a) Call the physician
(b) Massage the fundus
(c) Start IV fluids and give oxytocin
(d) Monitor vital signs

S6. Ans. (b)
Sol. A boggy uterus indicates uterine atony, the most common cause of postpartum hemorrhage. Fundal massage helps contract the uterus and reduce bleeding.

Q7. A 5-year-old asthmatic presents with wheezing, retractions, and SpO_2 88%. What should the nurse do first?
(a) Start oxygen
(b) Administer bronchodilator
(c) Notify the physician
(d) High Fowler's position

S7. Ans. (a)
Sol. Maintaining oxygenation is always the first priority. Once oxygen is provided, nebulization and other interventions can follow.

Q8. A ventilated ICU patient triggers a low-pressure alarm. Immediate action?
(a) Suction the airway
(b) Reconnect loose tubing
(c) Call respiratory therapist
(d) Check tubing for water

S8. Ans. (b)
Sol. A low-pressure alarm typically indicates disconnection. Reconnecting tubing is the fastest and most effective immediate step.

Q9. A laboring woman has severe abdominal pain, no contractions, and bleeding. What is the condition and action?
(a) Placental abruption – oxygen + IV fluids
(b) Uterine rupture – call obstetrician
(c) Cord prolapse – Trendelenburg
(d) Retained placenta – massage fundus

S9. Ans. (b)
Sol. These are classic signs of uterine rupture. It requires immediate surgical intervention. Delay can risk both mother and fetus.

Q10. A dehydrated 2-year-old on IV becomes irritable with puffy eyelids. What should the nurse suspect?
(a) Infection
(b) Hypoglycemia
(c) Fluid overload
(d) Electrolyte imbalance

S10. Ans. (c)
Sol. Puffy eyelids and irritability in a child on IV fluids are early signs of fluid overload. IV rate should be reassessed immediately.

Q11. A 65-year-old patient with a history of COPD is on oxygen therapy. He suddenly becomes confused and drowsy. What should the nurse do first?
(a) Increase the oxygen flow rate
(b) Assess the patient's respiratory rate and SpO_2
(c) Stop oxygen and call the physician
(d) Prepare for intubation

S11. Ans. (b)
Sol. Sudden confusion in a COPD patient on oxygen may indicate CO_2 retention. Assessing vitals helps determine if oxygen is contributing to hypoventilation. Increasing O_2 without assessment may worsen the condition.

Q12. A primigravida at 38 weeks presents with severe headache, blurred vision, and swelling of hands. Her BP is 160/110 mmHg. What is the priority nursing action?
(a) Check fetal heart rate
(b) Notify the physician immediately
(c) Administer antihypertensive as per prescription
(d) Recheck BP in 30 minutes

S12. Ans. (b)
Sol. These are classic signs of severe preeclampsia. Immediate notification is vital to prevent complications like eclampsia or placental abruption. Other actions follow physician orders.

Q13. A nurse is caring for a patient post abdominal surgery who reports sudden shortness of breath and sharp chest pain. Which of the following actions should the nurse take first?
(a) Administer analgesics
(b) Raise the head of the bed
(c) Call for a chest X-ray
(d) Encourage coughing and deep breathing

S13. Ans. (b)
Sol. These signs may indicate a pulmonary embolism. Raising the HOB improves oxygenation. Immediate assessment and reporting are essential, but initial airway support is the priority.

Q14. During medication rounds, a nurse finds that the prescribed IV medication is not in the patient's chart but the patient insists the doctor ordered it. What should the nurse do?
(a) Give the medication as patient says doctor ordered
(b) Check with the physician or medical records
(c) Inform the patient it cannot be given
(d) Ask another nurse if the patient usually takes it

S14. Ans. (b)
Sol. Always verify with the physician or medical order before administering any medication. Administering without a valid prescription is unsafe and unethical.

Q15. A psychiatric nurse observes a patient in a mental health unit becoming increasingly agitated, pacing and clenching fists. What is the nurse's immediate response?
(a) Restrain the patient
(b) Call security
(c) Use a calm voice and offer to talk in a quiet room
(d) Leave the patient alone to cool down

S15. Ans. (c)
Sol. Early signs of aggression should be de-escalated using therapeutic communication. Restraint and security should only be used if the situation escalates.
