PRACTICE EXAM 6: TCRN MIRROR EXAM - TRAUMA CERTIFIED REGISTERED NURSE SIMULATION (175 QUESTIONS)

This independent practice simulation contains 175 multiple-choice questions. The current TCRN examination uses 175 items, including 150 scored and 25 unscored pretest items, with 180 minutes of total seat time. BCEN currently lists 96 of the 150 scored items as the passing standard. This practice exam is for study use only and is not an official BCEN examination or endorsed by BCEN. Select the single best answer.

1. At another head-and-neck trauma admission, a patient with facial trauma has gurgling respirations, blood in the mouth, a Glasgow Coma Scale score of 7, and suspected cervical injury. Which action is the priority?

A. Sit the patient upright and offer sips of water
B. Suction the airway while maintaining inline cervical stabilization
C. Complete a detailed pupil examination before intervening
D. Insert an oral airway and release manual stabilization

2. During an additional cranial and cervical assessment, after a temporal blow, a patient briefly becomes lucid and then develops worsening headache, vomiting, and a progressively enlarging unilateral pupil. Which interpretation is most concerning?

A. An expanding epidural hematoma with impending herniation
B. A minor scalp injury that can be observed without escalation
C. An uncomplicated concussion with expected short-term symptoms
D. A chronic subdural process that usually develops gradually

3. In another head-and-neck presentation, a patient with severe traumatic brain injury develops hypertension, bradycardia, and irregular respirations. Which nursing response is most appropriate?

A. Administer a sedative and delay reassessment until it takes effect
B. Lower the head of the bed to improve cerebral blood flow
C. Recognize possible rising intracranial pressure and prepare urgent intervention
D. Reassure the family that this pattern indicates recovery

4. At another head-and-neck trauma admission, which positioning intervention best helps reduce avoidable increases in intracranial pressure for a hemodynamically stable patient with traumatic brain injury?

A. Place the patient flat with the chin pressed toward the chest
B. Flex the hips sharply to reduce movement during observation
C. Keep the head midline and avoid neck flexion or tight cervical straps
D. Turn the head toward the side of the suspected lesion

5. During an additional cranial and cervical assessment, a patient with head trauma has repeated vomiting, declining responsiveness, and no reliable protective reflexes. What is the priority nursing action?

A. Give oral antiemetic medication before any airway action
B. Protect the airway while maintaining cervical alignment
C. Place the patient supine without suction equipment nearby
D. Encourage coughing to clear secretions independently

6. In another head-and-neck presentation, a patient remains comatose after a high-speed crash, but the initial head CT shows little structural change. Which injury pattern should the nurse suspect?

A. Diffuse axonal injury caused by rotational acceleration
B. An isolated superficial scalp contusion
C. A simple linear skull fracture without brain injury

D. An uncomplicated sinus infection unrelated to the crash

7. At another head-and-neck trauma admission, an older adult develops progressively worsening confusion and gait instability several weeks after a seemingly minor fall. Which condition is most likely?

A. An acute isolated nasal fracture
B. A rapidly resolving concussion
C. A simple external ear infection
D. A chronic subdural hematoma

8. During an additional cranial and cervical assessment, a patient taking an anticoagulant strikes the head and initially has a normal neurologic examination. Which plan is safest?

A. Discharge immediately because the first examination is normal
B. Give aspirin to prevent delayed clot formation
C. Avoid all imaging because the patient denies severe pain
D. Continue serial neurologic assessment and follow the imaging or observation protocol

9. In another head-and-neck presentation, a trauma patient has clear drainage from the nose with a halo-like appearance on gauze and bruising behind the ear. Which action is appropriate?

A. Avoid nasal instrumentation and notify the trauma team about suspected basilar skull fracture
B. Pack both nares firmly with gauze
C. Insert a nasogastric tube through the most patent nostril
D. Apply direct pressure over the drainage site

10. At another head-and-neck trauma admission, a patient has an open depressed skull injury with exposed bone and controlled external bleeding. How should the wound be managed initially?

A. Irrigate deeply with force under pressure

B. Push the exposed bone back into its original position

C. Cover it with a sterile dressing without pressing on the depressed area

D. Apply a tight circumferential head wrap over the defect

11. During an additional cranial and cervical assessment, a patient with a cervical spinal cord injury becomes increasingly hypoxemic during transfer. Which intervention best prevents secondary injury?

A. Remove immobilization to make the patient more comfortable

B. Maintain spinal alignment while correcting oxygenation and supporting ventilation

C. Accept low oxygen saturation until definitive imaging is complete

D. Hyperventilate routinely regardless of the clinical picture

12. In another head-and-neck presentation, a patient with a high cervical injury has shallow respirations, a weak cough, and increasing fatigue. What should the nurse anticipate?

A. Routine oral fluids to strengthen the cough

B. Delayed respiratory support until cyanosis appears

C. A tight abdominal binder as the only intervention

D. Early assisted ventilation and a controlled definitive airway

13. At another head-and-neck trauma admission, after cervical trauma, a patient has hypotension, bradycardia, warm dry skin, and no obvious external bleeding. Which type of shock is most consistent with these findings?

A. Pure hypovolemic shock from concealed blood loss

B. Neurogenic shock related to loss of sympathetic tone

C. Obstructive shock from an isolated abdominal injury

D. Anaphylactic shock caused by a medication exposure

14. During an additional cranial and cervical assessment, immediately after spinal cord trauma, a patient has flaccid paralysis and absent reflexes below the injury. Which condition best describes this early finding?

A. Spinal shock
B. Neurogenic shock
C. Compartment syndrome
D. Autonomic dysreflexia

15. In another head-and-neck presentation, a patient with a cervical injury has bilateral arm weakness greater than leg weakness after a hyperextension mechanism. Which syndrome is most likely?

A. Complete anterior cord syndrome
B. Isolated cauda equina syndrome
C. Central cord syndrome
D. Peripheral radial nerve palsy

16. At another head-and-neck trauma admission, a patient with a hemisection injury has ipsilateral loss of motor function and vibration with contralateral loss of pain and temperature. Which syndrome is indicated?

A. Central cord syndrome
B. Brown-Sequard syndrome
C. Anterior cord syndrome
D. Conus medullaris syndrome

17. During an additional cranial and cervical assessment, a trauma patient has midline cervical tenderness and hand paresthesias but asks to have the collar removed because the CT has not yet been completed. What is the best response?

A. Remove the collar to obtain a more accurate pain score
B. Allow active neck rotation to test the range of motion

C. Replace the collar with a soft neck pillow
D. Maintain immobilization and continue the cervical injury evaluation

18. In another head-and-neck presentation, during repeated assessments of a patient wearing a rigid cervical collar, which nursing action is most important?

A. Inspect the skin and maintain neutral alignment during care
B. Loosen the collar whenever the patient reports discomfort
C. Place extra padding beneath the chin without reassessing fit
D. Remove the collar for every repositioning maneuver

19. At another head-and-neck trauma admission, a patient with penetrating neck trauma develops an expanding hematoma, hoarseness, and stridor. Which response is the priority?

A. Send the patient for routine radiography before airway planning
B. Apply firm pressure directly over the expanding airway
C. Prepare for an early definitive airway with surgical backup
D. Offer oral fluids to clear the throat

20. During an additional cranial and cervical assessment, a patient with blunt anterior neck trauma has hoarseness, tenderness over the larynx, and subcutaneous emphysema. Which complication is most urgent to anticipate?

A. Delayed isolated dental pain
B. Uncomplicated external bruising only
C. A self-limited middle-ear infection
D. Progressive laryngeal edema and airway obstruction

21. In another head-and-neck presentation, a patient with severe midface trauma has active oral bleeding and noisy respirations. Which action is most appropriate while the team prepares definitive airway care?

A. Insert fingers into the mouth to search for loose teeth
B. Use suction and maintain a protected airway while avoiding blind finger sweeps
C. Place the patient flat and leave the airway unsuctioned
D. Give water to wash blood into the stomach

22. At another head-and-neck trauma admission, a patient with an orbital blowout injury reports diplopia and pain with upward gaze. Which instruction is most appropriate?

A. Apply pressure over the orbit to reduce swelling
B. Encourage forceful nose blowing to clear the sinus
C. Avoid nose blowing and arrange urgent ophthalmic evaluation
D. Patch both eyes tightly and delay examination

23. During an additional cranial and cervical assessment, a patient struck in the eye has an irregular pupil, decreased vision, and a soft-feeling globe. Which action should the nurse take?

A. Place a rigid eye shield without applying pressure and avoid tonometry
B. Apply a pressure patch over the injured eye
C. Irrigate forcefully until the globe feels firm
D. Remove any protruding material before shielding

24. In another head-and-neck presentation, a patient with facial trauma has blood visible in the anterior chamber of the eye. Which intervention is appropriate?

A. Press firmly on the eyelid to stop the bleeding
B. Encourage bending forward to improve drainage
C. Protect the eye, elevate the head, and arrange ophthalmology follow-up
D. Patch the eye and postpone evaluation until pain resolves

25. At another head-and-neck trauma admission, following blunt eye trauma, a patient reports flashes of light, new floaters, and a curtain-like shadow across the visual field. What is the priority?

A. Reassure the patient that floaters are expected after every injury
B. Arrange urgent evaluation for possible retinal detachment
C. Apply a warm compress and reassess in several days
D. Irrigate the eye repeatedly to remove an unseen foreign body

26. During an additional cranial and cervical assessment, a chemical splash enters a patient's eye at work. Which action should occur first?

A. Begin copious irrigation immediately and remove contact lenses when possible
B. Wait for the product label before starting any irrigation
C. Neutralize the chemical with another solution
D. Cover the eye and send the patient directly for CT

27. In another head-and-neck presentation, a patient has sudden severe vision loss after facial trauma, but the globe appears intact and the anterior eye is clear. Which condition should be considered?

A. A superficial eyelid abrasion only
B. A routine conjunctival irritation
C. A simple refractive change caused by anxiety
D. Traumatic optic neuropathy requiring urgent ophthalmic evaluation

28. At another head-and-neck trauma admission, a patient with mandibular trauma has malocclusion, trismus, and swelling under the tongue. Which concern takes priority?

A. Delayed dental alignment after the swelling resolves
B. Routine oral intake to test swallowing ability
C. A minor lip laceration requiring cosmetic repair
D. Progressive tongue and floor-of-mouth swelling threatening the airway

29. During an additional cranial and cervical assessment, a patient with suspected basilar skull fracture has persistent nasal bleeding. Which intervention should be avoided?

A. Blind nasal packing or insertion of a nasogastric tube
B. Suctioning blood from the mouth with spinal protection
C. Using an oral route for airway support when indicated
D. Applying gentle external pressure without obstructing the airway

30. In another head-and-neck presentation, a patient with traumatic brain injury begins seizing. Which nursing response is most appropriate?

A. Force a bite block between the teeth
B. Protect the airway, provide oxygen, and prevent injury without restraining the patient
C. Hold the limbs down until the seizure ends
D. Offer oral medication during the seizure

31. At another head-and-neck trauma admission, a patient with head trauma becomes newly agitated and confused during observation. Which action should occur first?

A. Assume the behavior is emotional and apply restraints immediately
B. Give a sedative without reassessing airway or neurologic status
C. Repeat the primary assessment and check reversible causes such as hypoxemia or hypoglycemia
D. Document the behavior as expected after every concussion

32. During an additional cranial and cervical assessment, after blunt neck trauma, a patient develops a focal neurologic deficit and a new cervical bruit. Which evaluation should the nurse anticipate?

A. Routine hearing testing before further trauma evaluation
B. A delayed outpatient neurologic referral
C. Urgent vascular imaging for possible blunt cerebrovascular injury
D. A warm compress over the side of the neck

33. In another head-and-neck presentation, a patient with a cervical spinal cord injury has a weak cough and paradoxical abdominal movement. Which assessment is most important?

A. Evaluate ventilatory muscle function and prepare for respiratory support
B. Assess appetite before initiating any respiratory intervention
C. Encourage unassisted ambulation to strengthen the trunk
D. Remove cervical precautions to improve chest expansion

34. At another head-and-neck trauma admission, a patient with a mild head injury and a normal initial neurologic examination is taking a direct oral anticoagulant. Which plan is safest?

A. Rely only on the patient's symptom report at discharge
B. Give an antiplatelet medication for additional protection
C. Avoid repeat assessment because anticoagulants affect only the heart
D. Use the trauma service's imaging and observation pathway with repeated neurologic checks

35. During an additional cranial and cervical assessment, after intubation for severe traumatic brain injury, which ventilation approach is generally preferred when there are no signs of impending herniation?

A. Use prolonged aggressive hyperventilation for every severe head injury
B. Maintain adequate oxygenation and near-normal carbon dioxide rather than routine hyperventilation
C. Permit persistent hypoxemia to avoid increasing airway pressure
D. Target severe carbon dioxide retention to improve cerebral blood flow

36. In another head-and-neck presentation, a patient with severe head trauma develops a unilateral dilated pupil and weakness on the opposite side. Which complication should the nurse suspect?

A. Uncal herniation with compression of the third cranial nerve and cerebral structures
B. An isolated superficial facial laceration
C. A benign medication effect without neurologic significance
D. A simple middle-ear infection causing temporary imbalance

37. At another torso-trauma admission, a patient with chest trauma has severe respiratory distress, hypotension, distended neck veins, and absent breath sounds on one side. Which action is the priority?

A. Wait for a chest radiograph before treating the obstruction
B. Arrange immediate decompression for suspected tension pneumothorax
C. Administer a diuretic for presumed heart failure
D. Place the patient flat and observe the respiratory pattern

38. During an additional abdominal or thoracic assessment, a patient has a sucking chest wound after a stabbing. Which intervention is most appropriate?

A. Pack the wound deeply with gauze
B. Leave the wound open so air can escape freely
C. Apply a vented occlusive chest seal and monitor for tension physiology
D. Apply a circumferential bandage tightly around the chest

39. In another trunk-and-pelvis presentation, a patient with multiple rib fractures has paradoxical chest movement, shallow respirations, and fatigue. Which plan is most appropriate?

A. Apply a tight binder around the entire chest
B. Withhold analgesia to preserve the respiratory drive
C. Encourage forceful coughing without monitoring oxygenation
D. Provide effective analgesia and support ventilation when respiratory failure develops

40. At another torso-trauma admission, a patient with blunt chest trauma has increasing oxygen needs several hours after arrival, despite initially acceptable saturation. Which complication should the nurse suspect?

A. A healed rib fracture with no pulmonary effect
B. An isolated wrist injury causing false saturation readings

C. Progressive pulmonary contusion
D. A simple superficial chest abrasion

41. During an additional abdominal or thoracic assessment, a patient with a high-energy blunt chest injury develops persistent hypotension and a large volume of blood in the pleural space. Which intervention should the nurse anticipate?

A. Chest drainage with rapid blood replacement and surgical evaluation
B. A diuretic infusion to reduce thoracic fluid
C. Observation until the hemoglobin returns from the laboratory
D. A tight chest binder to stop internal bleeding

42. In another trunk-and-pelvis presentation, a patient with a high-speed motor vehicle crash has new ventricular ectopy but no external chest wound. Which monitoring is most important?

A. Intermittent skin temperature checks only
B. Continuous electrocardiographic monitoring for blunt cardiac injury
C. Routine oral intake observation
D. A focused examination of the lower extremities alone

43. At another torso-trauma admission, a patient with penetrating chest trauma has hypotension, muffled heart sounds, and distended neck veins. Which treatment should the team prioritize?

A. Large-volume diuresis to reduce venous pressure
B. Routine outpatient echocardiography after discharge
C. A chest binder placed over the sternum
D. Immediate evaluation and decompression for traumatic cardiac tamponade

44. During an additional abdominal or thoracic assessment, after a major deceleration event, a patient has chest pain and a widened mediastinal contour. Which action is most appropriate?

A. Treat the finding as possible great-vessel injury and expedite trauma imaging
B. Discharge the patient because the chest wall is not tender
C. Perform vigorous chest percussion to clear secretions
D. Delay evaluation until the patient develops a pulse deficit

45. In another trunk-and-pelvis presentation, a stable patient after a severe deceleration injury has persistent chest and interscapular pain despite normal initial blood pressure. Which concern remains important?

A. Simple muscular soreness that needs no further evaluation
B. Occult blunt great-vessel injury requiring definitive imaging
C. An isolated abdominal skin contusion
D. A minor ankle sprain causing referred pain

46. At another torso-trauma admission, a patient with chest trauma has a large persistent air leak, extensive subcutaneous emphysema, and poor lung expansion after tube placement. Which injury should be suspected?

A. An uncomplicated isolated rib bruise
B. A superficial skin tear without thoracic involvement
C. A routine viral cough developing by coincidence
D. Tracheobronchial injury requiring bronchoscopy and surgical consultation

47. During an additional abdominal or thoracic assessment, a patient after penetrating lower chest trauma develops chest pain, fever, and subcutaneous emphysema with concern for esophageal injury. Which order is most appropriate?

A. Start oral liquids to test swallowing
B. Insert a blind nasogastric tube without consultation

C. Keep the patient NPO and obtain urgent surgical evaluation
D. Discharge with antacid therapy and routine follow-up

48. In another trunk-and-pelvis presentation, imaging shows abdominal contents in the thorax after blunt trauma, with respiratory distress and decreased breath sounds on one side. Which injury is most likely?

A. An isolated clavicle fracture
B. Traumatic diaphragmatic rupture
C. A superficial chest-wall hematoma
D. A simple lower-lobe viral pneumonia

49. At another torso-trauma admission, a patient rescued after prolonged chest compression has facial cyanosis, conjunctival petechiae, and respiratory distress. Which priority is appropriate?

A. Support oxygenation and search for associated thoracic and airway injuries
B. Treat the skin findings as an isolated allergic rash
C. Delay assessment until the facial color normalizes
D. Restrict all oxygen because the chest was compressed

50. During an additional abdominal or thoracic assessment, a patient with left upper-quadrant trauma develops referred pain to the left shoulder and progressive tachycardia. Which injury should be suspected?

A. Isolated bladder irritation
B. A simple left shoulder strain
C. Splenic injury with internal hemorrhage
D. An uncomplicated gastric virus

51. In another trunk-and-pelvis presentation, a patient with right upper-quadrant trauma has increasing abdominal tenderness and falling blood pressure. Which injury is most concerning?

A. A superficial abdominal abrasion
B. An isolated right shoulder dislocation
C. A mild dietary intolerance
D. Hepatic injury causing concealed intra-abdominal hemorrhage

52. At another torso-trauma admission, a patient with abdominal trauma develops guarding, rebound tenderness, fever, and free air on imaging. Which condition is most likely?

A. Hollow-organ perforation with peritoneal contamination
B. A stable isolated abdominal-wall bruise
C. A simple closed extremity fracture
D. An uncomplicated tension headache

53. During an additional abdominal or thoracic assessment, a restrained passenger has a prominent abdominal seatbelt mark but initially minimal pain. Which plan is safest?

A. Discharge immediately because the abdomen is soft once
B. Apply a tight binder over the mark
C. Use serial examinations and appropriate imaging because occult bowel injury is possible
D. Give food to determine whether nausea develops

54. In another trunk-and-pelvis presentation, a patient struck in the epigastrium has persistent back pain and a small retroperitoneal fluid collection. Which injury should be considered?

A. An isolated superficial skin abrasion
B. A simple ankle sprain
C. An uncomplicated upper-respiratory infection
D. Pancreatic or duodenal injury

55. At another torso-trauma admission, a patient with flank trauma has gross hematuria and bruising over the kidney region. Which evaluation should the nurse anticipate?

A. Immediate Foley insertion without assessing the urethra
B. Imaging to assess renal injury and associated retroperitoneal bleeding
C. Discharge because renal injuries never cause shock
D. A chest radiograph as the only diagnostic test

56. During an additional abdominal or thoracic assessment, a pelvic-trauma patient has blood at the urethral meatus and cannot void. What should the nurse do?

A. Insert a Foley catheter with extra pressure
B. Avoid urethral catheterization and notify the trauma team for urethral evaluation
C. Ask the patient to forcefully bear down
D. Remove the blood with repeated urethral irrigation

57. In another trunk-and-pelvis presentation, a patient with an unstable pelvic fracture is hypotensive after a high-energy crash. Which intervention is most appropriate while hemorrhage control is organized?

A. Place the binder around the waist above the iliac crests
B. Repeatedly rotate the pelvis to assess stability
C. Apply a pelvic binder at the level of the greater trochanters and support resuscitation
D. Elevate one leg sharply to align the fracture

58. At another torso-trauma admission, a pelvic binder is applied to a patient with suspected pelvic-ring disruption. Which placement is correct?

A. At the lower ribs to compress the upper abdomen
B. At the waist over the iliac crests
C. Across the mid-thighs to pull the pelvis downward
D. Across the greater trochanters rather than around the abdomen

59. During an additional abdominal or thoracic assessment, a patient with an open pelvic injury has external bleeding near the perineum. Which action is appropriate?

A. Cover the wound with a sterile dressing, minimize manipulation, and expedite hemorrhage control
B. Probe the wound repeatedly to estimate its depth
C. Remove clots and pack blindly without trauma consultation
D. Delay treatment until the patient can provide a full history

60. In another trunk-and-pelvis presentation, a patient with pelvic trauma has new numbness in one leg and a weak distal pulse. Which response is the priority?

A. Document the finding as expected and reassess at discharge
B. Escalate urgently for vascular and neurologic evaluation
C. Apply heat to the limb and encourage walking
D. Remove all immobilization to improve circulation

61. At another torso-trauma admission, a patient with pelvic fracture has gross hematuria and lower-abdominal pain but no blood at the urethral meatus. Which injury should be evaluated?

A. An isolated scalp laceration
B. A simple chest-wall bruise
C. Bladder rupture with urinary extravasation
D. A routine upper-airway infection

62. During an additional abdominal or thoracic assessment, a patient with pelvic fracture has a contrast leak outside the bladder and no intraperitoneal fluid. Which management should the nurse anticipate?

A. Urologic management with drainage or repair guided by the injury pattern
B. Forceful bladder irrigation without imaging
C. Immediate oral intake to stimulate urination

D. No treatment because extraperitoneal leaks are always harmless

63. In another trunk-and-pelvis presentation, a patient after abdominal trauma has a tense distended abdomen, oliguria, rising airway pressures, and worsening hypotension. Which complication is most likely?

A. An isolated superficial contusion
B. A simple medication side effect without pressure effects
C. A stable healed abdominal scar
D. Abdominal compartment syndrome

64. At another torso-trauma admission, a patient with abdominal evisceration arrives after a penetrating injury. Which action is appropriate?

A. Cover the organs with a warm moist sterile dressing and do not replace them
B. Push the organs back into the abdominal cavity
C. Apply dry gauze directly to the exposed tissue
D. Allow the wound to remain open for repeated inspection

65. During an additional abdominal or thoracic assessment, a patient has an impaled metal rod through the abdomen with stable vital signs. Which action is safest?

A. Remove it immediately to inspect the wound
B. Rotate it gently to determine the direction of injury
C. Shorten it by pulling until only the tip remains
D. Stabilize the object in place and arrange controlled removal in a surgical setting

66. In another trunk-and-pelvis presentation, a patient with a stab wound has a loop of omentum protruding through the abdominal opening but is awake and perfusing. Which intervention is appropriate?

A. Pull the tissue outward to look for deeper injury
B. Cover the protruding tissue and prepare for urgent trauma evaluation
C. Push it back into the abdomen at the bedside
D. Clean it with concentrated antiseptic and close the skin

67. At another torso-trauma admission, a patient with abdominal trauma remains tachycardic and cool despite a brief blood-pressure improvement after initial fluid. Which interpretation is most concerning?

A. Definitive resolution of the bleeding source
B. An expected response that needs no further monitoring
C. Ongoing internal hemorrhage with only transient compensation
D. A primary anxiety reaction unrelated to the injury

68. During an additional abdominal or thoracic assessment, a patient with a high-energy flank injury has stable blood pressure but persistent flank pain and microscopic hematuria. Which plan is appropriate?

A. Continue evaluation for renal or retroperitoneal injury despite stable vital signs
B. Discharge because microscopic blood is never significant
C. Insert a catheter without evaluating for urethral injury
D. Treat only the skin bruising over the flank

69. In another trunk-and-pelvis presentation, a patient with blunt scrotal trauma has severe pain and an abnormal testicular contour. Which evaluation should the nurse anticipate?

A. Forceful manual manipulation until the contour normalizes
B. A tight compression wrap with no further assessment
C. Urgent scrotal ultrasound and urologic consultation
D. Discharge after applying ice for a few minutes

70. At another torso-trauma admission, a patient with a pelvic ring injury has a lower chest bruise and unexplained shortness of breath. Which principle should guide the assessment?

A. Assume the symptom is caused only by pelvic pain

B. Consider associated diaphragmatic and thoracoabdominal injury rather than focusing only on the pelvis

C. Limit the examination to the injured extremity

D. Delay chest assessment until ambulation is attempted

71. During an additional abdominal or thoracic assessment, after a chest tube is inserted, the patient suddenly becomes more dyspneic and hypotensive. What should the nurse do first?

A. Clamp the tube routinely to stop all bubbling

B. Remove the tube without assessment

C. Assume the change is expected after every insertion

D. Reassess for tension physiology and verify tube patency, connections, and position

72. In another trunk-and-pelvis presentation, a chest tube has continuous bubbling in the water-seal chamber and the patient's lung remains poorly expanded. Which action is appropriate?

A. Clamp the tube for an extended period without reassessment

B. Check the system and insertion site for an air leak and notify the trauma team

C. Strip the tubing forcefully toward the patient

D. Disconnect the system to let air escape into the room

73. At another torso-trauma admission, a patient with a penetrating cardiac injury has sudden loss of pulses, a narrow complex electrical rhythm, and a rapidly distending neck. Which response is required?

A. Begin routine ward observation for possible vasovagal syncope

B. Administer a diuretic for presumed right-sided failure

C. Delay intervention until a complete cardiac history is obtained
D. Activate the immediate surgical response for traumatic cardiac arrest

74. During an additional abdominal or thoracic assessment, after neck and chest trauma, a patient has a new unequal pulse and cool painful hand. Which complication should be considered?

A. A simple muscle strain without vascular involvement
B. A benign anxiety response causing permanent pulse loss
C. Great-vessel injury with arterial malperfusion
D. An isolated skin abrasion over the clavicle

75. In another trunk-and-pelvis presentation, a patient with blunt abdominal trauma has increasing abdominal girth, rising lactate, and worsening tachycardia although the initial scan was equivocal. Which action is most appropriate?

A. Repeat the trauma assessment and pursue evaluation for occult hemorrhage or bowel injury
B. Accept the first scan as definitive and stop monitoring
C. Give oral analgesia and wait for symptoms to resolve
D. Apply a binder over the abdomen to hide the distention

76. At another torso-trauma admission, a patient with lower chest trauma develops abdominal pain and repeated vomiting; imaging suggests elevation of one hemidiaphragm. Which injury should remain high on the differential?

A. An isolated superficial rib bruise
B. A simple shoulder sprain from the restraint
C. An uncomplicated upper-respiratory infection
D. Traumatic diaphragmatic rupture with possible herniation of abdominal contents

77. During an additional abdominal or thoracic assessment, a patient with an unstable pelvic fracture remains hypotensive despite a correctly positioned binder and blood replacement. Which concern is most important?

A. A resolved injury that needs only routine observation
B. Persistent pelvic or retroperitoneal arterial bleeding requiring definitive hemorrhage control
C. A medication reaction unrelated to the fracture
D. An isolated skin injury causing the continued hypotension

78. In another trunk-and-pelvis presentation, a patient has severe abdominal pain and rising lactate after a seatbelt injury, but no free air is visible on the first scan. Which injury still requires consideration?

A. Mesenteric or hollow-organ injury with evolving ischemia or perforation
B. A superficial belt mark without internal significance
C. A simple closed hand fracture
D. A primary headache caused by the crash

79. At another torso-trauma admission, a patient has a penetrating wound near the lower sternum with mild abdominal tenderness and normal blood pressure. Which assessment principle is most important?

A. Classify it as an isolated skin wound because the pressure is normal
B. Limit assessment to the chest wall and heart sounds
C. Treat it as a possible thoracoabdominal injury and evaluate both cavities
D. Close the wound at bedside before any imaging

80. During an additional abdominal or thoracic assessment, a patient with pelvic fracture has suprapubic pain, increasing distention, and inability to void, but no blood is seen at the meatus. Which problem should be evaluated?

A. An isolated superficial perineal abrasion
B. Bladder injury or urinary retention associated with pelvic trauma
C. A minor ankle injury causing referred pain

D. A benign finding that requires no urinary assessment

81. In another orthopedic presentation, a patient with a tibial fracture reports escalating pain despite opioids, pain with passive stretch, and tense swelling. Which action is the priority?

A. Elevate the limb high above the heart and reassess tomorrow
B. Apply a tighter cast to reduce movement
C. Reassure the patient because distal pulses are still present
D. Treat the findings as acute compartment syndrome and obtain emergent surgical evaluation

82. At another extremity-trauma admission, which finding most strongly supports compartment syndrome in a patient with an injured extremity?

A. Mild bruising that improves with elevation
B. A palpable pulse with normal capillary refill
C. Pain out of proportion with pain on passive stretch
D. Itching beneath an intact dressing

83. During an additional musculoskeletal and wound assessment, a patient is rescued after a prolonged crush injury and has dark urine, muscle pain, and weakness. Which complication should the nurse anticipate?

A. Rhabdomyolysis with hyperkalemia and acute kidney injury
B. A simple bruise with no systemic consequences
C. An isolated superficial infection of intact skin
D. A routine allergic reaction to the rescue environment

84. In another orthopedic presentation, a traumatic amputation is brought with the patient. How should the amputated part be handled?

A. Place it directly on ice in an unsealed container

B. Soak it in antiseptic solution for transport
C. Wrap in moist sterile gauze, bag it, and cool it without direct ice
D. Discard it if replantation is not immediately certain

85. At another extremity-trauma admission, a patient has an open tibial fracture with contamination and exposed bone. Which initial intervention is appropriate?

A. Push the bone back through the wound at bedside
B. Cover the wound, limit manipulation, and prepare antibiotics and tetanus care per protocol
C. Scrub the wound aggressively before imaging
D. Close the skin tightly before orthopedic evaluation

86. During an additional musculoskeletal and wound assessment, a patient with a femur fracture has severe pain and a shortened externally rotated leg. Which intervention is most appropriate?

A. Immobilize the limb and perform repeated distal neurovascular assessments
B. Encourage walking to determine whether the fracture is stable
C. Massage the thigh to reduce muscle spasm
D. Apply heat and delay splinting until swelling resolves

87. In another orthopedic presentation, when is a traction splint potentially appropriate for a patient with an isolated femoral shaft fracture?

A. Whenever any pelvic fracture is suspected
B. When distal pulses are absent and vascular injury is untreated
C. For every lower-extremity wound regardless of mechanism
D. When pelvic, knee, and lower-leg injuries have been excluded and protocol criteria are met

88. At another extremity-trauma admission, a patient with a long-bone fracture develops hypoxemia, confusion, and a petechial rash. Which complication is most likely?

A. Isolated cellulitis at the fracture site
B. A simple tension headache from analgesia
C. Fat embolism syndrome
D. A superficial pressure injury from the splint

89. During an additional musculoskeletal and wound assessment, a patient with a dislocated joint has absent distal pulses and increasing pain. Which response is the priority?

A. Obtain immediate reduction and vascular evaluation through the trauma team
B. Apply a heating pad and reassess after routine imaging
C. Encourage active range of motion to restore circulation
D. Delay intervention until swelling has completely resolved

90. In another orthopedic presentation, a patient with a posterior knee dislocation has a palpable foot pulse and minimal pain after spontaneous reduction. Which plan is safest?

A. Discharge because a palpable pulse excludes arterial injury
B. Arrange vascular assessment because popliteal injury can be occult
C. Apply a compression sleeve and permit unrestricted walking
D. Treat only the skin abrasion over the knee

91. At another extremity-trauma admission, a patient has a degloving injury with partially detached skin and exposed tissue. Which action is appropriate?

A. Trim away the detached skin at bedside
B. Leave the wound uncovered so the tissue can dry
C. Apply strong antiseptic directly to the exposed tissue
D. Cover the tissue with a sterile moist dressing and obtain urgent surgical consultation

92. During an additional musculoskeletal and wound assessment, a patient has a nail-gun injury with the nail embedded near the hand's flexor surface. Which intervention is safest?

A. Pull the nail out immediately to improve circulation
B. Stabilize the object and leave removal for controlled imaging or operative care
C. Rotate the nail to determine which tendon it crossed
D. Shorten the nail by twisting it against the hand

93. In another orthopedic presentation, a heavily contaminated laceration has devitalized edges and delayed presentation. Which approach is most appropriate?

A. Close the wound tightly before cleaning it
B. Seal it with adhesive over visible dirt
C. Irrigate and debride as indicated, then consider delayed closure after evaluation
D. Avoid all irrigation because contamination should remain undisturbed

94. At another extremity-trauma admission, a patient with a small puncture wound develops rapidly increasing pain, crepitus, fever, and systemic toxicity. Which action is the priority?

A. Apply a warm compress and observe for a day
B. Close the puncture tightly to contain drainage
C. Wait for a superficial culture before notifying the surgeon
D. Treat possible necrotizing soft-tissue infection as a surgical emergency

95. During an additional musculoskeletal and wound assessment, a patient with an open leg fracture develops a cool foot and absent distal pulse after splinting. Which action is most appropriate?

A. Reassess the splint and limb immediately while escalating for urgent neurovascular care
B. Tighten the splint to prevent any movement
C. Wait for swelling to resolve before checking the pulse again
D. Elevate the limb and document the absent pulse as expected

96. In another burn, pediatric, geriatric, pregnancy, or vulnerability presentation, an older adult taking an anticoagulant falls and strikes the head but remains oriented with no focal deficit. Which plan is safest?

A. Discharge because orientation excludes intracranial bleeding
B. Use the trauma imaging and observation pathway with repeated neurologic assessments
C. Give aspirin to prevent a delayed clot
D. Avoid imaging because the patient reports only mild pain

97. At another high-risk trauma admission, an older trauma patient remains normotensive but becomes cool, confused, and oliguric after a fall. Which interpretation is most appropriate?

A. Assume the findings reflect normal aging
B. Wait for profound hypotension before starting reassessment
C. Suspect evolving shock despite the absence of marked hypotension
D. Attribute the confusion only to unfamiliar surroundings

98. During an additional special-population assessment, which nursing intervention best protects an older adult with fragile skin during repeated trauma transfers?

A. Drag the patient quickly across the stretcher sheet
B. Apply adhesive tape directly over fragile skin
C. Keep the patient in one position without skin checks
D. Use adequate assistance, lift devices, and padding while minimizing shear

99. In another burn, pediatric, geriatric, pregnancy, or vulnerability presentation, an older adult after hip trauma becomes inattentive and fluctuates between agitation and drowsiness. Which response is most appropriate?

A. Assume dementia and avoid further assessment
B. Apply restraints before checking oxygenation or pain
C. Recognize possible delirium and evaluate reversible causes
D. Administer a sedative without evaluating medications or infection

100. At another high-risk trauma admission, a young child with facial burns has a hoarse cry and increasing work of breathing. Which concern should guide the plan?

A. Early airway control because edema can progress rapidly in a small pediatric airway
B. Delay airway preparation until cyanosis appears
C. Offer oral fluids to soothe the throat
D. Treat the hoarseness as a harmless response to crying

101. During an additional special-population assessment, a child with blunt abdominal trauma has tachycardia, delayed capillary refill, and increasing irritability but a nearly normal blood pressure. How should the nurse interpret these findings?

A. Rule out shock because the blood pressure is preserved
B. Suspect compensated shock and reassess for occult blood loss
C. Give food and observe whether irritability improves
D. Assume the child is anxious because children rarely bleed internally

102. In another burn, pediatric, geriatric, pregnancy, or vulnerability presentation, a child after a high-energy crash has a proportionally large head and neck with possible cervical tenderness. Which principle is most important?

A. Maintain age-appropriate cervical alignment and protect the airway during immobilization
B. Use an adult-sized device without checking fit
C. Flex the neck to match the child's rounded shoulders
D. Remove all support so the child can look around

103. At another high-risk trauma admission, a developmentally capable child with an isolated extremity injury can answer questions reliably. Which pain-assessment approach is best?

A. Rely only on the caregiver's estimate

B. Avoid asking about pain to prevent anxiety
C. Use adult numeric language regardless of development
D. Use the child's self-report with an age-appropriate pain scale

104. During an additional special-population assessment, a child with major trauma is wet and exposed during assessment. Which intervention should occur early?

A. Leave the child uncovered to observe every bruise
B. Apply ice packs to reduce expected swelling
C. Delay warming until all imaging and procedures are complete
D. Provide active warming while continuing life-threatening injury evaluation

105. In another burn, pediatric, geriatric, pregnancy, or vulnerability presentation, a caregiver's explanation does not match a child's patterned bruises and mechanism of injury. Which response is appropriate?

A. Confront the caregiver publicly and demand an admission
B. Alter the injury description to avoid family conflict
C. Ensure the child is safe, document objective findings, and follow mandated reporting policy
D. Discharge the child because the caregiver supplied a history

106. At another high-risk trauma admission, a pregnant patient arrives after a motor vehicle crash with abdominal pain but no obvious external bleeding. Which principle should guide the initial response?

A. Stabilize the mother first while simultaneously assessing for pregnancy-related trauma complications
B. Focus on fetal monitoring before addressing maternal airway
C. Assume the fetus is safe because the abdomen is not bruised
D. Delay trauma treatment until an obstetric history is complete

107. During an additional special-population assessment, a late-pregnancy trauma patient becomes dizzy and hypotensive while lying flat. Which intervention is appropriate?

A. Increase supine pressure with a tight abdominal binder
B. Use left uterine displacement or lateral positioning while continuing resuscitation
C. Place the patient prone despite the trauma mechanism
D. Delay repositioning until fetal imaging is complete

108. In another burn, pediatric, geriatric, pregnancy, or vulnerability presentation, a pregnant trauma patient is hemodynamically stabilized after blunt injury. What additional monitoring should the nurse anticipate?

A. No fetal assessment because maternal vital signs are normal
B. Routine discharge without warning-sign education
C. Only an extremity examination because pregnancy is unrelated to trauma
D. Fetal and uterine monitoring coordinated with obstetric evaluation

109. At another high-risk trauma admission, a pregnant trauma patient has abdominal pain, uterine tenderness, and a firm contracting uterus; vaginal bleeding is absent. Which condition is most concerning?

A. A simple abdominal-wall bruise
B. An uncomplicated urinary infection
C. Placental abruption
D. A minor ankle sprain with referred pain

110. During an additional special-population assessment, a pregnant patient who is Rh-negative sustains abdominal trauma. Which intervention should the nurse anticipate?

A. Evaluation for fetomaternal hemorrhage and Rh immune globulin according to protocol
B. Withhold all blood-related treatment until delivery
C. Administer routine iron only and provide no obstetric follow-up

D. Assume Rh status is irrelevant after trauma

111. In another burn, pediatric, geriatric, pregnancy, or vulnerability presentation, which restraint position is safest for a pregnant patient riding in a vehicle after trauma?

A. Place the lap belt across the upper abdomen
B. Put the shoulder belt behind the back
C. Use only a loose lap belt below the knees
D. Place the lap belt low across the hips with the shoulder belt across the chest

112. At another high-risk trauma admission, a patient with facial burns has soot around the mouth, carbonaceous sputum, and progressive hoarseness. Which plan is most appropriate?

A. Wait for complete obstruction before preparing equipment
B. Prepare early endotracheal intubation before airway edema makes access difficult
C. Apply topical cream to the face and discharge the patient
D. Encourage deep coughing without airway surveillance

113. During an additional special-population assessment, a patient arrives after exposure to a dry chemical powder with burns on the arm. Which action should occur before irrigation?

A. Rub the powder deeper into the skin
B. Apply a neutralizing chemical without identifying the substance
C. Remove contaminated clothing and brush off dry material while wearing appropriate protection
D. Cover the arm tightly and transport without decontamination

114. In another burn, pediatric, geriatric, pregnancy, or vulnerability presentation, a patient with an electrical injury has small entry and exit wounds but reports palpitations. Which priority is appropriate?

A. Discharge because the skin wounds are small
B. Place the patient on cardiac monitoring and evaluate for deep tissue injury

C. Apply ice directly to both wounds and avoid monitoring
D. Assume the current affected only the outer skin

115. At another high-risk trauma admission, a patient with a circumferential chest burn develops rising airway pressures and restricted chest expansion. Which intervention should the nurse anticipate?

A. Escharotomy to release restrictive burned tissue
B. A tighter chest dressing to limit movement
C. Routine elevation of the legs without chest reassessment
D. Topical lotion alone while ventilation worsens

116. During an additional special-population assessment, a patient with a circumferential limb burn develops increasing pain, cool fingers, and delayed capillary refill. Which action is most appropriate?

A. Apply a tighter wrap to control edema
B. Escalate for urgent escharotomy evaluation and continue neurovascular monitoring
C. Elevate the limb and wait for spontaneous improvement
D. Cover the hand with ice until sensation returns

117. In another burn, pediatric, geriatric, pregnancy, or vulnerability presentation, a bariatric trauma patient requires transfer from the floor to a stretcher. Which plan is safest?

A. Use rated equipment, adequate staff, a coordinated lift plan, and clear role assignment
B. Ask one staff member to pull the patient by the arms
C. Use standard equipment without checking its capacity
D. Delay all movement until the patient can walk independently

118. At another high-risk trauma admission, a bariatric trauma patient appears comfortable but has shallow respirations while supine. Which intervention is most appropriate?

A. Rely on appearance alone and remove continuous monitoring

B. Place the patient flatter to reduce staff workload

C. Use positioning and respiratory monitoring that support airway patency and ventilation

D. Give oral fluids before assessing breathing mechanics

119. During an additional special-population assessment, a patient privately discloses intimate partner violence while the suspected partner waits nearby. What is the best nursing response?

A. Confront the partner in the hallway

B. Tell the patient to return home and resolve the conflict

C. Promise absolute secrecy regardless of safety or law

D. Provide privacy, validate the disclosure, assess immediate safety, and follow reporting policy

120. In another burn, pediatric, geriatric, pregnancy, or vulnerability presentation, a trauma patient is accompanied by a controlling person who refuses to leave, answers every question, and holds the patient's identification. Which action is most appropriate?

A. Ask the companion to answer all questions for efficiency

B. Create a private opportunity for assessment and activate a trauma-informed safety pathway

C. Accuse the companion publicly before assessing the patient

D. Discharge the patient with the companion without additional screening

121. At another high-risk trauma admission, a trauma patient with substance use disorder reports severe pain and a history of opioid use. Which approach is most appropriate?

A. Withhold analgesia to prevent reinforcing drug use

B. Assume every symptom is intoxication and skip the trauma examination

C. Use multimodal analgesia with nonjudgmental assessment and monitoring for withdrawal or oversedation

D. Give repeated sedatives without assessing respiratory status

122. During an additional phase of trauma management, during the first trauma survey, a patient has uncontrolled arterial bleeding from the thigh. Which action should occur immediately?

A. Complete a head-to-toe history before touching the wound
B. Obtain routine laboratory results before applying pressure
C. Elevate the leg and wait for spontaneous clot formation
D. Control the catastrophic external hemorrhage while continuing the primary survey

123. In another trauma-care transition, a trauma patient with possible cervical injury has snoring respirations and falling oxygen saturation. Which principle guides airway management?

A. Open and secure the airway while maintaining cervical alignment
B. Remove all spinal support before assessing the mouth
C. Delay airway care until cervical imaging is completed
D. Rotate the neck to improve visualization

124. At another point in the trauma care pathway, when should a detailed secondary survey begin for a seriously injured patient?

A. After immediate life threats are addressed
B. Before controlling external hemorrhage
C. Only after discharge instructions are completed
D. Before checking airway, breathing, or circulation

125. During an additional phase of trauma management, a massive transfusion protocol is activated for a patient with ongoing hemorrhage. Which nursing action best supports safe team performance?

A. Allow each clinician to request products independently
B. Record only the final blood pressure after resuscitation
C. Pause communication so the team can work faster
D. Clarify roles, communicate product needs and laboratory trends, and reassess continuously

126. In another trauma-care transition, a patient with life-threatening traumatic hemorrhage has no stated contraindication to antifibrinolytic therapy. Which intervention best reflects coagulant therapy?

A. Delay all hemostatic treatment until the wound has stopped bleeding

B. Use a diuretic to remove fluid from the injured tissue

C. Administer an indicated antifibrinolytic according to protocol while arranging definitive hemorrhage control

D. Give an antiplatelet drug to increase clot breakdown

127. At another point in the trauma care pathway, a patient receiving large-volume blood replacement becomes cold, acidotic, coagulopathic, and hypocalcemic. Which plan is most appropriate?

A. Give more cold crystalloid and delay laboratory reassessment

B. Prevent and correct the trauma diamond of death while controlling hemorrhage

C. Treat only the blood pressure and ignore temperature

D. Stop all resuscitation until spontaneous clotting occurs

128. During an additional phase of trauma management, which strategy best represents damage-control resuscitation for a patient with uncontrolled traumatic hemorrhage and no severe brain injury?

A. Give repeated large crystalloid boluses as the only treatment

B. Delay blood products until the operating room is ready

C. Normalize every laboratory value before stopping resuscitation

D. Prioritize hemorrhage control and balanced blood resuscitation while limiting excess crystalloid

129. In another trauma-care transition, a patient with severe traumatic brain injury requires rapid-sequence intubation. Which pre-intubation action is most helpful?

A. Optimize oxygenation and hemodynamics, use apneic oxygenation, and prepare a backup airway

B. Induce paralysis without preoxygenation or rescue planning

C. Hyperventilate aggressively before any airway attempt

D. Remove monitoring to reduce equipment around the head

130. At another point in the trauma care pathway, during blood administration, a trauma patient develops fever, flank pain, hypotension, and dark urine. Which action is the priority?

A. Increase the infusion rate to finish the unit quickly
B. Discard the tubing and restart the same blood product
C. Stop the transfusion, maintain access with compatible fluid, and notify the response team
D. Document the symptoms after the full unit has infused

131. During an additional phase of trauma management, a patient with abdominal trauma is cool, tachycardic, restless, and hypotensive. Which shock pattern is most likely?

A. Isolated cardiogenic shock without chest findings
B. Hypovolemic shock from blood loss until proven otherwise
C. Neurogenic shock with preserved sympathetic tone
D. Obstructive shock caused by a simple skin wound

132. In another trauma-care transition, a trauma patient has sudden hypotension, distended neck veins, and absent breath sounds on the left. Which intervention addresses the shock mechanism?

A. Administer a diuretic and restrict oxygen
B. Give oral fluids while awaiting routine imaging
C. Apply a pelvic binder despite no pelvic findings
D. Relieve the obstructive chest process immediately

133. At another point in the trauma care pathway, a patient with cervical spinal cord injury has hypotension, bradycardia, warm skin, and no obvious hemorrhage. Which intervention is most appropriate?

A. Assume the patient is hemorrhaging and withhold all vasopressor support
B. Remove immobilization to improve venous return

C. Support perfusion while maintaining spinal precautions and evaluating for neurogenic shock
D. Treat the bradycardia as an unrelated baseline finding

134. During an additional phase of trauma management, a trauma patient develops fever, worsening perfusion, altered mentation, and increasing oxygen needs several days after an infected wound. Which response is most appropriate?

A. Recognize possible septic shock and coordinate cultures, antibiotics, resuscitation, and source control
B. Treat the fever with blankets alone and delay evaluation
C. Assume the change is normal after any operation
D. Give diuretics as the sole intervention

135. In another trauma-care transition, a patient with myocardial contusion develops hypotension, cool extremities, pulmonary congestion, and a new dysrhythmia. Which shock pattern should guide care?

A. Pure hypovolemic shock without ongoing blood loss
B. Cardiogenic shock from impaired cardiac pump function
C. Neurogenic shock caused by an isolated wrist injury
D. Distributive shock from a healed skin abrasion

136. At another point in the trauma care pathway, a hypotensive trauma patient briefly improves after fluid, then becomes tachycardic and cool again. Which interpretation is most concerning?

A. The bleeding is definitively resolved
B. The response proves no further treatment is needed
C. The patient likely has ongoing bleeding and needs renewed hemorrhage assessment
D. The change is a normal effect of pain medication

137. During an additional phase of trauma management, after a splint is applied and a chest tube is placed, which nursing action is most important?

A. Assume the procedures succeeded without reassessment
B. Repeat the primary assessment and verify that the interventions improved physiology
C. Delay vital signs until the next scheduled round
D. Focus only on documenting the equipment serial numbers

138. In another trauma-care transition, during transfusion, a patient develops acute hypoxemia and bilateral pulmonary edema without clear signs of circulatory overload. Which complication is most likely?

A. A simple isolated rib fracture
B. Chronic stable asthma with no transfusion relationship
C. A local reaction at the intravenous site
D. Transfusion-related acute lung injury

139. At another point in the trauma care pathway, a patient develops dyspnea, hypertension, jugular venous distention, and pulmonary edema during blood replacement. Which complication is most likely?

A. Transfusion-associated circulatory overload
B. An isolated wound infection without fluid involvement
C. A delayed concussion with normal breathing
D. A simple local allergic reaction to tape

140. During an additional phase of trauma management, a patient has been stabilized after a high-energy crash, but the first examination was performed during severe pain and distraction. What is the purpose of a tertiary survey?

A. Replace all imaging with a single final checklist
B. Identify injuries missed during the initial evaluation through repeated history and examination
C. Determine whether the patient is ready for discharge without reassessment

D. Limit evaluation to the body region that was initially painful

141. In another trauma-care transition, a critically ill trauma patient has fluctuating attention, disorganized thinking, and a reversed sleep-wake pattern. Which response is most appropriate?

A. Recognize delirium and correct contributing factors while using supportive reorientation
B. Label the behavior as intentional noncompliance
C. Apply restraints before checking oxygenation, pain, or medications
D. Assume the patient has permanent dementia

142. At another point in the trauma care pathway, a trauma patient develops severe refractory hypoxemia and bilateral infiltrates without evidence of left-sided heart failure. Which ventilatory principle is most appropriate?

A. Use the largest possible tidal volumes to force open every alveolus
B. Avoid positive pressure even when oxygenation is failing
C. Treat the infiltrates with diuresis alone without reassessing the lungs
D. Use lung-protective ventilation and coordinate advanced support for acute respiratory distress syndrome

143. During an additional phase of trauma management, a trauma patient develops declining urine output and rising creatinine after prolonged shock. Which nursing action is most important?

A. Ignore urine output until the patient reports flank pain
B. Give unrestricted fluid without considering lung status
C. Trend renal function and perfusion while avoiding or adjusting nephrotoxic exposures
D. Stop all medications without reviewing their indications

144. In another trauma-care transition, which intervention is most consistent with a ventilator-associated pneumonia prevention bundle for an intubated trauma patient?

A. Maintain oral care, appropriate head elevation, and daily review of ventilator necessity
B. Keep the patient flat and avoid oral assessment
C. Disconnect the circuit frequently for routine cleaning
D. Continue ventilation indefinitely without readiness review

145. At another point in the trauma care pathway, which nursing practice best reduces central-line bloodstream infection risk in a trauma patient?

A. Access the line repeatedly without disinfecting the hub
B. Use hand hygiene and aseptic line care while removing the line when no longer needed
C. Keep every line indefinitely for convenience
D. Cover the dressing with nonsterile material when it loosens

146. During an additional phase of trauma management, which intervention best helps prevent catheter-associated urinary tract infection in a trauma patient?

A. Disconnect the drainage bag during every repositioning
B. Irrigate routinely without an indication
C. Maintain a closed system and remove the catheter when no longer needed
D. Keep the catheter indefinitely to simplify intake and output

147. In another trauma-care transition, a trauma patient develops fever, tachycardia, hypotension, and purulent drainage from an operative wound. Which action is most appropriate?

A. Wait for the wound to close before treating infection
B. Cover the drainage and omit the finding from handoff
C. Treat only the heart rate with a beta blocker
D. Activate sepsis management while obtaining cultures, antibiotics, resuscitation, and source-control evaluation

148. At another point in the trauma care pathway, a patient with trauma history becomes tense during a dressing change and pulls away when approached. Which nursing approach is most trauma-informed?

A. Proceed silently so the procedure ends faster
B. Hold the patient down before explaining the procedure
C. Explain each step, ask permission, offer choices, and pause when safety permits
D. Tell the patient the reaction is irrational and unhelpful

149. During an additional phase of trauma management, a family asks for an update while the trauma patient is receiving an emergency procedure. Which response is best?

A. Promise a favorable outcome before the evaluation is complete
B. Provide honest, understandable information within privacy limits and identify a contact person
C. Share details loudly in the public hallway
D. Refuse all communication until the patient leaves the hospital

150. In another trauma-care transition, a patient who survived a violent crash reports nightmares, hypervigilance, and guilt during the hospital stay. Which intervention is most appropriate?

A. Acknowledge the stress response, assess safety, and arrange psychosocial follow-up
B. Tell the patient to suppress the memories and focus only on wounds
C. Assume symptoms prove a permanent psychiatric disorder
D. Avoid discussing emotional symptoms because they are unrelated to trauma care

151. At another point in the trauma care pathway, which activity is the primary focus of physical therapy after a trauma patient is medically stable?

A. Manage medication reconciliation without movement assessment
B. Perform independent wound closure
C. Determine legal responsibility for the injury

D. Improve strength, mobility, balance, and safe gait

152. During an additional phase of trauma management, which activity is most characteristic of occupational therapy during trauma rehabilitation?

A. Replace all respiratory therapy for an intubated patient
B. Restore safe performance of daily activities and adapt tasks or equipment
C. Determine the patient's blood type for transfusion
D. Perform the trauma surgeon's operative procedure

153. In another trauma-care transition, a trauma patient coughs during meals and has a wet voice afterward. Which consultation should the nurse request?

A. Speech-language pathology evaluation for swallowing and communication
B. A routine dermatology consultation
C. A vascular ultrasound without swallowing assessment
D. No evaluation because coughing is expected after every injury

154. At another point in the trauma care pathway, a mechanically ventilated trauma patient meets clinical triggers for potential organ donation after catastrophic neurologic injury. What should the nurse do?

A. Approach the family first with a personal recommendation about donation
B. Declare death independently before formal evaluation
C. Remove life support solely because donation is being considered
D. Notify the designated organ-donation referral organization according to facility policy

155. During an additional phase of trauma management, a patient lacks decision-making capacity and has a valid advance directive that addresses life-sustaining treatment. Which action is appropriate?

A. Ignore the directive because the family requests different treatment

B. Ask any visitor to choose treatment immediately

C. Review the directive and follow the patient's documented wishes with the authorized team

D. Assume the nurse may rewrite the patient's preferences

156. In another trauma-care transition, a family asks to remain at the bedside during resuscitation. Which approach is most appropriate?

A. Consider patient preference, safety, team readiness, and a trained staff liaison

B. Allow unlimited access without explaining safety boundaries

C. Refuse family presence in every circumstance

D. Ask the family to direct clinical interventions

157. At another point in the trauma care pathway, a trauma patient with painful injuries and a life-limiting diagnosis asks for help with comfort while still receiving disease-directed treatment. Which service is appropriate?

A. Hospice enrollment as the only possible response

B. Palliative care focused on symptom relief and goals that can occur alongside active treatment

C. No support until every curative option is stopped

D. A security consultation to determine the treatment plan

158. During an additional phase of trauma management, which statement about brain-death determination is most appropriate for the trauma nurse?

A. It can be declared by a nurse after one absent reflex

B. It is equivalent to a coma with uncertain prognosis

C. It is determined solely by the family's decision

D. It requires a formal evaluation by qualified clinicians using accepted institutional and legal standards

159. In another trauma-care transition, a trauma center notes a rising local rate of motorcycle injuries. Which prevention strategy is most appropriate?

A. Repeat a generic message without reviewing local patterns
B. Focus only on treating injuries after they occur
C. Use local injury data to target a community intervention and measure its outcome
D. Choose an intervention based on staff preference alone

160. At another point in the trauma care pathway, which information is most important in an EMS handoff for a newly arrived trauma patient?

A. Only the patient's insurance information
B. A brief statement that the patient looked stable
C. The receiving nurse's personal opinion about the scene
D. Mechanism and time, assessment findings, treatments, response, and trends

161. During an additional phase of trauma management, before moving an unstable trauma patient from the emergency department to radiology, which action is most important?

A. Transport without a monitor to reduce cable tangles
B. Send the patient alone after telling the department the patient is coming
C. Confirm stability, monitoring, equipment, staffing, destination readiness, and a contingency plan
D. Disconnect infusions because the trip is brief

162. In another trauma-care transition, a patient needs transfer to a regional trauma center for a service unavailable locally. Which preparation is essential?

A. Confirm acceptance, send clinical information, match transport capability, and maintain treatment during movement
B. Transfer before contacting the receiving center
C. Send only the diagnosis and omit current medications
D. Choose transport based solely on cost or convenience

163. At another point in the trauma care pathway, which discharge action best supports a trauma patient's safe transition home?

A. Give a diagnosis sheet without confirming understanding
B. Teach warning signs, medication and wound care, follow-up, activity limits, and when to seek help
C. Tell the patient to return only if pain becomes unbearable
D. Assume family members know the plan without involving the patient

164. During an additional professional-practice review, during a mass-casualty incident, which patient should receive priority when resources are limited?

A. A patient with a life-threatening but potentially survivable problem that can be treated with available resources
B. A patient with minor injuries who is easiest to treat
C. A patient with no signs of life when resources cannot support rescue
D. A patient selected by arrival order rather than clinical need

165. In another trauma-program situation, a patient arrives after chemical exposure with residue on clothing but stable airway and circulation. Which action is most appropriate?

A. Bring the patient directly into the crowded trauma bay
B. Use appropriate personal protective equipment, isolate the patient, and complete decontamination before routine-area entry
C. Remove protective equipment because the exposure is already over
D. Scrub the patient without first identifying the contamination risk

166. At another trauma-system case, a trauma program finds that many patients with serious injuries are initially sent to facilities without needed capabilities. Which quality-improvement response is best?

A. Exclude the cases from review because transfer eventually occurred

B. Focus only on increasing the number of low-acuity transfers

C. Change triage rules without examining outcomes or referral barriers

D. Review undertriage cases, identify system causes, and improve criteria, education, and feedback

167. During an additional professional-practice review, what is the primary purpose of a trauma registry?

A. Replace the patient's medical record during acute care

B. Assign personal blame for every unexpected outcome

C. Collect standardized injury and outcome data for surveillance, comparison, and improvement

D. Store only billing information without clinical context

168. In another trauma-program situation, a trauma unit is considering a new hemorrhage protocol. Which process best reflects evidence-based practice?

A. Adopt the protocol because another unit prefers it

B. Use one anecdotal success as the only evidence

C. Integrate current research, clinical expertise, patient values, and local outcome data

D. Reject all research that does not match current habit

169. At another trauma-system case, after a difficult resuscitation, which debriefing approach best supports trauma-team learning?

A. Identify one person to blame before reviewing the sequence

B. Use a structured, psychologically safe discussion focused on actions, systems, and improvement

C. Avoid discussion so distress will disappear on its own

D. Discuss only whether the patient survived

170. During an additional professional-practice review, which handoff statement best demonstrates the SBAR structure for a deteriorating trauma patient?

A. List every chart detail without identifying the urgent problem
B. Give only a diagnosis and ask the receiver to discover the risks
C. Transfer responsibility silently because the electronic record is complete
D. State the situation, relevant background, assessment findings, and requested recommendation

171. In another trauma-program situation, a medication near miss is caught before reaching a trauma patient. Which action is appropriate?

A. Report the event through the safety system and document the clinical record accurately without altering facts
B. Hide the event because no harm occurred
C. Change the chart to make the near miss appear impossible
D. Publicly identify the staff member before reviewing the process

172. At another trauma-system case, during an interfacility trauma handoff, which practice best protects privacy while supporting treatment?

A. Use a secure clinical channel and share needed information with the receiving treatment team
B. Discuss the case loudly in a public hallway
C. Post identifying details in a personal messaging group
D. Withhold essential information even from the receiving clinicians

173. During an additional professional-practice review, a Medicare-participating hospital with an emergency department receives a request to evaluate a patient with a possible emergency medical condition. What is the hospital's first EMTALA-related obligation?

A. Ask for payment before any screening occurs
B. Transfer the patient immediately without evaluation
C. Provide an appropriate medical screening examination regardless of the patient's ability to pay

D. Refuse care because another hospital may have more specialists

174. In another trauma-program situation, a visitor becomes threatening and blocks staff from leaving a trauma bay. Which action should the nurse take first?

A. Argue with the visitor until the person calms down
B. Physically restrain the visitor alone
C. Continue the procedure without alerting anyone
D. Create distance, summon security or the workplace-violence response, and protect an exit

175. At another trauma-system case, a regional trauma system wants to improve community referrals and injury prevention. Which activity is most appropriate?

A. Promote every facility as equally capable regardless of resources
B. Use verified trauma-system capabilities and local injury data to guide outreach and referral feedback
C. Give generic education without reviewing injury patterns
D. Limit outreach to internal staff and avoid EMS feedback

Practice Exam 6: Answer Key and Explanations

1. B — The intervention is appropriate: Blood and secretions are obstructing a threatened airway. It supports the plan to clear the airway while protecting the injured cervical spine and reduces aspiration, hypoxemia, and secondary neurologic injury. Alternatives are weaker because they either delay airway care or compromise spinal alignment. Reassess frequently and communicate changes promptly; trauma physiology can evolve.

2. A — A lucid interval followed by rapid decline can reflect arterial bleeding. This approach supports activate urgent trauma and neurosurgical evaluation and reduces brain compression and irreversible loss of perfusion. The alternatives are weaker because they do not explain the rapid focal deterioration. Continue reassessment and escalate abnormalities promptly. This supports timely escalation if the patient's condition changes.

3. C — The combination suggests impaired intracranial compliance and possible herniation. Prioritize care that will support oxygenation and rapidly alert the trauma team to limit continued brain compression and secondary injury. Other options are less appropriate because they delay treatment or apply unsafe positioning. Reassess frequently and escalate changes promptly; trauma physiology can evolve.

4. C — The intervention is appropriate: Midline alignment supports venous drainage from the brain. It supports the plan to maintain neutral alignment while continuing spinal precautions and reduces venous congestion and worsening intracranial pressure. Alternatives are weaker because they can obstruct venous outflow or distort spinal alignment. Reassess frequently and communicate changes promptly; trauma physiology can evolve.

5. B — Vomiting and reduced consciousness create an immediate aspiration threat. This approach supports use suction and prepare definitive airway support with spinal protection and reduces aspiration, hypoxemia, and further cerebral injury. The alternatives are weaker because the other actions depend on protective reflexes the patient may not have. Continue reassessment and escalate abnormalities promptly.

6. A — Shearing forces can disrupt axons without a large focal CT lesion. Prioritize care that will anticipate prolonged neurologic monitoring and supportive critical care to limit unrecognized secondary brain injury. Other options are less appropriate because they do not explain profound coma after rotational trauma. Reassess frequently and escalate changes promptly; trauma physiology can evolve.

7. D — The intervention is appropriate: Slow venous bleeding can accumulate gradually in an older adult. It supports the plan to arrange prompt neurologic evaluation and brain imaging and reduces delayed mass effect and neurologic decline. Alternatives are weaker because they do not account for progressive intracranial symptoms. Reassess frequently and communicate changes promptly; trauma physiology can evolve.

8. D — Anticoagulation increases concern for occult or delayed intracranial bleeding. This approach supports maintain observation and escalate any neurologic change and reduces missed hemorrhage and delayed deterioration. The alternatives are weaker because they create false reassurance or increase bleeding risk. Continue reassessment and escalate abnormalities promptly. This supports timely escalation if the patient's condition changes.

9. A — Clear drainage and Battle sign can indicate a skull-base fracture with cerebrospinal fluid leak. Act to protect the airway using a nonnasal approach and obtain evaluation, limiting meningeal contamination and intracranial placement of a tube. Alternatives fail because they can worsen a leak or introduce injury. Reassess and escalate. This supports timely escalation if the patient's condition changes.

10. C — The wound and depressed fragment may communicate with injured brain tissue. Act to protect the site and prevent contamination while awaiting surgical care, limiting additional tissue damage, contamination, and increased intracranial pressure. Alternatives fail because they can force debris inward or compress injured tissue. Reassess and escalate. This supports timely escalation if the patient's condition changes.

11. B — Hypoxemia and instability can worsen spinal cord ischemia. This approach supports coordinate airway and breathing support without sacrificing alignment and reduces extension of neurologic injury. The alternatives are weaker because they either remove protection or apply uncontrolled ventilation. Continue reassessment and escalate abnormalities promptly. This supports timely escalation if the patient's condition changes.

12. D — High cervical injury can impair respiratory muscles and secretion clearance. Prioritize care that will prepare airway equipment and involve the trauma airway team early to limit respiratory arrest and aspiration. Other options are less appropriate because they delay support or do not correct ventilatory failure. Reassess frequently and escalate changes promptly; trauma physiology can evolve.

13. B — Loss of sympathetic tone can produce vasodilation and relative bradycardia. Act to support perfusion while maintaining spinal precautions and searching for other causes, limiting impaired cord perfusion and missed hemorrhage. Alternatives fail because they do not fit the characteristic hemodynamic pattern alone. Reassess and escalate. This supports timely escalation if the patient's condition changes.

14. A — Spinal shock causes temporary loss of reflexes and motor tone below the lesion. This approach supports protect the spine and monitor for evolving neurologic recovery or complications and reduces misinterpretation of the neurologic examination. The alternatives are weaker because they describe hemodynamic or later autonomic syndromes. Continue reassessment and escalate abnormalities promptly.

15. C — Central cervical cord injury often affects the upper extremities disproportionately. Prioritize care that will maintain immobilization and arrange urgent spinal evaluation to limit missed instability and worsening cord compression. Other options are less appropriate because the other patterns do not match the mechanism and distribution. Reassess frequently and escalate changes promptly; trauma physiology can evolve.

16. B — A lateral cord lesion produces this crossed sensory and motor pattern. Act to document the baseline precisely and obtain specialist spinal evaluation, limiting missed progression or inaccurate prognostic communication. Alternatives fail because motor strength, proprioception, pain, temperature, and bowel or bladder function. Reassess and escalate. This supports timely escalation if the patient's condition changes.

17. D — Tenderness and paresthesias indicate possible unstable spinal injury. This approach supports preserve alignment until the clearance process is complete and reduces cord displacement and permanent neurologic injury. The alternatives are weaker because they permit motion before instability is excluded. Continue reassessment and escalate abnormalities promptly. This supports timely escalation if the patient's condition changes.

18. A — Immobilization can create pressure injury while poor fit permits movement. Prioritize care that will balance spinal protection with careful skin and device assessment to limit pressure injury and unrecognized displacement. Other options are less appropriate because alignment, occiput, jaw, neck skin, pulses, and neurologic findings. Reassess frequently and escalate changes promptly; trauma physiology can evolve.

19. C — Expanding tissue and laryngeal injury can make a delayed airway extremely difficult. Act to secure oxygenation while assembling advanced airway and surgical resources, limiting complete airway obstruction and loss of access. Alternatives fail because voice, stridor, swelling, oxygenation, and ability to handle secretions. Reassess and escalate. This supports timely escalation if the patient's condition changes.

20. D — Laryngeal injury can worsen as edema develops after the initial impact. This approach supports arrange controlled airway management before anatomy becomes distorted and reduces sudden inability to ventilate or intubate. The alternatives are weaker because voice quality, stridor, swelling, oxygenation, and respiratory effort. Continue reassessment and escalate abnormalities promptly. This supports timely escalation if the patient's condition changes.

21. B — Blood and debris can rapidly obstruct the airway, while blind sweeps can worsen injury. Prioritize care that will clear visible secretions and prepare controlled airway support to limit aspiration, obstruction, and provider injury. Other options are less appropriate because they increase contamination or delay airway control. Reassess frequently and escalate changes promptly; trauma physiology can evolve.

22. C — Orbital floor injury can allow air and bacteria to enter the orbit from the sinus. Act to protect the eye and obtain timely specialty assessment, limiting orbital emphysema, infection, and vision loss. Alternatives fail because they increase pressure or obscure changing vision. Reassess and escalate. This supports timely escalation if the patient's condition changes.

23. A — These findings suggest globe rupture, which is worsened by pressure or manipulation. This approach supports protect the eye and obtain emergent ophthalmic care and reduces extrusion of ocular contents and permanent vision loss. The alternatives are weaker because they can increase pressure or disturb the wound. Continue reassessment and escalate abnormalities promptly.

24. C — A hyphema can increase intraocular pressure and threaten vision. Prioritize care that will reduce pressure on the eye and obtain timely specialty assessment to limit rebleeding and optic nerve injury. Other options are less appropriate because they increase pressure or delay recognition of deterioration. Reassess frequently and escalate changes promptly; trauma physiology can evolve.

25. B — The intervention is appropriate: Flashes, floaters, and a curtain are classic warning symptoms of retinal separation. It supports the plan to protect vision through rapid ophthalmic assessment and reduces progressive retinal ischemia and permanent visual loss. Alternatives are weaker because they delay evaluation or do not address a posterior injury. Reassess frequently and communicate changes promptly; trauma physiology can evolve.

26. A — Chemical contact continues to damage ocular tissue until diluted and removed. This approach supports start irrigation while obtaining the substance information in parallel and reduces corneal damage and permanent visual loss. The alternatives are weaker because they waste time or may create a second chemical injury. Continue reassessment and escalate abnormalities promptly.

27. D — The optic nerve can be injured despite minimal external eye findings. Prioritize care that will protect the patient from further pressure and obtain urgent specialist assessment to limit irreversible optic nerve damage. Other options are less appropriate because they cannot explain abrupt profound vision loss. Reassess frequently and escalate changes promptly; trauma physiology can evolve.

28. D — The intervention is appropriate: Mandibular and floor-of-mouth injury can displace the tongue and obstruct ventilation. It supports the plan to prepare airway support while maintaining cervical precautions and reduces rapid airway obstruction and aspiration. Alternatives are weaker because they delay airway evaluation or introduce oral intake. Reassess frequently and communicate changes promptly; trauma physiology can evolve.

29. A — A skull-base defect may permit nasal instrumentation to enter injured structures. This approach supports use nonnasal methods and involve the trauma team and reduces intracranial placement, infection, and worsening bleeding. The alternatives are weaker because they protect the airway without traversing the suspected fracture. Continue reassessment and escalate abnormalities promptly.

30. B — Seizures threaten ventilation and safety, while forced objects and restraint cause harm. Prioritize care that will support breathing and prepare prescribed anticonvulsant treatment to limit hypoxemia, aspiration, and musculoskeletal injury. Other options are less appropriate because they can injure the patient or obstruct the airway. Reassess frequently and escalate changes promptly; trauma physiology can evolve.

31. C — New agitation can be an early sign of deteriorating oxygenation or intracranial injury. Act to identify and correct immediate physiologic threats before sedation, limiting masked deterioration and preventable secondary brain injury. Alternatives fail because they label or suppress a symptom without finding its cause. Reassess and escalate. This supports timely escalation if the patient's condition changes.

32. C — Arterial dissection or thrombosis can follow cervical trauma and cause stroke. This approach supports notify the trauma team and expedite the diagnostic pathway and reduces cerebral ischemia and completed stroke. The alternatives are weaker because they delay evaluation or do not address vascular injury. Continue reassessment and escalate abnormalities promptly.

33. A — High cervical injury can impair the muscles needed for effective ventilation and cough. Prioritize care that will support breathing while preserving spinal alignment to limit fatigue, secretion retention, and respiratory arrest. Other options are less appropriate because they delay respiratory care or risk spinal movement. Reassess frequently and escalate changes promptly; trauma physiology can evolve.

34. D — The intervention is appropriate: Anticoagulation can permit clinically important intracranial bleeding after a seemingly minor impact. It supports the plan to maintain a low threshold for reassessment and escalation and reduces delayed hemorrhage and missed neurologic deterioration. Alternatives are weaker because they create false reassurance or increase bleeding risk. Reassess frequently and communicate changes promptly; trauma physiology can evolve.

35. B — Routine hyperventilation can reduce cerebral blood flow and worsen ischemia. This approach supports titrate ventilation to oxygenation, perfusion, and the evolving neurologic picture and reduces secondary cerebral ischemia. The alternatives are weaker because they create hypoxemia or harmful changes in cerebral blood flow. Continue reassessment and escalate abnormalities promptly. This supports timely escalation if the patient's condition changes.

36. A — Increasing mass effect can displace the temporal lobe and compress nearby neural pathways. Prioritize care that will escalate immediately for intracranial pressure management and neurosurgical care to limit irreversible brainstem injury and death. Other options are less appropriate because they cannot explain the focal pupil and motor findings. Reassess frequently and escalate changes promptly; trauma physiology can evolve.

37. B — The intervention is appropriate: Pressure in the pleural space can rapidly impair ventilation and venous return. It supports the plan to relieve the obstruction according to trauma protocol and prepare definitive drainage and reduces cardiovascular collapse and cardiac arrest. Alternatives are weaker because they delay treatment of a clinical emergency. Reassess frequently and communicate changes promptly; trauma physiology can evolve.

38. C — The wound permits air entry while a vented seal limits further ingress. This approach supports cover the defect while reassessing for a developing tension pneumothorax and reduces worsening respiratory failure and obstructive shock. The alternatives are weaker because they either worsen contamination or restrict chest expansion. Continue reassessment and escalate abnormalities promptly.

39. D — Pain and unstable chest mechanics impair ventilation and secretion clearance. Prioritize care that will improve breathing mechanics while treating evolving respiratory failure to limit hypoxemia, atelectasis, and pneumonia. Other options are less appropriate because they restrict expansion or leave the underlying problem untreated. Reassess frequently and escalate changes promptly; trauma physiology can evolve.

40. C — The intervention is appropriate: Contused lung tissue can worsen as edema and hemorrhage evolve. It supports the plan to increase respiratory surveillance and notify the trauma team about deterioration and reduces delayed respiratory failure. Alternatives are weaker because they do not explain worsening gas exchange after chest impact. Reassess frequently and communicate changes promptly; trauma physiology can evolve.

41. A — Major hemothorax compromises ventilation and reflects substantial blood loss. This approach supports restore oxygenation and perfusion while arranging definitive hemorrhage control and reduces exsanguination and respiratory compromise. The alternatives are weaker because they delay resuscitation or cannot control intrathoracic bleeding. Continue reassessment and escalate abnormalities promptly. This supports timely escalation if the patient's condition changes.

42. B — Myocardial contusion can produce dysrhythmias without visible chest penetration. Prioritize care that will detect and treat rhythm changes while assessing perfusion to limit hemodynamic instability and sudden deterioration. Other options are less appropriate because they do not monitor the injured organ system. Reassess frequently and escalate changes promptly; trauma physiology can evolve.

43. D — The intervention is appropriate: Blood in the pericardial sac restricts cardiac filling and can cause obstructive shock. It supports the plan to restore cardiac filling through emergent trauma intervention and reduces cardiac arrest and irreversible shock. Alternatives are weaker because they do not relieve pericardial pressure. Reassess frequently and communicate changes promptly; trauma physiology can evolve.

44. A — Deceleration can injure the thoracic aorta before obvious shock appears. This approach supports limit physiologic stress and coordinate urgent vascular evaluation and reduces rupture, hemorrhage, and death. The alternatives are weaker because they create dangerous delay or add unnecessary force. Continue reassessment and escalate abnormalities promptly. This supports timely escalation if the patient's condition changes.

45. B — Great-vessel injury may be clinically subtle before rupture or malperfusion. Prioritize care that will maintain trauma precautions and complete the indicated vascular workup to limit catastrophic hemorrhage or organ ischemia. Other options are less appropriate because they do not fit the mechanism and pain pattern. Reassess frequently and escalate changes promptly; trauma physiology can evolve.

46. D — The intervention is appropriate: A major airway disruption can prevent lung re-expansion and drive air into tissues. It supports the plan to maintain oxygenation and arrange definitive airway evaluation and reduces progressive respiratory failure. Alternatives are weaker because they cannot explain the persistent air leak and emphysema. Reassess frequently and communicate changes promptly; trauma physiology can evolve.

47. C — Esophageal contamination can rapidly cause mediastinal infection and sepsis. This approach supports avoid oral intake and coordinate definitive diagnostic and surgical care and reduces mediastinitis, sepsis, and perforation extension. The alternatives are weaker because they increase contamination or delay source control. Continue reassessment and escalate abnormalities promptly. This supports timely escalation if the patient's condition changes.

48. B — A torn diaphragm permits abdominal organs to move into the chest. Prioritize care that will support ventilation and prepare for urgent surgical repair to limit respiratory compromise, strangulation, and missed abdominal injury. Other options are less appropriate because they do not explain the organ displacement after trauma. Reassess frequently and escalate changes promptly; trauma physiology can evolve.

49. A — The intervention is appropriate: Traumatic asphyxia reflects severe compression and may accompany occult chest injury. It supports the plan to stabilize breathing while completing a careful trauma assessment and reduces unrecognized airway, pulmonary, or cardiac injury. Alternatives are weaker because they minimize a potentially life-threatening mechanism. Reassess frequently and communicate changes promptly; trauma physiology can evolve.

50. C — Splenic bleeding can irritate the diaphragm and present with concealed shock. This approach supports escalate the trauma evaluation and prepare hemorrhage-control resources and reduces rapid exsanguination. The alternatives are weaker because they do not explain the mechanism and evolving perfusion change. Continue reassessment and escalate abnormalities promptly. This supports timely escalation if the patient's condition changes.

51. D — The liver is vascular and can bleed substantially after blunt impact. Prioritize care that will support circulation while arranging urgent imaging or operative hemorrhage control to limit shock and abdominal compartment complications. Other options are less appropriate because they do not account for progressive abdominal findings and shock. Reassess frequently and escalate changes promptly; trauma physiology can evolve.

52. A — The intervention is appropriate: Perforation releases gastrointestinal contents and produces peritonitis. It supports the plan to keep the patient NPO and arrange urgent source-control treatment and reduces sepsis, shock, and progressive tissue injury. Alternatives are weaker because they cannot explain free air and peritoneal signs. Reassess frequently and communicate changes promptly; trauma physiology can evolve.

53. C — A seatbelt sign can accompany bowel or mesenteric injury that declares itself later. This approach supports maintain observation and a low threshold for surgical reassessment and reduces delayed perforation, ischemia, and sepsis. The alternatives are weaker because they create false reassurance or add pressure and oral intake. Continue reassessment and escalate abnormalities promptly.

54. D — Retroperitoneal organs can be injured with limited early external findings. Prioritize care that will obtain targeted imaging and monitor for delayed inflammation or leakage to limit missed perforation, pancreatitis, and sepsis. Other options are less appropriate because they do not fit the mechanism or retroperitoneal findings. Reassess frequently and escalate changes promptly; trauma physiology can evolve.

55. B — The intervention is appropriate: Flank trauma and hematuria suggest injury to the kidney or urinary tract. It supports the plan to protect perfusion and coordinate urinary-tract evaluation and reduces ongoing hemorrhage, urinary extravasation, and renal loss. Alternatives are weaker because they delay evaluation or ignore the injured region. Reassess frequently and communicate changes promptly; trauma physiology can evolve.

56. B — Blood at the meatus suggests possible urethral disruption. This approach supports protect the injury and obtain appropriate imaging before instrumentation and reduces complete disruption and urinary extravasation. The alternatives are weaker because they can convert a partial injury into a complete one. Continue reassessment and escalate abnormalities promptly. This supports timely escalation if the patient's condition changes.

57. C — Correct binder placement reduces pelvic volume without worsening displacement. Prioritize care that will limit movement and coordinate blood-based resuscitation and definitive control to limit continued pelvic bleeding and shock. Other options are less appropriate because they can be ineffective or increase bleeding and instability. Reassess frequently and escalate changes promptly; trauma physiology can evolve.

58. D — The trochanters provide the correct level to reduce pelvic volume. Act to verify placement and avoid repeated manipulation of the unstable ring, limiting ineffective hemorrhage control and skin injury. Alternatives fail because they do not stabilize the pelvic ring at the intended level. Reassess and escalate. This supports timely escalation if the patient's condition changes.

59. A — Open pelvic wounds can communicate with deep bleeding and contamination. This approach supports protect the wound and coordinate multidisciplinary trauma management and reduces exsanguination, infection, and disruption of the pelvic ring. The alternatives are weaker because they increase bleeding or delay definitive care. Continue reassessment and escalate abnormalities promptly. This supports timely escalation if the patient's condition changes.

60. B — Pelvic displacement can injure nerves and vessels even when bleeding is not obvious. Prioritize care that will protect alignment and obtain immediate trauma specialist input to limit limb ischemia and permanent neurologic injury. Other options are less appropriate because they delay care or increase movement of the injured pelvis. Reassess frequently and escalate changes promptly; trauma physiology can evolve.

61. C — The intervention is appropriate: Pelvic trauma can injure the bladder and cause hematuria even without meatal blood. It supports the plan to coordinate bladder imaging and protect renal perfusion and reduces peritonitis, infection, and impaired urinary drainage. Alternatives are weaker because they do not explain urinary findings after pelvic injury. Reassess frequently and communicate changes promptly; trauma physiology can evolve.

62. A — Extraperitoneal bladder injuries are associated with pelvic fractures and require planned urinary management. This approach supports maintain drainage and coordinate urology-directed care and reduces infection, urinary leakage, and impaired healing. The alternatives are weaker because they can worsen injury or create false reassurance. Continue reassessment and escalate abnormalities promptly. This supports timely escalation if the patient's condition changes.

63. D — Increased intra-abdominal pressure impairs renal, respiratory, and cardiovascular function. Prioritize care that will measure pressure through the bladder and obtain urgent surgical evaluation to limit organ failure and cardiovascular collapse. Other options are less appropriate because they do not explain the linked respiratory, renal, and circulatory changes. Reassess frequently and escalate changes promptly; trauma physiology can evolve.

64. A — The intervention is appropriate: Exposed bowel must be protected from drying and additional mechanical injury. It supports the plan to prevent contamination and heat loss while preparing definitive surgical care and reduces ischemia, desiccation, and infection. Alternatives are weaker because they traumatize or dry the exposed organs. Reassess frequently and communicate changes promptly; trauma physiology can evolve.

65. D — The object may be tamponading major bleeding or attached to internal structures. This approach supports protect the patient from movement and expedite operative evaluation and reduces catastrophic hemorrhage and organ disruption. The alternatives are weaker because they can release tamponade or worsen tissue injury. Continue reassessment and escalate abnormalities promptly.

66. B — Protruding tissue indicates a penetrating abdominal injury that may involve deeper structures. Prioritize care that will protect the tissue and avoid bedside manipulation to limit hemorrhage, contamination, and organ injury. Other options are less appropriate because they disturb injured structures or force contamination inward. Reassess frequently and escalate changes promptly; trauma physiology can evolve.

67. C — The intervention is appropriate: Temporary pressure improvement does not prove that hemorrhage has stopped. It supports the plan to repeat the trauma assessment and pursue definitive bleeding control and reduces progressive shock and delayed recognition of blood loss. Alternatives are weaker because they mistake a transient response for recovery. Reassess frequently and communicate changes promptly; trauma physiology can evolve.

68. A — Stable vital signs do not exclude renal or retroperitoneal damage. This approach supports use appropriate imaging and serial examinations to detect occult injury and reduces delayed hemorrhage and renal complications. The alternatives are weaker because they create false reassurance or ignore the urinary tract. Continue reassessment and escalate abnormalities promptly.

69. C — Blunt trauma can rupture the testis or disrupt blood flow. Prioritize care that will protect the injury and obtain timely evaluation for tissue salvage to limit ischemia, rupture, and permanent loss of function. Other options are less appropriate because they can worsen injury or delay repair. Reassess frequently and escalate changes promptly; trauma physiology can evolve.

70. B — The intervention is appropriate: Force transmission can injure adjacent compartments and diaphragmatic structures. It supports the plan to repeat a complete trauma assessment when symptoms do not fit the first impression and reduces missed thoracic or abdominal injury. Alternatives are weaker because they anchor the team to one body region. Reassess frequently and communicate changes promptly; trauma physiology can evolve.

71. D — Acute deterioration can reflect recurrent tension, malposition, obstruction, or a new complication. This approach supports repeat the primary survey while troubleshooting the drainage system and reduces cardiovascular collapse and worsening respiratory failure. The alternatives are weaker because they may worsen pressure or remove needed drainage. Continue reassessment and escalate abnormalities promptly.

72. B — Continuous bubbling can indicate an ongoing air leak or system problem. Prioritize care that will maintain a functioning drainage system while locating the source to limit recurrent pneumothorax and respiratory compromise. Other options are less appropriate because they can obstruct drainage or contaminate the system. Reassess frequently and escalate changes promptly; trauma physiology can evolve.

73. D — The intervention is appropriate: Penetrating cardiac injury can cause obstructive or exsanguinating arrest that needs surgical control. It supports the plan to perform resuscitation while mobilizing the trauma operating team and reduces irreversible cardiac arrest. Alternatives are weaker because they cannot treat a surgically correctable traumatic cause. Reassess frequently and communicate changes promptly; trauma physiology can evolve.

74. C — Traumatic vessel disruption or dissection can reduce distal perfusion. This approach supports escalate urgently for vascular imaging and specialist intervention and reduces limb ischemia and embolic injury. The alternatives are weaker because they do not explain an objective pulse and temperature change. Continue reassessment and escalate abnormalities promptly. This supports timely escalation if the patient's condition changes.

75. A — Evolving perfusion changes can indicate bleeding or injury not visible early. Prioritize care that will reassess physiology and coordinate repeat imaging or operative review to limit delayed shock, ischemia, and perforation. Other options are less appropriate because they suppress warning signs or rely on an incomplete snapshot. Reassess frequently and escalate changes promptly; trauma physiology can evolve.

76. D — Diaphragm disruption may be subtle initially and can allow organs to enter the chest. Act to support ventilation and arrange definitive thoracoabdominal evaluation, limiting strangulation, respiratory compromise, and delayed obstruction. Alternatives fail because they do not explain the mechanism and abnormal diaphragm. Reassess and escalate. This supports timely escalation if the patient's condition changes.

77. B — Ongoing shock despite initial measures suggests bleeding beyond the binder's control. This approach supports escalate to trauma, interventional, or operative hemorrhage-control resources and reduces exsanguination and organ ischemia. The alternatives are weaker because they do not account for refractory shock after major pelvic trauma. Continue reassessment and escalate abnormalities promptly.

78. A — Bowel and mesenteric injuries may develop delayed ischemia without early free air. Prioritize care that will continue serial examination and involve the trauma surgeon early to limit delayed necrosis, perforation, and sepsis. Other options are less appropriate because they ignore the mechanism and worsening perfusion signal. Reassess frequently and escalate changes promptly; trauma physiology can evolve.

79. C — The trajectory can cross the diaphragm and injure thoracic or abdominal organs. Act to maintain a broad trauma evaluation despite initially stable vital signs, limiting missed cardiac, diaphragmatic, or abdominal injury. Alternatives fail because they anchor assessment to one region or delay diagnosis. Reassess and escalate. This supports timely escalation if the patient's condition changes.

80. B — Bladder injury can occur without visible meatal blood and may impair drainage. This approach supports obtain appropriate urinary evaluation before inserting a catheter and reduces urinary extravasation, infection, and worsening renal function. The alternatives are weaker because they do not explain acute urinary symptoms after pelvic injury. Continue reassessment and escalate abnormalities promptly.

81. D — Pressure threatens muscle and nerve perfusion before pulses disappear. Prioritize care that will remove external constriction when ordered and prepare for fasciotomy to limit ischemia, contracture, and permanent neurologic loss. Other options are less appropriate because they delay decompression or may worsen tissue pressure. Reassess frequently and escalate changes promptly; trauma physiology can evolve.

82. C — The intervention is appropriate: Early compartment ischemia produces severe pressure-related pain and stretch pain. It supports the plan to escalate before late vascular signs develop and reduces irreversible muscle and nerve injury. Alternatives are weaker because they are nonspecific or falsely reassuring. Reassess frequently and communicate changes promptly; trauma physiology can evolve.

83. A — Damaged muscle releases myoglobin and intracellular electrolytes into circulation. This approach supports monitor cardiac rhythm, renal function, urine output, and prescribed fluid response and reduces dysrhythmia and renal failure. The alternatives are weaker because they cannot explain dark urine and systemic risk after crush injury. Continue reassessment and escalate abnormalities promptly.

84. C — Cool protected tissue may remain eligible for replantation while direct ice and chemicals cause injury. Act to label and transport the part with the patient for specialist evaluation, limiting tissue freezing, contamination, and loss of replantation options. Alternatives fail because they damage tissue or discard potentially useful information. Reassess and escalate.

85. B — The intervention is appropriate: Open fractures are contaminated and require protection, antimicrobial care, and surgical planning. It supports the plan to preserve alignment and coordinate urgent orthopedic treatment and reduces infection, tissue loss, and compartment complications. Alternatives are weaker because they increase contamination or injure exposed tissue. Reassess frequently and communicate changes promptly; trauma physiology can evolve.

86. A — Femur fractures can bleed substantially and threaten alignment and perfusion. This approach supports stabilize the limb according to protocol and monitor for shock and reduces additional displacement, hemorrhage, and neurovascular injury. The alternatives are weaker because they increase movement or delay protection. Continue reassessment and escalate abnormalities promptly. This supports timely escalation if the patient's condition changes.

87. D — Traction can reduce femoral shortening but may worsen injuries outside the isolated shaft. Prioritize care that will confirm indications and contraindications before applying the device to limit bleeding, displacement, and additional neurovascular injury. Other options are less appropriate because they ignore contraindications or apply the device indiscriminately. Reassess frequently and escalate changes promptly; trauma physiology can evolve.

88. C — The intervention is appropriate: Fat droplets can trigger pulmonary and neurologic dysfunction after marrow injury. It supports the plan to support oxygenation and escalate for critical-care management and reduces progressive respiratory failure and neurologic injury. Alternatives are weaker because they do not explain the combined pulmonary, neurologic, and skin findings. Reassess frequently and communicate changes promptly; trauma physiology can evolve.

89. A — Dislocation can compress or tear a vessel, making ischemia time-sensitive. This approach supports protect the joint and expedite reduction with neurovascular support and reduces limb loss and permanent nerve injury. The alternatives are weaker because they delay restoration of perfusion or increase tissue damage. Continue reassessment and escalate abnormalities promptly.

90. B — Collateral circulation can preserve a pulse despite a significant arterial injury. Prioritize care that will maintain immobilization and complete serial vascular evaluation to limit delayed limb ischemia. Other options are less appropriate because they rely on a single reassuring finding. Reassess frequently and escalate changes promptly; trauma physiology can evolve.

91. D — The intervention is appropriate: Avulsed tissue may remain useful and must be protected from desiccation and contamination. It supports the plan to preserve tissue while arranging reconstructive and vascular assessment and reduces necrosis, infection, and loss of coverage. Alternatives are weaker because they destroy or further injure potentially viable tissue. Reassess frequently and communicate changes promptly; trauma physiology can evolve.

92. B — The object may involve tendons, nerves, vessels, or bone and may tamponade bleeding. This approach supports prevent movement and coordinate specialist evaluation and reduces hemorrhage, tendon damage, and loss of function. The alternatives are weaker because they can enlarge the injury or release tamponade. Continue reassessment and escalate abnormalities promptly.

93. C — Devitalized contaminated tissue increases infection risk and may not be ready for primary closure. Prioritize care that will remove contamination while preserving viable tissue and reassessing the wound to limit deep infection and wound breakdown. Other options are less appropriate because they trap contamination or prevent adequate assessment. Reassess frequently and escalate changes promptly; trauma physiology can evolve.

94. D — Rapid severe pain and toxicity can reflect deep tissue destruction that antibiotics alone cannot control. Act to activate urgent surgical assessment and broad supportive care, limiting sepsis, shock, and tissue loss. Alternatives fail because they delay source control during a time-sensitive infection. Reassess and escalate. This supports timely escalation if the patient's condition changes.

95. A — New ischemia after immobilization may reflect compression, displacement, or vascular injury. This approach supports protect alignment while correcting reversible external pressure and seeking urgent evaluation and reduces limb loss and permanent nerve damage. The alternatives are weaker because they add pressure or delay recognition of ischemia. Continue reassessment and escalate abnormalities promptly.

96. B — Older adults and anticoagulated patients may have occult or delayed intracranial bleeding. Prioritize care that will maintain a low threshold for imaging, observation, and escalation to limit missed hemorrhage and delayed neurologic deterioration. Other options are less appropriate because they create false reassurance or increase bleeding risk. Reassess frequently and escalate changes promptly; trauma physiology can evolve.

97. C — The intervention is appropriate: Older adults may have limited physiologic reserve and a blunted vital-sign response. It supports the plan to use trends and perfusion findings to search for occult injury and reduces delayed recognition of hemorrhage and organ dysfunction. Alternatives are weaker because they dismiss clinically important changes. Reassess frequently and communicate changes promptly; trauma physiology can evolve.

98. D — Aging skin tears easily and tolerates pressure and shear poorly. This approach supports combine safe handling with frequent inspection and repositioning and reduces skin tears, pressure injury, and delayed healing. The alternatives are weaker because they create friction, adhesive trauma, or unrecognized pressure. Continue reassessment and escalate abnormalities promptly. This supports timely escalation if the patient's condition changes.

99. C — Acute fluctuating inattention is more consistent with delirium than a fixed baseline deficit. Prioritize care that will assess oxygenation, pain, infection, medications, and metabolic problems to limit falls, missed deterioration, and prolonged cognitive impairment. Other options are less appropriate because they label or suppress the problem without identifying its cause. Reassess frequently and escalate changes promptly; trauma physiology can evolve.

100. A — The intervention is appropriate: Small airways can narrow quickly when edema develops after thermal or inhalation injury. It supports the plan to prepare a controlled airway and involve pediatric expertise early and reduces complete obstruction and difficult rescue ventilation. Alternatives are weaker because they delay intervention or introduce aspiration risk. Reassess frequently and communicate changes promptly; trauma physiology can evolve.

101. B — Children can maintain pressure until significant compensation is exhausted. This approach supports use perfusion and behavior trends to trigger rapid trauma evaluation and reduces sudden cardiovascular collapse. The alternatives are weaker because they rely on late or unreliable reassuring signs. Continue reassessment and escalate abnormalities promptly. This supports timely escalation if the patient's condition changes.

102. A — Pediatric anatomy changes alignment and increases the importance of correct device fit. Prioritize care that will adapt immobilization to the child while monitoring ventilation to limit cord injury, pressure injury, and airway compromise. Other options are less appropriate because they can create malalignment or remove protection. Reassess frequently and escalate changes promptly; trauma physiology can evolve.

103. D — Self-report is the preferred source when a child can understand and communicate pain. Act to combine the child's report with examination and behavioral observations, limiting undertreatment, distress, and impaired recovery. Alternatives fail because they ignore the child's experience or use an unsuitable tool. Reassess and escalate. This supports timely escalation if the patient's condition changes.

104. D — Children lose heat quickly, and hypothermia worsens coagulopathy and physiologic stress. This approach supports preserve temperature during resuscitation without delaying hemorrhage control and reduces worsening shock and impaired coagulation. The alternatives are weaker because they increase heat loss or add unnecessary cold. Continue reassessment and escalate abnormalities promptly. This supports timely escalation if the patient's condition changes.

105. C — Inconsistent history and patterned injuries require protection, objective documentation, and safeguarding. Prioritize care that will separate safety assessment from accusation and activate the required process to limit repeated harm, evidence loss, and unsafe discharge. Other options are less appropriate because they are unsafe, nonobjective, or interfere with protection. Reassess frequently and escalate changes promptly; trauma physiology can evolve.

106. A — The intervention is appropriate: Maternal oxygenation and perfusion are essential to fetal survival and guide immediate care. It supports the plan to perform a trauma assessment while coordinating obstetric evaluation and reduces maternal collapse and fetal compromise. Alternatives are weaker because they delay life-saving maternal interventions or create false reassurance. Reassess frequently and communicate changes promptly; trauma physiology can evolve.

107. B — The gravid uterus can reduce venous return when it compresses major abdominal vessels. This approach supports improve maternal circulation without abandoning spinal and trauma precautions and reduces refractory hypotension and reduced uteroplacental perfusion. The alternatives are weaker because they worsen compression or delay circulation support. Continue reassessment and escalate abnormalities promptly.

108. D — Placental and uterine complications may evolve after maternal stabilization. Prioritize care that will continue maternal reassessment while observing for contractions, bleeding, or fetal change to limit occult placental injury and fetal compromise. Other options are less appropriate because they ignore pregnancy-specific deterioration. Reassess frequently and escalate changes promptly; trauma physiology can evolve.

109. C — The intervention is appropriate: Abruption can present with concealed bleeding and uterine irritability or tenderness. It supports the plan to escalate obstetric evaluation while supporting maternal perfusion and reduces maternal hemorrhage and fetal compromise. Alternatives are weaker because they do not explain the uterine findings after trauma. Reassess frequently and communicate changes promptly; trauma physiology can evolve.

110. A — Trauma can expose an Rh-negative patient to fetal red cells and requires obstetric management. This approach supports verify blood type and coordinate timely pregnancy-specific prophylaxis and reduces alloimmunization and later pregnancy complications. The alternatives are weaker because they ignore a preventable pregnancy-related risk. Continue reassessment and escalate abnormalities promptly. This supports timely escalation if the patient's condition changes.

111. D — Proper restraint placement protects both the patient and fetus while limiting abdominal compression. Prioritize care that will continue pregnancy-appropriate positioning and assess for injury to limit direct uterine trauma and ineffective restraint protection. Other options are less appropriate because they increase abdominal force or fail to secure the torso. Reassess frequently and escalate changes promptly; trauma physiology can evolve.

112. B — The intervention is appropriate: Soot, sputum, and hoarseness suggest inhalation injury with progressive edema. It supports the plan to secure a controlled airway while oxygenation remains possible and reduces failed rescue airway and respiratory arrest. Alternatives are weaker because they delay or fail to protect a threatened airway. Reassess frequently and communicate changes promptly; trauma physiology can evolve.

113. C — Dry material can continue reacting and may spread to rescuers or additional skin. This approach supports protect staff, remove the source, and then irrigate according to protocol and reduces continued tissue injury and secondary contamination. The alternatives are weaker because they spread or trap the chemical. Continue reassessment and escalate abnormalities promptly.

114. B — Electrical energy can disrupt cardiac rhythm and damage tissue along its internal path. Prioritize care that will monitor the heart and assess the complete injury pathway to limit dysrhythmia, rhabdomyolysis, and hidden tissue necrosis. Other options are less appropriate because they rely on superficial appearance or delay monitoring. Reassess frequently and escalate changes promptly; trauma physiology can evolve.

115. A — The intervention is appropriate: Inelastic burned tissue can restrict chest excursion as edema develops. It supports the plan to notify the burn team and support ventilation while preparing release and reduces progressive hypoventilation and respiratory failure. Alternatives are weaker because they increase restriction or do not restore chest movement. Reassess frequently and communicate changes promptly; trauma physiology can evolve.

116. B — Inelastic eschar can impair distal circulation as swelling increases. This approach supports protect perfusion and obtain immediate burn-surgical assessment and reduces ischemia, nerve injury, and limb loss. The alternatives are weaker because they add pressure, delay release, or cause cold injury. Continue reassessment and escalate abnormalities promptly. This supports timely escalation if the patient's condition changes.

117. A — Safe bariatric handling requires equipment and staffing matched to the patient's size and condition. Prioritize care that will protect the patient and team while maintaining trauma alignment to limit falls, staff injury, skin shear, and device failure. Other options are less appropriate because they are unsafe or delay necessary care. Reassess frequently and escalate changes promptly; trauma physiology can evolve.

118. C — The intervention is appropriate: Body habitus and supine positioning can worsen airway collapse and hypoventilation. It supports the plan to optimize position and monitor ventilation throughout care and reduces occult hypoxemia, aspiration, and respiratory failure. Alternatives are weaker because they ignore a high-risk respiratory pattern. Reassess frequently and communicate changes promptly; trauma physiology can evolve.

119. D — Private, nonjudgmental assessment supports safety planning and preserves trust. This approach supports offer resources and document objectively while following applicable requirements and reduces retaliation, repeated injury, and unsafe discharge. The alternatives are weaker because they increase danger or make promises the nurse cannot keep. Continue reassessment and escalate abnormalities promptly.

120. B — Control of communication and documents can signal exploitation or trafficking. Prioritize care that will protect privacy and coordinate social work, security, and safeguarding resources to limit continued coercion and unsafe discharge. Other options are less appropriate because they reinforce control or escalate danger without assessment. Reassess frequently and escalate changes promptly; trauma physiology can evolve.

121. C — Substance use history changes monitoring and planning but does not eliminate the need for analgesia. Act to treat pain while evaluating tolerance, withdrawal, respiratory risk, and injury, limiting undertreatment, stigma, respiratory depression, and missed injury. Alternatives fail because they deny care or increase sedation risk. Reassess and escalate. This supports timely escalation if the patient's condition changes.

122. D — Uncontrolled external bleeding can cause rapid preventable death. This approach supports apply direct pressure or a tourniquet according to protocol and reassess perfusion and reduces exsanguination and shock. The alternatives are weaker because they delay a time-critical life-saving intervention. Continue reassessment and escalate abnormalities promptly. This supports timely escalation if the patient's condition changes.

123. A — Airway obstruction is immediately life-threatening, but spinal movement can worsen injury. Prioritize care that will coordinate airway support with manual stabilization and appropriate equipment to limit hypoxemia, aspiration, and secondary cord injury. Other options are less appropriate because they delay oxygenation or sacrifice spinal protection. Reassess frequently and escalate changes promptly; trauma physiology can evolve.

124. A — The intervention is appropriate: The secondary survey is comprehensive but cannot replace immediate resuscitation. It supports the plan to complete the history and systematic examination after primary threats are managed and reduces missed airway, breathing, or circulation emergencies. Alternatives are weaker because they reverse trauma priorities. Reassess frequently and communicate changes promptly; trauma physiology can evolve.

125. D — Coordinated communication prevents duplication and identifies worsening coagulopathy or shock. This approach supports use closed-loop communication and maintain a shared resuscitation picture and reduces delays, product errors, and unrecognized deterioration. The alternatives are weaker because they fragment care or remove essential trend information. Continue reassessment and escalate abnormalities promptly. This supports timely escalation if the patient's condition changes.

126. C — Antifibrinolytic therapy can support clot stability when used in an appropriate hemorrhage pathway. Prioritize care that will pair protocol-directed medication with blood resuscitation and source control to limit continued bleeding and worsening coagulopathy. Other options are less appropriate because they delay hemostasis or oppose clot preservation. Reassess frequently and escalate changes promptly; trauma physiology can evolve.

127. B — The intervention is appropriate: Hypothermia, acidosis, coagulopathy, and hypocalcemia reinforce one another during shock. It supports the plan to warm the patient and products and correct metabolic problems as ordered and reduces refractory bleeding and cardiovascular collapse. Alternatives are weaker because they worsen or ignore the interacting physiologic problems. Reassess frequently and communicate changes promptly; trauma physiology can evolve.

128. D — Excess crystalloid can worsen dilution, edema, and coagulopathy before bleeding is controlled. This approach supports support perfusion while moving rapidly toward definitive source control and reduces continued bleeding, hypothermia, and dilutional coagulopathy. The alternatives are weaker because they delay blood replacement or encourage harmful fluid loading. Continue reassessment and escalate abnormalities promptly.

129. A — Preoxygenation and hemodynamic preparation reduce peri-intubation hypoxemia and collapse. Prioritize care that will anticipate difficulty and maintain a clear rescue plan to limit secondary brain injury and failed airway management. Other options are less appropriate because they increase physiologic stress or remove safety measures. Reassess frequently and escalate changes promptly; trauma physiology can evolve.

130. C — The intervention is appropriate: The findings suggest a serious transfusion reaction requiring immediate interruption. It supports the plan to protect the patient and preserve the product and tubing for investigation and reduces hemolysis, renal injury, and shock. Alternatives are weaker because they continue exposure or destroy important evidence. Reassess frequently and communicate changes promptly; trauma physiology can evolve.

131. B — The combination reflects reduced circulating volume and inadequate tissue perfusion. This approach supports control bleeding and support circulation while searching for the source and reduces progressive organ ischemia and cardiovascular collapse. The alternatives are weaker because they do not fit the mechanism and perfusion pattern. Continue reassessment and escalate abnormalities promptly.

132. D — Tension physiology obstructs venous return and ventilation. Prioritize care that will decompress the chest according to protocol and prepare definitive drainage to limit cardiovascular collapse and respiratory arrest. Other options are less appropriate because they do not relieve the obstruction. Reassess frequently and escalate changes promptly; trauma physiology can evolve.

133. C — The intervention is appropriate: Loss of sympathetic tone can cause vasodilation and relative bradycardia. It supports the plan to support circulation and continue searching for concealed bleeding or other causes and reduces cord ischemia and missed hemorrhage. Alternatives are weaker because they ignore spinal physiology or remove protection. Reassess frequently and communicate changes promptly; trauma physiology can evolve.

134. A — Infection can produce distributive shock and progressive organ dysfunction. This approach supports start the sepsis pathway while identifying and controlling the source and reduces irreversible organ failure and death. The alternatives are weaker because they delay antimicrobial care or treat only a symptom. Continue reassessment and escalate abnormalities promptly. This supports timely escalation if the patient's condition changes.

135. B — Cardiac injury can reduce pump performance and cause congestion and dysrhythmia. Prioritize care that will support oxygenation and perfusion while coordinating cardiac evaluation to limit low cardiac output and cardiac arrest. Other options are less appropriate because they do not explain congestion with rhythm disturbance after chest trauma. Reassess frequently and escalate changes promptly; trauma physiology can evolve.

136. C — The intervention is appropriate: A transient pressure response can mask continuing blood loss. It supports the plan to repeat the primary survey and pursue definitive hemorrhage control and reduces progressive shock and delayed intervention. Alternatives are weaker because they mistake temporary compensation for recovery. Reassess frequently and communicate changes promptly; trauma physiology can evolve.

137. B — Trauma interventions can create complications or fail to correct the original threat. This approach supports reassess airway, breathing, circulation, disability, and exposure after treatment and reduces missed deterioration and ineffective intervention. The alternatives are weaker because they do not confirm response or detect new life threats. Continue reassessment and escalate abnormalities promptly.

138. D — TRALI causes acute noncardiogenic pulmonary edema after transfusion. Prioritize care that will stop the transfusion and provide respiratory support while notifying the team to limit severe hypoxemia and respiratory failure. Other options are less appropriate because they do not explain the timing and bilateral lung findings. Reassess frequently and escalate changes promptly; trauma physiology can evolve.

139. A — Excess intravascular volume produces hydrostatic pulmonary edema and venous congestion. Act to stop or slow the transfusion as directed and support cardiac and respiratory status, limiting worsening pulmonary edema and cardiac strain. Alternatives fail because they do not fit the volume-overload pattern. Reassess and escalate. This supports timely escalation if the patient's condition changes.

140. B — Injuries become apparent after resuscitation, analgesia, and improved communication. This approach supports repeat the examination and review new symptoms, tests, and consultant findings and reduces delayed diagnosis and preventable complications. The alternatives are weaker because they narrow assessment or confuse tertiary review with discharge. Continue reassessment and escalate abnormalities promptly.

141. A — Acute fluctuating inattention suggests delirium and often has reversible contributors. Prioritize care that will assess oxygenation, infection, pain, medications, sleep, and metabolic changes to limit falls, self-harm, and missed physiologic deterioration. Other options are less appropriate because they stigmatize or suppress the symptom without finding the cause. Reassess frequently and escalate changes promptly; trauma physiology can evolve.

142. D — The intervention is appropriate: ARDS requires support that limits ventilator-induced injury while improving gas exchange. It supports the plan to titrate ventilation with the critical-care team and treat the underlying cause and reduces barotrauma and worsening hypoxemia. Alternatives are weaker because they increase injury or fail to support oxygenation. Reassess frequently and communicate changes promptly; trauma physiology can evolve.

143. C — Ischemic acute kidney injury may develop after shock and requires careful trend assessment. This approach supports coordinate fluid, medication, and renal-management decisions with the team and reduces progressive kidney failure and fluid or electrolyte complications. The alternatives are weaker because they ignore trends or create new treatment hazards. Continue reassessment and escalate abnormalities promptly.

144. A — Bundle elements reduce aspiration, secretion colonization, and unnecessary ventilator exposure. Prioritize care that will combine infection prevention with daily assessment for liberation to limit pneumonia, longer ventilation, and critical illness. Other options are less appropriate because they increase aspiration or prolong exposure. Reassess frequently and escalate changes promptly; trauma physiology can evolve.

145. B — The intervention is appropriate: Line manipulation and unnecessary duration increase opportunities for bloodstream infection. It supports the plan to use the bundle consistently and review line necessity each day and reduces sepsis and prolonged hospitalization. Alternatives are weaker because they introduce contamination or preserve avoidable risk. Reassess frequently and communicate changes promptly; trauma physiology can evolve.

146. C — Closed drainage and limited duration reduce ascending contamination. This approach supports use alternatives to indwelling drainage whenever clinically appropriate and reduces urinary infection, sepsis, and delayed recovery. The alternatives are weaker because they break the system or extend unnecessary exposure. Continue reassessment and escalate abnormalities promptly. This supports timely escalation if the patient's condition changes.

147. D — Infected surgical wounds can progress to systemic shock and organ dysfunction. Prioritize care that will recognize the source and coordinate prompt treatment and surgical review to limit septic shock and wound breakdown. Other options are less appropriate because they delay source control or hide clinically important data. Reassess frequently and escalate changes promptly; trauma physiology can evolve.

148. C — The intervention is appropriate: Predictability and control can reduce re-traumatization and improve cooperation. It supports the plan to build trust while completing necessary care safely and reduces distress, refusal, and loss of therapeutic rapport. Alternatives are weaker because they remove control or shame the patient. Reassess frequently and communicate changes promptly; trauma physiology can evolve.

149. B — Families need timely information that is accurate, private, and proportionate to the situation. This approach supports use an interpreter when needed and explain what is known and unknown and reduces misunderstanding, loss of trust, and privacy breaches. The alternatives are weaker because they create false hope, expose information, or abandon communication. Continue reassessment and escalate abnormalities promptly.

150. A — Early distress deserves validation, safety assessment, and connection to ongoing support. Prioritize care that will provide compassionate screening without diagnosing beyond the available assessment to limit worsening anxiety, depression, or impaired recovery. Other options are less appropriate because they dismiss symptoms or apply an unsupported label. Reassess frequently and escalate changes promptly; trauma physiology can evolve.

151. D — The intervention is appropriate: Physical therapy targets movement and functional mobility after injury. It supports the plan to coordinate graded activity with precautions and pain control and reduces deconditioning, falls, and loss of independence. Alternatives are weaker because they do not address physical mobility goals. Reassess frequently and communicate changes promptly; trauma physiology can evolve.

152. B — Occupational therapy focuses on meaningful daily function and adaptive strategies. This approach supports evaluate self-care, cognition, equipment, and home demands and reduces unsafe discharge and prolonged dependence. The alternatives are weaker because they fall outside occupational therapy's functional role. Continue reassessment and escalate abnormalities promptly. This supports timely escalation if the patient's condition changes.

153. A — Coughing and wet voice may signal aspiration or impaired oropharyngeal control. Prioritize care that will hold unsafe intake and coordinate a swallowing assessment to limit aspiration pneumonia and inadequate nutrition. Other options are less appropriate because they delay evaluation or address the wrong system. Reassess frequently and escalate changes promptly; trauma physiology can evolve.

154. D — Timely referral allows trained specialists to evaluate donation without placing that role on the bedside nurse. Act to continue appropriate treatment and follow the referral process, limiting loss of donation opportunity and distress for the family. Alternatives fail because they exceed the nurse's role or stop care prematurely. Reassess and escalate.

155. C — An advance directive communicates the patient's values when capacity is lost. This approach supports verify the document and involve the appropriate decision-makers and clinicians and reduces care that conflicts with the patient's expressed wishes. The alternatives are weaker because they disregard autonomy or assign authority incorrectly. Continue reassessment and escalate abnormalities promptly.

156. A — Family presence can be supported when safe and structured without disrupting care. Prioritize care that will set clear expectations and provide a calm communication role to limit interference, distress, and misunderstanding. Other options are less appropriate because they either create unsafe access or impose an unnecessary blanket rule. Reassess frequently and escalate changes promptly; trauma physiology can evolve.

157. B — Palliative care addresses symptoms, communication, and goals at any stage of serious illness. Act to coordinate comfort and decision support with ongoing trauma treatment, limiting uncontrolled symptoms and care that does not match patient goals. Alternatives fail because they create a false either-or choice or delay relief. Reassess and escalate.

158. D — Brain death is a formal medical determination requiring standardized assessment. This approach supports support the patient and family while the qualified team completes the process and reduces misdiagnosis, conflict, and inappropriate withdrawal decisions. The alternatives are weaker because they confuse diagnoses or assign authority improperly. Continue reassessment and escalate abnormalities promptly.

159. C — Data-driven prevention addresses the actual mechanism and population at risk. Prioritize care that will partner with community groups and evaluate whether injuries decrease to limit continued preventable injury and ineffective resource use. Other options are less appropriate because they are not targeted or measurable. Reassess frequently and escalate changes promptly; trauma physiology can evolve.

160. D — The intervention is appropriate: Prehospital context and response to interventions shape immediate trauma decisions. It supports the plan to use a structured handoff and invite clarification of high-risk findings and reduces duplicated care, missed injury, and delayed escalation. Alternatives are weaker because airway, bleeding, vitals, medications, procedures, response, and mechanism. Reassess frequently and communicate changes promptly; trauma physiology can evolve.

161. C — Intrafacility movement can expose a patient to interruption of support and delayed rescue. This approach supports maintain treatment continuity and clear responsibility throughout the transfer and reduces cardiorespiratory deterioration away from immediate resources. The alternatives are weaker because they remove monitoring or create unclear accountability. Continue reassessment and escalate abnormalities promptly.

162. A — Safe interfacility transfer requires receiving coordination and continuity of critical care. Prioritize care that will communicate risks, interventions, and contingency needs before departure to limit treatment interruption and deterioration during transport. Other options are less appropriate because they create an unaccepted or poorly supported transfer. Reassess frequently and escalate changes promptly; trauma physiology can evolve.

163. B — The intervention is appropriate: Clear tailored education reduces preventable complications after discharge. It supports the plan to use teach-back and address transportation, equipment, and caregiver barriers and reduces readmission, wound problems, and unsafe recovery. Alternatives are weaker because they do not verify understanding or readiness. Reassess frequently and communicate changes promptly; trauma physiology can evolve.

164. A — Disaster triage seeks the greatest achievable benefit from limited resources. This approach supports apply the incident command system and reassess priorities as conditions change and reduces unnecessary deaths and inefficient use of critical resources. The alternatives are weaker because they ignore survivability, resources, or dynamic reassessment. Continue reassessment and escalate abnormalities promptly.

165. B — Decontamination protects staff, other patients, and the facility from secondary exposure. Prioritize care that will follow the facility's hazardous-materials pathway while continuing clinical surveillance to limit secondary contamination and delayed treatment. Other options are less appropriate because they spread exposure or ignore responder safety. Reassess frequently and escalate changes promptly; trauma physiology can evolve.

166. D — The intervention is appropriate: Undertriage represents missed recognition of patients needing higher-level trauma resources. It supports the plan to use registry and referral data to target a measurable system change and reduces delayed definitive care and preventable morbidity. Alternatives are weaker because they ignore learning opportunities or act without evidence. Reassess frequently and communicate changes promptly; trauma physiology can evolve.

167. C — Structured registry data reveal patterns that support trauma-system evaluation. This approach supports protect data quality and use findings in performance-improvement work and reduces missed trends and ineffective interventions. The alternatives are weaker because they confuse registry functions with documentation, discipline, or billing. Continue reassessment and escalate abnormalities promptly. This supports timely escalation if the patient's condition changes.

168. C — Evidence-based care combines external evidence with expertise, patient needs, and context. Prioritize care that will appraise the evidence and measure implementation and patient outcomes to limit ineffective or unsafe practice adoption. Other options are less appropriate because they rely on preference or anecdote rather than a balanced appraisal. Reassess frequently and escalate changes promptly; trauma physiology can evolve.

169. B — The intervention is appropriate: Effective debriefing examines teamwork and system factors without scapegoating. It supports the plan to invite participation, identify strengths and gaps, and assign follow-up actions and reduces repeated errors, moral distress, and loss of team trust. Alternatives are weaker because they suppress learning or create blame. Reassess frequently and communicate changes promptly; trauma physiology can evolve.

170. D — SBAR organizes information around the immediate concern and the action needed. This approach supports use concise closed-loop communication and confirm the receiver's understanding and reduces omitted risks, duplication, and delayed intervention. The alternatives are weaker because they lack prioritization or a clear request. Continue reassessment and escalate abnormalities promptly. This supports timely escalation if the patient's condition changes.

171. A — Near misses reveal hazards before harm and support system-level prevention. Prioritize care that will preserve an objective record and participate in a fair review to limit repeated errors and lost safety data. Other options are less appropriate because they suppress learning, compromise records, or create blame. Reassess frequently and escalate changes promptly; trauma physiology can evolve.

172. A — Secure treatment communication supports continuity while reducing inappropriate exposure of protected information. Act to verify the recipient and use approved systems for the handoff, limiting privacy breach, treatment delay, and loss of trust. Alternatives fail because they expose information or obstruct necessary care. Reassess and escalate. This supports timely escalation if the patient's condition changes.

173. C — EMTALA requires screening when examination or treatment for an emergency condition is requested. Act to continue stabilizing treatment and arrange an appropriate transfer when the hospital cannot stabilize within its capability, limiting delayed stabilization and unlawful denial of emergency access. Alternatives fail because they condition care on payment or bypass required evaluation. Reassess and escalate.

174. D — Immediate safety and access to help take priority during a threat. Prioritize care that will use trained de-escalation when safe and follow the facility response plan to limit injury to staff, patients, or the visitor. Other options are less appropriate because they increase confrontation or leave the team unsupported. Reassess frequently and escalate changes promptly; trauma physiology can evolve.

175. B — The intervention is appropriate: Accurate capability information and local data improve prevention and destination decisions. It supports the plan to partner with EMS, referring facilities, and community groups using measurable goals and reduces inappropriate transfers and preventable injuries. Alternatives are weaker because they misrepresent resources or omit essential partners. Reassess frequently and communicate changes promptly; trauma physiology can evolve.