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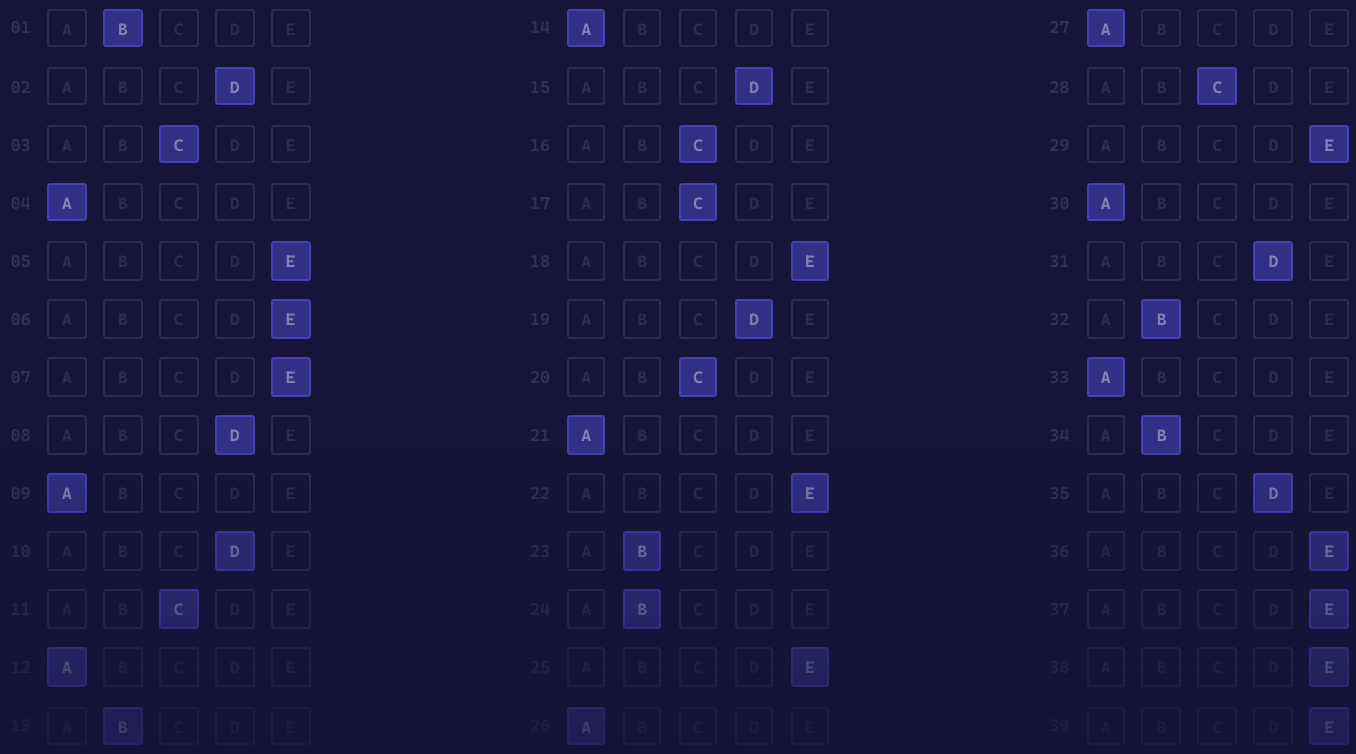

PRACTICE QUESTIONS

Inspire Global Assessments/Inspire Évaluations Mondiales

ADV

Registered Nurse

EDITION	QUESTIONS	FORMAT
Demo	9	Limited Edition PDF

WEB www.mometrix.net

SUPPORT support@mometrix.net

Before you begin

What this is

9 practice questions for Inspire Global Assessments/Inspire Évaluations Mondiales `ADV`, each with its answer key and an explanation. Answer a question before you read its key — the explanation is worth more once you have committed.

If something looks wrong

Send us three things and we will check it:

- the exam code, `ADV`
- the question number
- the email address on your order

Write to **support@mometrix.net**. We reply within one business day.

QUESTION 1 SINGLE CHOICE

A nurse is preparing to administer heparin subcutaneously to a patient. Which action is essential before giving the injection?

A Aspirate the syringe after needle insertion to confirm placement

B Verify the patient's identity using two identifiers and confirm the correct dose

C Massage the injection site to enhance absorption

D Administer the injection at a 90-degree angle using a 1-inch needle into the deltoid

ANSWER B

WHY Two-identifier patient verification and correct-dose confirmation are core safety steps in medication administration (rights of medication administration). Heparin is given subcutaneously into the abdomen (not the deltoid), the injection is given at 90 degrees without aspiration, and the site should NOT be massaged because massage can cause bruising/bleeding from the anticoagulant effect.

QUESTION 2 SINGLE CHOICE

Which step of the nursing process involves establishing measurable, time-limited goals and expected outcomes for the patient?

A Assessment

B Diagnosis

C Planning

D Evaluation

ANSWER C

WHY Planning is the third step of the nursing process, in which the nurse formulates SMART goals (Specific, Measurable, Achievable, Relevant, Time-limited) and identifies expected outcomes. Assessment gathers data, diagnosis identifies the clinical judgment, and evaluation determines whether outcomes have been met.

QUESTION 3 SINGLE CHOICE

An adult patient suddenly becomes unresponsive and pulseless. According to current basic life support guidelines, what is the correct compression rate and depth?

A 60 to 80 compressions per minute, depth of 1 inch (2.5 cm)

B 100 to 120 compressions per minute, depth of at least 2 inches (5 cm)

C 80 to 100 compressions per minute, depth of 1.5 inches (3.8 cm)

D 120 to 140 compressions per minute, depth of 3 inches (7.5 cm)

ANSWER B

WHY Current AHA BLS guidelines for adult CPR specify a compression rate of 100–120 per minute and a depth of at least 2 inches (5 cm) but not more than 2.4 inches (6 cm). Allowing complete chest recoil and minimizing interruptions are also emphasized.

QUESTION 4 SINGLE CHOICE

Which personal protective equipment (PPE) combination is required when caring for a patient on airborne precautions for suspected pulmonary tuberculosis?

A Surgical mask only

B Gown and gloves only

C N95 respirator, gown, gloves, and eye/face protection if splash risk exists

D Goggles and a surgical mask

ANSWER C

WHY Airborne precautions require a fit-tested N95 (or higher-level) respirator because M. tuberculosis is transmitted via small airborne droplet nuclei that remain suspended. Gown and gloves are added per standard precautions, and eye/face protection is added when splashes or sprays are anticipated. A standard surgical mask is insufficient for airborne pathogens.

QUESTION 5 SINGLE CHOICE

A nurse witnesses a colleague falsifying a patient's vital signs in the medical record. What is the most appropriate initial action?

A Confront the colleague directly at the nurses' station

B Report the observation to the unit charge nurse or nurse manager following the institution's chain of reporting

C Call the news media to expose the misconduct

D Wait to see if the behavior happens again before acting

ANSWER B

WHY Falsifying documentation is a breach of professional, ethical (e.g., ANA Code of Ethics) and legal standards. Nurses have a duty to report through the appropriate chain of command, beginning with the charge nurse or manager, who can escalate to administration and the licensing board. Direct confrontation at the nurses' station is not the proper reporting channel, going to the media bypasses institutional process, and waiting is a failure to act.

QUESTION 6 SINGLE CHOICE

When providing discharge teaching to a patient newly diagnosed with type 2 diabetes, which statement by the nurse best demonstrates effective patient education?

A You must follow the diabetic diet exactly as written and never deviate.

B Let's review your glucometer use so you feel confident checking your blood sugar at home.

C Don't worry about your medications; the nurse will give them to you.

D Diabetes is not a serious disease and you will be fine as long as you take a pill.

ANSWER B

WHY Effective patient education assesses readiness, builds on the patient's existing knowledge, involves teach-back and hands-on demonstration, and promotes self-management. Options A and D are authoritarian or dismissive, and option C discourages self-care and is inaccurate about post-discharge responsibility.

QUESTION 7 SINGLE CHOICE

A patient receiving IV potassium replacement reports burning at the IV site and the site appears red and swollen. What is the nurse's priority action?

A Increase the infusion rate to complete the replacement quickly

B Stop the infusion immediately and assess the site, as extravasation is suspected

C Apply warm compresses only

D Document the finding but continue the infusion

ANSWER B

WHY Signs of burning, redness, and swelling at an IV site during potassium infusion suggest infiltration or extravasation. Potassium is irritating and can cause tissue injury; the priority is to stop the infusion, disconnect it, assess the site, remove the catheter if needed, and notify the prescriber. Increasing the rate worsens the injury, and continuing the infusion is unsafe.

QUESTION 8 SINGLE CHOICE

A patient is prescribed an opioid analgesic by patient-controlled analgesia (PCA). Which nursing assessment is most important before administering a bolus dose?

A Verifying the patient's favorite music preference

B Assessing pain level using a standardized pain scale and respiratory status including rate and sedation level

C Confirming the patient's dietary preferences

D Asking the patient to rate their satisfaction with the hospital

ANSWER B

WHY Pain assessment using a standardized scale (e.g., 0–10) and respiratory assessment (rate, depth, sedation score such as the Pasero Opioid-Induced Sedation Scale) are essential before and during PCA opioid therapy because opioids can cause life-threatening respiratory depression. Music preference, diet, and satisfaction are not related to safe opioid administration.

QUESTION 9 MULTIPLE CHOICE

Which of the following are components of informed consent that the nurse must confirm before a patient signs a procedure consent form? (Choose two.)

A **The patient has been informed of the procedure's purpose, risks, benefits, and alternatives**

B **The patient voluntarily agrees and demonstrates understanding**

C The patient signs without reading the document

D The patient is given a routine dose of sedation before signing

ANSWER **A** · **B**

WHY Informed consent requires disclosure of relevant information (purpose, risks, benefits, alternatives), voluntariness, and demonstrated comprehension by the patient. Signing without reading (C) does not demonstrate understanding, and sedation before signing (D) impairs decisional capacity and therefore invalidates consent.