Practice Exam Questions

AMERICAN ASSOCIATION of CRITICAL-CARE NURSES

CCRN-Adult

Acute/Critical Care Nursing

EXAMKILLER

Help Pass Your Exam At First Try

Total Question: 752 QAs

Question No: 1
The nurse provides discharge instructions to a client with a graft site on the right leg. Which statement, if made by the client, would indicate the need for further instruction?
A. "I will elevate and immobilize the graft site."
B. "Weight bearing is allowed to reduce edema and maintain the leg's strength."
C. "Fabric softeners and harsh detergents should be avoided."
D. "I should avoid wearing shorts when going outside during the day."
Answer: B
Explanation: The graft site must be free from pressure and should be immobilized; therefore, weight bearing must be avoided. The graft site must also be protected from harsh materials or ingredients and sunlight.

Question No: 2
A 20-year-old male client with a BMI of 33 has been admitted for recurrent chest pains and difficulty breathing. During the assessment, it is found that his father and mother have both suffered from myocardial infarction before the age of 50. Which of the following nursing actions is the first step to prevent the client from developing myocardial infarction?
A. Encourage the client in initiating and maintaining a regular exercise program.
B. Instruct the client to avoid fatty and high-calorie meals.
C. Assess the client's level of interest in weight reduction programs.
D. Educate the client about the risks of obesity and myocardial infarction.
Answer: C
Explanation: A sedentary lifestyle and poor diet are associated with obesity and myocardial infarction; however, the client must be willing and committed to participate in a weight reduction program. Therefore, assessment of interest in reducing weight is the most critical step in prevention of these diseases.

Question No: 3
The nurse is reviewing the goals of the treatment plan for a new patient admitted with Septic Shock with a nursing student. What is the best summary of the priorities of care for the patient with Septic Shock?
A. Maintain the patient's oxygenation and ventilation without mechanical help.
B. Identify and treat the infecting pathogen.
C. Obtain blood cultures and use broad spectrum antibiotic coverage.
D. Maintain the hemodynamic stability of the patient.
Answer: B
Explanation: The best way to summarize the priority of care for the patient with Septic Shock is to identify and treat the infecting pathogen (infectious organism). Treatment goals will include maintaining the oxygenation, perfusion and hemodynamic body systems otherwise known as the circulatory system.

Question No: 4
The nurse is preparing to transfer the patient to a telemetry unit after treatment for a new diagnosis of Atrial Fibrillation and Status Post Mechanical Valve. The patient will be on long term Warfarin Therapy. What is the goal International Normalized Ratio (INR) for this patient?

A. 4 to 5
B. 3 to 4
C. 1 to 2
D. 2 to 3
Answer: B
Explanation: The International Normalized Ratio (INR) goal for a patient who has Status Post Mechanical Valve surgery is 3.0 to 4.0. If the patient just was on Warfarin, a medication taken to prevent the blood from clotting and to treat blood clots and overly thick blood for Atrial Fibrillation (Abnormal or irregular heart rhythm), he would have an International Normalized Ratio (INR) goal of 2.0 to 3.0.

Question No: 5
A patient has been transferred to the intensive care unit after being diagnosed with Diabetes Ketoacidosis. The nurse would expect to see the following signs and symptoms:
A. Severe dehydration, rapid and deep breathing and abdominal cramps
B. Polyuria, polydipsia, polyphagia
C. Extreme thirst, nocturia, hypotension and tachycardia
D. Muscle aches, frequent urination, hyponatremia
Answer: A
Explanation: In a patient with Diabetes Ketoacidosis the nurse would expect to see severe dehydration, rapid and deep breathing (also known as Kussmaul's respirations) and abdominal cramps. Polyuria, polydipsia, and polyphagia are signs and symptoms of Diabetes Mellitus. Extreme thirst, nocturia, hypotension and tachycardia are symptoms of Diabetes Insipidus.

Question No: 6
The nurse is taking care of a 51 year old with Acute Lymphocytic Leukemia (ALL) with a White Blood Cell count of 6.0. What would the nurse NOT do when preventing infection from occurring in the patient?
A. Take vital signs every 2 hours.
B. Insert a Foley Catheter.
C. Check the patient's mouth frequently and give saline solution rinses.
D. Give antibiotic therapy immediately when white counts fall.
Answer: B
Explanation: When working to prevent an infection in a patient with Acute Lymphocytic Leukemia (ALL) with a White Blood Cell count of 6.0, the nurse would avoid inserting a Foley Catheter or any other non-critical device that would increase the risk of a patient obtaining an infection. The nurse should take vital signs every 2 to 4 hours; check the patient's mouth often to assess for mouth ulceration and give antibiotic therapy quickly.

Question No: 7
A patient has second and third degree burn injuries to his anterior chest and abdomen, anterior left arm, anterior right arm and left anterior leg. Using the Rule of Nines, what percentage of the body surface area (BSA) is affected?
A. 36%
B. 50%
C. 27%
D. 31%

Answer: A
Explanation: Using the Rule of Nines, a method of estimating the extent of body surface that has been burned in an adult, dividing the body into sections of 9 per cent or multiples of 9 per cent; the percentage of the body surface area (BSA) of the patient is 36%. The various percentages of affected area would be 18% for the anterior chest and abdomen, 4.5% for the anterior left arm, 4.5% for the anterior right arm and 9% for the anterior left leg.

Question No: 8
When working the family of the patient in critical care, a nurse should use this kind of Therapeutic Communication:
A. Advise the family to remain quiet while visiting and avoid stimulating the patient.
B. Consider the family a part of the team and listen to their input.
C. Refer them to the primary care doctor for all of their questions.
D. Enforce visiting hours to maintain a routine of care for the patient.
Answer: B
Explanation: When working with the family of the patient in critical care, the nurses' best method of Therapeutic Communication to use is to consider the family to be an integral part of the team and engage them in the patient's care. Therapeutic Communication involving the family as part of the team can ease anxiety, tension and frustration on the part of the family helping ensure better patient outcomes and family satisfaction.

Question No: 9
A patient is beginning IV Phenytoin for diagnosis of a new onset of Seizures. What adverse effects would the nurse asses for after administering the medication?
A. Hemorrhage, prolonged clotting time and thrombocytopenia
B. Increased Intracranial Pressure (ICP), cerebral edema and somnolence
C. Gastrointestinal bleeding, acute renal insufficiency, liver dysfunction
D. Slurred speech, thrombocytopenia, Stevens-Johnson syndrome
Answer: D
Explanation: After administering Phenytoin for a diagnosis of new onset of Seizures, the adverse effects the nurse would assess for include slurred speech, thrombocytopenia, and Stevens-Johnson syndrome. Hemorrhage, prolonged clotting time and thrombocytopenia are adverse effects of Heparin. Gastrointestinal bleeding, acute renal insufficiency and liver dysfunction are adverse reactions of Aspirin. Fosphenytoin may cause increased Intracranial Pressure (ICP), cerebral edema and somnolence.

Question No: 10
A patient has been admitted to the intensive care unit with a diagnosis of "rule out" Guillain-Barre syndrome. The nurse is completing the admission data base and asking about the patient's history. What diagnosis might precipitate a diagnosis of Guillian-Barre syndrome?
A. Myocardial infarction within the last 6 months
B. Headache, nausea and nuchal rigidity
C. Mild fevers, upper respiratory infection or a minor virus
D. Slurred speech and weakness in one or both sides of the body
Answer: C

Explanation: When completing the admission data base and asking about the patient's history the diagnosis that might precipitate Gullian-Barre syndrome is mild fevers, upper respiratory infections or minor viruses. The nurse should pay particular attention to any mild infections and fevers the patient has recently had. The primary cause of Guillian-Barre syndrome is not known; however; about 50% of patients with Guillian-Barre have a recent history of infection.

Question No: 11
The nurse is assessing the tests of a patient with a diagnosis of acute right-sided Heart Failure. What parameter would be elevated in right-sided Heart Failure?
A. Central Venous Pressure (CVP)
B. Cardiac Output
C. Left-ventricular end-diastolic pressure
D. Pulmonary Capillary Wedge Pressure (PCWP)
Answer: A
Explanation: When looking at the parameters for a patient with a diagnosis of right-sided Heart Failure, the Central Venous Pressure (CVP) would be elevated. The Central Venous Pressure (CVP) describes the amount of blood that is returning to the heart and is a measure of the pressure of the blood in the thoracic vena cava.

Question No: 12
The nurse is preparing to wean a patient from mechanical ventilation. What option is NOT a method of weaning the patient from mechanical ventilation?
A. Pressure support ventilation
B. Controlled mandatory ventilation
C. Using a T-piece, perform spontaneous breathing trials
D. Intermittent mandatory ventilation
Answer: B
Explanation: The option that is NOT appropriate for weaning a patient from mechanical ventilation is controlled mandatory ventilation. This method is only used when the patient is unable to take breaths on their own. Controlled mandatory ventilation is not a weaning method.

Question No: 13
A patient admitted with suspected renal disease and severe low back pain is preparing to go to have a Renal Arteriography test. Before going to the test, the nurse would ensure that:
A. The patient is not allergic to iodine and shellfish.
B. Cancel the morning lab requisitions until after the test is complete.
C. Administer Benadryl 30 minutes before the test.
D. Check the potassium and sodium serum levels to ensure normal levels.
Answer: A
Explanation: Before sending a patient with suspected renal disease and severe low back pain for a Renal Arteriography test, it is important to ensure the patient is not allergic to iodine and shellfish. Allergies to iodine and shellfish may cause an adverse reaction to the dye. The lab values serum creatinine and urea nitrogen should be checked. All abnormal lab values should be reported to the attending physician.

Question No: 14

The nurse is assisting the physician during an Abdominal Paracentesis. What is the maximum amount of fluid that should be aspirated?
A. 1,000 to 1,500 mL
B. 2,000 to 2,500 mL
C. 1,500 to 2,000 mL
D. 2,500 to 3,000 mL
Answer: C
Explanation: The maximum amount of fluid that should be removed during an Abdominal Paracentesis is 1,500 to 2,000 mL. Removing more than 2,000 mL of peritoneal fluid during one Paracentesis may cause an episode of Hypovolemic Shock.

Question No: 15
More patients are being diagnosed with Multi Organ Dysfunction Syndrome (MODS) and being treated in the Intensive Care Unit. This is because:
A. Only intensive care units have adequate facilities to deal with multi infectious disease processes.
B. The progress of health care treatments and services are more effective resulting in a greater increase of patients surviving traumatic injuries and infections.
C. Physicians and emergency room staff are faster at identifying multi organ dysfunction syndrome.
D. Staffing is more efficient in intensive care units.
Answer: B
Explanation: More patients are being diagnosed with Multi Organ Dysfunction syndrome (MODS) and being treated in the intensive care unit because of the progress of health care treatments and services being more effective resulting in a greater advancement of treatments and services. The more progress made in health care treatments and services; the greater increase in positive patient outcomes such as those with traumatic injuries and infections.

Question No: 16
Which gland is responsible for the release of Calcitonin?
A. Thyroid
B. Parathyroid
C. Adrenal
D. Pituitary
Answer: A
Explanation: The gland responsible for the release of Calcitonin is the Thyroid gland. Calcitonin is a hormone produced by C-cells of the thyroid gland and is responsible for reducing the levels of calcium in the blood.

Question No: 17
A patient has developed Acute Respiratory Acidosis, with a pH of 7.25 and a $PaCO_2$ of 55. What is the underlying cause of Respiratory Acidosis?
A. The lungs are not sufficiently ventilating.
B. The lungs are working excessively resulting in “over breathing.”
C. There is an underlying gastric disorder.
D. There are elevated levels of aldosterone present.
Answer: A

Explanation: The underlying cause of respiratory acidosis is that the lungs are not sufficiently ventilating. Acute Respiratory Acidosis is a sudden collapse of the body's ventilation system often resulting from central nervous system disease, drugs or toxins or Chronic Obstructive Pulmonary Disease (COPD).

Question No: 18
What are the signs and symptoms of patient who is in stage 3 of Hepatic Encephalopathy?
A. Coma, unresponsive to pain, posturing.
B. Fatigue, restlessness, irritability and decreased attention span.
C. Severe confusion, inability to follow commands.
D. Drowsiness, confusion and lethargy.
Answer: C
Explanation: The signs and symptoms of the patient in stage 3 of Hepatic Encephalopathy are severe confusion and an inability to follow commands. Hepatic Encephalopathy results from a build up of ammonia in the body due to the inability of the liver. This is primarily due to cirrhosis of the liver.

Question No: 19
A patient's family begins to ask several questions about the variety of numbers on the patient's monitor. What would be the most appropriate response for the nurse to give?
A. "The numbers tell us when we need to call the doctor."
B. "Why don't you understand the numbers on the monitor?"
C. "Tell me about which numbers are concerning you."
D. "When the doctor comes in, I'll have her explain the numbers to you."
Answer: C
Explanation: The most appropriate response for the nurse to give in such a situation is "Tell me about which numbers are concerning to you." This response acknowledges the family's concerns and helps them understand the patient's condition. It is normal for families to feel helpless and powerless and the nurse has the opportunity to offer empowerment and comfort through simple but focused explanations.

Question No: 20
A patient comes to the Cardiovascular Care Unit with a blood pressure of 94/68, a heart rate of 124 and chest pain rated as 8/10. The patient has already taken one 0.04 mg tablet of Nitroglycerin five minutes ago. What should the nurse do next?
A. Take the patient's blood pressure and put them on the monitor.
B. Administer a dose of Morphine 2 mg IV and re-assess pain.
C. Obtain a stat EKG.
D. Administer another dose of 0.04 mg tablet of Nitroglycerin.
Answer: D
Explanation: The next thing the nurse should do with this patient is to give an additional dose of 0.04 mg tablet of Nitroglycerin. Patients can take up to three sublingual Nitroglycerin tablets within 15 minutes. It may take 5 to 10 minutes to relieve chest pain. After administering the Nitroglycerin, the nurse can take vital signs and obtain an EKG. However, it is primarily important to relieve the chest pain.

Question No: 21
A patient is suspected of developing an Upper Gastrointestinal bleed two days after a total hip replacement.

What are the most appropriate nursing actions?
A. Make the patient NPO (nothing by mouth) and insert a Nasogastric tube to intermittent suction.
B. Make the patient NPO (nothing by mouth) and saline lock the intravenous device (IV).
C. Check the vital signs and check the labs to evaluate the Hemoglobin and Hematocrit.
D. Give the patient ice chips only and evaluate the patient for signs and symptoms of bleeding.
Answer: A
Explanation: The most appropriate action for a suspected diagnosis of an Upper Gastrointestinal bleed includes making the patient NPO (nothing by mouth to eat or drink) and inserting a Nasogastric tube to the intermittent suction. This will prevent any chance of increasing irritation to the suspected upper gastrointestinal bleed and allow for appropriate management.

Question No: 22
A patient comes to the ICU after undergoing a penetrating trauma to his chest. The object is a long stick off a tree and is still present. The patient's vital signs include a blood pressure of 98/50, a heart rate of 118 and respiratory rate of 20. Which action would the nurse follow as the best course of action?
A. Remove the object and hold pressure for 25 minutes.
B. Do not remove the object.
C. Cut off the end of the stick.
D. Slightly move the object to the side to avoid interference with the tubes and wires.
Answer: B
Explanation: The most appropriate course of action when a patient experiencing a penetrating trauma in his chest due to a long stick present in the chest would be to NOT remove the object. Removing or manipulating the object could lead to further internal injury.

Question No: 23
A nurse is performing a neurological assessment on a patient admitted to the Intensive Care Unit with a right-sided stroke. What would be the sign of a positive Babinski's reflex in the stroke victim?
A. The knee jerks up when the pressure is applied directly above the patella.
B. The great toe dorsiflexes and the other toes fan out.
C. All the toes flex inward.
D. The toes do not move individually, but the whole foot stiffens and retracts.
Answer: B
Explanation: When a nurse is performing a neurological assessment on a patient admitted to the Intensive Care Unit with a right-sided stroke, the nurse would see a positive Babinski reflex in the stroke victim if the great toe dorsiflexes (turning the toes upward.) and the other toes fan out. Babinkski's reflex is tested by stroking the lateral aspect of the sole of the foot with a semi sharp object such as a thumbnail.

Question No: 24
A nurse is ending his shift and comes in to re-assess his patient, a seventy six year old woman who was diagnosed with a brain lesion. He notes that the patient appears restless and does not know where she is. Upon further examination, he notes that her pupils are sluggish to react to light and are unequal in size. She is unable to sit up at the side of the bed and her blood pressure has risen to 190/88. What does the nurse suspect is occurring?
A. Increased Intracranial Pressure

B. Cerebral aneurysm
C. Stroke
D. Myocardial infarction
Answer: A
Explanation: Upon assessing the symptoms of sluggish and unequal pupils, restlessness and change in level of consciousness, increased weakness and rising blood pressure, the nurse would suspect early signs of increased intracranial pressure. Late signs of increased intracranial pressure include fixed pupils, profound weakness, an inability to arouse and an increased systolic pressure with Bradycardia.

Question No: 25
What is the best way to describe what happens during a Cerebral Aneurysm?
A. An obstruction or narrowing of the lumen of the aorta and its major branches.
B. An obstruction of an artery at the brain stem which results in lack of oxygen to the brain.
C. Blood flow exerts pressure against a weak artery wall resulting in a rupture of the arterial wall.
D. Inflammation of the brain and spinal cord meninges that affects all three meningeal membranes.
Answer: C
Explanation: The best way to describe a Cerebral Aneurysm is that it occurs when blood flow exerts so much pressure against a weak artery wall that it results in a rupture of that wall. Inflammation of the brain and spinal cord meninges is Meningitis.

Question No: 26
What are some signs and symptoms of an impending Aneurysm rupture?
A. Profuse sweating, headache, lethargy, nausea and vomiting.
B. Shortness of breath at rest, rapid heart rate, low grade fever, hypotension
C. High blood pressure, onset of chest pain and shortness of breath
D. Headache, nausea, back and leg stiffness that lasts several days
Answer: D
Explanation: The signs and symptoms of an impending Aneurysm rupture include headache, nausea, and back and leg stiffness that persists over several days. Shortness of breath at rest, rapid heart rate, low grade fever and hypotension are signs and symptoms of a pulmonary embolism. Headache, lethargy, nausea and vomiting are signs and symptoms of Meningitis.

Question No: 27
A 47 year old man has been admitted immediately to the Intensive Care Unit after a tree fell on him at a construction site. What will be the primary treatment for a Spinal Injury?
A. Place the patient in a hard cervical collar.
B. Perform a neurological assessment every four hours to assess further injury.
C. Reduce inflammation promptly by administering Methylprednisolone.
D. Stabilize the spine and prevent cord damage.
Answer: D
Explanation: The main treatment for a patient who has undergone a Spinal Injury is to immobilize the patient to stabilize the spine and prevent spinal cord damage. A, B, and C are part of the treatment plan but are not the main goal of treatment for a Spinal Injury.

Question No: 28
What is the best way a nurse can prevent the development of pressure ulcers in a patient who is in a drug induced coma?
A. Closely monitor the patient's intracranial pressure (ICP), electrocardiogram and vital signs.
B. Make sure that all visitors wash their hands before entering the room and making contact with the patient.
C. Turn and reposition the patient every two hours.
D. Assess the heels for signs of redness and foot drop.
Answer: C
Explanation: The best way a nurse can prevent the development of pressure ulcers in a patient who is in drug induced coma is to reposition the patient every two hours to increase circulation and ensure that no part of the patient's skin is unrelieved of pressure. Assessing the heels for redness does not prevent pressure ulcers.

Question No: 29
A nurse is caring for a 37-year-old patient with a ventricular drain. The nurse continues to assess for complications of rapid cerebrospinal fluid drainage. The signs and symptoms of complications of excessive CSF drainage include:
A. Headache, tachycardia, diaphoresis, and nausea
B. Shortness of breath, rapid heart rate, and hypotension
C. Severe headache, shallow and irregular respirations, and decrease in level of consciousness
D. Vomiting, amnesia, irritability, and dizziness
Answer: A
Explanation: The signs and symptoms of excessive cerebrospinal fluid drainage include headache, tachycardia, nausea, and diaphoresis (also referred to as excessive sweating). Vomiting, amnesia, irritability and dizziness are symptoms of a concussion. Severe headache, shallow and irregular respirations and a decrease in level of consciousness are symptoms of an epidural hematoma

Question No: 30
A nurse is reviewing the tests results of a patient with a diagnosis of rule out contusion. What would a computerized tomography CT scan show in a patient who has a contusion?
A. No changes would be seen on a CT scan.
B. Changes in tissue density and evidence of hematomas.
C. Structural shifts within the cranium.
D. Altered blood flow within the area.
Answer: B
Explanation: In the Computerized Tomography, scan of a patient who has a contusion, changes of density and evidence of hematomas would be seen. Others things that might be seen on the computerized tomography of the patient with a contusion include fractures and displacement of the surrounding structures.

Question No: 31
Why are the signs and symptoms of a hematoma late in coming for the elderly patient verses the younger or middle aged adult?
A. Older adults do not seek medical attention as quickly as young or middle aged adults.
B. Older adults who have cerebral atrophy can tolerate a larger subdural hematoma for a longer time than younger adults.

C. Older adults have a higher pain threshold than younger or middle aged adults.
D. There is no difference in the timing of the signs and symptoms of a patient with a hematoma, regardless of age.
Answer: B
Explanation: The signs and symptoms of a hematoma are late in coming for the elderly patient verses the younger or middle aged adult because for older adults with cerebral atrophy, the subdural hematoma has more time to grow. Because of this, the symptoms of a head bleed in an older adult will take longer to appear.

Question No: 32
Because meningitis is usually related to an infection, what priorities should the nurse highlight in the plan of care?
A. Assess neurological function frequently.
B. Watch for deterioration in the form of change in consciousness, onset of seizures and altered respirations.
C. Monitor fluid balance to avoid both fluid overload and cerebral edema.
D. Follow strict sterile technique when treating head wounds and dressing changes.
Answer: D
Explanation: Because meningitis is usually related to an infection, in the plan of care, the nurse should place a priority of avoiding further infection in the patient with meningitis by following sterile technique during dressing changes.

Question No: 33
A 59 year old male with new onset seizures is beginning treatment with Fosphenytoin sodium. What would be a contraindication to begin this drug?
A. History of cardiac disease
B. Sinus bradycardia
C. Gastrointestinal bleed
D. Hypertension
Answer: B
Explanation: For a 59 year old male with new onset seizures, a contraindication to beginning Fosphenytoin sodium would be sinus bradycardia which is characterized as a regular but unusually slow heart beat (60 beats/minute or less at rest). Other contraindications include Sino-atrial block, 2nd and 3rd degree AV block and Adams-Stokes syndrome.

Question No: 34
What would not be a nursing intervention for the patient with tonic-clonic seizures?
A. Restraining a patient during a seizure.
B. Clear the area of hard objects.
C. Turn the patient's head or turn him on his side.
D. Assist the patient to a lying position and loosen any tight clothing.
Answer: A
Explanation: Restraining a patient during a tonic-clonic seizure, would NOT be a nursing intervention. A tonic-clonic seizure is the classic type of seizure consisting of two phases; during the clonic phase the entire body becomes rigid and in the tonic phase, there is uncontrollable jerking. Clearing the area of hard objects, turning the patient to the side and helping them to a lying position (if standing) are all appropriate nursing actions to

prevent injury and maintain a patent airway during a seizure.

Question No: 35
An experienced Intensive Care Unit nurse is precepting a new nurse to the intensive care unit. What would she explain is the most sensitive indicator of neurological change?
A. Speech
B. Level of consciousness
C. Behavior
D. Cognitive Function
Answer: B
Explanation: The most sensitive indicator of neurological change in a patient is the level of consciousness. Changes in speech, behavior and cognitive function come later in the neurological change.

Question No: 36
A nurse is observing her patient after a computerized tomography (CT) scan to assess whether they are having an adverse reaction to the contrast medium. Signs and symptoms of an adverse reaction would include everything but:
A. Facial flushing
B. Urticaria
C. Bradycardia
D. Restlessness
Answer: C
Explanation: Signs and symptoms of an adverse reaction to contrast medium include everything except Bradycardia, which is characterized as a regular but unusually slow heart beat (60 beats/minute or less at rest). A patient experiencing an adverse reaction to contrast medium would experience Tachycardia.

Question No: 37
Which type of seizure is characterized by brief, involuntary muscle movements and typically occurs early in the morning?
A. Akinetic
B. Myoclonic
C. Generalized tonic-clonic
D. Jacksonian
Answer: B
Explanation: Myoclonic seizures are characterized by brief, involuntary muscle movements. They typically occur early in the morning. Myoclonic seizures are typically treated with drug therapy.

Question No: 38
For a patient with a massive stroke, when is the best time to begin exercises and physical therapy?
A. As soon as possible.
B. Three to four days after the stroke.
C. When the systolic blood pressure falls below 200.
D. After the patient is able to tolerate a mechanical soft diet.
Answer: A

Explanation: The patient who has had a stroke should begin exercises as soon as possible. Simple exercises such as range of motion for the affected and unaffected sides are important to prevent muscle atrophy and skin breakdown.

Question No: 39
For a patient to be considered for Thrombolytic Therapy after an ischemic stroke, when must the Thrombolytic Therapy begin?
A. Within 6 hours of arriving in the emergency room.
B. Within 5 hours of the onset of stroke symptoms.
C. Within 60 minutes after arrival in the emergency room.
D. Within 3 hours after onset of symptoms.
Answer: D
Explanation: For a patient to be considered for Thrombolytic Therapy after an ischemic stroke, the patient must be treated within 3 hours after the onset of symptoms. If there was no one to witness the onset of the stroke, the patient is unable to be treated with Thrombolytic Therapy. Thrombolytic therapy is the use of drugs that dissolve blood clots.

Question No: 40
Bleeding prevention is important with patients who have been diagnosed with Arteriovenous Malformation. What interventions would not be included in preventing a bleed?
A. Playing the patient's favorite type of music and allow visitors as a distraction.
B. Monitor and control hypertension with medication ordered.
C. Assess for headache and seizure activity.
D. Provide emotional support.
Answer: A
Explanation: The intervention that would NOT be included in preventing a head bleed in a patient with Arteriovenous Malformation would be promoting a noisy environment, which could precipitate bleeding. Instead, a quiet, therapeutic environment should be maintained.

Question No: 41
A 37 year old woman is admitted to the intensive care unit after experiencing an anterior spinal cord injury status post trauma. What kind of gastrointestinal problems would this patient be at risk for?
A. Uncontrolled nausea and vomiting
B. Gastrointestinal ulcers
C. Constipation
D. Small bowel obstruction
Answer: B
Explanation: Patients who experience anterior spinal cord injuries are at risk for developing gastrointestinal ulcers and bleeding. The nurses should asses the abdomen for distention, look for signs and symptoms of bleeding and anticipate orders for appropriate medications.

Question No: 42
The nurse is taking care of a patient who is has been admitted with a diagnosis of "brain dead post traumatic injury." The nurse would expect all of the following clinical manifestations except:

A. Absent papillary responses
B. Slight eye movement during the caloric test.
C. No corneal reflex present.
D. Fixed eyes during the doll's eyes test.
Answer: B
Explanation: The nurse would expect to see no eye movement during the caloric test in a patient with a diagnosis of "brain dead." During the caloric test, cold water is instilled into the ears. Normally, the eyes would move toward the ear where the water is instilled.

Question No: 43
A nurse documents on a patient's chart that they are experiencing "reality disturbances" during their admission in the intensive care unit. What would NOT be an example of a "reality disturbance?"
A. Disorientation to time.
B. Inability to decipher whether it is day or night.
C. Increased agitation.
D. Misinterpretation of environmental stimuli.
Answer: C
Explanation: An example of something that is NOT a "reality disturbance" is increased anxiety. Reality disturbance occurs when a patient's ability to interpret the environment is altered. Increased agitation would be a result of delirium.

Question No: 44
The importance of evidenced based care is gaining credibility and acknowledgement. Nurses in the critical care setting are often learning new techniques and adapting their care to reflect evidenced based outcomes. Evidence based care would be based on all the following sources except:
A. Formal nursing research
B. Clinical knowledge
C. Scientific knowledge
D. Cultural practice
Answer: D
Explanation: Evidence based care is based on formal nursing research, clinical knowledge and scientific knowledge. Cultural practices are not a basis for evidence based care. The critical care nurse has the opportunity to educate and inform the patients and their families about the best care for them based on research and knowledge.

Question No: 45
The purpose of the multidisciplinary team in the critical care setting is to:
A. Minimize mistakes and errors made on the unit.
B. Assist the nurse in caring for the critically ill unit.
C. Provide holistic care for the patient.
D. Increase the efficiency of the unit and assist in moving patients to a lower level of care.
Answer: C
Explanation: The goal of the multidisciplinary team in the critical care unit is to provide holistic care for the patient. The multidisciplinary team includes the physicians, nurses, occupational therapists, physical therapists,

speech therapists, discharge planners and social workers.

Question No: 46
When administering the non-opioid analgesics Acetaminophen, why is the total daily intake monitored and limited to not more than 4 grams/day?
A. More than 4 grams a day may cause injury to the kidneys.
B. No damage will occur unless the patient has sensitivity to acetaminophen.
C. More than 4 grams a day will cause injury to the liver.
D. More than 4 grams /day only adversely affects the geriatric population.
Answer: C
Explanation: Acetaminophen intake is limited to 4 grams/day because of the harm it can cause to the liver. Anyone who takes more than 4 grams of Acetaminophen a day on a consistent basis may have damage to the liver, regardless of age.

Question No: 47
The anticoagulant, Heparin, is appropriate to use in all of the following diagnosis except:
A. Embolism prophylaxis
B. Cerebral thrombosis
C. Ischemic Stroke
D. New onset atrial fibrillation
Answer: C
Explanation: Heparin, an anticoagulant is appropriate for all of the diagnosis except hemorrhagic stroke. In a hemorrhagic stroke, Heparin may increase the bleeding into the brain more severely.

Question No: 48
Which anticonvulsant may cause Status Epilepticus when abruptly withdrawn?
A. Carbamazepine
B. Fosphenytoin
C. Primidone
D. Valproic acid
Answer: C
Explanation: When abruptly withdrawn, Primidone may cause Status Epilepticus. However please note that a smaller dose should be used in the elderly.

Question No: 49
The nurse is caring for a patient who has been placed in a barbiturate coma. How would the nurse explain the purpose of the coma to a nursing student?
A. It relieves increased intracranial pressure and protects cerebral tissue.
B. It reduces the cerebral blood flow and eases the patient's ability to breathe.
C. It allows the team to perform procedures without agitating the patient.
D. It helps the patient rest from traumatic injury.
Answer: A
Explanation: The best way to explain the purpose of the barbiturate induced coma is that it produces a state where increased intracranial pressure (ICP) can be reduced and cerebral tissue is protected. It is a last resort

intervention when conventional treatments such as fluid restriction or corticosteroid therapy have been unable to correct increased intracranial pressure.

Question No: 50
What is the drug of choice for patients who have been exposed to Bacterial Meningitis?
A. Rifampin
B. Acyclovir
C. Penicillin
D. Ceftriaxone
Answer: A
Explanation: The drug of choice for patients who have been exposed to Bacterial Meningitis is Rifampin. Rifampin is used for healthcare workers, household contacts, school and preschool contacts who may have been exposed.

Question No: 51
The nurse is taking care of a 48 year old woman who has suffered a closed head injury secondary to a motor vehicle accident. She has started to experience tonic-clonic seizures. Which nursing intervention is most appropriate for this patient?
A. Pad the bedside rails.
B. Ensure that someone is with the patient at all times.
C. Have the equipment for oxygen and suction at the bedside.
D. Place a padded tongue blade on the bedside table.
Answer: C
Explanation: The most appropriate nursing intervention for the patient who has suffered a closed head injury and tonic-clonic seizures is to have oxygen and suction at the bedside. Maintaining the airway is always critically important.

Question No: 52
What precautions should be followed when administering Phenytoin?
A. Phenytoin should always be mixed with a dextrose solution when given in an intravenous form.
B. Phenytoin should be given as a pill only.
C. Most people don't react well to Phenytoin so Fosphenytoin is given as an alternate.
D. Phenytoin should not be mixed with a dextrose solution.
Answer: D
Explanation: When administering Phenytoin, it should NOT be administered with a dextrose solution because it will form precipitation and crystallization of the solution.

Question No: 53
What teaching is important to include for women who have experienced a spinal cord injury and have questions about having children?
A. After a spinal cord injury, women should not have children.
B. Women can continue to conceive and deliver children but should only use a diaphragm, condom or foam birth control.
C. Women can continue to conceive and deliver children and the type of birth control used should be

discussed with their doctor.
D. There are no restrictions on birth control measures for women who have had spinal cord injuries. They should follow up with their doctors.
Answer: C
Explanation: After a spinal cord injury, many women have questions about child bearing. They should be taught that they can still conceive and deliver children but should use a birth control measure that does not increase the risk for clot formation.

Question No: 54
A patient with a T6 spinal cord injury develops autonomic Dysreflexia, an emergency situation that can occur after spinal shock. What is the first line and initial treatment for the patient?
A. Maintain pulmonary integrity through oxygenation delivery and maintaining a patent airway.
B. Remove the noxious stimulant.
C. Assess to see if the patient has taken Viagra within the last 24 hours.
D. Administer pain and anti anxiety medication.
Answer: B
Explanation: The first line and initial treatment for autonomic Dysreflexia is to remove the noxious stimulant and then administer antihypertensive medications. The patient should be assessed to see if they have had Viagra since nitrates are often used to manage the hypertension and Viagra interacts with nitrates. Noxious stimulants that are often the culprit of autonomic Dysreflexia include urinary catheters, distended bowel, skin pressure or pressure ulcers.

Question No: 55
What is the drug of choice for treatment of anaphylactic and anaphylactoid shock?
A. Epinephrine
B. Albuterol
C. Diphenhydramine
D. Narcan
Answer: A
Explanation: The drug of choice for treatment of anaphylactic and anaphylactoid shock is Epinephrine. Albuterol treatments and diphenhydramine may be administered later as secondary treatments. Epinephrine works as a vasoconstrictor.

Question No: 56
A nurse is taking care of a patient who has Hemoglobin of 4.2. The nurse hung the second unit of packed red blood cells five minutes ago and the patient is suddenly flushed, breathing rapidly. The monitor shows a heart rate of 150. What is the first thing the nurse should do?
A. Apply oxygen via a non-rebreather mask to the patient.
B. Administer antihistamines or beta 2 agonists.
C. Call the rapid response team.
D. Discontinue the blood.
Answer: D
Explanation: The first thing the nurse should do when a patient shows signs of a reaction are to find the potential cause of the reaction and stop it. After that, calling the rapid response team, administering oxygen

and administering antihistamines or beta 2 agonists would be appropriate.

Question No: 57
What is the most common cause for Cardiogenic shock?
A. Stroke
B. Hypertensive crisis
C. Myocardial infarction
D. Acute pulmonary edema
Answer: C
Explanation: The most common cause for Cardiogenic shock is a Myocardial infarction where more than 40% of the ventricle of the heart has been damaged. Shock occurs when, because of the decreased function of the heart, there is a decreased flow of oxygen rich blood the tissues.

Question No: 58
The patient who is experiencing cardiogenic shock is at risk for what complication?
A. Another myocardial infarction.
B. Pulmonary embolus.
C. Pulmonary edema.
D. Congestive heart failure.
Answer: C
Explanation: The patient who has experienced cardiogenic shock is at risk for Pulmonary Edema. During cardiogenic shock, when the stroke volume and cardiac output decrease, blood backs up into the pulmonary system, eventually leaking out of the pulmonary capillaries and into the lung tissue and alveoli.

Question No: 59
A 49 year old male patient has experienced a myocardial infarction with an approximate 55% damage to his ventricle. What interventions would most likely NOT be performed for this patient to avoid the complication of cardiogenic shock?
A. Intraaortic balloon pump
B. Angioplasty
C. Bypass surgery
D. Chest tube insertion
Answer: D
Explanation: The interventions that would most likely NOT be performed for this patient is insertion of a chest tube. All treatments are aimed with the goal of restoring blood flow and oxygenation early and quickly to avoid organ damage.

Question No: 60
Dopamine is a drug commonly used with patients who are going through cardiogenic shock. What is the primary effect of Dopamine?
A. Promotes arterial resistance and reduces systolic blood pressure.
B. Decreases venous resistance and helps decrease angina pain.
C. Increases renal perfusion and increases the pumping action of the heart.
D. Promotes arterial vasodilation and reduces the preload and afterload, increasing the pumping action of

the heart.
Answer: C
Explanation: The primary effect of Dopamine is to increase renal perfusion. This causes in increase in cardiac output, heart rate and systemic arterial pressure. In turn, this helps the heart pump more.

Question No: 61
The nurse is evaluating her patient's arterial blood oxygenation level on a patient who is status post a myocardial infarction 2 days ago. What would be the minimal oxygenation saturation level that would reflect adequate oxygen supply to the tissues?
A. 88%
B. 90%
C. 92%
D. 95%
Answer: B
Explanation: The minimal oxygenation saturation that would reflect adequate oxygen supply to the tissues is 90%. In an arterial blood gas reading, the measurement of oxygen tension in the arterial blood (PaO2) needs to be greater than 80 mm Hg.

Question No: 62
When the patient is being monitored for cardiogenic shock with one of the devices like extracorporeal life support, left ventricular assist device, or intraaortic balloon pump, what lab value must be monitored to prevent these devices from becoming clotted?
A. Potassium and sodium
B. Prothrombin time, International Normalized Ratio (INR)
C. Cardiac markers and Troponin
D. B-type Natriuretic Peptide
Answer: B
Explanation: To prevent the extracorporeal life support, left ventricular assist device or intraaortic balloon pump from becoming clotted, the Prothrombin time (PT, INR) reflects the "thinness" of the blood and the likeliness of the blood's ability to clot.

Question No: 63
What is the most common cause of Hypovolemic shock?
A. Loss of fluids by the gastrointestinal tract
B. Hemorrhage
C. Plasma losses
D. Renal losses
Answer: B
Explanation: The most common cause of hypovolemic shock is hemorrhage. Examples include trauma, surgery, ruptured spleen, hemothorax and pelvic fractures. Hypovolemic shock can also be caused by loss of fluids from the gastrointestinal tract, plasma losses and renal losses. However, these causes are not as common.

Question No: 64
All of these signs and symptoms are early stages of Hypovolemic shock except for:

A. Tachycardia
B. Hypotension
C. Tachypnea
D. Decreased urinary output
Answer: B
Explanation: All of these are early stages of Hypovolemic shock except for hypotension. Patients can lose more than 30% of their intravascular volume before Hypotension occurs.

Question No: 65
What would be priority interventions to restore intravascular volume to the patient suffering from Hypovolemic shock?
A. Administer respiratory treatments and oxygen to maintain patent airway and easier breathing.
B. Administer large bore intravenous catheters in both the right and left antecubital vein.
C. Insert a foley catheter to monitor the urinary output.
D. Take vital signs every 15 minutes.
Answer: B
Explanation: The nurse should insert large bore intravenous catheters in each arm for rapid infusion of fluids. The patient in Hypovolemic shock may need rapid fluid resuscitation.

Question No: 66
Which patient is at the greatest risk for septic shock?
A. An 84 year old woman with a long term foley catheter, a stage four pressure ulcer on her coccyx and insulin dependent diabetes.
B. A 55 year old woman with pneumonia.
C. A 38 year old woman with asthma and status post day 2 appendectomy.
D. A 63 year old man who had bypass surgery two weeks ago.
Answer: A
Explanation: The patient at the greatest risk for septic shock would be the 84 year old woman. She has multiple areas of entrance for bacteria.

Question No: 67
What is the best way to position the patient who is unstable, hypotensive and in a Hypovolemic state?
A. Supine with the head of bed elevated 30 degrees
B. Supine with the head of bed elevated 90 degrees
C. Supine and flat
D. Prone and flat
Answer: C
Explanation: The best position for the patient who is unstable, hypotensive and in a Hypovolemic state is supine and flat. If the patient is mildly Hypovolemic, the best position is supine with the head of the bed elevated 30-60 degrees.

Question No: 68
What medication would most likely be used to prevent agitation in a patient with a traumatic brain injury (TBI)?
A. Mannitol