Nursing
AACN-PCCN
American Association of Critical-Care Nurses: Progressive Care Certified Nurse

Latest Version: 6.1

Question: 1

View the SUPPORTING DETAILS to answer the following question:
Based on the patient's Arterial Blood Gas (ABG) results provided, which of the following do you suspect?
The patient's blood gas results are as follows:

pH	7.21
$PaCO_2$	51
HCO_3	25
Base excess	-1
PaO_2	63
SaO_2	89

A. Respiratory acidosis, no compensation, with hypoxemia
B. Metabolic acidosis, no compensation, without hypoxemia
C. Respiratory alkalosis, no compensation, with hypoxemia
D. Respiratory acidosis, full compensation, with hypoxemia

Answer: A

Explanation:
Based on these ABG results, the patient is experiencing uncompensated respiratory acidosis with hypoxemia. The elevated $PaCO_2$ indicates that the acidosis is due to a respiratory issue, as there is no metabolic compensation (normal HCO_3 and base excess). The low PaO_2 and SaO_2 indicate that the patient also has hypoxemia, likely due to the respiratory condition.

Question: 2

Which of the following statements about Gastrointestinal (GI) bleeding is TRUE?

A. In acute upper GI bleeding, death is typically a direct result of blood loss
B. A rapid upper GI bleed may present as blood in the lower GI tract
C. Life-threatening GI bleeding originates most commonly in the lower GI tract
D. Lower GI bleeding is more common than upper GI bleeding

Answer: B

Explanation:
A rapid upper GI bleed can lead to the presence of blood in the lower GI tract, manifesting as melena (black, tarry stools) or hematochezia (bright red blood in the stool), depending on the rate and volume

of bleeding. This occurs because the blood has moved quickly through the GI tract, reaching the lower sections before being fully digested.
Lower GI bleeding is less common than upper GI bleeding; upper GI sources account for the majority of clinically significant GI bleeds. Life-threatening GI bleeding more commonly originates in the upper GI tract, where conditions like peptic ulcers or variceal hemorrhage can cause severe and rapid blood loss.
In acute upper GI bleeding, death is not typically a direct result of blood loss alone; it is more often due to the underlying cause of the bleed, such as shock, multiple organ failure, or comorbid conditions exacerbating the situation.

Question: 3

A 50-year-old female patient with hypothyroidism presents with increasing fatigue, weight gain, and a heart rate of 50 bpm. Lab results show elevated TSH and low T4. Which of the following interventions is MOST likely needed to correct her condition?

A. Administering iodine supplementation
B. Reducing dietary intake of goitrogens
C. Increasing her dose of levothyroxine
D. Starting beta-blockers to manage bradycardia

Answer: C

Explanation:
The patient's symptoms and lab results suggest that her hypothyroidism is inadequately treated, and increasing her dose of levothyroxine, a synthetic form of thyroxine (T4), is the appropriate intervention to restore normal thyroid hormone levels.
Iodine supplementation is necessary only in cases of iodine deficiency, which is not suggested by her lab results. Beta-blockers would not address the underlying issues of hypothyroidism and bradycardia, which are due to insufficient thyroid hormone.
Reducing intake of goitrogens may help in some cases of thyroid disease, but it would not correct the low T4 and high TSH levels or alleviate her symptoms.

Question: 4

Of the following, which is an absolute contraindication for insertion of a chest tube?

A. A lung that is adherent to the chest wall through the hemithorax
B. Extensive pulmonary blebs
C. Multiple adhesions
D. Coagulopathy

Answer: A

Explanation:
A lung that is adherent to the chest wall through the hemithorax is an absolute contraindication for chest tube insertion because the adherence makes it nearly impossible to insert a chest tube without

causing significant damage to the lung. This condition poses a high risk of complications, such as lung perforation or other serious injuries.
While coagulopathy increases the risk of bleeding, it is a relative contraindication rather than an absolute one. The decision to proceed with chest tube insertion in a patient with coagulopathy depends on the risks and benefits.
Multiple adhesions within the pleural space could complicate the insertion of a chest tube, but they are not an absolute contraindication. Careful insertion techniques and imaging guidance can often overcome these challenges.
Extensive pulmonary blebs increase the risk of a pneumothorax during chest tube insertion, but this is not an absolute contraindication. The procedure can be performed with precautions, such as imaging guidance, to avoid damaging the blebs.

Question: 5

A 70-year-old male patient with a history of hypertension and coronary artery disease presents to the emergency department with complaints of shortness of breath, fatigue, and difficulty lying flat at night. On physical examination, you note crackles in the lungs and a rapid, irregular pulse. The patient's wife mentions that he has been increasingly short of breath over the past few weeks, especially during physical activities.
Which of the following are clinical signs and symptoms specific to left heart failure?

A. Pulmonary congestion and orthopnea
B. Ascites and hepatomegaly
C. Jugular venous distension and peripheral edema
D. Weight gain and ankle swelling

Answer: A

Explanation:
These are classic signs of left heart failure. Pulmonary congestion occurs because the left ventricle fails to pump blood effectively, leading to a buildup of fluid in the lungs. Orthopnea, or difficulty breathing when lying flat, is another hallmark of left heart failure due to the redistribution of fluid when the patient is in a supine position.
Jugular venous distension and peripheral edema are more specific to right heart failure. They occur due to the backflow of blood into the systemic circulation when the right ventricle fails to pump effectively.
Ascites and hepatomegaly are also more indicative of right heart failure, in which the failure of the right ventricle leads to congestion in the abdominal organs.
Weight gain and ankle swelling can occur in left heart failure, but they are more typically associated with right heart failure due to fluid retention in the systemic circulation.

Question: 6

Which of the following symptoms is MOST consistent with a lower Gastrointestinal (GI) bleed?

A. Melena
B. Hematochezia

C. Coffee-ground emesis
D. Hematemesis

Answer: B

Explanation:
Bright red blood per rectum (hematochezia) is the hallmark of lower Gastrointestinal (GI) bleeding, often due to sources in the colon, rectum, or anus.
Melena, or black, tarry stool, is more consistent with upper GI bleeding because the blood has been digested by gastric acids, giving it a dark appearance. Hematemesis refers to vomiting blood, which is also more typical of an upper GI bleed. Coffee-ground emesis results from partially digested blood in the stomach, again indicating an upper GI source rather than a lower GI one.

Question: 7

Which of the following is the preferred route of medication administration in the acutely ill patient?

A. Subcutaneous
B. Oral
C. Intravenous
D. Intramuscular

Answer: C

Explanation:
In acutely ill patients, the Intravenous (IV) route is the preferred method of medication administration because it permits reliable, complete delivery.
The Subcutaneous (SC) or Intramuscular (IM) routes of medication administration are rarely used in the acutely ill for several reasons:
• Delayed onset of action
• Unpredictable, incomplete, erratic, or unreliable absorption, possibly due to decreased tissue perfusion
• Decreased subcutaneous fat or inadequate muscle tissue
• Bleeding complications or hematomas in compromised patients
Medication administration via the SC or IM routes may also be painful for these patients.
The oral (PO) route of medication administration in the acutely ill may also result in incomplete, unpredictable, or erratic drug absorption.

Question: 8

In the acute post-injury period, how often should motor function be assessed in a patient with a spinal cord injury?

A. At least every two hours
B. At least every four hours
C. At least every eight hours

D. Every shift

Answer: B

Explanation:
In the acute period following a spinal cord injury, motor function should be assessed at least every four hours. This frequent assessment is crucial to monitor for any changes in neurological status that could indicate worsening of the injury or the development of complications, such as spinal cord edema.
In the acute phase, when rapid changes can occur and early detection of deterioration is essential, at least every eight hours is too infrequent.
At least every two hours is more frequent than necessary for standard monitoring and could lead to patient fatigue and discomfort without added benefit in most cases.
Every shift is typically every eight to 12 hours, which is also too infrequent during the acute phase of a spinal cord injury when closer monitoring is required.

Question: 9

A 45-year-old male patient with a Traumatic Brain Injury (TBI) is being monitored for signs of cerebral herniation.
Which of the following symptoms is LEAST likely to occur during cerebral herniation?

A. Hyperthermia
B. Unilateral dilated pupil
C. Hypotension
D. Contralateral hemiparesis

Answer: C

Explanation:
Cerebral herniation typically causes hypertension, not hypotension, as the body tries to maintain cerebral perfusion.
Contralateral hemiparesis occurs due to pressure on motor pathways. A unilateral dilated pupil is a common sign of herniation due to compression of cranial nerves. Hyperthermia may occur due to damage to the brain's temperature regulation centers.

Question: 10

A 43-year-old male patient presents with fever, chills, and confusion. Which of the following is the MOST common early sign of sepsis?

A. Hypertension
B. Bradycardia
C. Tachycardia
D. Hypothermia

Answer: C

Explanation:
In the early stages of sepsis, the body often responds to infection with an increased heart rate (tachycardia) as a compensatory mechanism to maintain cardiac output and tissue perfusion. Hypertension is generally not an early sign of sepsis; instead, hypotension is more commonly observed as sepsis progresses. Bradycardia is uncommon in the early stages of sepsis and typically suggests another cause or a late-stage deterioration. Hypothermia can occur in sepsis, particularly in older adults, but it is less common than fever and is typically a later sign.

Question: 11

You are caring for a 76-year-old male patient with a history of chronic heart failure, admitted with shortness of breath and swelling in his legs. His vital signs are blood pressure 132/86 mmHg, heart rate 85 beats per minute, respiratory rate 20 breaths per minute, and SpO_2 94% on room air. He has a history of chronic heart failure.
Which of the following is the MOST common cause of heart failure exacerbation?

A. Hypertension
B. Atrial fibrillation
C. Myocardial infarction
D. Noncompliance with medications

Answer: D

Explanation:
Noncompliance with prescribed heart failure medications, particularly diuretics, is the most common cause of heart failure exacerbations. Patients may skip their medications for various reasons, leading to fluid overload and decompensation of heart failure.
Myocardial infarction can exacerbate heart failure but is less common than noncompliance. Atrial fibrillation can also lead to exacerbations but usually in combination with other factors. Hypertension is a common contributing factor in chronic heart failure, but poorly controlled blood pressure is not the most frequent cause of exacerbation in stable heart failure patients.

Question: 12

A 62-year-old male patient presents with chest discomfort, diaphoresis, and nause
a. His ECG shows ST-segment elevation in the anterior leads, and his vital signs are as follows: blood pressure 85/60 mmHg, heart rate 90 beats per minute, and respiratory rate 20 breaths per minute.
Which clinical finding suggests the MOST likely complication associated with this presentation?
A. Pulmonary embolism due to deep vein thrombosis
B. Hypotension due to cardiogenic shock
C. Bradycardia due to AV block
D. Atrial fibrillation due to myocardial ischemia

Answer: B

Explanation:
The patient's ST-segment elevation in the anterior leads, along with hypotension, suggests a large myocardial infarction affecting the left ventricle. This can lead to cardiogenic shock, a condition in which the heart cannot pump effectively, resulting in low blood pressure.
Bradycardia due to AV block is less likely in this case, as the patient is not bradycardic (heart rate is 90 beats per minute). Pulmonary embolism is not suggested by the ECG findings or clinical presentation in this case. Atrial fibrillation may occur with myocardial ischemia, but there is no indication of arrhythmias in this patient's presentation.

Question: 13

Which of the following is the MOST common cause of distributive shock?

A. Pulmonary embolism
B. Sepsis
C. Hypovolemia
D. Myocardial infarction

Answer: B

Explanation:
Distributive shock most commonly results from sepsis, in which widespread vasodilation occurs due to the body's response to infection, leading to hypotension and inadequate tissue perfusion.
Myocardial infarction is associated with cardiogenic shock rather than distributive shock. Hypovolemia leads to hypovolemic shock due to fluid loss, not distributive shock. Pulmonary embolism is a cause of obstructive shock, not distributive shock.

Question: 14

To evaluate functional capacity as evidence of the patient's ability to reason about their own choices, which comment or question would be BEST for the nurse to make/ask?

A. "Please tell me about some of the difficult healthcare choices you've made in the past."
B. "What is the name of your doctor?"
C. "Do you know what day it is?"
D. "Why are you in the hospital?"

Answer: A

Explanation:
This question directly assesses the patient's ability to reason and reflect on their own decision-making processes regarding healthcare. It requires the patient to recall past experiences, analyze those

situations, and articulate their thought processes, providing insight into their functional capacity and understanding of their healthcare decisions.
"Do you know what day it is?" assesses orientation rather than the ability to reason about choices. While important, it does not evaluate the patient's decision-making capacity.
"What is the name of your doctor?" tests memory but not reasoning ability or understanding of healthcare decisions. It's a simple recall question that doesn't provide insight into the patient's functional capacity to make choices.
"Why are you in the hospital?" assesses the patient's understanding of their current situation, which is useful but does not delve into their capacity to reason about past or future healthcare decisions in a meaningful way.

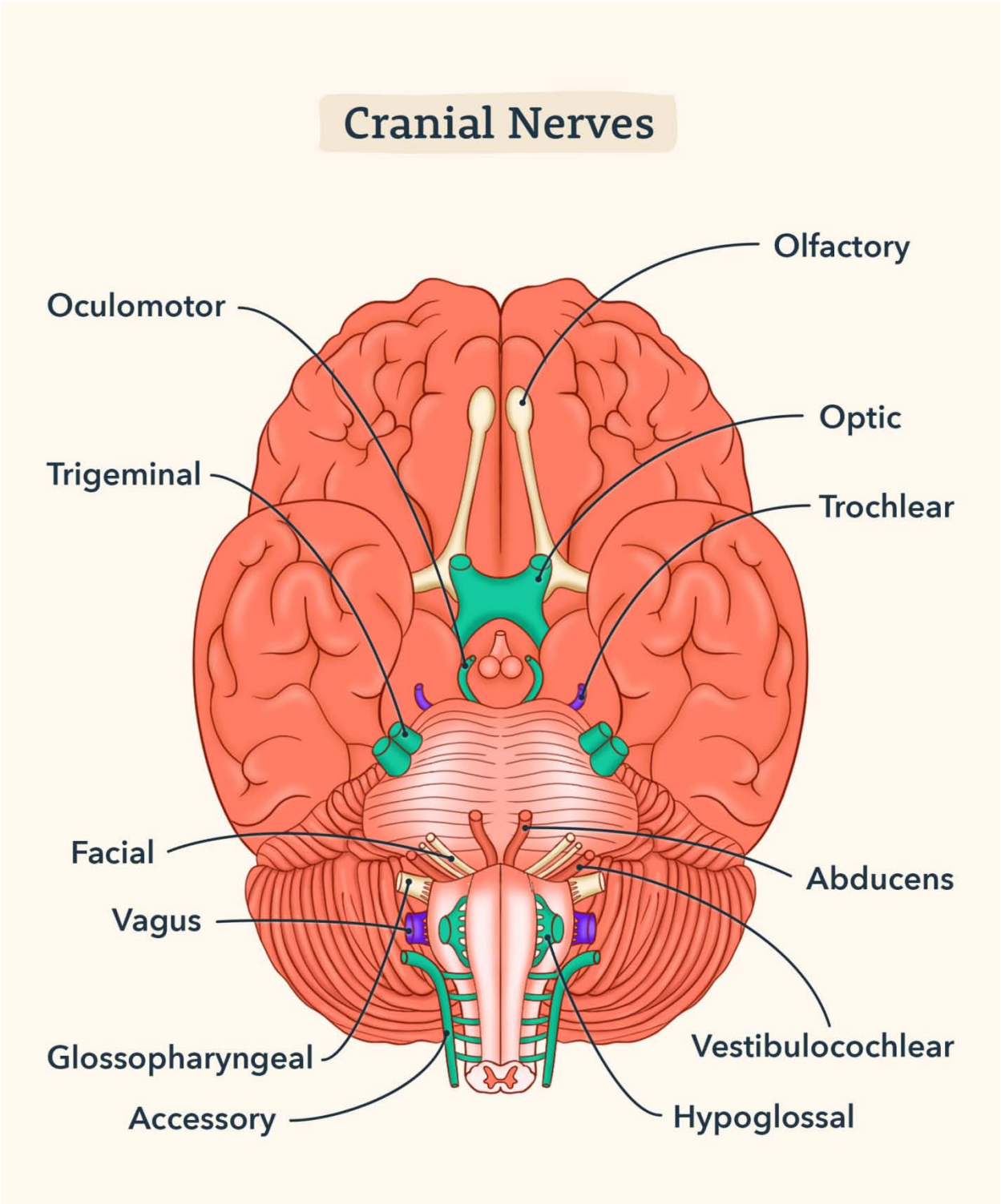
Question: 15

Patients with dysfunction of which cranial nerve are unable to close the eyelid on the affected side?

A. VII
B. VI
C. V
D. VIII

Answer: A

Explanation:
The facial nerve, or Cranial Nerve VII (CN VII), controls the muscles of facial expression, including the orbicularis oculi muscle, which is responsible for closing the eyelids. Dysfunction of the facial nerve can result in an inability to close the eyelid on the affected side, a condition often referred to as lagophthalmos.
The abducens nerve, or CN VI, controls the lateral rectus muscle, which is responsible for eye movement (specifically lateral gaze). Dysfunction does not affect eyelid closure.
The vestibulocochlear nerve, or CN VIII, is responsible for hearing and balance. It does not play a role in eye movement or eyelid closure.
The trigeminal nerve, or CN V, is primarily responsible for facial sensation and motor functions related to mastication (chewing). While it contributes to corneal reflexes through its sensory function, it does not control eyelid closure.



An illustration of the human brain highlights the 12 cranial nerves:
1. The olfactory nerve is located within the nasal cavity below the frontal lobe.
2. The optic nerve emerges from the optic disc in the forebrain.
3. The oculomotor nerve originates from the midbrain of the brainstem.
4. The trochlear nerve originates from the medial midbrain.

5. The trigeminal nerve emerges from the semilunar ganglion near the apex of the temporal bone.
6. The abducens is located on the floor of the fourth ventricle in the pons.
7. The facial nerve emerges from the pons.
8. The vestibulocochlear nerve is located in the pons of the brainstem.
9. The glossopharyngeal nerve emerges from the medulla oblongata.
10. The vagus nerve arises from the medulla oblongata.
11. The hypoglossal nerve originates near the top of the spinal cord at the base of the brain.
12. The accessory nerve arises from the cervical spinal cord and caudal medulla.

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