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PRACTICE QUESTIONS

Elsevier Remotely Proctored Exams

RNEV1

RN Exit Exam Version 1

EDITION

Demo

QUESTIONS

9

FORMAT

Limited Edition PDF

Before you begin

What this is

9 practice questions for Elsevier Remotely Proctored Exams **RNEV1**, 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, **RNEV1**
- 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 caring for a client who is prescribed a new antihypertensive medication. Which action by the nurse best reflects the integration of evidence-based practice (EBP) into client care?

- ☐ A Administering the medication exactly as the physician wrote the order without questioning it.
- ☒ B Reviewing current research and clinical guidelines about the medication before administering it and educating the client accordingly.
- ☐ C Asking a coworker who has taken the same medication what it felt like.
- ☐ D Waiting until the client asks about the medication before providing any education.

ANSWER B

WHY Evidence-based practice integrates the best current research evidence with clinical expertise and patient values. Reviewing current research and clinical guidelines before administration and teaching the client reflects all three components. Administering without question ignores the research component; relying on a coworker's personal experience is anecdotal and not evidence; waiting for the client to ask omits the nurse's responsibility to provide education.

QUESTION 2

SINGLE CHOICE

A registered nurse (RN) is assigned four clients on a medical-surgical unit. Which task is appropriate for the RN to delegate to the unlicensed assistive personnel (UAP)?

- ☐ A Assessing a newly admitted client's pain level.
- ☐ B Evaluating the effectiveness of pain medication administered one hour ago.
- ☒ C Obtaining vital signs on a stable client and reporting the results to the RN.
- ☐ D Teaching a client about a newly prescribed anticoagulant.

ANSWER C

WHY Obtaining vital signs on a stable client is a routine, repetitive task within the UAP's training and scope of practice. Assessment, evaluation of interventions, and client teaching all require nursing judgment and must be performed by the RN and cannot be delegated to UAP.

QUESTION 3

SINGLE CHOICE

A client diagnosed with major depressive disorder tells the nurse, 'I don't think anyone would care if I didn't come back tomorrow.' Which response by the nurse is the best example of therapeutic communication?

- ☐ A 'Don't say that — you have so much to live for.'
- ☐ B 'Why would you say something like that?'
- ☒ C 'Are you having thoughts of harming yourself?'
- ☐ D 'Everyone feels that way sometimes; you'll feel better.'

ANSWER C

WHY When a client hints at self-harm or hopelessness, the nurse must directly assess for suicidal ideation. Asking clearly whether the client is having thoughts of self-harm is a direct, non-judgmental therapeutic communication technique. Dismissing or minimizing the statement, using 'why' questions that provoke defensiveness, or offering false reassurance all block communication and may compromise safety.

QUESTION 4

SINGLE CHOICE

A client who had abdominal surgery 24 hours ago has orders for patient-controlled analgesia (PCA) with morphine. The nurse assesses the client and notes respirations of 8 breaths per minute, a heart rate of 58 bpm, and the client is difficult to arouse. What is the nurse's priority action?

- ☐ A Document the findings and continue to monitor the client.
- ☐ B Notify the surgeon and wait for new orders.
- ☒ C Stop the PCA pump, stay with the client, and administer naloxone as prescribed.
- ☐ D Stimulate the client by shaking and shouting, then reassess in 15 minutes.

ANSWER C

WHY The client is showing signs of opioid toxicity/overdose: respiratory depression, bradycardia, and decreased level of consciousness. The priority is to stop the source of the opioid (PCA pump), remain with the client for safety, and administer the opioid antagonist naloxone per protocol, then notify the provider. Simply documenting delays treatment; waiting for orders is unsafe; stimulating alone does not reverse opioid toxicity.

QUESTION 5 SINGLE CHOICE

A nurse is preparing to administer a medication to a client. Which action is required to verify the correct client using two identifiers?

- ☐ A Ask the client to state their full name and check the room number on the door.
- ☐ B Check the client's name on the medication administration record (MAR) and the name on the client's identification band.
- ☒ C Ask the client to state their full name and check their identification band; the room number is not an acceptable identifier.
- ☐ D Verify the client's name with the roommate and check the MAR.

ANSWER C

WHY According to the Joint Commission's two-identifier requirement, acceptable identifiers include the client's name (stated by the client or family) and an identification band, medical record number, or date of birth. The client's room number is NOT an acceptable identifier because clients can be moved. Using the roommate is unreliable. The MAR and band alone confirm the record but not the client's identity through direct verification.

QUESTION 6 SINGLE CHOICE

A nurse is teaching a client with newly diagnosed type 2 diabetes about self-monitoring blood glucose (SMBG). Which statement by the client indicates a need for additional teaching?

- ☐ A 'I should rotate my fingerstick sites to prevent tissue damage.'
- ☐ B 'I will check my blood sugar before meals and at bedtime as instructed.'
- ☒ C 'I will use the same lancet for the entire week to save money.'
- ☐ D 'I will record my results and bring them to my follow-up appointment.'

ANSWER C

WHY Lancets are single-use items. Reusing a lancet for a week increases the risk of infection, dull lancets cause more pain and skin trauma, and inaccurate samples can result from a dull tip. Site rotation, following prescribed timing, and recording/bringing results are all appropriate behaviors.

QUESTION 7

SINGLE CHOICE

A client with heart failure develops new onset of shortness of breath, crackles bilaterally in all lung fields, and an oxygen saturation of 86%. Which nursing action is the priority?

- ☐ A Place the client in a supine position and assess bowel sounds.
- ☒ B Position the client in high-Fowler's and apply oxygen as prescribed.
- ☐ C Encourage the client to ambulate to improve circulation.
- ☐ D Restrict fluids to 500 mL per 24 hours without a provider order.

ANSWER B

WHY The client is experiencing acute pulmonary edema. The priority is to improve oxygenation by placing the client in high-Fowler's position to decrease venous return and ease breathing, and to administer supplemental oxygen as prescribed. Supine positioning worsens pulmonary congestion; ambulation would increase oxygen demand; fluid restriction requires a provider order.

QUESTION 8

SINGLE CHOICE

A nurse documents in a client's chart: 'Client reports pain rated 8/10 after ambulation. Pain reduced to 3/10 within 30 minutes after administration of prescribed analgesic. Client resting comfortably.' Which step of the nursing process does this documentation most clearly reflect?

- ☐ A Assessment
- ☐ B Nursing diagnosis
- ☐ C Implementation
- ☒ D Evaluation

ANSWER D

WHY Documentation that compares the client's status before and after an intervention (pain 8/10 reduced to 3/10 after the analgesic, with the client now resting comfortably) reflects evaluation — the step in which the nurse determines whether planned outcomes have been met. Assessment would describe initial data only; nursing diagnosis would identify the problem; implementation would describe only the action taken.

QUESTION 9

SINGLE CHOICE

A nurse is preparing to administer a subcutaneous injection of heparin to a client. Which site is most appropriate for the nurse to select?

- ☐ A The deltoid muscle of the upper arm
- ☐ B The dorsogluteal site on the upper outer quadrant of the buttock
- ☒ C The abdomen, at least 2 inches away from the umbilicus
- ☐ D The inner aspect of the forearm over the antecubital area

ANSWER C

WHY Heparin is typically administered subcutaneously in the abdomen because this site has readily accessible subcutaneous tissue, consistent absorption, and minimal underlying muscle or bone. Injections should be given at least 2 inches away from the umbilicus and rotated between sites. The deltoid and dorsogluteal sites are intramuscular locations, and the antecubital area is reserved for venipuncture, not subcutaneous injection.