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PRACTICE QUESTIONS

American Association of Critical Care Nurses (AACN)

BMY5NN95

CSC - Adult Examination

EDITION

Demo

QUESTIONS

9

FORMAT

Limited Edition PDF

Before you begin

What this is

9 practice questions for American Association of Critical Care Nurses (AACN) BMY5NN95 , each with its answer key and an explanation. Answer a question before you read its key — the explanation is worth more once you have committed.

If something looks wrong

Send us three things and we will check it:

- the exam code, BMY5NN95
- the question number
- the email address on your order

Write to **support@mometrix.net**. We reply within one business day.

QUESTION 1

MULTIPLE CHOICE

A patient 6 hours post–ST-elevation myocardial infarction (STEMI) develops sudden dyspnea, a new holosystolic murmur at the left lower sternal border, and a jugular venous distention (JVD) that was not present on admission. Hemodynamics show a step-up in oxygen saturation from the right atrium to the right ventricle. Which two findings are most consistent with the suspected mechanical complication? (Choose two.)

- ☒ **A** Acute ventricular septal rupture
- ☐ **B** Acute papillary muscle rupture
- ☐ **C** Right atrial pressure waveform with a dominant 'v' wave
- ☒ **D** Increase in oxygen saturation from right atrium to right ventricle
- ☐ **E** Tall, peaked T waves on the 12-lead ECG

ANSWER A - D

WHY An oxygen saturation step-up from the right atrium to the right ventricle is the hemodynamic hallmark of a left-to-right shunt at the ventricular level, which in this post-MI timeframe is consistent with ventricular septal rupture. A holosystolic murmur at the left lower sternal border also fits. Papillary muscle rupture typically produces severe mitral regurgitation with a dominant 'v' wave in the pulmonary capillary wedge tracing, not an RA-to-RV saturation step-up. Tall peaked T waves suggest hyperkalemia, not a mechanical complication.

QUESTION 2

MULTIPLE CHOICE

A patient with severe ARDS is being mechanically ventilated. Which two ventilator strategies are consistent with current lung-protective ventilation recommendations? (Choose two.)

- ☐ A Tidal volume of 8 mL/kg predicted body weight
- ☒ B Plateau pressure goal of ≤ 30 cm H₂O
- ☐ C Routine use of a recruitment maneuver followed by a PEEP titration
- ☒ D Allowing PaCO₂ to rise gradually (permissive hypercapnia) when pH remains acceptable
- ☐ E Routine neuromuscular blockade for the first 72 hours in all patients with moderate ARDS

ANSWER B • D

WHY Lung-protective ventilation for ARDS targets a tidal volume of approximately 6 mL/kg predicted body weight (not 8), a plateau pressure ≤ 30 cm H₂O, and accepting a higher PaCO₂ (permissive hypercapnia) provided pH is acceptable. Routine neuromuscular blockade is not recommended for all moderate ARDS patients, and while recruitment maneuvers may be used selectively, they are not a routine standing order for every patient.

QUESTION 3

SINGLE CHOICE

A patient with a severe traumatic brain injury has an external ventricular drain (EVD) in place. Which action by the nurse best reduces the risk of an upward transtentorial herniation when repositioning the patient?

- ☐ A Clamp the EVD during repositioning and immediately reopen it once positioning is complete.
- ☒ B Level the transducer at the foramen of Monro and turn the patient with the drain unclamped and the system leveled at the new position.
- ☐ C Instill 2 mL of preservative-free normal saline through the EVD to clear the line before turning.
- ☐ D Lower the head of the bed to 0 degrees during repositioning and return it to 30 degrees once repositioning is complete.

ANSWER B

WHY Repositioning an EVD requires leveling the transducer to the anatomical reference point (the foramen of Monro, the external landmark of which is the tragus) at the new position and keeping the system unclamped so CSF can drain freely. Clamping risks a sudden rise in ICP. Flushing an EVD is contraindicated because of the risk of forcing CSF and any pathogens retrograde into the ventricles. Lowering the head of the bed can increase ICP.

QUESTION 4

SINGLE CHOICE

A patient with cardiogenic shock has a pulmonary artery catheter with the following values: right atrial pressure 10 mm Hg, pulmonary artery pressure 60/30 mm Hg, pulmonary capillary wedge pressure (PCWP) 22 mm Hg, and cardiac index 1.6 L/min/m². Which pharmacologic agent is most appropriate as the initial inotropic/vasopressor support?

- ☒ **A** Norepinephrine
- ☐ **B** Phenylephrine
- ☐ **C** Vasopressin
- ☐ **D** Nitroprusside

ANSWER A

WHY The hemodynamics show elevated filling pressures (PCWP 22) with a low cardiac index (1.6) and an elevated systemic vascular resistance pattern consistent with cardiogenic shock. Norepinephrine provides vasopressor support with some inotropic activity and is the preferred initial agent in many cardiogenic shock scenarios. Phenylephrine and vasopressin are pure vasopressors and would worsen end-organ perfusion without addressing the depressed cardiac index. Nitroprusside would reduce afterload but is contraindicated when SBP is marginal and cardiac index is already low.

QUESTION 5

SINGLE CHOICE

A patient with sepsis has received 30 mL/kg crystalloid resuscitation, is on norepinephrine at 0.25 mcg/kg/min, and now has a MAP of 65 mm Hg, lactate of 5.4 mmol/L, and continued mottling of the lower extremities. Which intervention is the most appropriate next step according to current sepsis management guidelines?

- ☒ **A** Add hydrocortisone 200 mg IV per day, particularly if the patient remains on vasopressor support.
- ☐ **B** Initiate a continuous infusion of furosemide for fluid removal.
- ☐ **C** Discontinue norepinephrine and start dopamine.
- ☐ **D** Administer albumin 25% to repeat volume expansion.

ANSWER A

WHY In patients with septic shock who continue to require vasopressor therapy despite fluid resuscitation, IV hydrocortisone is recommended. Furosemide would worsen hemodynamics in a MAP of 65 with persistent tissue hypoperfusion. Dopamine is no longer recommended as a first-line vasopressor in septic shock due to higher arrhythmia risk. Albumin 25% is not a standard bolus for further resuscitation and 0.9% sodium chloride or balanced crystalloid remains the first-line fluid.

QUESTION 6

SINGLE CHOICE

A patient in the ICU has a 12-lead ECG that shows peaked T waves, widened QRS complexes, and loss of P waves. Laboratory studies return with a serum potassium of 7.2 mEq/L. Which intervention is the priority to prevent imminent cardiac arrest?

- ☒ **A** Administer IV calcium gluconate or calcium chloride.
- ☐ **B** Administer IV sodium bicarbonate as the first therapy.
- ☐ **C** Administer IV insulin and dextrose and then wait 30 minutes to recheck the potassium.
- ☐ **D** Initiate immediate hemodialysis before any other pharmacologic intervention.

ANSWER A

WHY When hyperkalemia produces ECG changes, IV calcium (gluconate or chloride) is the priority to stabilize the cardiac membrane and prevent lethal arrhythmias. Insulin with dextrose shifts potassium intracellularly but acts more slowly and does not protect the myocardium acutely. Sodium bicarbonate is reserved for acidotic patients and is not the first choice. Hemodialysis is definitive therapy but should not precede membrane-stabilizing calcium in a patient with ECG changes.

QUESTION 7

SINGLE CHOICE

A patient presents with hypotension (BP 78/44 mm Hg), tachycardia, fever of 39.0° C (102.2° F), and a serum sodium of 122 mEq/L. The patient takes chronic corticosteroids for rheumatoid arthritis and was unable to take oral medications for 48 hours due to a gastrointestinal illness. Which intervention is the priority?

- ☒ **A** Administer a stress dose of IV hydrocortisone immediately.
- ☐ **B** Administer a 3% hypertonic saline bolus for the sodium of 122 mEq/L.
- ☐ **C** Administer IV vancomycin and piperacillin-tazobactam for presumed septic shock.
- ☐ **D** Administer desmopressin (DDAVP) to address the hyponatremia.

ANSWER A

WHY A patient on chronic corticosteroids who has been unable to take them orally for 48 hours and now presents with hypotension, fever, and hyponatremia is exhibiting signs of an adrenal crisis. Stress-dose IV hydrocortisone should be administered immediately—after a single dose of hydrocortisone, dexamethasone, or etomidate will not interfere with the cosyntropin stimulation test if needed, but treatment should not be delayed. Hypertonic saline is reserved for severe symptomatic hyponatremia (seizures, coma) and should not be the first action here. Empiric antibiotics should not delay steroid administration. Desmopressin is not indicated and would worsen water retention.

QUESTION 8

SINGLE CHOICE

A patient develops chills, fever, hypotension, and flank pain approximately 30 minutes into a packed red blood cell transfusion. Which complication is most likely occurring?

- ☐ A Febrile non-hemolytic transfusion reaction
- ☒ B Acute hemolytic transfusion reaction
- ☐ C Transfusion-related acute lung injury (TRALI)
- ☐ D Transfusion-associated circulatory overload (TACO)

ANSWER B

WHY Fever, chills, hypotension, and flank pain within minutes of starting a transfusion are classic for an acute hemolytic transfusion reaction, which is most often due to ABO incompatibility. Febrile non-hemolytic reactions typically cause isolated fever and chills without hypotension or flank pain. TRALI presents as acute hypoxemia and bilateral pulmonary infiltrates during or within six hours of transfusion. TACO presents with signs of volume overload such as hypertension, jugular venous distention, and pulmonary edema.

QUESTION 9

SINGLE CHOICE

A patient with cirrhosis and known esophageal varices develops massive hematemesis and becomes hypotensive. Two large-bore IVs have been established. Which intervention is the priority while awaiting emergent endoscopy?

- ☒ **A** Administer IV octreotide and a prophylactic IV antibiotic such as ceftriaxone.
- ☐ **B** Place a Blakemore tube before starting any pharmacologic therapy.
- ☐ **C** Administer IV proton pump inhibitor therapy as the only pharmacologic measure.
- ☐ **D** Initiate vasopressin alone because it provides more potent splanchnic vasoconstriction than octreotide.

ANSWER A

WHY Initial management of suspected variceal hemorrhage includes vasoactive therapy (octreotide is preferred because of a more favorable safety profile than vasopressin) and a prophylactic IV antibiotic such as ceftriaxone, which reduces the risk of infection and rebleeding in cirrhotic patients. A Blakemore tube is reserved for uncontrolled bleeding after pharmacologic and endoscopic therapy have failed, not as a first-line intervention. Proton pump inhibitors are more appropriate for non-variceal upper GI bleeding. Vasopressin alone is no longer recommended because of ischemic complications; it must be combined with IV nitroglycerin if used.