

Practice Exam Questions



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EXAMAIDES

PASS YOUR EXAM AT FIRST TRY

Total Question: 208 QAs + 175 QAs

Question No: 1

You are administering a Snellen chart test to a patient. What results would you expect to get if your patient was legally blind?

- A. 20/20 vision
- B. 20/40 vision
- C. 20/60 vision
- D. 20/200 vision

Answer: D

Explanation: The patient would be considered legally blind if the result of the Snellen chart test is 20/200 vision. This means that the patient is able to read at 20 feet what a person with normal vision can read at 200 feet. Legal blindness is defined as 20/200 or less with corrected vision or visual acuity of less than 20 degrees of the visual field in the better eye.

Question No: 2

What is the normal intraocular pressure of the eye?

- A. 2 to 7 mm Hg
- B. 10 to 21 mm Hg
- C. 22 to 30 mm Hg
- D. 31 to 35 mm Hg

Answer: B

Explanation: The normal intraocular pressure of the eye is 10 to 21 mm Hg. The test used to measure intraocular pressure is called a tonometry. This is how glaucoma is diagnosed. A patient with glaucoma would have an intraocular pressure of 30 to 70 mm Hg.

Question No: 3

Your patient has been diagnosed with a hyphema following hitting their head on the steering wheel during a car accident. What position would you want to place this patient in?

- A. Supine
- B. Semi- fowlers
- C. Lateral
- D. Trendelenburg

Answer: B

Explanation: The patient should be placed in semi-fowlers position on bed rest. A hyphema is caused by a force, such as hitting your head on the steering wheel, strong enough to break the blood vessels in the eye. Placing the patient in semi-fowlers position lets gravity work to keep the hyphema away from the optical center of the cornea.

Question No: 4

Your patient has arrived in the emergency department with a penetrating eye injury. You are assessing the patient. What should your first action be?

- A. Remove any objects from the eye.

- B. Place a patch over the eye.
- C. Perform a visual acuity test.
- D. Use sterile saline to irrigate the eye.

Answer: C

Explanation: You would want to perform visual acuity tests on the affected eye first. This allows the nurse to assess any damage to the vision. Any foreign objects in the eye should only be removed by an ophthalmologist. Do not cover or rinse eye because it may dislodge foreign objects and cause further damage to the eye.

Question No: 5

Your patient has arrived in the emergency department with a chemical eye injury. Your first action should be to:

- A. Perform a visual acuity test
- B. Use sterile saline to irrigate the eye
- C. Place antibiotic ointment in the eye
- D. Place a patch over the eye

Answer: B

Explanation: The first reaction by the nurse should be to irrigate the eye with normal saline. This should be done for at least 10 minutes to remove any chemicals from the eye. Following irrigation of the eye the patient should have visual acuity tests to determine the extent of damage to the eye.

Question No: 6

You are caring for a patient who has come into the emergency department with a foreign body in his right ear. After further investigation you determine that the foreign object is an insect. What intervention would the physician order first for this client?

- A. Sterile normal saline irrigation
- B. Diluted alcohol irrigation
- C. Antibiotic ear drops
- D. Corticosteroids ointment

Answer: B

Explanation: The nurse would know that the physician will order diluted alcohol irrigation of the affected ear. This will suffocate the insect so it can be removed from the ear with forceps. If the foreign object were vegetable matter, irrigation would not be performed due to the enlargement of the object when it is hydrated, which would make the impaction worse.

Question No: 7

When caring for a patient what sign would indicate that he might have a basal skull fracture?

- A. The auditory canal has purulent drainage.
- B. The auditory canal has bloody or clear drainage.
- C. Epistaxis
- D. Periorbital edema

Answer: B

Explanation: A basal skull fracture would be indicated by bloody or clear drainage from the auditory canal. This indicates a cerebrospinal fluid leak from the fracture. This is a medical emergency and needs to be

addressed by the physician immediately.

Question No: 8

You are caring for a patient who complains of tinnitus. What part of the ear do you suspect is the most likely cause of the patient's complaint?

- A. External ear
- B. Middle ear
- C. Inner ear
- D. Auricle

Answer: C

Explanation: Tinnitus is the most common complaint of patients with disorders of the inner ear. Tinnitus is a ringing in the ear that can be loud intolerable ringing or mild ringing that can be unnoticed during the day.

Question No: 9

You are caring for a patient who has had a right eye cataract removal. What discharge instruction would you want to include in the plan of care?

- A. Do not sleep on right side.
- B. Do not sleep on left side.
- C. Do not sleep with head elevated.
- D. Do wear glasses until physician says it is okay.

Answer: A

Explanation: The patient should not sleep on the right side following surgery. The patient should be placed in a semi-Fowler position to minimize edema and intraocular pressure. The patient should wear glasses and a protective shield over the affected eye.

Question No: 10

You have delegated the care of an older patient with hearing loss to a nursing assistant. You tell the nursing assistant that patients with this diagnosis:

- A. Are often distracted.
- B. Respond better to low pitched sounds.
- C. Have middle ear changes.
- D. Develop moist cerumen production.

Answer: B

Explanation: Older patients with hearing loss respond better to low pitch sounds. Age-related changes of the inner ear are called presbycusis. As a result of these changes the patient often loses the ability to hear high-pitched sounds.

Question No: 11

The most appropriate action by the nurse who is preparing to communicate with an older patient who has hearing loss is:

- A. Stand in front of the patient.
- B. Exaggerate lip movements.
- C. Obtain a sign language interpreter.
- D. Pantomime and write the patient notes.

Answer: A

Explanation: The nurse should stand in front of the patient with hearing loss while trying to communicate with them. By standing in front of the patient and providing adequate lighting, the nurse insures that the patient can see the nurse clearly. If there is still difficulty communicating, then notes and pantomime can be used.

Question No: 12

Which of the following assessments would make the nurse suspect that a child has strabismus?

- A. Tilts head to see
- B. Turns head to see
- C. Does not respond when spoken to
- D. Has difficulty hearing

Answer: A

Explanation: A child with strabismus will tilt head to see. Strabismus is when the extraocular muscles have a lack of coordination so the eyes do not align. The patient may complain of frequent headaches and squint to see and may need to go to surgery to realign the weak muscles if nonsurgical interventions do not work.

Question No: 13

You are caring for a child with chlamydial conjunctivitis. What would you want to investigate if you had a patient with this diagnosis?

- A. Presence of an allergy
- B. Possible trauma
- C. Possible sexual abuse
- D. Presence of a respiratory infection

Answer: C

Explanation: The nurse would want to investigate possible sexual abuse. This diagnosis in a child who is not sexually active should trigger suspicions in the nurse. Allergy, trauma and infection can all cause conjunctivitis, but chlamydia is a sexually transmitted disease.

Question No: 14

You are caring for a child who is going to have a tonsillectomy. Which of the following laboratory results would you want to check preoperatively?

- A. Prothrombin time
- B. Sedimentation rate
- C. Blood urea nitrogen
- D. Creatinine

Answer: A

Explanation: The nurse would want to check the prothrombin time preoperatively and report any abnormal results to the surgeon. The tonsillar area is very vascular, which can increase the patient's chance of bleeding. If the prothrombin time is not adequate, the patient could bleed to death.

Question No: 15

You are caring for a child who will have a tonsillectomy. Which of the following would increase the child's risk of aspiration during surgery?

- A. Difficulty swallowing

- B. Loose teeth
- C. Bleeding
- D. Exudate in the throat

Answer: B

Explanation: If the child has loose teeth it increases the risk of aspiration. A and D are symptoms that indicate the need for surgery. C will be taken care of during surgery with suctioning and packing. Therefore it is important that the nurse check the child for loose teeth prior to surgery to prevent aspiration.

Question No: 16

You are caring for the child who has had a tonsillectomy. The physician has written postoperative orders. Which of the following orders would the nurse question?

- A. Clear, cool liquids when awake
- B. No milk or milk products
- C. Monitor for bleeding
- D. Suction every 2 hours

Answer: D

Explanation: You would not want to suction a patient who just had a tonsillectomy. Suction equipment should be available at bedside in case of airway obstruction. Otherwise, a patient would not be suctioned due to the risk of trauma to the oropharynx. All other orders listed are appropriate for this patient.

Question No: 17

You are monitoring a child who had a tonsillectomy. On assessment, which findings would indicate to you that the child might be bleeding?

- A. Decreased pulse
- B. Elevation in blood pressure
- C. Complaints of discomfort
- D. Frequent swallowing

Answer: D

Explanation: Frequent swallowing by the child might indicate that there is bleeding. Other signs or symptoms might include restlessness, vomiting blood, and a fast, thready pulse. Elevation of blood pressure and discomfort do not indicate bleeding.

Question No: 18

After a tonsillectomy, your patient begins to vomit. What intervention should be your priority?

- A. Administer an antiemetic
- B. Turn the patient to the side
- C. Notify the physician
- D. Maintain the patient's "nothing by mouth" status

Answer: B

Explanation: Your first priority should be to turn the patient on the side to prevent aspiration. Only then should you notify the physician. It is also important to continue to maintain the "nothing by mouth" feeding status of the patient and give antiemetic if prescribed.

Question No: 19

When caring for a patient with glaucoma, which of the following symptoms would you not expect to see on the patient's chart?

- A. Severe eye pain
- B. Frequent pink-eye infections
- C. Blurred vision
- D. Nausea and vomiting

Answer: B

Explanation: Frequent pink-eye infections are not symptomatic of glaucoma, but reddening of the eyes is a common symptom.

Question No: 20

Which of the following orders would the physician prescribe for the patient with retinal detachment?

- A. Bathroom privileges
- B. Head of bed up 45 degrees
- C. Eye patch to affected eye
- D. Dark glasses to read or watch television

Answer: C

Explanation: The physician would order an eye patch to the affected eye. This decreases movement of the eye and prevents further damage to the eye. The physician may limit activity until the eye can be repaired.

Question No: 21

What is the accurate procedure for performing a confrontational peripheral vision test?

- A. Both examiner and patient cover the same eye and stare at each other while an object is brought into the line of sight.
- B. Examiner and patient cover opposite eyes and stare at each other while an object is brought into the line of sight.
- C. The patient is asked to discriminate numbers from a chart composed of colored dots.
- D. The room is darkened and the patient is asked to identify colored blocks and shapes when they appear in the visual field.

Answer: B

Explanation: The examiner and the patient cover the opposite eyes and stare at each other while an object is brought into the line of sight. This test assumes that the examiner has normal vision. The patient indicates when they can see the object. This tests nasal, superior, temporal and inferior visual fields.

Question No: 22

Which of the following would the nurse do when performing an otoscopic exam on a patient?

- A. Pull the pinna up and back.
- B. Pull the earlobe down and back.
- C. Use the smallest speculum available.
- D. Tilt the patients head forward and down.

Answer: A

Explanation: The nurse would pull the pinna up and back before inserting the speculum, holding the head slightly away and holding the otoscope upside down like a large pen. The other three options are incorrect.

Question No: 23

Your patient is scheduled to go for cataract surgery. What nursing diagnosis should you include in the patient's plan of care?

- A. Self care deficit
- B. Imbalanced nutrition
- C. Disturbed sensory perception
- D. Anxiety

Answer: C

Explanation: Disturbed sensory perception should be included in this patient's plan of care. The patient's vision would be disturbed related to lens extraction and replacement. The other nursing diagnoses may be appropriate for this patient, but are not relevant to cataract surgery.

Question No: 24

What clinical manifestations would you see if your patient had cataracts?

- A. Eye pain
- B. Floating spots
- C. Blurred vision
- D. Diplopia

Answer: C

Explanation: Blurred vision is a clinical manifestation of cataracts. The patient may also exhibit decreased color perception. All other signs are not signs of cataracts.

Question No: 25

What type of eye drops would be ordered for the patient who is being prepared for cataract surgery?

- A. Osmotic diuretic
- B. Miotic agent
- C. Mydriatic medication
- D. Thiazide diuretic

Answer: C

Explanation: A mydriatic medication would be ordered for the patient who is being prepared for cataract surgery. This will produce mydriasis and dilation of the pupil. It will also constrict blood vessels.

Question No: 26

Which of the following would be associated with detached retina?

- A. Pain in the affected eye
- B. Total loss of vision
- C. Feeling like a curtain had fallen over their eyes
- D. Yellow discoloration of the scleroses

Answer: C

Explanation: A patient with a detached retina would complain of a sense of a curtain falling across their field of vision. There is no pain associated with retinal detachment, but it is an ophthalmic emergency in that immediate steps must be taken to protect the patient's vision.

Question No: 27

What intervention would you need to take if your patient had a contusion of the eyeball following a traumatic injury?

- A. Notify the physician.
- B. Irrigate the eye with cool water.
- C. Apply ice to the affected eye.
- D. Accompany the patient to the emergency room.

Answer: C

Explanation: The priority intervention for this patient would be to apply ice to the affected eye. The patient should then be seen by a physician to rule out any other eye injury. Do not irrigate the eye with cool water until it is examined by a physician.

Question No: 28

What nursing action would the nurse take when caring for a patient with enucleation with bright red drainage?

- A. Notify the physician.
- B. Continue to monitor the drainage.
- C. Document the finding.
- D. Mark the drainage on the dressing.

Answer: A

Explanation: The nurse's first priority would be to notify the physician. The presence of bright red drainage on the dressing is an indication of hemorrhage. The other options are inappropriate for this patient.

Question No: 29

You are completing a hearing screening on a patient. You note that the sound lateralizes to the patient's left ear during a Weber test. What does this finding indicate?

- A. A normal finding
- B. Conductive hearing loss in the right ear
- C. Sensorineural or conductive loss
- D. Presence of nystagmus

Answer: C

Explanation: This test indicates sensorineural or conductive loss in the right ear. The Weber test is done by placing a vibrating tuning fork at the middle of the forehead. The patient should hear sound by bone conduction equally in both ears; if not, then the patient has hearing loss in the ear that did not hear the sound.

Question No: 30

When caring for a hearing impaired patient what approach will facilitate communication?

- A. Speak frequently.
- B. Speak loudly.
- C. Speak directly into the impaired ear.
- D. Speak in a normal tone.

Answer: D

Explanation: The nurse should speak in a normal tone of voice when addressing the patient. The nurse should talk directly to the patient while facing them. If the patient still does not understand then the nurse should move closer to the better ear to facilitate communication.

Question No: 31

You have delegated care of a patient in restraints to a nursing assistant. How often should the nursing assistant assess skin integrity for this patient?

- A. Every 30 minutes
- B. Every 2 hours
- C. Every 3 hours
- D. Every 4 hours

Answer: A

Explanation: The nursing assistant should assess the patient's skin integrity every 30 minutes for as long as the patient is in restraints. In order to delegate this task to the nursing assistant the nurse must insure that the nursing assistant is clear on what care the patient requires.

Question No: 32

You are working in the emergency department and find out that a tornado has hit the local area. Numerous casualties are being sent to the emergency department. What action should you take at this time?

- A. Prepare the triage room.
- B. Obtain additional supplies.
- C. Activate the agency disaster plan.
- D. Call in additional staff.

Answer: C

Explanation: The nurse should activate the agency disaster plan. All the other options may be part of the disaster plan, but the first priority of the nurse should be to activate the disaster plan. This will cover all the necessary steps that the will need to take.

Question No: 33

You receive an order for 1000 mL of normal saline over 12 hours. The drop factor is 15 drops per 1 mL. You prepare to set the flow rate at how many drops per minute?

- A. 15 drops a minute
- B. 17 drops a minute
- C. 21 drops a minute
- D. 23 drops a minute

Answer: C

Explanation: The drop rate is 21 drops a minute.

$(\text{Total volume} \div \text{Time in minutes}) \times \text{Drop factor} = \text{Drops per minute}$

$(1000 \text{ mL} \div 720 \text{ minutes}) \times 15 \text{ gtts} = 1.4 \text{ mL/min} \times 15 \text{ gtts} = 21 \text{ drops a minute}$

Question No: 34

You are preparing to give an intravenous dose of 400,000 units of penicillin G benzathine (Bicillin). The 10 mL ampule label reads penicillin G benzathine 300,000 units per mL. You prepare to administer how much of the medication?

- A. 1.3 mL
- B. 1.5 mL
- C. 10 mL
- D. 13 mL