

DUMPSBOSS.

Omani Examination for Nurses

OMSB OMSB OEN

Version Demo

Total Demo Questions: 9

Total Premium Questions: 98

Buy Premium PDF

<https://dumpsboss.co>

support@dumpsboss.co

support@dumpsboss.co
dumpsboss.co

QUESTION NO: 1

The doctor heard a staff nurse saying "That doctor is incompetent".

The doctor can file a complaint against the staff nurse for:

- A. Libel
- B. Assault
- C. Slander
- D. Malpractice

ANSWER: C

Explanation:

Slander is the appropriate term because it is a form of defamation communicated through spoken words. In this situation, the staff nurse made an oral statement alleging that the doctor is incompetent. A statement of this nature can damage a physician's professional reputation, potentially affecting colleagues' confidence, patient trust, and professional standing. For a defamation claim, the statement generally must be communicated to another person, be presented as a false statement of fact rather than protected opinion, and cause or be capable of causing reputational harm. The fact that the doctor heard the statement supports that it was spoken; whether a legal claim ultimately succeeds would depend on the full context, including whether others heard it and whether the assertion was false. In clinical practice, nurses should communicate concerns about a practitioner's competence through appropriate reporting, supervisory, credentialing, or patient-safety channels and use factual, objective documentation. This helps protect patients while maintaining professional accountability and respectful communication. The Legal Information Institute defines slander as spoken defamation and distinguishes it from written defamation. Guidance on professional conduct also emphasizes respectful, ethical communication among health professionals. See [Cornell Legal Information Institute: Slander](#) and the [American Nurses Association Code of Ethics for Nurses](#).

QUESTION NO: 2

A 50-year-old multi-para woman complains of a soft bulge of tissue in her vagina. It is uncomfortable to her and is protruding through her vaginal orifice. The woman expresses her anxiety regarding her situation.

What is the IMMEDIATE action of the nurse?

- A. Refers the woman to the doctor
- B. Educates the woman about her diet
- C. Reassures the woman about her condition
- D. Teaches the woman about Kegel exercises

ANSWER: A

Explanation:

Refers the woman to the doctor is the appropriate immediate action. A symptomatic vaginal bulge that protrudes through the vaginal opening is strongly suggestive of pelvic organ prolapse, which may involve descent of the uterus, bladder, rectum, or vaginal walls. Although it is usually not an emergency in the absence of severe pain, bleeding, urinary retention, or tissue discoloration, the woman needs prompt clinical assessment to confirm the type and degree of prolapse, evaluate associated urinary or bowel symptoms, and determine an individualized management plan. The nurse should provide calm, respectful support while arranging referral, acknowledging the woman's anxiety and maintaining privacy and dignity. Medical assessment enables consideration of conservative measures, such as pelvic-floor rehabilitation or a vaginal pessary, as well as specialist treatment if symptoms are substantial. The American College of Obstetricians and Gynecologists notes that pelvic organ prolapse is assessed through history and pelvic examination, with treatment guided by symptoms and patient goals. Referral therefore ensures timely diagnosis and appropriate counseling rather than relying on education alone. See [ACOG: Pelvic Support Problems](#) and [NHS: Pelvic organ prolapse](#).

QUESTION NO: 3

A nursing student who has a high percentage of absenteeism frequently visits the health center complaining of GI symptoms before examinations. The student continues to believe of having a terminal illness despite normal test results.

The student is MOST probably suffering from:

- A. Conversion
- B. Derealization
- C. Hypochondriasis
- D. Depersonalization

ANSWER: C

Explanation:

Hypochondriasis is the correct diagnosis because the central feature is a persistent, excessive fear or belief that one has a serious or terminal disease despite normal investigation results and medical reassurance. The student repeatedly seeks assessment for gastrointestinal symptoms and remains convinced of severe illness even though testing has not identified a medical cause. This pattern reflects an illness-focused preoccupation rather than a transient, proportionate concern about symptoms. The timing around examinations may indicate that stress intensifies bodily sensations and health-related anxiety, but the defining diagnostic clue is the continuing conviction of grave disease in the face of reassuring evidence. In current DSM-5 terminology, the historical term hypochondriasis is generally encompassed by illness anxiety disorder when somatic symptoms are absent or mild; when symptoms are prominent and distressing, a somatic symptom disorder formulation may be considered. However, for this question's terminology and the described persistent fear of terminal illness after normal results, hypochondriasis is the intended and best answer. Further diagnostic information is available in the [Merck Manual overview of illness anxiety disorder](#) and the [NCBI StatPearls review](#).

QUESTION NO: 4

A nurse is assessing a patient admitted with major depression. The patient states, "My family would be better off without me."

Which of the following responses by the nurse is MOST appropriate?

- A. "You should focus on the people who need you."
- B. "Are you thinking about harming yourself?"
- C. "You will feel better after you have rested."
- D. "Try not to worry about things you cannot change."

ANSWER: B

Explanation:

"Are you thinking about harming yourself?" is the most appropriate response because it directly assesses suicidal ideation. Asking about suicide does not create suicidal thoughts; rather, it allows the nurse to identify immediate risk and take protective action. If the patient confirms suicidal thoughts, the nurse should assess plan, means, intent, previous attempts, and protective factors, maintain safety precautions, and notify the appropriate healthcare team. Changing the subject or offering reassurance without assessment may miss an urgent safety concern.

QUESTION NO: 5

A nurse is assigned to provide health teaching about the prevention strategies for a patient who complains of frequent severe low back pain.

Which of the following exercises would the nurse include in the teaching?

- A. Sit-ups
- B. Leg lifts
- C. Running
- D. Swimming

ANSWER: D

Explanation:

Swimming is an appropriate exercise to include because it provides aerobic conditioning while placing relatively little impact and mechanical loading on the spine. Water buoyancy supports part of the body's weight, which can allow a person with low back pain to move more comfortably and practise gentle trunk, hip, and leg movements. Regular, appropriately paced physical activity can help maintain mobility, improve general fitness, and strengthen muscles that contribute to spinal support. Swimming may therefore be a useful component of a back-pain prevention and self-management plan, particularly when it is begun gradually and adjusted to the individual's symptoms and ability. The nurse should encourage the patient to use a comfortable stroke and intensity, warm up, and stop activity that clearly aggravates symptoms. Because the pain is described as frequent and severe, exercise teaching should also be accompanied by clinical assessment for red-flag symptoms and individualized advice from the treating clinician or physiotherapist. The National Institute for Health and Care Excellence recommends supporting people with low back pain to continue normal activities and to participate in exercise programmes tailored to their needs. The American Academy of Orthopaedic Surgeons also identifies low-impact aerobic exercise, including aquatic exercise, as useful in back-conditioning programmes. See [NICE guideline NG59](#) and [AAOS Low Back Conditioning Program](#).

QUESTION NO: 6

A nurse is visiting an Asian family and found that both parents have cardiac problems. The nurse is aware of Asian genetic predisposition to cardiovascular diseases.

The nurse assessment falls below which of the following cultural assessment category?

- A. Bio-cultural factors
- B. Socio-cultural practices
- C. Ethnic/racial background
- D. Cultural dietary practices

ANSWER: A

Explanation:

Bio-cultural factors is correct because this cultural-assessment category addresses biologic features that may affect health, including inherited traits, genetic risk, physiologic variation, and patterns of disease susceptibility. In the scenario, the assessment focus is the parents' cardiac history together with a possible inherited predisposition to cardiovascular disease. Family history is clinically relevant because it can identify people who may have an increased risk of coronary heart disease and can guide individualized prevention, screening, education, and referral. The National Heart, Lung, and Blood Institute notes that family history is a risk factor for coronary heart disease and should be considered alongside modifiable risks such as blood pressure, cholesterol, smoking, diabetes, physical activity, and diet. See [NHLBI: Coronary Heart Disease Causes and Risk Factors](#). The nurse should use bio-cultural information as one component of a person-centred assessment, rather than assuming that every person within a broad racial or ethnic population has the same genetic risk. A culturally safe assessment verifies the individual family history, diagnoses, lifestyle, access to care, and the family's own health beliefs. This approach supports appropriate cardiovascular risk assessment while avoiding stereotyping. The CDC also emphasizes that cardiovascular risk is influenced by multiple health and social factors, as described at [CDC: Heart Disease Risk Factors](#).

QUESTION NO: 7

A nurse is educating a client who was involved in a gunshot incident for the purpose of preventing post-trauma syndrome.

Which of the following behaviors indicates client's understanding of the education?

- A. Client expresses beliefs and values freely
- B. Client demonstrates an increase in activity level
- C. Client maintains anxiety level at manageable level
- D. Client demonstrates ability to deal with emotional reactions

ANSWER: D

Explanation:

Client demonstrates ability to deal with emotional reactions is the best indicator that education aimed at preventing post-traumatic stress symptoms has been understood. Following a violent event such as a gunshot incident, emotional responses can include fear, helplessness, anger, sadness, intrusive memories, disturbed sleep, and heightened alertness. Effective early coping does not mean that the client has no emotional reaction; rather, it means the client can recognize reactions, express feelings safely, use supportive coping strategies, and seek assistance when symptoms become distressing or persistent. This reflects emotional processing and adaptive coping, both of which are central nursing goals after trauma exposure.

Nursing education should encourage the client to discuss the event and related feelings at a tolerable pace, use available social supports, maintain routines as appropriate, and obtain professional mental-health assessment if symptoms interfere with functioning or continue. The National Institute of Mental Health notes that post-traumatic stress disorder may involve ongoing distressing symptoms after a traumatic event and that effective treatments are available. The American Psychiatric Association also describes trauma-related symptoms and their functional impact in its clinical information on PTSD. These principles support evaluating understanding through the client's demonstrated capacity to manage and respond constructively to emotional reactions. See [NIMH: Post-Traumatic Stress Disorder](#) and [American Psychiatric Association: What Is PTSD?](#).

QUESTION NO: 8

A nurse is checking laboratory findings of a patient with Sickle Cell Disease (SCD).

Which of the following laboratory values would be MOSTLY seen in this disease?

- A. High platelet level
- B. Low hematocrit level
- C. Low leucocyte level
- D. High reticulocyte level

ANSWER: D

Explanation:

High reticulocyte level is the best answer because sickle cell disease causes chronic hemolytic anemia. Sickled red cells have a markedly shortened life span and are continuously removed from circulation, particularly by the spleen and other components of the reticuloendothelial system. In response to the reduced circulating red-cell mass and reduced oxygen-carrying capacity, the kidneys increase erythropoietin production. Erythropoietin stimulates the bone marrow to accelerate erythropoiesis and release more reticulocytes, which are immature red blood cells, into peripheral blood. Therefore, an elevated reticulocyte count is an expected marker of an appropriate marrow response to ongoing hemolysis in a patient with sickle cell disease. Reticulocyte measurement is clinically useful when assessing anemia in this population: a count that is lower than expected for the degree of anemia may suggest an additional problem, such as marrow suppression or aplastic crisis. The National Heart, Lung, and Blood Institute describes sickle cell disease as a disorder in which red blood cells

become rigid and die early, producing anemia and related complications. See the [NHLBI overview of sickle cell disease](#) and the [American Society of Hematology patient resource on sickle cell disease](#).

QUESTION NO: 9

A nurse is preparing a mixed insulin dose of regular insulin and NPH insulin for a patient with diabetes mellitus.

Which of the following actions is correct?

- A. Draw up NPH insulin before regular insulin
- B. Draw up regular insulin before NPH insulin
- C. Mix the two insulins by shaking both vials vigorously
- D. Withdraw insulin from the cloudy vial only

ANSWER: B

Explanation:

The nurse should draw up regular insulin before NPH insulin. Regular insulin is clear and NPH insulin is cloudy. Drawing the clear insulin first prevents contamination of the regular-insulin vial with NPH insulin, which could alter the action of future doses. The nurse should verify the prescribed doses, inject air into the NPH vial first, inject air into the regular-insulin vial, and then withdraw the regular insulin before the NPH insulin.