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PRACTICE QUESTIONS

Elsevier Remotely Proctored Exams

RNCRC

Registered Nursing Critical Care

EDITION

Demo

QUESTIONS

9

FORMAT

Limited Edition PDF

Before you begin

What this is

9 practice questions for Elsevier Remotely Proctored Exams **RNCRC**, 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, **RNCRC**
- the question number
- the email address on your order

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

QUESTION 1 SINGLE CHOICE

A patient with an acute anterior wall myocardial infarction develops new ST elevation in the precordial leads, hypotension (BP 82/54 mmHg), and a new holosystolic murmur at the left lower sternal border. Which complication is most likely occurring?

- ☐ A Papillary muscle rupture
- ☒ B Ventricular septal rupture
- ☐ C Free wall rupture with cardiac tamponade
- ☐ D Aortic dissection with aortic regurgitation

ANSWER B

WHY Acute ventricular septal rupture classically presents 3–7 days post-MI with a new holosystolic murmur at the left lower sternal border, biventricular failure, and hypotension due to a left-to-right shunt. Papillary muscle rupture also causes a holosystolic murmur but is heard best at the apex with radiation to the axilla and causes acute pulmonary edema; free wall rupture leads to tamponade and pulseless electrical activity, not a new murmur; aortic dissection produces a diastolic murmur of aortic insufficiency.

QUESTION 2 SINGLE CHOICE

A patient with ARDS is being mechanically ventilated. Which ventilator strategy is most appropriate to reduce the risk of ventilator-induced lung injury?

- ☐ A Tidal volume of 12 mL/kg predicted body weight with a PEEP of 5 cm H₂O
- ☒ B Tidal volume of 6 mL/kg predicted body weight with plateau pressures ≤ 30 cm H₂O
- ☐ C Tidal volume of 10 mL/kg predicted body weight with permissive hypercapnia to a PaCO₂ of 60 mmHg
- ☐ D Tidal volume of 8 mL/kg predicted body weight with routine use of pulmonary artery catheters

ANSWER B

WHY Lung-protective ventilation in ARDS uses low tidal volumes (4–8 mL/kg predicted body weight, targeting 6 mL/kg) and limits plateau pressure to ≤ 30 cm H₂O to minimize volutrauma and barotrauma, per the ARDSNet protocol. Tidal volumes of 10–12 mL/kg are associated with increased mortality. Routine pulmonary artery catheterization is not recommended in ARDS.

QUESTION 3

SINGLE CHOICE

A patient's pulmonary artery catheter readings are: RAP 2 mmHg, PAP 28/14 mmHg, PCWP 16 mmHg, and cardiac index 2.0 L/min/m². Which hemodynamic profile best describes these findings?

- ☐ A Hypovolemic shock
- ☒ B Left ventricular failure with pulmonary congestion
- ☐ C Right ventricular failure with normal left-sided pressures
- ☐ D Distributive (septic) shock

ANSWER B

WHY An elevated PCWP (>15 mmHg) reflects elevated left atrial/left ventricular end-diastolic pressure, indicating left-sided failure with pulmonary venous congestion. The low cardiac index (2.0 L/min/m², normal 2.5–4.0) confirms cardiogenic pump failure. The normal RAP (2 mmHg) argues against isolated right ventricular failure or hypovolemia, and septic/distributive shock typically presents with low or normal PCWP.

QUESTION 4

MULTIPLE CHOICE

A patient with a severe traumatic brain injury has an intracranial pressure (ICP) of 26 mmHg. Which nursing interventions are appropriate to lower ICP? (Choose two.)

- ☒ A Position the head of the bed at 30 degrees with the neck in neutral alignment
- ☐ B Cluster all nursing care activities together to minimize total stimulation time
- ☒ C Maintain the patient's head and neck in midline position to promote venous drainage
- ☐ D Perform routine endotracheal suctioning every hour to prevent ventilator-associated pneumonia

ANSWER A - C

WHY Elevating the head of the bed to 30 degrees and keeping the head/neck in midline position both promote cerebral venous outflow via the jugular veins, reducing ICP. Clustering care and routine hourly suctioning actually increase ICP by raising intrathoracic pressure and stimulating the Valsalva/cough response; suctioning should be performed only when clinically indicated and pre-oxygenated.

QUESTION 5

SINGLE CHOICE

A patient in DKA is receiving an insulin infusion. Which laboratory change best indicates that treatment is resolving the acidosis?

- ☐ A Rising blood glucose to within normal range
- ☐ B Rising serum potassium concentration
- ☒ C Rising serum bicarbonate and narrowing of the anion gap
- ☐ D Rising serum sodium concentration

ANSWER C

WHY Resolution of the metabolic acidosis is reflected by a rising serum bicarbonate and narrowing/closure of the anion gap as ketone bodies are metabolized. Glucose normalization alone does not confirm acidosis resolution; in fact, dextrose is added to IV fluids once glucose reaches ~200 mg/dL precisely to allow continued insulin administration until the anion gap closes. Potassium typically falls with insulin therapy and must be aggressively replaced. Sodium may shift with osmolar changes.

QUESTION 6

MULTIPLE CHOICE

Which statements accurately describe nursing management of a patient on continuous veno-venous hemofiltration (CVVH)? (Choose two.)

- ☒ **A** Replacement fluid is added either before (pre-filter) or after (post-filter) the hemofilter
- ☐ **B** Effluent (ultrafiltrate) is replaced entirely with sterile replacement solution to maintain volume
- ☒ **C** Anticoagulation is commonly achieved with citrate or systemic heparin to prevent circuit clotting
- ☐ **D** Hemodynamic instability is uncommon because CRRT removes fluid more rapidly than intermittent hemodialysis

ANSWER A • C

WHY In CVVH, replacement fluid can be delivered pre- or post-filter (or both) and anticoagulation with citrate or heparin is routine to prolong filter life. It is the ultrafiltrate (effluent) that is removed, not replaced — replacement solution replaces solutes and fluid lost. CRRT is, in fact, preferred over intermittent hemodialysis precisely because it is gentler and more hemodynamically stable, removing fluid slowly over 24 hours.

QUESTION 7

SINGLE CHOICE

On the cardiac monitor, a patient in the ICU suddenly demonstrates a wide-complex rhythm at a rate of 180 bpm with no discernible P waves, hemodynamic instability (BP 76/40 mmHg), and absent pulses. Which is the priority nursing action?

- ☐ A Administer amiodarone 150 mg IV bolus
- ☐ B Perform synchronized cardioversion at 100 joules
- ☒ C Initiate defibrillation at 200 joules (biphasic) and begin CPR
- ☐ D Administer adenosine 6 mg IV push

ANSWER C

WHY A pulseless wide-complex tachycardia at 180 bpm is treated as pulseless ventricular tachycardia. Defibrillation (unsynchronized shock) is the priority, with immediate high-quality CPR and ACLS protocols. Synchronized cardioversion requires pulses and is for unstable patients with a pulse. Amiodarone is given after the first shock if the rhythm persists; adenosine is used for stable supraventricular tachycardia and would be inappropriate and dangerous here.

QUESTION 8

SINGLE CHOICE

According to the Surviving Sepsis Campaign 1-hour bundle, which intervention should be completed within the first hour for a patient with suspected septic shock?

- ☒ A Obtain a lactate level, obtain blood cultures, and administer broad-spectrum antibiotics
- ☐ B Administer stress-dose hydrocortisone and begin tight glycemic control
- ☐ C Place a pulmonary artery catheter and initiate inotropic support
- ☐ D Perform a complete immunological workup including autoimmune serologies

ANSWER A

WHY The 1-hour Surviving Sepsis bundle includes: measuring lactate, obtaining blood cultures prior to antibiotics, administering broad-spectrum antibiotics, beginning rapid administration of 30 mL/kg crystalloid for hypotension or lactate ≥ 4 mmol/L, and applying vasopressors if hypotensive during/after fluid resuscitation to maintain MAP ≥ 65 mmHg. Steroids, pulmonary artery catheters, and immune workups are not part of the initial 1-hour bundle.

QUESTION 9

SINGLE CHOICE

A patient with hematemesis and melena becomes hypotensive (BP 88/56 mmHg) and tachycardic (HR 122 bpm) in the ICU. After two large-bore IVs and initiation of crystalloid resuscitation, what is the most appropriate next step in management?

- ☒ **A** Begin a continuous infusion of pantoprazole and prepare for upper endoscopy
- ☐ **B** Transfuse packed red blood cells to a target hemoglobin of 12 g/dL
- ☐ **C** Begin total parenteral nutrition to support metabolic demands
- ☐ **D** Administer a continuous infusion of vasopressin to reduce splanchnic blood flow

ANSWER A

WHY High-dose proton pump inhibitor therapy (e.g., pantoprazole 80 mg bolus then 8 mg/h infusion) should be started in suspected upper GI bleeding to reduce rebleeding risk and stabilize clots, and urgent endoscopy should be performed within 24 hours (ideally within 12) for diagnosis and therapeutic intervention. Transfusion is now restricted to a threshold of 7 g/dL (8 g/dL in active cardiac disease) per restrictive transfusion guidelines, not 12 g/dL. TPN is not indicated acutely. Vasopressin is rarely used due to ischemic complications.