

PROPHECY EMERGENCY DEPARTMENT REGISTERED NURSE (RN) PRACTICE TEST (SAMPLE)

STUDY GUIDE



Prepare with structure. Pass with confidence



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Introduction

Preparing for a certification exam can feel overwhelming, but with the right tools, it becomes an opportunity to build confidence, sharpen your skills, and move one step closer to your goals. At Examzify, we believe that effective exam preparation isn't just about memorization, it's about understanding the material, identifying knowledge gaps, and building the test-taking strategies that lead to success.

This guide was designed to help you do exactly that.

Whether you're preparing for a licensing exam, professional certification, or entry-level qualification, this book offers structured practice to reinforce key concepts. You'll find a wide range of multiple-choice questions, each followed by clear explanations to help you understand not just the right answer, but why it's correct.

The content in this guide is based on real-world exam objectives and aligned with the types of questions and topics commonly found on official tests. It's ideal for learners who want to:

- Practice answering questions under realistic conditions,
- Improve accuracy and speed,
- Review explanations to strengthen weak areas, and
- Approach the exam with greater confidence.

We recommend using this book not as a stand-alone study tool, but alongside other resources like flashcards, textbooks, or hands-on training. For best results, we recommend working through each question, reflecting on the explanation provided, and revisiting the topics that challenge you most.

Remember: successful test preparation isn't about getting every question right the first time, it's about learning from your mistakes and improving over time. Stay focused, trust the process, and know that every page you turn brings you closer to success.

Let's begin.

How to Use This Guide

This guide is designed to help you study more effectively and approach your exam with confidence. Whether you're reviewing for the first time or doing a final refresh, here's how to get the most out of your Examzify study guide:

1. Start with a Diagnostic Review

Skim through the questions to get a sense of what you know and what you need to focus on. Your goal is to identify knowledge gaps early.

2. Study in Short, Focused Sessions

Break your study time into manageable blocks (e.g. 30 – 45 minutes). Review a handful of questions, reflect on the explanations.

3. Learn from the Explanations

After answering a question, always read the explanation, even if you got it right. It reinforces key points, corrects misunderstandings, and teaches subtle distinctions between similar answers.

4. Track Your Progress

Use bookmarks or notes (if reading digitally) to mark difficult questions. Revisit these regularly and track improvements over time.

5. Simulate the Real Exam

Once you're comfortable, try taking a full set of questions without pausing. Set a timer and simulate test-day conditions to build confidence and time management skills.

6. Repeat and Review

Don't just study once, repetition builds retention. Re-attempt questions after a few days and revisit explanations to reinforce learning. Pair this guide with other Examzify tools like flashcards, and digital practice tests to strengthen your preparation across formats.

There's no single right way to study, but consistent, thoughtful effort always wins. Use this guide flexibly, adapt the tips above to fit your pace and learning style. You've got this!

Questions

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- 1. What is the purpose of employing sterile technique in wound care within an emergency department?**
 - A. To improve the healing time of wounds
 - B. To prevent infection
 - C. To enhance patient comfort
 - D. To facilitate quicker assessments

- 2. If a nurse threatens to place a patient in restraints without justification, what is this an example of?**
 - A. Battery
 - B. Assault
 - C. Negligence
 - D. False imprisonment

- 3. What is an early sign of hypoxia in a patient?**
 - A. Dyspnea
 - B. Restlessness or altered mental status
 - C. Cyanosis
 - D. Bradycardia

- 4. What vital sign changes might indicate a patient is experiencing shock?**
 - A. Hyperthermia, bradycardia, and confusion
 - B. Tachycardia, hypotension, and altered mental status
 - C. Elevated blood pressure, shortness of breath, and sweating
 - D. Weakness, fever, and rash

- 5. What ECG finding is indicative of right-sided heart strain?**
 - A. Left axis deviation
 - B. Shortened QT interval
 - C. Right axis deviation
 - D. ST elevation

- 6. In an acute adrenal crisis, which electrolyte imbalance is most likely to occur?**
- A. Hypomagnesemia
 - B. Hyperkalemia
 - C. Hypochloremia
 - D. Hyponatremia
- 7. What is a common intervention for a pregnant patient involved in a motor vehicle collision?**
- A. Continuous fetal monitoring
 - B. Immediate delivery of the baby
 - C. Providing pain relief
 - D. Restricting movement
- 8. What is one of the first actions a nurse should take in an emergency situation?**
- A. Document the incident for records
 - B. Call for back-up immediately
 - C. Assess the environment for hazards
 - D. Begin immediate treatment
- 9. Which patient requires referral to the closest burn center?**
- A. Partial-thickness burns on the arm
 - B. Full-thickness burns involving the chest
 - C. Partial-thickness and full-thickness burns involving genitalia
 - D. Superficial burns on the leg
- 10. Which parameter is crucial for assessing a patient's fluid status in the emergency department?**
- A. Blood pressure
 - B. Urine output
 - C. Heart rate
 - D. Respiratory rate

Answers

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1. B
2. B
3. B
4. B
5. C
6. B
7. A
8. C
9. C
10. B

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Explanations

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1. What is the purpose of employing sterile technique in wound care within an emergency department?

- A. To improve the healing time of wounds
- B. To prevent infection**
- C. To enhance patient comfort
- D. To facilitate quicker assessments

Employing sterile technique in wound care within an emergency department primarily serves to prevent infection. When dealing with open wounds or invasive procedures, maintaining a sterile environment is critical to reduce the risk of introducing pathogens that could lead to infections. This practice involves using sterile instruments, wearing gloves, and ensuring that the surrounding environment is clean to minimize exposure to bacteria and other microorganisms. Infection can significantly complicate the healing process, leading to prolonged recovery times, increased morbidity, and in severe cases, could necessitate further medical interventions such as surgery or prolonged antibiotic therapy. Therefore, the emphasis on preventing infection through sterile techniques is central to patient safety and positive outcomes in wound management. While improving healing time, enhancing patient comfort, and facilitating quicker assessments are important aspects of patient care, they do not specifically address the primary reason for using sterile techniques in wound care. The focus on preventing infection is foundational to effective wound management in the emergency department.

2. If a nurse threatens to place a patient in restraints without justification, what is this an example of?

- A. Battery
- B. Assault**
- C. Negligence
- D. False imprisonment

The scenario described aligns with the definition of assault in the medical and legal context. Assault involves the threat or attempt to inflict harm on another person, creating a reasonable apprehension of imminent harm. In this case, the nurse's threat to use restraints without a valid clinical reason would place the patient in a state of fear or apprehension regarding their safety and personal freedom. Assault does not require actual physical contact; the mere threat of harm is sufficient to constitute assault. This behavior can be damaging to the patient's emotional and psychological well-being, which is crucial in the healthcare setting where trust and safety are foundational. Understanding assault in this context underscores the importance of ethical conduct and appropriate communication in nursing practice.

3. What is an early sign of hypoxia in a patient?

- A. Dyspnea
- B. Restlessness or altered mental status**
- C. Cyanosis
- D. Bradycardia

Restlessness or altered mental status is an early sign of hypoxia because it reflects the brain's response to insufficient oxygen levels. When the body experiences hypoxia, the brain becomes deprived of the oxygen it needs to function optimally, leading to changes in cognitive function and behavior. Restlessness can manifest as anxiety, agitation, or an inability to stay still, indicating that the patient is experiencing discomfort due to a lack of oxygen. In the context of hypoxia, early recognition of these subtle changes in mental status is crucial for prompt intervention. By addressing hypoxia early, healthcare providers can prevent further complications and deterioration of the patient's condition. It's also important to monitor vital signs and oxygen saturation levels, as this can guide clinical decisions and treatment plans.

4. What vital sign changes might indicate a patient is experiencing shock?

- A. Hyperthermia, bradycardia, and confusion
- B. Tachycardia, hypotension, and altered mental status**
- C. Elevated blood pressure, shortness of breath, and sweating
- D. Weakness, fever, and rash

The identification of tachycardia, hypotension, and altered mental status as vital sign changes indicative of shock is grounded in the physiological responses of the body to inadequate perfusion and oxygenation. Tachycardia, or an increased heart rate, occurs as the body attempts to compensate for reduced blood flow and blood volume, aiming to maintain adequate circulation to vital organs. This compensatory mechanism helps to ensure that oxygen reaches tissues even when perfusion is compromised. Hypotension, or low blood pressure, is a direct indicator that the body's circulatory system is under stress. In a state of shock, the pressure within the arteries falls due to decreased blood volume or cardiac output, placing the patient at risk for organ dysfunction as vital organs may not receive sufficient blood flow. Altered mental status signifies that the brain is not receiving adequate oxygen and nutrients, resulting in confusion, disorientation, or other neurological deficits. This change is often a critical sign of shock, as brain perfusion is especially sensitive to decreases in blood pressure. Together, these signs—elevated heart rate, decreased blood pressure, and changes in mental status—form a classic triad that healthcare professionals monitor closely to assess and identify a patient's state of shock. Recognizing

5. What ECG finding is indicative of right-sided heart strain?

- A. Left axis deviation
- B. Shortened QT interval
- C. Right axis deviation**
- D. ST elevation

Right axis deviation is a key finding on an electrocardiogram (ECG) that suggests strain on the right side of the heart. This condition often occurs when there is increased pressure in the right ventricle, which can happen due to various conditions such as pulmonary hypertension, right ventricular hypertrophy, or a pulmonary embolism. The right axis deviation indicates that the electrical activity is shifting towards the right side of the heart, which is consistent with the adaptation of the right ventricle to increased workload or pressure. This is an important clinical indicator for healthcare professionals to recognize, as it guides further diagnosis and management of patients exhibiting signs of right-sided heart strain. Understanding this concept is crucial in emergency nursing, where quick identification of cardiac issues can significantly influence patient outcomes.

6. In an acute adrenal crisis, which electrolyte imbalance is most likely to occur?

- A. Hypomagnesemia
- B. Hyperkalemia**
- C. Hypochloremia
- D. Hyponatremia

In an acute adrenal crisis, hyperkalemia is the most likely electrolyte imbalance due to the adrenal glands' role in the regulation of potassium levels. When the adrenal glands do not produce sufficient glucocorticoids, particularly cortisol, the body's ability to excrete potassium through the kidneys decreases, leading to an accumulation of potassium in the bloodstream. This results in hyperkalemia, which can have significant cardiovascular and neuromuscular implications, including arrhythmias and muscle weakness. The adrenal glands also produce aldosterone, which helps regulate sodium and potassium levels. In adrenal insufficiency, decreased aldosterone secretion can lead to a reduction in sodium reabsorption and an increase in potassium retention, further contributing to hyperkalemia. Recognizing and managing this electrolyte disturbance is critical in treating an acute adrenal crisis. Other imbalances like hypomagnesemia, hypochloremia, and hyponatremia can occur due to various factors, but in the context of an adrenal crisis, hyperkalemia is the primary concern due to the direct impact of adrenal hormone deficiency on potassium regulation.

7. What is a common intervention for a pregnant patient involved in a motor vehicle collision?

- A. Continuous fetal monitoring**
- B. Immediate delivery of the baby
- C. Providing pain relief
- D. Restricting movement

Continuous fetal monitoring is a critical intervention for a pregnant patient involved in a motor vehicle collision because it enables healthcare providers to assess the wellbeing of the fetus in response to potential trauma. In the event of a car accident, there may be risks of placental abruption, uterine rupture, or fetal distress, and continuous monitoring allows for real-time evaluation of fetal heart rate patterns. This helps identify any signs of distress that may require immediate intervention, which could include further medical treatment or even urgent delivery if the fetus is compromised. Monitoring ensures that both the mother's and baby's health are carefully evaluated, facilitating timely responses to any concerning findings. The other interventions, while they may be relevant in specific contexts, do not prioritize the immediate need for monitoring the fetus's health, which is paramount after a traumatic event like a motor vehicle collision. Providing pain relief and restricting movement might be appropriate for the mother's comfort and safety, but they do not address the critical need to monitor fetal status directly following the incident. Immediate delivery, while necessary in certain situations, is not a common first step unless there's clear evidence of jeopardy to the fetus that warrants it.

8. What is one of the first actions a nurse should take in an emergency situation?

- A. Document the incident for records
- B. Call for back-up immediately
- C. Assess the environment for hazards**
- D. Begin immediate treatment

In an emergency situation, one of the first critical actions a nurse should take is to assess the environment for hazards. This is essential to ensure both the safety of the patient and the healthcare team. By evaluating the immediate environment, the nurse can identify potential dangers such as spills, electrical hazards, or the presence of aggressive individuals that could compromise the care being provided or the safety of everyone involved. This assessment allows the nurse to create a safe space for delivering care, preventing accidents or injuries that could further complicate the situation. Once the environment is deemed safe, the nurse can then move forward with appropriate interventions, call for additional personnel if needed, or document the incident accurately after managing the emergency. Prioritizing safety through environmental assessment lays the groundwork for effective and efficient emergency care.

9. Which patient requires referral to the closest burn center?

- A. Partial-thickness burns on the arm
- B. Full-thickness burns involving the chest
- C. Partial-thickness and full-thickness burns involving genitalia**
- D. Superficial burns on the leg

Referring a patient to the closest burn center is crucial for ensuring they receive the most appropriate care based on the severity and location of their burns. Full-thickness burns and those that involve sensitive areas, such as the genitalia, pose a higher risk of complications, including infection, functional impairment, and psychological trauma. In this case, the presence of both partial-thickness and full-thickness burns involving the genitalia indicates an intricate situation that necessitates specialized treatment. The genital area has unique anatomical and physiological considerations; thus, burns in this region can have significant implications for healing and function. Referral to a burn center allows for advanced care, including surgical intervention if necessary, management of pain, and comprehensive rehabilitation. While partial-thickness burns on the arm or superficial burns on the leg may require medical attention, they are often manageable in a less specialized setting as they typically have a lower risk of complications compared to burns involving the genital area. Full-thickness burns on the chest would also warrant specialized care due to the risk of respiratory complications, but the dual nature and sensitive location of the genital burns underscore the critical need for referral. Therefore, transitioning the care of the patient with partial-thickness and full-thickness burns in the genital region to a burn center

10. Which parameter is crucial for assessing a patient's fluid status in the emergency department?

- A. Blood pressure
- B. Urine output**
- C. Heart rate
- D. Respiratory rate

Assessing a patient's fluid status in the emergency department is critical, especially for determining whether a patient is hypovolemic (low fluid volume) or experiencing fluid overload. Urine output is a crucial parameter in this assessment, as it provides direct insight into kidney function and the body's ability to excrete fluid. A decrease in urine output often indicates that the kidneys are not receiving adequate perfusion due to low blood volume, which can occur in cases of dehydration or hemorrhage. Conversely, an increase in urine output, particularly if significantly high in the context of other symptoms, may suggest fluid overload or that the body is effectively managing excess fluid. While other parameters like blood pressure, heart rate, and respiratory rate can offer valuable information about a patient's overall condition and potential fluid status, they do not specifically reflect the body's fluid balance the way urine output does. Blood pressure can be affected by several factors, including vascular resistance and heart contractility, while heart rate can change in response to stress, pain, or fever, which are not solely dependent on fluid status. Respiratory rate, although important in assessing the overall health of the patient, does not provide a direct measurement of fluid volume or balance. Therefore, monitoring urine output is essential for a more

Next Steps

Congratulations on reaching the final section of this guide. You've taken a meaningful step toward passing your certification exam and advancing your career.

As you continue preparing, remember that consistent practice, review, and self-reflection are key to success. Make time to revisit difficult topics, simulate exam conditions, and track your progress along the way.

If you need help, have suggestions, or want to share feedback, we'd love to hear from you. Reach out to our team at hello@examzify.com.

Or visit your dedicated course page for more study tools and resources:

<https://prophecyemergencydeptrn.examzify.com>

We wish you the very best on your exam journey. You've got this!

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