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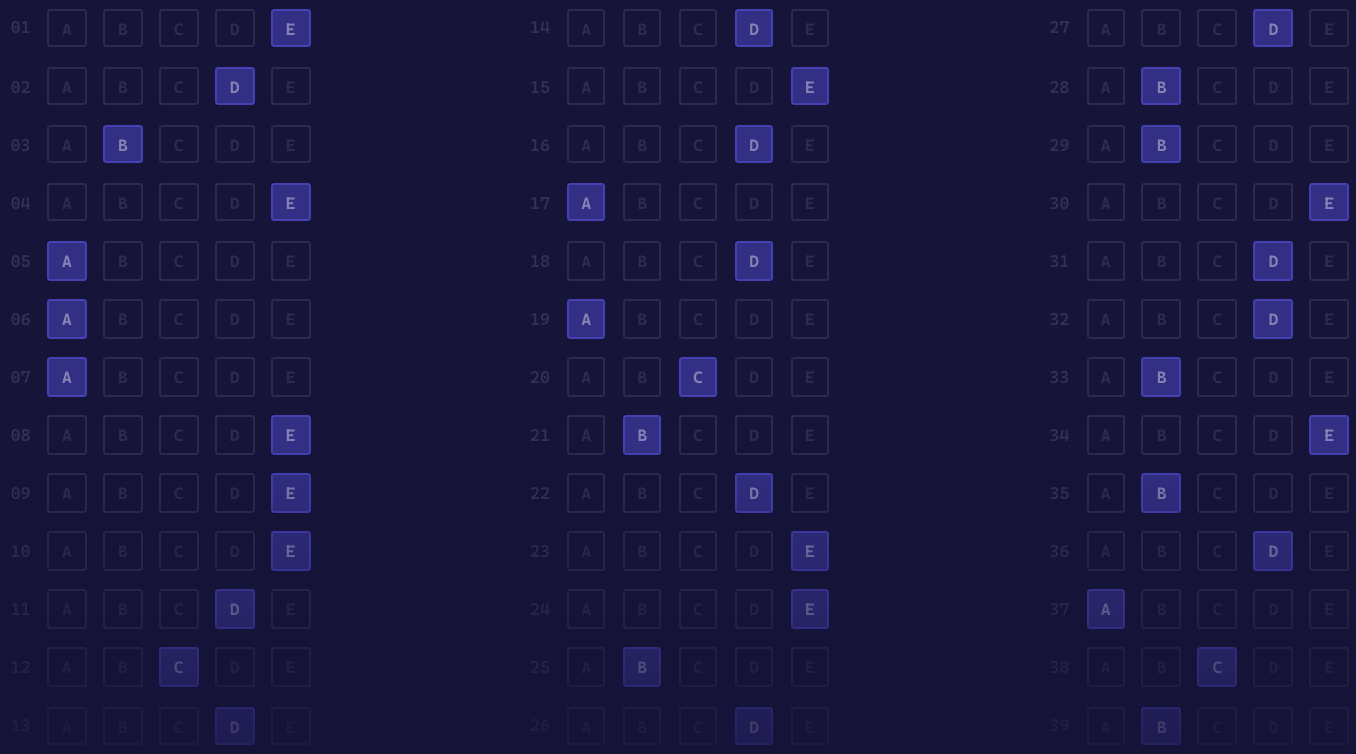

PRACTICE QUESTIONS

Elsevier Remotely Proctored Exams

RNCTT

Registered Nursing Critical Thinking Test

EDITION	QUESTIONS	FORMAT
Demo	9	Limited Edition PDF

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Before you begin

What this is

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

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

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QUESTION 1 SINGLE CHOICE

A nurse enters a patient's room and sees the patient grimacing while lying still in bed. The patient states, 'I'm fine, just tired.' Which statement best identifies an assumption the nurse is making when deciding whether to assess pain further?

A The patient has the right to refuse pain medication.

B **The patient's verbal report should be interpreted alongside nonverbal cues such as grimacing.**

C Pain assessment must include vital signs before any intervention.

D All patients who grimace are experiencing moderate to severe pain.

ANSWER B

WHY Assumption identification requires recognizing what the nurse is taking for granted. The nurse is assuming that the patient's verbal denial overrides the nonverbal cue of grimacing. Option B correctly states the critical-thinking principle that subjective report and nonverbal data should be interpreted together. Option A is a patient-rights principle, not an assumption being made. Option C invents an order of assessment steps that does not exist. Option D is an unsupported generalization, not a defensible clinical assumption.

QUESTION 2 SINGLE CHOICE

A post-operative patient is diaphoretic, has a heart rate of 118 beats per minute, and reports incisional pain rated 8 out of 10. Which statement represents a clinical inference rather than an interpretation?

A The patient is describing pain using a numeric rating scale.

B The patient's vital signs are elevated above baseline.

C **The pain and tachycardia suggest possible inadequate pain control or early hypovolemia.**

D The numeric rating scale is a standard self-report pain assessment tool.

ANSWER C

WHY Interpretation assigns meaning to data within the data itself (describing or labeling what is observed). Inference goes further by drawing a probable conclusion that is not directly stated. Option C moves beyond describing findings to concluding what they likely mean. Options A, B, and D describe or label data and therefore reflect interpretation, not inference.

QUESTION 3 SINGLE CHOICE

Using the ABCDE (Airway, Breathing, Circulation, Disability, Exposure) prioritization framework, which patient should the nurse assess first?

A **A patient with a surgical dressing that is saturated with bright red blood.**

B A patient reporting incisional pain rated 6 out of 10 after ambulation.

C A patient who is alert and oriented but requests assistance turning in bed.

D A patient waiting for discharge education on wound care.

ANSWER A

WHY Within ABCDE prioritization, Circulation concerns threats from bleeding. Saturated bright red bleeding from a surgical site is an active Circulation problem that can rapidly compromise perfusion. Pain management, repositioning, and discharge teaching are important but are lower priority than an active bleeding threat. This question tests application of the framework to triage competing demands.

QUESTION 4 SINGLE CHOICE

An elderly patient with a history of chronic pain reports new abdominal pain rated 9 out of 10. The nurse thinks, 'Elderly patients always exaggerate pain.' Which critical-thinking error is the nurse demonstrating?

A Confirmation bias

B Availability heuristic

C **Stereotyping based on age**

D Anchoring on a previous diagnosis

ANSWER C

WHY The nurse's belief that 'elderly patients always exaggerate pain' is a generalization applied because of the patient's age group. That is age-based stereotyping. Confirmation bias involves seeking data that supports an existing belief; the availability heuristic involves judging likelihood by what comes easily to mind; anchoring involves fixating on an initial impression. None of those fit as well as stereotyping.

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QUESTION 5 SINGLE CHOICE

A nurse reviews assessment data on four hospitalized patients with dyspnea and notices they all have decreased oxygen saturation, tachypnea, and use of accessory muscles. The nurse concludes that hypoxemia typically presents with these findings. Which type of reasoning is the nurse using?

A Deductive reasoning, applying a general principle to a specific case

B Inductive reasoning, forming a generalization from specific observations

C Diagnostic reasoning, applying a single disease label to the cluster

D Intuitive reasoning, relying on pattern recognition without data

ANSWER B

WHY Inductive reasoning moves from specific observations to a general conclusion, which is exactly what the nurse is doing by generalizing from four cases to a typical presentation. Deductive reasoning moves the opposite direction, from a general rule to a specific case. Diagnostic reasoning is a separate clinical process that assigns a label, and intuitive reasoning involves pattern recognition independent of deliberate data review.

QUESTION 6 SINGLE CHOICE

A colleague argues, 'Patient X had nausea after starting medication Y, so medication Y always causes nausea.' Which logical fallacy is the colleague committing?

A Hasty generalization

B Post hoc ergo propter hoc

C Ad hominem

D Red herring

ANSWER A

WHY Drawing a universal conclusion ('always causes') from a single case is the textbook definition of hasty generalization. Post hoc ergo propter hoc would require claiming the medication caused the nausea because the nausea followed it in time; that is a related but distinct temporal-causation error. Ad hominem attacks the person making the argument, and red herring introduces an unrelated topic. The phrasing here is about universal scope from one case, which fits hasty generalization.

QUESTION 7 SINGLE CHOICE

Which item represents a sign rather than a symptom?

A A patient reports nausea after eating.

B A patient rates dizziness as 7 out of 10.

C A patient has a measured blood pressure of 88/54 mm Hg.

D A patient describes tingling in the fingers.

ANSWER C

WHY Signs are objective data that can be observed or measured by the clinician, while symptoms are subjective experiences reported by the patient. Measured blood pressure is objective, so it is a sign. The other three options are all subjective reports from the patient and therefore symptoms.

QUESTION 8 SINGLE CHOICE

Which description best characterizes expert nurse decision-making as described in nursing judgment and critical thinking literature?

A Reliance on step-by-step rules and lengthy deliberation for every patient.

B Pattern recognition developed through experience that allows rapid situation appraisal.

C Avoidance of intuition in favor of strictly analytical reasoning.

D Decision-making that ignores context in favor of standardized protocols.

ANSWER B

WHY Expert decision-making in nursing is characterized by deep experiential knowledge that enables rapid pattern recognition and situation appraisal, while still integrating analytical and intuitive processes as appropriate. Novices rely on rules and lengthy deliberation, intuition is acknowledged as a valid component of expert practice, and context is integrated rather than ignored. Option B reflects the accepted description of expert practice.

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QUESTION 9 SINGLE CHOICE

A nurse is admitting a patient with a suspected infection. Which of the following assessment findings is classified as a sign rather than a symptom?

A Patient reports a burning sensation during urination

B Patient complains of generalized muscle aches

C Oral temperature measured at 39.2°C (102.6°F)

D Patient states she feels nauseated

ANSWER C

WHY A sign is an objective finding that the nurse can detect through observation, measurement, or examination, whereas a symptom is a subjective experience reported by the patient. An oral temperature of 39.2°C is objectively measured by the nurse using a thermometer, making it a sign. The other options all describe patient-reported subjective experiences and are therefore symptoms.

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