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39	A	B	C	D	E

PRACTICE QUESTIONS

Elsevier Remotely Proctored Exams

RA2V2

RN Admission Assessment Version 2

EDITION

Demo

QUESTIONS

9

FORMAT

Limited Edition PDF

Before you begin

What this is

9 practice questions for Elsevier Remotely Proctored Exams **RA2V2**, 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, **RA2V2**
- the question number
- the email address on your order

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

QUESTION 1

SINGLE CHOICE

When initiating a nursing admission assessment, which initial action by the registered nurse (RN) is most appropriate?

- ☐ A Perform a full head-to-toe physical examination before introducing yourself to the patient.
- ☒ B Introduce yourself, verify the patient's identity using two identifiers, and explain the purpose of the assessment.
- ☐ C Begin documenting the patient's medical history in the electronic health record before gathering any information.
- ☐ D Delegate the collection of vital signs to unlicensed assistive personnel while starting the interview.

ANSWER B

WHY The first step in a nursing admission assessment is to establish rapport, verify patient identity using two identifiers (per safety standards such as The Joint Commission), and explain the assessment process. Performing the physical exam, documenting, or delegating before engaging with the patient is premature and does not align with patient-centered, safety-focused admission practice.

QUESTION 2

SINGLE CHOICE

A patient is admitted with a language barrier and reports pain. Which pain assessment tool is most appropriate for the RN to use first?

- ☐ A Numeric Rating Scale (0–10) using written instructions in the patient's primary language.
- ☒ B Wong-Baker FACES Pain Rating Scale with culturally appropriate visual cues.
- ☐ C Verbal descriptor scale requiring the patient to read English adjectives.
- ☐ D Critically ill patient (CPOT) behavioral tool as a first-line measure.

ANSWER B

WHY When a patient has a language barrier, the Wong-Baker FACES Pain Rating Scale is widely recommended because it uses universal facial expressions and does not require the patient to read or speak a specific language. The Numeric and Verbal Descriptor scales depend on language proficiency, and the CPOT is reserved for non-verbal/critically ill patients.

QUESTION 3

SINGLE CHOICE

During an admission assessment, which finding is classified as objective data?

- ☐ A The patient states, 'I feel short of breath when I walk to the bathroom.'
- ☐ B The patient reports an ache of 9 on a 0–10 pain scale.
- ☒ C The nurse auscultates crackles in the bilateral lower lung lobes.
- ☐ D The patient expresses anxiety about upcoming surgery.

ANSWER C

WHY Objective data are measurable, observable findings the nurse detects through examination, inspection, auscultation, percussion, or palpation. Crackles heard on auscultation are objective. The other options are subjective data because they reflect what the patient reports or feels.

QUESTION 4

SINGLE CHOICE

Which patient factor identified at admission places the patient at highest risk for falls?

- ☐ A Admission for an elective same-day procedure.
- ☐ B History of hypertension controlled with one antihypertensive medication.
- ☒ C Recent administration of a sedative-hypnotic and unsteady gait.
- ☐ D Patient is 45 years old with no prior fall history.

ANSWER C

WHY Recent sedative-hypnotic administration combined with unsteady gait represents a high fall-risk profile commonly captured by validated tools such as the Morse Fall Scale (which includes mental status, history of falling, secondary diagnosis, ambulatory aid, IV/heparin lock, and gait). The other scenarios reflect low-risk patients.

QUESTION 5

SINGLE CHOICE

When performing a psychosocial admission assessment, which question by the RN best elicits the patient's coping patterns and support systems?

- ☐ A What prescribed medications do you take at home?
- ☒ B Who do you rely on for help when you are ill, and how have you handled stressful situations in the past?
- ☐ C Can you describe the location and quality of any pain you are having?
- ☐ D Do you have any drug or food allergies?

ANSWER B

WHY Psychosocial assessment focuses on emotional state, support systems, and coping mechanisms. Asking about who helps when ill and prior coping strategies directly assesses these areas. Medication, pain, and allergy questions belong to the biophysical history and are not the focus of the psychosocial portion.

QUESTION 6

SINGLE CHOICE

The RN is performing admission medication reconciliation. Which action is essential to complete this process accurately?

- ☐ A Copy the medication list from a previous visit without re-verification.
- ☒ B Ask the patient to bring all current medication containers, including OTCs and supplements, and compare them to prescribed orders.
- ☐ C Rely solely on the pharmacy fill history for accuracy.
- ☐ D Document only scheduled prescription medications.

ANSWER B

WHY Accurate medication reconciliation (a Joint Commission National Patient Safety Goal) requires comparing what the patient is actually taking—including OTCs, herbal products, and supplements—with newly prescribed orders, ideally using the 'brown bag' method. Copying old lists, relying only on pharmacy data, or omitting OTCs creates risk for omissions, duplications, and interactions.

QUESTION 7

SINGLE CHOICE

A patient is admitted from a long-term care facility with a draining foot wound and a productive cough. Which transmission-based precaution should the RN initiate first?

- ☐ A Strict isolation for all body fluids regardless of confirmed diagnosis.
- ☐ B Standard precautions only, because the diagnosis is unknown.
- ☒ C Contact precautions for the wound and airborne precautions for the cough until further workup clarifies the etiology.
- ☐ D Droplet precautions only.

ANSWER C

WHY Standard precautions apply to all patients, but additional transmission-based precautions are added based on presenting signs. A draining wound suggests contact precautions, and a productive cough suggests droplet or airborne precautions depending on suspected pathogen. Initiating both pending diagnostic clarification is appropriate until ruled out.

QUESTION 8

SINGLE CHOICE

On admission, the patient states they have an advance directive at home but did not bring it. What is the most appropriate RN action?

- ☐ A Document that the patient has none because the document is not on file.
- ☐ B Tell the patient the document is not needed.
- ☒ C Note the patient's verbal report in the chart, advise them to provide a copy, and continue the admission process without delaying care.
- ☐ D Refuse admission until the document is produced.

ANSWER C

WHY Per patient rights and the Patient Self-Determination Act, the hospital must ask about and document advance directive status but cannot deny care. Recording the patient's verbal statement, encouraging them to supply the document, and proceeding with care is correct. Documenting 'none' or refusing admission is incorrect.

QUESTION 9

SINGLE CHOICE

A registered nurse is completing an admission assessment on a newly admitted adult patient. Which component of the assessment is primarily intended to establish a baseline against which future clinical changes can be compared?

- ☐ A The patient's stated goals for the hospitalization
- ☒ B A full set of vital signs and physical examination findings
- ☐ C The patient's preferred learning style
- ☐ D A review of advance directive documentation

ANSWER B

WHY Vital signs and physical examination findings provide an objective baseline of the patient's initial clinical status, allowing the nurse to detect and document changes that occur throughout the hospital stay. Patient goals, learning preferences, and advance directive review, while important, do not serve as clinical comparison points.