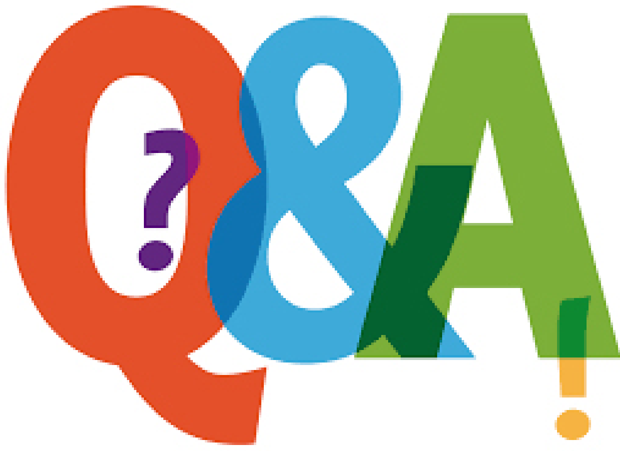


Up-to-date Questions and Answers from authentic resources to improve knowledge and pass the exam at very first attempt. ----- Guaranteed.

TCRN MCQs
TCRN Exam Questions
TCRN Practice Test
TCRN TestPrep
TCRN Study Guide

killexams.com

BCEN

TCRN

Trauma Certified Registered Nurse Exam

ORDER FULL VERSION

https://killexams.com/pass4sure/exam-detail/TCRN

Question: 668

A 25-year-old male driver is admitted following a motor vehicle rollover. He sustained a closed fracture of the mid-shaft humerus. On initial assessment, the patient is unable to extend his right wrist or fingers, resulting in a characteristic "wrist drop." He also reports numbness over the first dorsal interosseous space on the back of his hand. The brachial and radial pulses are 2+ and equal bilaterally. Based on these findings, which nerve has been injured?

A. Radial nerve
B. Ulnar nerve
C. Axillary nerve
D. Median nerve

Answer: A

KILL EXAMS

Explanation: The radial nerve courses through the spiral groove of the mid-shaft humerus, making it highly vulnerable to injury in fractures of this region. Radial nerve injury impairs innervation to the extensor muscles of the wrist and fingers, causing wrist drop (an inability to dorsiflex the wrist and extend the metacarpophalangeal joints). It also provides sensory innervation to the anatomical snuffbox and the first dorsal web space on the dorsum of the hand, where the patient reports numbness. Axillary nerve injury is more common with proximal humerus fractures or shoulder dislocations and affects deltoid muscle function (shoulder abduction) and sensation over the lateral shoulder. Median nerve injury causes weakness in forearm pronation, wrist flexion, and thumb opposition, alongside sensory loss on the palmar aspect of the first three digits. Ulnar nerve injury results in weak finger adduction/abduction ("claw hand" deformity) and sensory loss on the fifth digit and medial half of the fourth digit.

Question: 669

A 67-year-old female with a history of chronic obstructive pulmonary disease (COPD) and atrial fibrillation managed with warfarin sustained five unilateral rib fractures after a fall at home. She was admitted to the intermediate care unit for pain management and respiratory

monitoring. On day two, she becomes increasingly lethargic, her respiratory rate drops to 10 breaths per minute, and her oxygen saturation is 89% on a 40% air-entrainment mask. Her arterial blood gas shows: pH 7.21, $PaCO_2$ 68 mmHg, PaO_2 54 mmHg, and HCO_3^- 26 mEq/L. Which intervention should the TCRN anticipate as the priority?

A. Urgent administration of prothrombin complex concentrate (PCC) to reverse warfarin therapy
B. Initiation of non-invasive positive pressure ventilation (BiPAP) with close clinical monitoring
C. Immediate endotracheal intubation and initiation of invasive mechanical ventilation
D. Administration of intravenous naloxone to reverse potential opioid-induced respiratory depression

Answer: B

Explanation: This patient is experiencing acute-on-chronic respiratory acidosis and hypoxemic respiratory failure secondary to splinting from rib fractures and her underlying COP**D.** In a patient with COPD and rib fractures who is tiring but still maintaining a patent airway, non-invasive positive pressure ventilation (BiPAP) is the preferred initial intervention. It assists with the work of breathing, improves alveolar recruitment, reverses hypercapnia, and may prevent the complications associated with endotracheal intubation. While opioid overuse is possible, abruptly reversing pain control in a patient with multiple rib fractures with naloxone can cause severe pain, a sympathetic surge, and worse splinting. Intubation is indicated if BiPAP fails or if she becomes unresponsive. Reversing warfarin is required for active bleeding or urgent surgery, which is not described here.

Question: 670

A 62-year-old male with blunt chest trauma has widened mediastinum on CXR, BP differential between arms (right 142/80, left 98/62), and CT confirming traumatic aortic disruption distal to left subclavian with pseudoaneurysm.

A. Endovascular stent graft placement (TEVAR) with blood pressure control
B. Conservative management with strict blood pressure control below 100 mmHg systolic

C. Immediate median sternotomy and ascending aortic repair
D. Open surgical repair via left thoracotomy with cross-clamping

Answer: A

Explanation: Traumatic aortic injury at the isthmus is optimally managed with TEVAR in suitable anatomy, providing rapid stabilization with lower morbidity than open repair. Systolic blood pressure control (target <120 mmHg) reduces wall stress until repair. Open repair is reserved for complex anatomy unsuitable for endovascular approach.

Question: 671

A 38-year-old female is admitted to the intensive care unit with a severe pelvic fracture and retroperitoneal hematoma following an industrial crush accident. On post-injury day four, she develops an increased oxygen requirement, a temperature of 38.9 degrees Celsius, a heart rate of 124 beats per minute, and a blood pressure of 88/44 mmHg despite receiving a 30 mL/kg fluid bolus of balanced crystalloid. Laboratory values reveal a white blood cell count of 18,000/µL, a serum lactate of 3.4 mmol/L, and a platelet count of 75,000/µL. Which clinical syndrome is this patient demonstrating, and what is the target mean arterial pressure for her management?

A. Systemic Inflammatory Response Syndrome; target mean arterial pressure greater than 50 mmHg
B. Multi-Organ Dysfunction Syndrome; target mean arterial pressure greater than 90 mmHg
C. Hypovolemic shock; target mean arterial pressure greater than 80 mmHg
D. Septic shock; target mean arterial pressure greater than 65 mmHg

Answer: D

Explanation: The patient meets the criteria for septic shock. According to the Surviving Sepsis Campaign guidelines, septic shock is defined as a subset of sepsis in which underlying circulatory and cellular/metabolic abnormalities are profound enough to substantially increase mortality. It is clinically identified by a persistent hypotension

requiring vasopressors to maintain a mean arterial pressure of 65 mmHg or greater, and a serum lactate level greater than 2 mmol/L despite adequate fluid resuscitation. This patient has an infectious or inflammatory source, severe tachycardia, leukocytosis, elevated lactate, and persistent hypotension refractory to initial fluid boluses. While Systemic Inflammatory Response Syndrome and Multi-Organ Dysfunction Syndrome are related concepts on the continuum of critical illness, the specific therapeutic target for perfusion pressure in septic shock is a mean arterial pressure of 65 mmHg or greater using vasopressors like norepinephrine.

Question: 672

A trauma nurse is participating as a co-investigator in a clinical trial evaluating a new intraosseous infusion device. The study protocol requires obtaining written informed consent from patients prior to enrollment. A severely injured, obtunded trauma patient arrives without any family or legally authorized representative present. The trauma surgeon wants to enroll the patient using an exception from informed consent (EFIC) pathway. Which of the following criteria must be met to legally and ethically utilize EFIC?

A. The institution must have a general consent form signed by the patient during a previous inpatient admission within the past calendar year
B. The clinical trial must be funded by a federal agency, and the device must have already achieved full food and drug administration approval
C. The patient must be in a life-threatening situation, existing treatments must be unproven or unsatisfactory, and the research cannot practically be carried out without the waiver
D. The trauma medical director and the attending emergency physician must jointly agree that the research will benefit the hospital's financial standing

Answer: C

Explanation: Exception from Informed Consent (EFIC) for emergency research is regulated by strict ethical and federal guidelines (such as 21 CFR 50.24). To utilize EFIC, the research subjects must be in a life-threatening situation, available treatments must be unproven or unsatisfactory, the research must hold the potential to directly benefit the subject, the research could not practicably be carried out without the waiver, and the institutional review

board must have approved the specific EFIC protocol, which includes community consultation and public disclosure. Prior consent from a year ago does not apply to an emergency trial. Federal funding or prior full device approval is not a prerequisite for EFIC, and financial benefits to the hospital are never an ethical justification for research involving human subjects.

Question: 673

A 31-year-old male is admitted to the intensive care unit with a severe traumatic brain injury and an external ventricular drain (EVD) in place. The nurse notes that the patient's hourly urine output has increased to 450 mL/hour for the past two consecutive hours. Laboratory evaluation reveals a serum sodium of 152 mEq/L, a serum osmolality of 315 mOsm/kg, and a urine specific gravity of 1.002. Which condition is most consistent with these clinical findings?

A. Syndrome of inappropriate antidiuretic hormone secretion
B. Cerebral salt wasting syndrome due to natriuretic peptide release
C. Acute kidney injury secondary to hypovolemic shock
D. Diabetes insipidus resulting from posterior pituitary dysfunction

Answer: D

Explanation: Severe traumatic brain injury can cause injury to the hypothalamus or posterior pituitary gland, leading to a deficiency in the synthesis or release of antidiuretic hormone (ADH), known as central diabetes insipidus (DI). Without ADH, the renal collecting ducts cannot reabsorb water, resulting in polyuria (typically greater than 250 mL/hour), low urine specific gravity (under 1.005), low urine osmolality, rising serum sodium (hypernatremia), and elevated serum osmolality. Syndrome of inappropriate antidiuretic hormone (SIADH) and cerebral salt wasting (CSW) both present with hyponatremia, which directly contradicts this patient's findings.

Question: 674

A 45-year-old female involved in a high-speed MVC presents to the ED with suspected pelvic fracture, BP 90/60 mmHg after 500 mL crystalloid, HR 122, lactate 4.8 mmol/L, and base deficit -8. The trauma team initiates massive transfusion protocol. Which resuscitation parameter best guides ongoing balanced resuscitation?

A. Serial crystalloid boluses until urine output exceeds 0.5 mL/kg/hr
B. Administration of tranexamic acid only if fibrinogen <150 mg/dL
C. Maintaining 1:1:1 ratio of RBC:plasma:platelets
D. Targeting hemoglobin >10 g/dL with packed RBCs only

Answer: C

Explanation: Damage control resuscitation emphasizes early balanced blood product administration in a 1:1:1 ratio, minimization of crystalloid, and use of viscoelastic assays (TEG/ROTEM) to guide component therapy. Permissive hypotension (SBP ~80-90 mmHg) until definitive hemorrhage control prevents disruption of early clot formation while addressing the trauma diamond of death (hypothermia, acidosis, coagulopathy, hypocalcemia).

Question: 675

A 55-year-old male fell 20 feet from a scaffold, landing directly on his right side. He is awake but in severe pain, splinting his right chest wall. Paradoxical chest wall movement is observed on the right anterolateral chest during respiration. Arterial blood gas on 4 L/min nasal cannula shows: pH 7.31, $PaCO_2$ 51 mmHg, PaO_2 64 mmHg, and HCO_3^- 24 mEq/L. Which management strategy should the trauma nurse expect to initiate first to optimize oxygenation and ventilation?

A. Application of a tight chest binder over the paradoxical segment
B. Intravenous administration of heavy systemic opioid sedation
C. Immediate endotracheal intubation for positive pressure ventilation
D. Targeted regional analgesia combined with noninvasive ventilation

Answer: D

Explanation: The patient has a flail chest, defined by multiple adjacent rib fractures in two or more places, resulting in a free-floating segment and paradoxical chest wall motion. The underlying pulmonary contusion significantly impairs gas exchange, as evidenced by respiratory acidosis and hypoxemia. The cornerstone of contemporary management focuses on aggressive pain control, ideally via regional techniques like epidural analgesia or intercostal nerve blocks, paired with noninvasive positive pressure ventilation. This avoids the complications of invasive mechanical ventilation while preventing atelectasis and improving ventilation-perfusion matching.

Question: 676

A 48-year-old female involved in a high-speed MVC has an ECG showing new right bundle branch block and elevated troponin I to 4.8 ng/mL. Bedside echo reveals right ventricular dilation with hypokinesis and elevated pulmonary artery systolic pressure. Chest CT shows multiple bilateral pulmonary emboli and sternal fracture. Which diagnosis integrates these findings?

A. Massive pulmonary embolism from lower extremity venous injury
B. Fat embolism syndrome from associated long bone fractures
C. Blunt cardiac injury with myocardial contusion and secondary right heart strain
D. Traumatic aortic disruption causing acute right heart failure

Answer: C

Explanation:
Blunt cardiac injury can manifest with conduction abnormalities, troponin elevation, and ventricular dysfunction, particularly right ventricular contusion due to its anterior position. Associated chest trauma increases risk of pulmonary hypertension and right heart strain. While pulmonary emboli are present, the acute ECG and echo changes in the context of direct chest trauma point primarily to myocardial contusion. Differentiation is critical as management includes monitoring for arrhythmias and supportive care rather than immediate

thrombolysis.

Question: 677

A 50-year-old male who was involved in an industrial explosion is being transferred from a rural community hospital to a regional burn center. The patient has sustained partial and full-thickness burns covering approximately 45% of his total body surface area, along with suspected inhalation injury. He is intubated and mechanically ventilated. The transferring nurse notes that the patient's urine output over the last hour was 15 mL, and his heart rate has risen from 110 to 135 beats/minute. Which action should the flight nurse implement during transit?

A. Increase the ventilator's positive end-expiratory pressure to clear pulmonary edema and reduce hydrostatic pressures in the thorax
B. Restrict fluid administration to avoid worsening laryngeal and chest wall edema that could compromise mechanical ventilation efforts
C. Increase the maintenance intravenous fluid rate using the Consensus Formula guidelines, aiming for a urine output of 0.5 to 1 mL/kg/hour
D. Administer an immediate intravenous bolus of 40 mg furosemide to protect renal perfusion and prevent acute tubular necrosis

KILL EXAMS

Answer: C

Explanation: In the early phase of severe burn injury, fluid shifts lead to profound intravascular hypovolemia and burn shock. Oliguria and tachycardia indicate inadequate resuscitation. The correct management is to increase fluid administration using crystalloids (such as Lactated Ringer's) titrated to clinical endpoints, primarily a urine output of 0.5 to 1 mL/kg/hour for an adult (or 30 to 50 mL/hour). Diuretics are contraindicated in hypovolemic burn shock as they will worsen intravascular depletion. Restricting fluids or focusing solely on ventilator adjustments without addressing the underlying volume deficit will exacerbate tissue ischemia and acute kidney injury.

Question: 678

A 25-year-old female is brought to the emergency department after being struck in the right anterior neck by a flying piece of debris from a lawnmower. She has an expanding hematoma over the right side of her neck, severe stridor, subcutaneous emphysema, and is violently coughing up bright red blood. Her oxygen saturation is dropping rapidly and is currently 86% on a non-rebreather mask. Which of the following describes the most appropriate and immediate sequence of airway management for this patient?

A. Sedate the patient with a high dose of a neuromuscular blocker and attempt routine direct laryngoscopy without backup equipment
B. Perform an emergency blind nasotracheal intubation immediately while the patient is sitting upright to minimize aspiration of blood
C. Place a laryngeal mask airway (LMA) to bypass the laryngeal swelling and defer surgical intervention until a CT scan is completed
D. Establish immediate access for an emergent surgical cricothyroidotomy at the bedside due to the distorted anatomy and expanding hematoma

Answer: D

Explanation: This patient is exhibiting signs of an impending catastrophic airway loss due to a penetrating neck injury with an expanding hematoma, laryngotracheal trauma (stridor and subcutaneous emphysema), and severe active airway hemorrhage. In the presence of an expanding neck hematoma and distorted airway anatomy with severe bleeding, traditional endotracheal intubation via direct laryngoscopy is highly likely to fail and can completely occlude the remaining airway. The safest and most definitive immediate intervention for a patient deteriorating rapidly under these conditions is to establish a surgical airway via emergent cricothyroidotomy or emergency tracheostomy. Blind nasotracheal intubation is strictly contraindicated in laryngotracheal trauma due to the risk of completing a partial airway transection or misplacing the tube into a false passage. Delaying for a CT scan or utilizing an LMA is inappropriate as an LMA does not protect against aspiration of blood or bypass subglottic airway disruptions.

Question: 679

A 19-year-old male is admitted with multiple rib fractures on the left side and a suspected pulmonary contusion. During assessment, the nurse notes that the patient's neck veins are flat, breath sounds are significantly decreased on the left side, and percussion of the left chest reveals dullness. The patient's blood pressure is 88/50 mmHg, and his heart rate is 126 beats/minute. What clinical condition do these findings differentiate from a tension pneumothorax?

A. Tension pneumothorax
B. Pulmonary embolism
C. Cardiac tamponade
D. Massive hemothorax

Answer: D

Explanation: A massive hemothorax and a tension pneumothorax can both present with decreased breath sounds on the affected side and profound hypotension. However, they are differentiated by percussion and neck vein assessment. A massive hemothorax presents with dullness to percussion (due to blood accumulation) and flat neck veins (due to severe hypovolemia), whereas a tension pneumothorax presents with hyperresonance to percussion (due to trapped air) and distended neck veins (due to impaired venous return to the heart).

Question: 680

A 46-year-old patient with blunt abdominal trauma has left flank ecchymosis, hematuria, and CT demonstrating left renal artery avulsion with non-enhancing kidney and associated splenic injury.

A. Diaphragmatic injury with renal herniation repaired thoracoscopically
B. Solid organ and vascular retroperitoneal injury requiring nephrectomy and splenectomy in unstable patient
C. Renal contusion managed non-operatively with embolization for active bleeding
D. Hollow viscus colonic injury with renal devascularization observed

Answer: B

Explanation: Renal artery avulsion with non-viable kidney in the setting of polytrauma and instability typically leads to nephrectomy along with management of concurrent injuries like splenic laceration to achieve rapid hemostasis.

Question: 681

Post-implementation of a new electronic health record, documentation errors increase in trauma flowsheets affecting billing and PI. Which resolution prioritizes accuracy?

A. Ignore minor errors
B. Provide targeted super-user training
C. Revert to paper records
D. Blame individual users

Answer: B

Explanation: Documentation standards support regulatory compliance, accurate registry function, and quality improvement. Implementation requires robust training and validation.

Question: 682

An 18-year-old female is brought to the trauma center after being thrown from an all-terrain vehicle, landing hard on her right side. She is awake but tachypneic. Assessment reveals severe tenderness over the right lower rib cage (ribs 9–11), splinting, and ecchymosis. Her blood pressure is 104/62 mmHg, and heart rate is 110 beats/minute. Given the anatomical location of the injured ribs, the trauma nurse should maintain a high index of suspicion for an injury to which organ?

A. The stomach wall, resulting from high intra-abdominal compression forces

B. The liver, owing to its anatomical position directly under the right lower rib cage
C. The pancreas, because it is suspended directly beneath the right pleural margin
D. The left spleen due to contrecoup forces across the peritoneal cavity

Answer: B

Explanation: Fractures of the lower rib cage on the right side (ribs 9, 10, and 11) carry a very high risk of concurrent solid organ injury to the liver, which sits directly beneath the right hemidiaphragm. Conversely, lower rib fractures on the left side are associated with splenic injuries. The nurse must monitor this patient closely for signs of internal hemorrhage (tachycardia, hypotension, abdominal guarding) indicative of a hepatic laceration.

Question: 683

KILL EXAMS KILL EXAMS

A 44-year-old female is admitted to the trauma unit after an assault where she sustained multiple facial contusions, a fractured zygoma, and soft tissue swelling around her neck. While performing a routine reassessment four hours post-admission, the nurse notes that the patient has developed a muffled, hoarse voice, inspiratory stridor, and is utilizing accessory muscles to breathe. Her respiratory rate is 28 breaths per minute, and her oxygen saturation has dropped from 98% to 91% on a 4 L/min nasal cannula. Which of the following conditions must be suspected, and what is the immediate priority?

A. Acute pulmonary contusion; increase the nasal cannula flow rate to 6 L/min and apply a cold compress to the neck
B. Developing retropharyngeal hematoma or progressive airway edema; secure the airway immediately via endotracheal intubation
C. Bilateral pneumothorax; perform immediate bilateral needle chest decompression in the resuscitation room
D. Post-traumatic stress response causing globus hystericus; administer a low-dose intravenous benzodiazepine

Answer: B

Explanation: Maxillofacial and neck trauma can cause progressive airway compromise due to expanding hematomas or escalating soft tissue edema. Initial assessments can be deceptively stable. The development of hoarseness, stridor, and accessory muscle use are critical warning signs of imminent, complete upper airway obstruction. The immediate priority is to secure a definitive airway before complete occlusion occurs, which makes intubation technically difficult or impossible. Increasing oxygen flow will not resolve the mechanical airway obstruction. Globus hystericus is a psychological sensation of a lump in the throat and does not present with objective inspiratory stridor and hypoxia. Stridor is an upper airway sign, whereas a pneumothorax presents with diminished breath sounds and chest wall changes, not stridor or voice alterations.

Question: 684

A Level II trauma center is undergoing ACS verification review. The surveyor notes inconsistent application of massive transfusion protocol (MTP) activation criteria (e.g., ABC score ≥2 or base deficit <-6). Which response by the trauma program demonstrates understanding of quality improvement and standards?

A. Provide only the written MTP policy without outcome data
B. Report activation rates without linking to patient outcomes or process measures
C. Present data showing recent MTP audits with 95% compliance to criteria
D. Explain that activation is at physician discretion without formal criteria

Answer: C

Explanation: Trauma center verification requires demonstrated performance improvement with data from the registry, including process measures (compliance), outcome measures (e.g., resource utilization, survival), and loop closure. Evidence-based MTP criteria improve hemostatic resuscitation and are evaluated through risk-adjusted benchmarking.

Question: 685

A 19-year-old with incomplete spinal cord injury at T4 demonstrates preserved light touch sensation but loss of motor function and temperature sensation below the level. What syndrome best describes this pattern, and what is a key nursing priority?

A. Posterior cord syndrome; emphasize proprioception training
B. Central cord syndrome; focus on upper extremity rehabilitation
C. Anterior cord syndrome; prioritize respiratory monitoring and DVT prophylaxis
D. Brown-Séquard syndrome; monitor for ipsilateral motor and contralateral pain/temperature loss

Answer: C

Explanation: Anterior cord syndrome (flexion injury) spares dorsal columns (light touch/vibration) but affects motor, pain, and temperature pathways. Priorities include preventing secondary injury, respiratory support (if high thoracic), and autonomic management.

Question: 686

Following traumatic below-knee amputation in a motor vehicle collision, the patient is hemodynamically unstable with ongoing hemorrhage from the stump. Which sequence of interventions is prioritized?

A. Replantation attempt if ischemia time is under 6 hours
B. Direct pressure dressing, intravenous fluid bolus, and pain management
C. Application of a commercial tourniquet proximal to the injury, and transport for completion amputation
D. Irrigation of the amputated part with sterile saline and placement on ice

Answer: C

Explanation: Life-threatening hemorrhage from major amputation requires immediate tourniquet control and resuscitation with blood products. Replantation is secondary to

patient stabilization and is often not feasible in unstable patients with significant tissue damage.

Question: 687

An elderly patient with pelvic fracture requires discharge planning. Family reports a single-story home but notes the patient lives alone with limited support. Which barrier assessment is most critical for safe transition?

A. Insurance coverage for durable medical equipment
B. Functional assessment for mobility
C. Medication reconciliation only
D. Dietary preferences

KILL EXAMS

Answer: B

Explanation: Successful discharge requires multidisciplinary evaluation of home readiness, including mobility, fall risk, caregiver availability, and support services. Elderly trauma patients have high readmission risk due to frailty and comorbidities.

Question: 688

A 19-year-old female is brought to the trauma center after being crushed against a loading dock. She is alert but tachypneic. Assessment reveals multiple petechiae across her anterior chest, neck, and conjunctivae, alongside facial edema and a deep purple discoloration of the skin above the nipple line. Her bilateral radial pulses are palpable and equal. Which immediate management strategy is most appropriate for this patient?

A. Immediate application of a circumferential binders around the upper thorax
B. Prompt elevation of the head of the bed and administration of high-flow oxygen
C. Emergent bilateral needle decompression of the second intercostal spaces
D. Urgent transfer to the operating room for a median sternotomy intervention

Answer: B

Explanation: The patient presents with classic signs of traumatic asphyxia, which occurs when a severe, sustained crushing injury to the thorax forces blood backward from the right atrium into the veins of the head, neck, and upper extremities, causing capillary rupture (petechiae) and venous engorgement. Management is primarily supportive once other life-threatening injuries (like tension pneumothorax or cardiac tamponade) are ruled out. Elevating the head of the bed reduces cephalic venous pressure and edema, while high-flow oxygen supports oxygenation.

Question: 689

KILL EXAMS KILL EXAMS

A 62-year-old female driver is admitted to the resuscitation bay after a severe motor vehicle crash. She has multiple rib fractures, a pulmonary contusion, and a suspected grade III splenic laceration. Her vital signs are: heart rate 112 beats per minute, blood pressure 94/56 mmHg, and respiratory rate 24 breaths per minute. The trauma surgeon orders a bolus of 2 liters of normal saline. The trauma nurse recommends initiating balanced resuscitation with blood products instead, based on current evidence-based practices. The surgeon becomes verbally aggressive, shouting at the nurse in front of the team and reiterating the crystalloid order. What is the most appropriate action by the nurse?

KILL EXAMS

A. Shout back at the surgeon to defend professional nursing autonomy and ensure the entire trauma team understands the surgeon's outdated practice
B. Refuse the order, leave the room immediately, and file an anonymous complaint with the hospital's corporate compliance hotline
C. Administer the 2 liters of normal saline silently to avoid further conflict and maintain harmony among the resuscitation team members
D. Use a structured communication technique like the two-challenge rule or CUS to restate the safety risks of large crystalloid volumes

Answer: D

Explanation: Team dynamics and patient safety require effective communication, especially during high-stress resuscitations. Utilizing structured communication tools like CUS (I am Concerned, I am Uncomfortable, this is a Safety issue) or the two-challenge rule allows the nurse to assertively advocate for evidence-based patient care (avoiding large crystalloid volumes which cause dilutional coagulopathy and worsened mortality in bleeding trauma patients) without escalating a personal conflict. Complying silently with an unsafe or sub-optimal order compromises patient safety. Leaving the room disrupts care and abandons the patient. Shouting back degrades team communication, increases situational stress, and compromises professional conduct.

Question: 690

A 40-year-old male with deceleration injury has widened mediastinum and CT aortogram showing grade III aortic injury with large pseudoaneurysm. He has associated severe traumatic brain injury with elevated ICP.

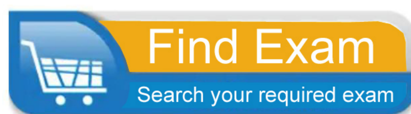
A. Immediate open surgical repair
B. Strict anti-impulse therapy with beta blockade only
C. Delayed endovascular repair after ICP stabilization
D. TEVAR with permissive hypertension to maintain cerebral perfusion

Answer: C

Explanation: In patients with concomitant severe TBI, delayed repair of traumatic aortic injury after neurologic stabilization is preferred to avoid hypotension or anticoagulation risks during acute brain injury management. Anti-impulse therapy is used in the interim. Immediate repair risks worsening brain injury.

KILLEXAMS.COM

Killexams.com is a leading online platform specializing in high-quality certification exam preparation. Offering a robust suite of tools, including MCQs, practice tests, and advanced test engines, Killexams.com empowers candidates to excel in their certification exams. Discover the key features that make Killexams.com the go-to choice for exam success.



Exam Questions Based on Current Exam Objectives

Killexams.com provides exam questions aligned with the latest official exam objectives and latest syllabus. Our content is reviewed and updated regularly to reflect recent changes announced by certification vendors. By studying these questions, candidates will become cover the structure, difficulty level, and topic coverage of the actual exam, helping them prepare more effectively and efficiently.

Comprehensive Exam MCQs (PDF Format)

Killexams.com offers multiple-choice questions (MCQs) in easy-to-read PDF format, covering all major domains of the exam. Each PDF contains a structured collection of questions and verified answers designed to support focused study. These MCQs help candidates reinforce key concepts, identify knowledge gaps, and improve exam readiness through consistent practice.

Realistic Practice Tests (Online & Desktop)

To support hands-on preparation, Killexams.com provides practice tests through both an Online Test Engine and a Desktop Exam Simulator. These tools are designed to simulate a real exam environment, allowing candidates to practice under exam-like conditions. Performance tracking, test history, and result analysis help users evaluate their progress and focus on areas that need improvement.

Risk-Free Purchase Policy

Killexams.com follows a transparent and customer-friendly purchase policy. If users are not satisfied with the study materials, they may request assistance or a refund in accordance with our published terms and conditions. This policy reflects our commitment to customer satisfaction, fairness, and confidence in our preparation resources.

Regularly Updated Content

Our question bank is reviewed and updated on an ongoing basis to stay aligned with the latest exam outlines and vendor updates. This ensures candidates are studying relevant material and preparing with content that reflects current exam expectations, helping them stay confident and well-prepared.