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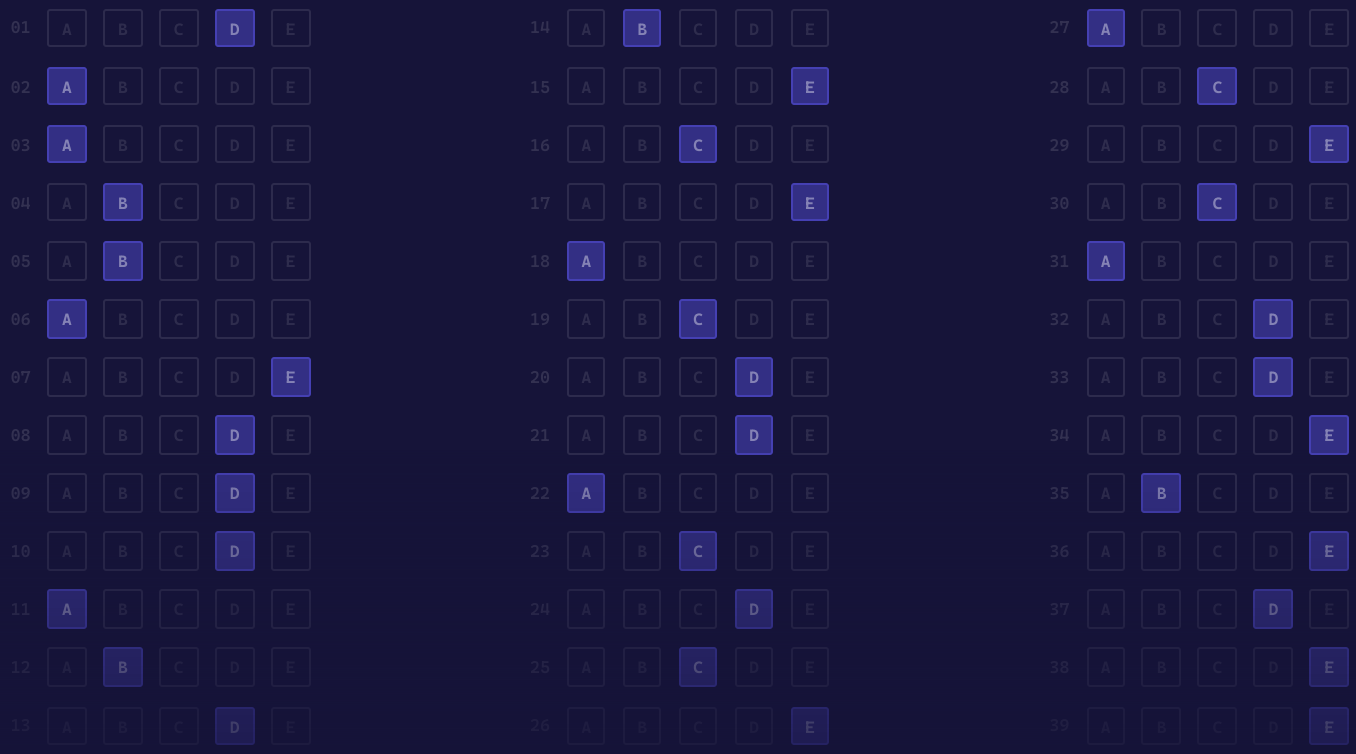

PRACTICE QUESTIONS

Elsevier Remotely Proctored Exams

RNEV2

RN Exit Exam Version 2

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 `RNEV2`, 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, `RNEV2`
- 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 is preparing to administer a scheduled dose of digoxin to a client with heart failure. Before giving the medication, the nurse should assess which of the following as the priority?

A Respiratory rate

B Apical heart rate

C Blood pressure

D Temperature

ANSWER B

WHY Digoxin is a cardiac glycoside that can cause bradycardia and other dysrhythmias. The standard nursing assessment before administration is to auscultate the apical heart rate for one full minute. The medication is generally withheld if the apical pulse is below 60 beats per minute in an adult (or per the established parameter). While respiratory rate and blood pressure are part of a focused assessment, the apical pulse is the priority pre-administration assessment for digoxin.

QUESTION 2 SINGLE CHOICE

A client with active tuberculosis is being admitted to a hospital room. Which type of isolation precaution and room assignment is required?

A Contact precautions in a standard private room

B Droplet precautions in a standard private room

C Airborne precautions in a negative-pressure room

D Standard precautions only in a room with the door closed

ANSWER C

WHY Mycobacterium tuberculosis is transmitted via airborne droplet nuclei that remain suspended in the air. CDC and facility guidelines require airborne precautions, which include placing the client in a negative-pressure (airborne infection isolation) room and requiring the use of an N95 or higher-level respirator by staff entering the room. Contact precautions are used for organisms spread by direct/indirect contact (e.g., MRSA, C. difficile), and droplet precautions are used for organisms transmitted by larger respiratory droplets (e.g., influenza, pertussis).

QUESTION 3 SINGLE CHOICE

A nurse is caring for a client who is 1 day postoperative following abdominal surgery. The client reports a sudden onset of shortness of breath, tachycardia, and chest pain. Which of the following conditions should the nurse suspect first?

A Pneumonia

B Atelectasis

C Pulmonary embolism

D Wound dehiscence

ANSWER C

WHY The classic triad of sudden-onset dyspnea, tachycardia, and pleuritic chest pain in a postoperative client is highly suggestive of pulmonary embolism (PE). Postoperative clients are at increased risk for venous thromboembolism due to immobility, hypercoagulability, and venous stasis (Virchow's triad). Pneumonia and atelectasis typically develop more gradually with fever, diminished breath sounds, and productive cough. Wound dehiscence presents with separation of the surgical incision, not respiratory symptoms. The nurse should immediately notify the provider and prepare for further evaluation (e.g., CT pulmonary angiography).

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QUESTION 4 SINGLE CHOICE

A nurse is assessing a newborn 1 hour after birth. Which of the following findings requires immediate intervention?

A Acrocyanosis of the hands and feet

B Respiratory rate of 50 breaths per minute

C Heart rate of 110 beats per minute

D Apnea lasting 20 seconds with cyanosis

ANSWER D

WHY Periodic breathing with brief pauses (less than 10–15 seconds) without color change is normal in the newborn. Apnea lasting 20 seconds or longer, or any apnea accompanied by cyanosis, bradycardia, or decreased oxygen saturation, is abnormal (pathologic apnea) and requires immediate intervention. Acrocyanosis of the extremities is a normal finding in the first 24 hours. A respiratory rate of 50/min is within the normal newborn range of 30–60 breaths per minute, and a heart rate of 110/min is within the normal range of 110–160 beats per minute.

QUESTION 5 MULTIPLE CHOICE

A client diagnosed with major depressive disorder states, "I don't think anyone would care if I disappeared." Which of the following nursing responses are appropriate? (Choose two.)

A "Are you having thoughts of harming yourself?"

B "Don't talk like that; you have so much to live for."

C "Tell me more about what you're feeling right now."

D "Why would you say something like that?"

ANSWER A · C

WHY A direct, non-judgmental assessment of suicidal ideation (Option A) is essential whenever a client makes statements that suggest hopelessness or self-harm. An open-ended invitation to share feelings (Option C) is therapeutic and demonstrates active listening. Option B is dismissive and invalidates the client's feelings, which can shut down communication. Option D asks "why," which can make the client feel defensive; clarifying with an open-ended prompt is preferred.

QUESTION 6 SINGLE CHOICE

A client tells the nurse, "I don't want to be resuscitated if my heart stops." The client is alert and oriented, and the provider has documented that the client has decision-making capacity. Which of the following is the most appropriate nursing action?

A Inform the client that only the provider can make this decision

B Document the client's wishes and notify the provider so a DNR order can be written

C Ask the client's family to confirm the client's wishes

D Request that the hospital ethics committee review the situation

ANSWER B

WHY An alert, oriented adult client with decision-making capacity has the right to make decisions about his or her own healthcare, including the right to refuse treatment such as cardiopulmonary resuscitation. The nurse should document the client's expressed wishes and notify the primary provider so that a do-not-resuscitate (DNR) order can be written and entered into the medical record. Verbal communication alone is not sufficient; the order must be written by the provider. Family confirmation is not required when the client has capacity, and ethics committee consultation is not necessary for a routine advance-directive discussion.

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QUESTION 7 SINGLE CHOICE

A client with chronic obstructive pulmonary disease (COPD) is admitted with an acute exacerbation and is receiving oxygen at 2 L/min via nasal cannula. Which arterial blood gas result indicates that oxygen therapy is appropriate?

A **PaO2 of 60 mmHg and PaCO2 of 55 mmHg**

B PaO2 of 80 mmHg and PaCO2 of 35 mmHg

C PaO2 of 92 mmHg and PaCO2 of 50 mmHg

D PaO2 of 88 mmHg and PaCO2 of 40 mmHg

ANSWER **A**

WHY In clients with COPD, the hypoxic drive to breathe is the primary respiratory stimulus. Administering too much oxygen can suppress this drive and cause CO2 retention (hypercapnia). The goal is to maintain the PaO2 between 55 and 60 mmHg, with an SpO2 of approximately 88–92%, while accepting a higher PaCO2 (permissive hypercapnia). Option A reflects this expected target range in a client with COPD exacerbation. Option B and C reflect oxygen levels that are too high for a CO2-retaining client, and Option D does not show the elevated PaCO2 typical of an acute exacerbation.

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QUESTION 8 SINGLE CHOICE

A nurse is caring for a client receiving continuous enteral feedings through a nasogastric tube. To reduce the risk of aspiration, which of the following nursing actions is most appropriate?

A **Keep the head of the bed elevated to at least 30 degrees during feedings**

B Check gastric residual volumes every 8 hours

C Flush the tube with 10 mL of water before each feeding

D Administer feedings at room temperature

ANSWER **A**

WHY Elevating the head of the bed to at least 30 degrees (commonly 30–45 degrees) during continuous enteral feedings and for 30–60 minutes afterward helps prevent aspiration of formula into the lungs by using gravity to keep gastric contents in the stomach. While checking gastric residuals and flushing the tube are appropriate interventions, residual checks every 8 hours is not the most effective single measure for aspiration prevention, and flushing before each feeding applies to intermittent, not continuous, feedings. Administration at room temperature is correct, but does not specifically address aspiration risk.

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QUESTION 9 SINGLE CHOICE

A nurse finds a client unresponsive in bed. After calling for help and confirming the client is unresponsive, which of the following is the priority nursing action?

A Auscultate breath sounds

B Palpate the carotid pulse

C Open the airway using the head-tilt/chin-lift maneuver

D Obtain a set of vital signs

ANSWER C

WHY According to the basic life support (BLS) algorithm, after unresponsiveness is confirmed and help is summoned, the next step is to assess circulation by checking the carotid pulse for no more than 10 seconds while simultaneously opening the airway and assessing for breathing. Among the choices given, opening the airway using the head-tilt/chin-lift maneuver (jaw-thrust if cervical spine injury is suspected) is the priority action to ensure a patent airway. Without a patent airway, subsequent assessment and resuscitation efforts are ineffective. Auscultating breath sounds and obtaining vital signs are not part of the initial primary survey in a pulseless, unresponsive client.

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