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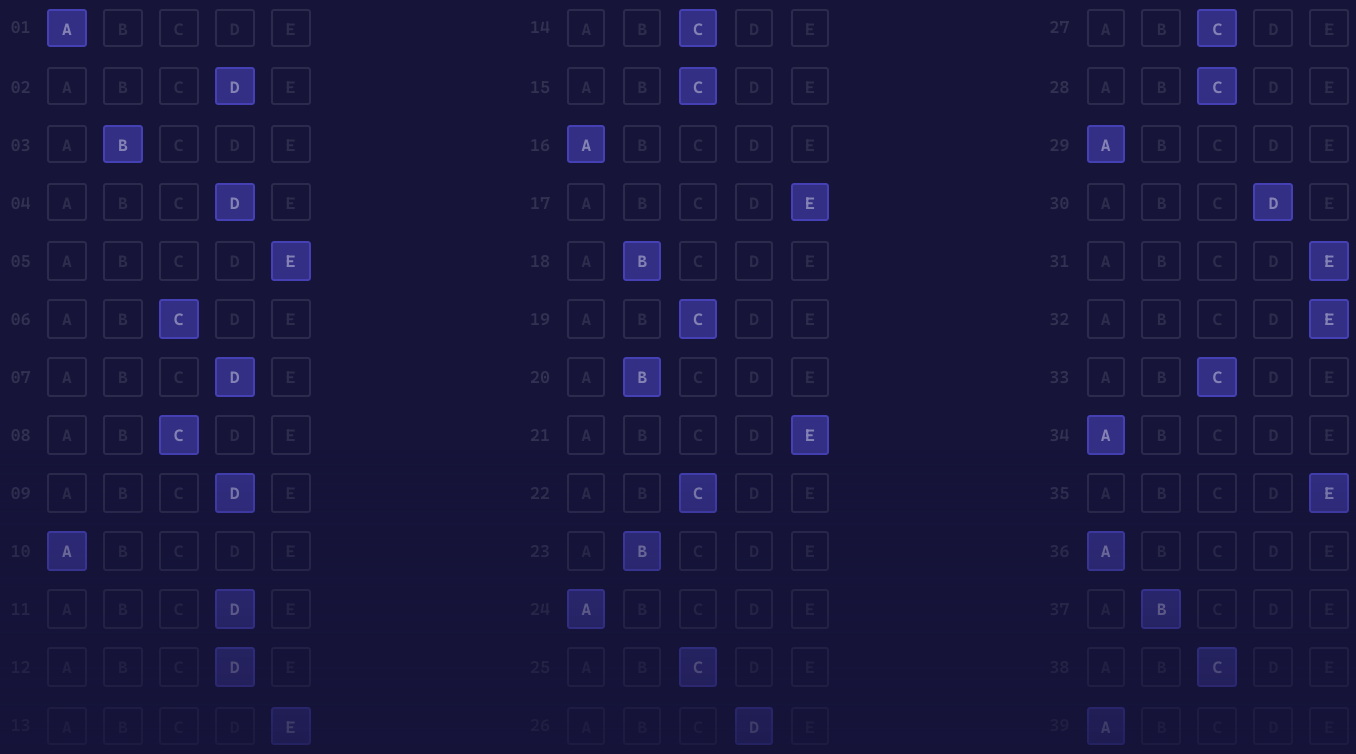

PRACTICE QUESTIONS

Elsevier Remotely Proctored Exams

PA2C2

PN Admission Assessment with Critical Thinking Version 2

EDITION	QUESTIONS	FORMAT
Demo	9	Limited Edition PDF

WEB www.mometrix.net

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Before you begin

What this is

9 practice questions for Elsevier Remotely Proctored Exams `PA2C2`, 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, `PA2C2`
- 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 client is one day postoperative abdominal surgery and reports pain rated 8 on a 0-10 scale. The client's vital signs are BP 140/90, HR 104, RR 22. Which is the most appropriate first nursing action?

A **Administer the prescribed PRN analgesic medication**

B Reassess the pain in 30 minutes to determine a trend

C Notify the surgeon of the elevated vital signs

D Document the findings and continue to monitor

ANSWER A

WHY Postoperative pain rated 8/10 with associated tachycardia and tachypnea requires prompt intervention. The nurse should administer the prescribed PRN analgesic and then reassess. Waiting to reassess without intervention delays pain relief, and the findings alone do not require immediate notification of the surgeon.

QUESTION 2 SINGLE CHOICE

A client with type 2 diabetes mellitus has a blood glucose level of 60 mg/dL. Which assessment finding would the nurse expect to observe?

A Polyuria and dehydration

B Kussmaul respirations and fruity breath

C **Diaphoresis, tremors, and tachycardia**

D Flushed skin and slow, shallow respirations

ANSWER C

WHY A blood glucose of 60 mg/dL indicates hypoglycemia. The sympathetic nervous system response to hypoglycemia causes diaphoresis, tremors, tachycardia, anxiety, and hunger. Polyuria and Kussmaul respirations with fruity breath are associated with hyperglycemia and diabetic ketoacidosis, not hypoglycemia.

QUESTION 3 SINGLE CHOICE

A client has a fracture of the left femur. The nurse assesses for which complication that is most likely to develop within the first 24 hours after injury?

A Fat embolism syndrome

B Compartment syndrome

C Osteomyelitis

D Pulmonary embolism

ANSWER B

WHY Compartment syndrome is an early complication of fractures, particularly long bone fractures such as the femur. It typically develops within the first 24-48 hours due to increased pressure within a fascial compartment, which compromises circulation and tissue perfusion. Fat embolism syndrome usually develops 24-72 hours after injury, osteomyelitis is a later infectious complication, and pulmonary embolism typically occurs later due to immobility.

QUESTION 4 SINGLE CHOICE

A client has just been admitted with a diagnosis of rule-out myocardial infarction. Which assessment finding would the practical nurse report to the registered nurse immediately?

A Client reports pain rated 5 on a 0-10 scale

B Client has not eaten breakfast

C Client states anxiety about test results

D Client's family is requesting visiting hours

ANSWER A

WHY Chest pain rated 5/10 in a client being evaluated for myocardial infarction requires immediate reporting to the registered nurse because it may indicate ongoing cardiac ischemia and the need for intervention. The other options are routine psychosocial or logistical concerns that do not require immediate RN notification.

QUESTION 5 SINGLE CHOICE

A client with chronic obstructive pulmonary disease (COPD) has an oxygen saturation of 88% on room air. Which is the priority nursing action?

A Apply supplemental oxygen via nasal cannula at 2 L/min

B Place the client in high Fowler's position

C Encourage the client to take slow, deep breaths

D Notify the healthcare provider of the oxygen saturation

ANSWER B

WHY Placing the client in high Fowler's position is the priority nursing action because it maximizes lung expansion and improves oxygenation without the risk of oxygen-induced respiratory depression that can occur with high-flow oxygen in COPD clients. While oxygen may be needed, it must be administered at low flow rates in COPD clients to avoid suppressing their hypoxic drive. Slow, deep breaths are beneficial but positioning takes priority for immediate oxygenation improvement.

QUESTION 6 SINGLE CHOICE

An elderly client is admitted with a diagnosis of dehydration. Which assessment finding is most consistent with this diagnosis?

A Bounding peripheral pulses

B Distended neck veins

C Dry mucous membranes and tenting skin

D Crackles bilaterally in the lung bases

ANSWER C

WHY Dry mucous membranes and skin tenting (poor skin turgor) are classic signs of dehydration in the elderly. Bounding pulses, distended neck veins, and crackles in the lung bases are more consistent with fluid volume excess, not deficit.

QUESTION 7 SINGLE CHOICE

A client with a history of seizures is admitted to the nursing unit. Which action is most important for the practical nurse to include in the plan of care?

A Keep the client's bed in the high position with all side rails up

B Ensure that the client's oxygen and suction equipment are at the bedside

C Restrain the client during a seizure to prevent injury

D Place a tongue depressor at the bedside for use during a seizure

ANSWER B

WHY Maintaining oxygen and suction equipment at the bedside is essential for clients with seizure disorders to manage airway and breathing during and after a seizure. The bed should be in the lowest position, not high. Clients should never be restrained during a seizure because this can cause injury. Tongue depressors should never be inserted into the mouth during a seizure due to the risk of injury and broken teeth.

QUESTION 8 SINGLE CHOICE

A client receiving heparin therapy develops tarry, black stools. Which is the priority nursing action?

A Document the finding and continue to monitor

B Notify the healthcare provider immediately

C Encourage the client to increase fluid intake

D Administer a prescribed antacid medication

ANSWER B

WHY Tarry, black stools (melena) indicate upper gastrointestinal bleeding. In a client receiving heparin therapy, this is a serious complication that requires immediate notification of the healthcare provider, who may need to discontinue the heparin and evaluate the client for bleeding. Continuing to monitor without notifying the provider delays necessary medical intervention.

QUESTION 9 SINGLE CHOICE

A client newly diagnosed with breast cancer states, 'I just know the surgery won't work and I'll never be the same again.' Which response by the practical nurse is most therapeutic?

A 'Don't worry; the surgeon has an excellent success rate.'

B **'Why do you feel that way? Tell me more about what concerns you most.'**

C 'Many women feel that way at first, but you should stay positive.'

D 'Let's not focus on negatives; you need to think about recovery.'

ANSWER **B**

WHY Therapeutic communication uses open-ended statements that invite the client to elaborate and explore feelings. Option B is nonjudgmental and encourages further expression. Option A provides false reassurance, Option C dismisses feelings with a cliché, and Option D shuts down communication by redirecting away from the client's concern.