

ReMar Nurse V2 Practice Exam (Sample)

Study Guide



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SAMPLE

Questions

- 1. In which location is the urinary meatus found in a female?**
 - A. Above the clitoris**
 - B. Below the vaginal opening**
 - C. On the perineum**
 - D. Within the vestibule**
- 2. Prior to providing nasogastric feeding for a 1-year-old infant, which method should the nurse use to ensure proper tube placement?**
 - A. Instill air and auscultate stomach**
 - B. Obtain a chest X-ray**
 - C. Verify gastric pH**
 - D. Measure the tube insertion length**
- 3. What is a common side effect of opioid use that nurses should monitor?**
 - A. Hypertension**
 - B. Bradycardia**
 - C. Hyperactivity**
 - D. Constipation**
- 4. What indicates a life-threatening condition in a client with symptoms such as nausea and vomiting?**
 - A. Digoxin toxicity**
 - B. Low blood sugar**
 - C. Anaphylaxis**
 - D. Acute kidney injury**
- 5. What condition might result from untreated gestational diabetes?**
 - A. Hypoglycemia in the mother**
 - B. Large for gestational age (LGA) infant**
 - C. Preterm labor**
 - D. Low birth weight**

- 6. What is the first step in the nursing health assessment?**
- A. Gather the necessary equipment**
 - B. Greet the client**
 - C. Wash the hands**
 - D. Provide privacy to the client**
- 7. At what point does a Rh-negative client typically first receive Rho(D) immune globulin?**
- A. 16 weeks**
 - B. 22 weeks**
 - C. 28 weeks**
 - D. At the time of delivery**
- 8. Which symptom is most indicative of a generalized infection?**
- A. Localized redness**
 - B. Fever and muscle aches**
 - C. Fatigue**
 - D. Swelling**
- 9. In analyzing arterial blood gas results with a pH of 7.25 and Paco₂ of 53 mmHg, what condition does this indicate?**
- A. Metabolic acidosis**
 - B. Respiratory alkalosis**
 - C. Metabolic alkalosis**
 - D. Respiratory acidosis**
- 10. Which of the following signs indicates a potential allergic reaction during medication administration?**
- A. Flushing**
 - B. Hives**
 - C. Dry skin**
 - D. Increased heart rate**

Answers

SAMPLE

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

SAMPLE

Explanations

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1. In which location is the urinary meatus found in a female?

- A. Above the clitoris**
- B. Below the vaginal opening**
- C. On the perineum**
- D. Within the vestibule**

The urinary meatus in a female is located within the vestibule, which is the area enclosed by the labia minora. This meatus opens into the urethra, allowing for the passage of urine. The anatomical positioning is significant because the vestibule is centrally located between the clitoris, vaginal opening, and other surrounding structures, making it an essential component of the female external genitalia. The orientation of the urinary meatus within the vestibule also plays a practical role in terms of hygiene and the function of the urinary system. Understanding this anatomical structure is crucial for nurses and healthcare professionals, particularly when it comes to assessments and treatments involving the female urinary system. In other locations mentioned, such as above the clitoris, below the vaginal opening, or on the perineum, the urinary meatus would be improperly positioned and would not align with its actual anatomical placement. Thus, the identification of the meatus as being within the vestibule is a key aspect of female anatomy.

2. Prior to providing nasogastric feeding for a 1-year-old infant, which method should the nurse use to ensure proper tube placement?

- A. Instill air and auscultate stomach**
- B. Obtain a chest X-ray**
- C. Verify gastric pH**
- D. Measure the tube insertion length**

Verifying gastric pH is considered the most reliable method to ensure proper nasogastric tube placement, particularly in a pediatric patient such as a 1-year-old infant. When a nasogastric tube is correctly positioned in the stomach, the aspirate from the tube should reveal a gastric pH of 5.5 or lower. This acidic environment is a strong indicator that the tube is in the stomach rather than the esophagus or lungs. Using pH to confirm placement is beneficial because it provides a more immediate and accurate assessment compared to other methods. It allows the nurse to avoid potential complications that can arise from placing the tube in the wrong position, such as aspiration pneumonia. Other methods, such as auscultation after instilling air or measuring insertion length, can be less reliable and may lead to false assumptions about tube placement. Additionally, while chest X-rays are a definitive method, they often require more time and resources, making them less practical for routine use in verifying tube placement during feeding. Thus, checking gastric pH is the preferred and effective method for confirming nasogastric tube placement in infants before administering feedings.

3. What is a common side effect of opioid use that nurses should monitor?

- A. Hypertension**
- B. Bradycardia**
- C. Hyperactivity**
- D. Constipation**

Constipation is a well-documented side effect of opioid use that nurses need to monitor closely. Opioids work by binding to specific receptors in the brain and gastrointestinal tract, which leads to reduced gastrointestinal motility. This slowed movement through the intestines can result in delayed transit time and increased water absorption from stool, making it harder and drier. As a result, patients may experience infrequent bowel movements, straining during stools, or a feeling of incomplete evacuation. Monitoring for constipation is particularly important because patients may be on opioids for pain management and may not report side effects unless specifically asked. Nursing assessment should include regular evaluation of bowel habits and proactive measures, such as offering stool softeners, dietary fiber, hydration, and encouraging physical activity when appropriate. Recognizing and managing this side effect is vital to improving the overall quality of life for patients receiving opioid therapy.

4. What indicates a life-threatening condition in a client with symptoms such as nausea and vomiting?

- A. Digoxin toxicity**
- B. Low blood sugar**
- C. Anaphylaxis**
- D. Acute kidney injury**

Digoxin toxicity is indeed a serious condition that can present with symptoms such as nausea and vomiting. In cases of digoxin toxicity, the electrolyte imbalances that accompany the condition can lead to significant cardiac disturbances, including arrhythmias that can be life-threatening. The presence of gastrointestinal symptoms like nausea is a common early sign of digoxin toxicity, but the life-threatening aspect arises from its potential to affect the heart's rhythm and function. While low blood sugar can lead to nausea and vomiting, it is generally manageable and unlikely to result in immediate life-threatening consequences if treated promptly. Anaphylaxis, while also a critical condition that can lead to rapid deterioration, is typically characterized by severe allergic reactions including difficulty breathing and swelling, which are not directly indicated in the symptoms given. Acute kidney injury may lead to nausea and vomiting due to toxin build-up but does not necessarily present immediate life-threatening risks in the same direct way as digoxin toxicity, especially if interventions are made in a timely manner. In summary, digoxin toxicity stands out as a condition that signifies potential immediate cardiac risks alongside the symptoms of nausea and vomiting, making it the most concerning option in this context.

5. What condition might result from untreated gestational diabetes?

- A. Hypoglycemia in the mother**
- B. Large for gestational age (LGA) infant**
- C. Preterm labor**
- D. Low birth weight**

Untreated gestational diabetes can lead to a large for gestational age (LGA) infant, a condition primarily caused by elevated maternal blood glucose levels. When the mother has gestational diabetes, the excess glucose passed through the placenta to the fetus stimulates increased insulin production in the developing baby. Insulin acts as a growth hormone, prompting the fetus to store more fat and grow larger than average, which is characterized as LGA. Additionally, there are significant impacts on the pregnancy, including complications during labor and delivery, and an increased risk for both mother and child in terms of potential future health issues. Addressing gestational diabetes through proper management, including diet, physical activity, and sometimes insulin therapy, is essential for reducing these risks and promoting healthier outcomes for both the mother and the infant.

6. What is the first step in the nursing health assessment?

- A. Gather the necessary equipment**
- B. Greet the client**
- C. Wash the hands**
- D. Provide privacy to the client**

In a nursing health assessment, the first step is to wash the hands. This practice is essential for maintaining infection control and ensuring the safety of both the nurse and the client. By washing hands before beginning any assessment or procedure, the nurse minimizes the risk of transmitting potential pathogens, thereby safeguarding the client's health. This is a crucial aspect of standard precautions in nursing and reflects the importance of hygiene in healthcare settings. While gathering equipment, greeting the client, and providing privacy are all important components of the assessment process, hand hygiene must always be prioritized first. This demonstrates a commitment to patient safety and respect for infection control protocols, which are foundational to quality nursing care.

7. At what point does a Rh-negative client typically first receive Rho(D) immune globulin?

- A. 16 weeks**
- B. 22 weeks**
- C. 28 weeks**
- D. At the time of delivery**

A Rh-negative client typically first receives Rho(D) immune globulin at 28 weeks of gestation as part of standard prenatal care. This administration is crucial for preventing Rh sensitization, which occurs if an Rh-negative mother is exposed to Rh-positive blood, either during pregnancy or more commonly at the time of delivery. By providing Rho(D) immune globulin around this time, healthcare providers can effectively reduce the risk of developing antibodies that could affect current or future pregnancies. Administering the immune globulin later in pregnancy ensures that maternal immune exposure is minimized, particularly as the fetal blood cells may start crossing into the maternal circulation. The timing at 28 weeks is well-established in medical guidelines, highlighting the importance of proactive management in obstetric care to protect both the mother and future pregnancies. This timing is a preventive strategy rather than a response to an Rh-positive baby at birth, which is why administration during delivery is not the initial focus.

8. Which symptom is most indicative of a generalized infection?

- A. Localized redness**
- B. Fever and muscle aches**
- C. Fatigue**
- D. Swelling**

Fever and muscle aches are classic systemic symptoms that indicate a generalized infection. When the body is fighting an infection, the immune system responds by raising the body temperature, which manifests as a fever. This is a common physiological response to help eliminate pathogens. Simultaneously, muscle aches often accompany fever due to the release of inflammatory mediators like cytokines, which signal the body to react. Localized redness, fatigue, and swelling are more associated with localized infections or responses to injury rather than the systemic symptoms of a generalized infection. While fatigue can occur in the context of a variety of conditions, it is less specific and often arises from non-infectious causes as well. Localized redness and swelling indicate inflammation in a specific area, suggesting a more localized process rather than a widespread infection throughout the body. Therefore, the combination of fever and muscle aches serves as a clearer indication of a generalized infection.

9. In analyzing arterial blood gas results with a pH of 7.25 and Paco2 of 53 mmHg, what condition does this indicate?

- A. Metabolic acidosis**
- B. Respiratory alkalosis**
- C. Metabolic alkalosis**
- D. Respiratory acidosis**

The condition indicated by a pH of 7.25 and a Paco2 of 53 mmHg reflects respiratory acidosis. In arterial blood gas analysis, a pH below the normal range (7.35-7.45) signifies acidemia, meaning the blood is more acidic than normal. The Paco2 level, which is elevated in this case, suggests that there is an accumulation of carbon dioxide in the blood, leading to increased carbonic acid. This primarily occurs when the lungs are unable to effectively eliminate carbon dioxide, which is characteristic of respiratory acidosis. In respiratory acidosis, the body may also attempt to compensate through metabolic pathways, but the primary indicator here is the higher level of carbon dioxide and the lower pH, which confirm that the acid-base disturbance is primarily respiratory in nature. Hence, monitoring Paco2 levels is critical in diagnosing respiratory conditions and understanding their impact on acid-base balance.

10. Which of the following signs indicates a potential allergic reaction during medication administration?

- A. Flushing**
- B. Hives**
- C. Dry skin**
- D. Increased heart rate**

Hives, also known as urticaria, are a classic sign of an allergic reaction. This skin manifestation is typically characterized by raised, itchy welts that can vary in size and appear suddenly. When a patient is administered a medication they are sensitive to, the immune system may overreact, resulting in the release of histamine and other chemicals, which causes hives as part of an allergic response. Recognizing hives during medication administration is crucial, as it can indicate the potential for more severe allergic reactions, such as anaphylaxis. Observing hives or similar skin rashes prompts immediate action, including stopping the medication, notifying the healthcare provider, and monitoring the patient closely for any further symptoms. While flushing, dry skin, and increased heart rate can be associated with various conditions or medication side effects, they are not definitive signs of an allergic reaction. For example, flushing can occur due to vasodilation or certain drug effects, and increased heart rate might result from anxiety or other non-allergic responses. Dry skin typically represents dermatological issues and does not indicate an allergic response. Therefore, distinguishing hives as a sign of potential allergic reactions is essential for patient safety during medication administration.