

PRACTICE EXAM 10: TRAUMA CERTIFIED REGISTERED NURSE SIMULATION (175 QUESTIONS)

This practice exam contains 175 original multiple-choice questions with four options each. It is aligned to the BCEN TCRN examination content outline effective November 2025. The current BCEN examination seat time is 180 minutes; passing standards are form-specific and established through Angoff and statistical-equating procedures. Select the single best answer for each question. This independent study material is not affiliated with or endorsed by BCEN.

1. A patient taking apixaban falls and develops a worsening unilateral headache with new arm weakness. Which action is the priority?

- A. Offer oral fluids and observe for several hours
- B. Perform a lumbar puncture before contacting the team
- C. Activate rapid brain imaging and trauma-neurosurgical evaluation
- D. Apply a warm compress and repeat the examination later

2. A patient with a Glasgow Coma Scale score of 7 has gurgling respirations after a motorcycle crash. Which intervention should occur first?

- A. Suction the airway and support oxygenation with cervical stabilization
- B. Wait for a family member to describe the patient's baseline
- C. Give oral medication to prevent agitation
- D. Place the patient flat without airway support

3. After a head injury, a patient has a brief seizure followed by persistent confusion. What is the best initial nursing response?

- A. Restrain the extremities to prevent another seizure
- B. Protect the airway, assess glucose, and escalate for neurologic evaluation

- C. Give food and water when the shaking stops
- D. Leave the patient alone to sleep off the confusion

4. A patient has a mean arterial pressure of 84 mmHg and an intracranial pressure of 22 mmHg. What is the cerebral perfusion pressure?

- A. 50 mmHg
- B. 62 mmHg
- C. 84 mmHg
- D. 106 mmHg

5. A patient with a suspected cervical spine injury reports tingling in both hands after extrication. Which nursing action is safest?

- A. Maintain neutral alignment and perform repeated motor and sensory checks
- B. Remove the collar to test active neck range of motion
- C. Ask the patient to walk to identify the painful area
- D. Flex the neck forward to improve venous drainage

6. An older adult has arm weakness greater than leg weakness after a hyperextension neck injury. Which condition should the nurse suspect?

- A. Complete cauda equina syndrome
- B. Isolated lumbar radiculopathy
- C. Central cord syndrome
- D. Uncomplicated peripheral neuropathy

7. A patient with a thoracic spinal cord injury has loss of motor function and pain-temperature sensation but retains vibration and position sense. Which pattern is most consistent?

- A. Posterior cord syndrome

- B. Isolated dorsal root injury
- C. Cerebellar injury
- D. Anterior cord syndrome

8. Immediately after a severe spinal cord injury, a patient has flaccid paralysis and absent reflexes below the lesion. Which phase is most likely?

- A. Spinal shock
- B. Autonomic dysreflexia
- C. Neurogenic pulmonary edema
- D. Chronic contracture syndrome

9. A patient with suspected basilar skull fracture needs gastric decompression. Which route should the nurse avoid?

- A. The oral route
- B. The intravenous route
- C. The nasal route
- D. The rectal route

10. A patient with midface trauma has loose teeth, blood in the mouth, and increasing work of breathing. What is the priority?

- A. Delay airway care until facial swelling completely resolves
- B. Insert a blind nasal tube to bypass the mouth
- C. Give oral analgesia before suctioning secretions
- D. Clear the airway and prepare for controlled definitive airway management

11. A patient has mobility of the entire midface and severe malocclusion after a facial impact. Which fracture pattern should the nurse recognize?

- A. A simple isolated nasal fracture
- B. A Le Fort III pattern
- C. A nondisplaced mandibular chip
- D. An uncomplicated orbital floor fracture

12. After orbital trauma, a patient reports sudden vision loss and has a tense swollen eyelid with proptosis. Which response is most appropriate?

- A. Patch both eyes tightly and reassess at shift change
- B. Escalate immediately for orbital pressure relief and ophthalmology evaluation
- C. Apply direct pressure over the closed eyelid
- D. Irrigate the eye vigorously with tap water

13. A patient has a suspected open-globe injury with visible ocular contents after a metal fragment strike. Which action should the nurse take?

- A. Apply a pressure patch to stop the leakage
- B. Remove the visible fragment with sterile forceps
- C. Place a rigid eye shield without pressure and keep the patient NPO
- D. Instill topical medication and test visual acuity repeatedly

14. A patient splashes an alkaline cleaning product into one eye. What should the nurse do first?

- A. Begin copious irrigation immediately while removing contact lenses
- B. Wait for the product label before starting treatment
- C. Cover the eye tightly and send the patient for imaging
- D. Neutralize the chemical with a different solution

15. A patient with a penetrating neck wound has active bleeding but no obvious airway obstruction. Which nursing action is appropriate?

- A. Explore the wound with a gloved finger to locate the vessel
- B. Pack deeply with gauze without observing the airway
- C. Remove any clot to inspect the full wound track
- D. Apply controlled direct pressure while preparing for airway and vascular support

16. Several minutes after a neck injury, a patient develops hoarseness, stridor, and an expanding neck swelling. What is the priority?

- A. Place the patient supine and observe the swelling
- B. Offer ice chips to soothe the throat
- C. Call the airway team for early controlled airway management
- D. Send the patient alone for routine radiography

17. A patient with blunt neck trauma develops transient weakness and a partial Horner syndrome. Which evaluation should the nurse anticipate?

- A. A routine ankle radiograph
- B. Vascular imaging for possible carotid or vertebral artery injury
- C. A gastric emptying study
- D. A skin culture from the neck

18. Which mechanism most strongly supports screening for blunt cerebrovascular injury?

- A. A cervical fracture involving a foramen transversarium
- B. A superficial forehead abrasion without symptoms
- C. A stable isolated finger sprain
- D. A minor bruise over the anterior shin

19. A patient in a rigid cervical collar reports new jaw pain and numbness at the occiput. What should the nurse do?

- A. Remove the collar permanently to relieve pressure
- B. Tighten it until the patient cannot speak
- C. Rotate the neck to compare both sides
- D. Inspect the skin and fit while maintaining spinal alignment

20. A patient with a traumatic subarachnoid hemorrhage becomes more restless and vomits repeatedly. Which nursing action is best?

- A. Assume the symptoms are expected and dim the lights
- B. Reassess airway and neurologic status and notify the trauma team
- C. Give oral fluids to replace the emesis
- D. Place the patient in a prone position

21. A patient with severe traumatic brain injury and unilateral pupillary dilation becomes hypotensive. Which intervention has priority?

- A. Withhold fluids and oxygen to avoid increasing brain swelling
- B. Perform a lumbar puncture at the bedside
- C. Support oxygenation and perfusion while escalating for herniation management
- D. Wait for the next scheduled neurologic check

22. A patient with a high cervical injury has weak cough, shallow respirations, and pooling secretions. What should the nurse anticipate?

- A. Assisted ventilation, suction, and early definitive airway planning
- B. Routine oral hydration and ambulation
- C. Independent incentive spirometry without supervision
- D. Discharge after a single normal oxygen reading

23. A patient with chronic cervical spinal cord injury develops a severe headache, flushing, and marked hypertension during bladder distention. Which action is first?

- A. Lay the patient flat and administer oral fluids
- B. Apply a tight abdominal binder
- C. Encourage the patient to strain against the bladder
- D. Sit the patient upright and remove the triggering stimulus

24. A patient with a thoracic spinal injury has hypotension, bradycardia, and warm dry skin after bleeding is controlled. Which finding explains the pattern?

- A. Isolated dehydration without vasodilation
- B. Obstructive shock from a small pleural effusion
- C. Loss of sympathetic vascular tone from neurogenic shock
- D. Cardiogenic shock from a closed wrist fracture

25. A young child with a head injury becomes irritable, vomits, and cannot be consoled after initially acting normally. What should the nurse do?

- A. Repeat the neurologic assessment and escalate for possible intracranial injury
- B. Assume the behavior is normal stranger anxiety
- C. Give a snack and wait for the parent to return
- D. Encourage vigorous play to assess coordination

26. A patient has clear nasal drainage after a basilar skull injury. Which instruction is appropriate?

- A. Pack the nostril firmly to stop the drainage
- B. Insert a nasal airway to improve airflow
- C. Ask the patient to bend forward and blow forcefully
- D. Use a light sterile drip pad and avoid nose blowing

27. A patient has a depressed open skull fracture with a small area of exposed tissue. Which action is safest?

- A. Push the depressed bone back into alignment
- B. Cover loosely with sterile material and avoid pressing on the defect
- C. Scrub the exposed area vigorously
- D. Apply a tight circumferential head wrap

28. A patient struck by glass has a deep eyelid laceration with a visible embedded fragment. What should the nurse do?

- A. Remove the fragment at the bedside
- B. Apply pressure directly over the orbit
- C. Close the wound with adhesive strips
- D. Stabilize the fragment, shield the eye, and obtain urgent ophthalmic evaluation

29. A patient rescued from a house fire has facial burns, soot in the mouth, and a normal oxygen saturation. Which plan is best?

- A. Wait until oxygen saturation falls before assessing the airway
- B. Prepare for early expert airway management and monitor for progressive edema
- C. Give oral fluids to clear soot
- D. Apply a tight mask over the swollen face

30. A patient with a mild concussion is ready for discharge after a normal examination. Which teaching is most important?

- A. Return promptly for worsening headache, repeated vomiting, or confusion
- B. Resume alcohol use to promote sleep
- C. Drive long distances immediately to test concentration
- D. Ignore new symptoms unless a fever develops

31. An older adult on warfarin has a head strike, a normal first scan, and no focal deficit. Which plan is safest?

- A. Discharge immediately because the scan is normal
- B. Perform a lumbar puncture before observation
- C. Continue observation and repeat assessment according to the trauma protocol
- D. Encourage vigorous exercise to reveal symptoms

32. A toddler has bruises in different healing stages and a caregiver gives an inconsistent injury history. What is the nurse's priority?

- A. Confront the caregiver in front of the child
- B. Ensure safety, document objectively, and follow mandated reporting policy
- C. Delete photographs after the social-work interview
- D. Wait for the caregiver to provide a consistent story

33. A patient with a cervical spinal cord injury suddenly develops increasing work of breathing and a weak cough. Which intervention is appropriate?

- A. Encourage the patient to whisper through the secretions
- B. Remove all monitoring to reduce anxiety
- C. Give a large oral meal before respiratory therapy arrives
- D. Provide assisted cough, suction, and escalating respiratory support

34. A patient with multiple rib fractures has paradoxical chest movement and increasing respiratory distress. Which intervention should the nurse prioritize?

- A. Bind the entire chest tightly with an elastic wrap
- B. Encourage forceful coughing without analgesia
- C. Support oxygenation and prepare for positive-pressure ventilation
- D. Place the patient prone for prolonged observation

35. After positive-pressure ventilation, a trauma patient develops severe dyspnea, hypotension, and absent breath sounds on one side. What is the priority?

- A. Call for immediate decompression of a suspected tension pneumothorax
- B. Increase airway pressure and wait for a chest radiograph
- C. Lay the patient flat and give oral fluids
- D. Remove the ventilator and observe the chest

36. A trauma patient has a blood pressure of 90/48 mmHg. Using $\text{MAP} = (\text{systolic pressure} + 2 \text{ times diastolic pressure}) \div 3$, what is the MAP?

- A. 46 mmHg
- B. 69 mmHg
- C. 62 mmHg
- D. 78 mmHg

37. A patient after a blunt chest impact has hypotension, distended neck veins, muffled heart sounds, and narrowing pulse pressure. Which condition is most likely?

- A. Cardiac tamponade
- B. Uncomplicated isolated rib fracture
- C. Simple dehydration
- D. Stable pulmonary contusion

38. A patient with a penetrating chest wound has worsening shock and large-volume blood drainage from the chest tube. What should the nurse anticipate?

- A. Clamping the tube for several hours
- B. Urgent surgical evaluation for ongoing intrathoracic hemorrhage
- C. Discharging after the drainage slows briefly
- D. Encouraging oral fluids instead of blood support

39. A patient with blunt cardiac injury develops frequent ventricular ectopy. Which monitoring plan is appropriate?

- A. Routine discharge after one normal blood pressure
- B. A warm blanket without cardiac monitoring
- C. Oral rehydration followed by ambulation
- D. Continuous ECG monitoring with serial assessment for hemodynamic change

40. A patient has chest pain and unequal pulses after a high-speed deceleration. Which injury should the nurse suspect?

- A. A minor isolated clavicle bruise
- B. An uncomplicated superficial abrasion
- C. Blunt thoracic aortic injury
- D. A stable ankle sprain

41. A patient with an open chest wound is hypoxic and has air moving through the wound. Which dressing is appropriate initially?

- A. A vented or three-sided occlusive dressing with close reassessment
- B. A fully sealed nonvented dressing without monitoring
- C. Dry loose gauze packed into the chest cavity
- D. A circumferential elastic wrap around the thorax

42. A patient with a pulmonary contusion has worsening hypoxemia and patchy infiltrates several hours after blunt trauma. Which plan is best?

- A. Give large fluid boluses until the infiltrates clear
- B. Use supportive lung care and avoid unnecessary fluid loading
- C. Suppress all coughing and repositioning
- D. Discharge because the first chest film was normal

43. After a high-energy chest injury, a patient has massive air leak, subcutaneous emphysema, and persistent lung collapse despite a chest tube. What should the nurse anticipate?

- A. Routine incentive spirometry alone
- B. Removal of the chest tube to stop the air leak
- C. Bronchoscopic and surgical evaluation for tracheobronchial disruption
- D. Oral antibiotics without airway assessment

44. A patient develops chest pain, fever, and subcutaneous emphysema after forceful vomiting during a crash response. Which complication should concern the nurse?

- A. A simple chest wall bruise
- B. An isolated wrist sprain
- C. A superficial scalp laceration
- D. Traumatic or spontaneous esophageal rupture with mediastinal contamination

45. A patient with lower chest trauma has abdominal pain and bowel sounds over one hemithorax. Which injury is most likely?

- A. An isolated abdominal skin contusion
- B. Traumatic diaphragmatic rupture with herniation
- C. A simple distal radius fracture
- D. An uncomplicated nasal fracture

46. A trauma patient has a pulseless electrical activity arrest with distended neck veins and a recent penetrating chest wound. Which reversible cause deserves immediate attention?

- A. Simple anxiety
- B. An isolated ankle injury
- C. Mild dehydration without bleeding
- D. Obstructed cardiac filling from tamponade

47. A patient with abdominal evisceration after a penetrating injury is alert but in pain. Which nursing action is correct?

- A. Cover the organs with sterile moist dressings and avoid replacing them
- B. Push the organs back through the wound
- C. Apply dry gauze tightly over the exposed tissue
- D. Irrigate the organs with antiseptic solution

48. A patient with an unstable pelvic fracture has hypotension and increasing pelvic pain. Which intervention should occur promptly?

- A. Apply a pelvic binder centered over the greater trochanters
- B. Place the binder across the upper abdomen
- C. Repeatedly logroll the patient to inspect the back
- D. Encourage walking to assess pelvic stability

49. A patient with pelvic trauma has flank bruising, hypotension, and a falling hemoglobin level without obvious external bleeding. Which source is concerning?

- A. A superficial thigh abrasion
- B. Retroperitoneal hemorrhage
- C. A stable shoulder dislocation
- D. A minor scalp contusion

50. A patient with left upper-quadrant trauma reports left shoulder pain and becomes tachycardic. Which injury should the nurse suspect?

- A. An isolated right ankle fracture
- B. A superficial abdominal abrasion
- C. Splenic injury with referred diaphragmatic pain
- D. An uncomplicated ear laceration

51. A patient struck across the right upper abdomen has worsening pain, tachycardia, and guarding. Which organ injury is most concerning?

- A. A stable finger contusion
- B. A minor facial abrasion
- C. An uncomplicated toe dislocation
- D. Hepatic injury with possible intra-abdominal bleeding

52. A patient with blunt abdominal trauma develops rigid guarding and free intraperitoneal air on imaging. Which injury is most likely?

- A. An isolated closed rib fracture
- B. Hollow-organ perforation requiring urgent surgical evaluation
- C. A superficial bruise without internal injury
- D. A stable lower-leg strain

53. A patient with a handlebar injury has epigastric pain that worsens after several hours and a rising heart rate. Which injury should be considered?

- A. Pancreatic or duodenal trauma with delayed retroperitoneal complications
- B. An uncomplicated wrist sprain
- C. A superficial knee abrasion
- D. An isolated ear canal laceration

54. A patient with pelvic trauma has gross hematuria and blood at the urethral meatus. Which action should the nurse take?

- A. Insert a Foley catheter forcefully
- B. Ask the patient to void repeatedly
- C. Avoid blind urinary catheterization and notify the trauma team
- D. Apply pressure over the meatus with a clamp

55. A stable trauma patient has gross hematuria and flank tenderness after a fall from height. Which evaluation should the nurse anticipate?

- A. A routine throat culture
- B. A lumbar puncture
- C. A bedside hearing test
- D. Contrast-enhanced imaging for renal injury

56. A patient after pelvic fracture has a tense abdomen, falling urine output, and increasing ventilator pressures. What condition should the nurse suspect?

- A. An uncomplicated ankle sprain
- B. Abdominal compartment syndrome
- C. Simple postoperative nausea
- D. A stable isolated scalp laceration

57. A pregnant patient beyond mid-pregnancy is injured and becomes dizzy while lying supine. Which positioning change is appropriate?

- A. Raise both legs while keeping the uterus midline
- B. Place the patient prone over the abdomen
- C. Turn the patient fully onto the injured side without support
- D. Use left uterine displacement or a left lateral tilt

58. A pregnant trauma patient is Rh-negative and has abdominal impact without obvious bleeding. Which treatment should the nurse anticipate?

- A. Rh immune globulin according to obstetric evaluation and protocol
- B. Withholding all blood products until delivery
- C. Routine anticoagulation for every abdominal impact
- D. A laxative to prevent uterine contractions

59. A pregnant patient has abdominal tenderness, uterine irritability, and fetal heart-rate abnormalities after a motor-vehicle crash. Which complication is most concerning?

- A. An isolated wrist sprain
- B. A minor scalp abrasion
- C. Placental abruption
- D. Stable chronic heartburn

60. A pregnant patient in cardiac arrest has received high-quality resuscitation without return of circulation. What should the trauma nurse anticipate?

- A. Stopping compressions to wait for fetal imaging
- B. Immediate coordinated obstetric and resuscitation planning for perimortem delivery
- C. Turning the patient prone for better chest access
- D. Delaying all decisions until a family member arrives

61. A patient has a visible seat-belt mark across the abdomen but normal vital signs and minimal pain. Which plan is safest?

- A. Discharge immediately because the abdomen is soft
- B. Apply heat to the skin mark and reassess next week
- C. Maintain observation and evaluate for occult bowel or mesenteric injury
- D. Encourage a large meal to test tolerance

62. A patient with an abdominal stab wound has a loop of omentum protruding through the incision. Which action is appropriate?

- A. Cover the protruding tissue and prepare for operative evaluation
- B. Push the tissue back into the abdominal cavity
- C. Clamp the protruding tissue to stop contamination
- D. Have the patient walk to determine pain severity

63. A stable patient with a low-grade renal injury has controlled pain and no ongoing shock. Which management is commonly anticipated?

- A. Immediate unrestricted activity and discharge
- B. Blind urinary instrumentation every hour
- C. Routine abdominal compression over the flank
- D. Close observation with serial hemoglobin, urine output, and examinations

64. A pelvic fracture causes a shortened, externally rotated leg with severe pain. Which action is safest before definitive treatment?

- A. Minimize movement, support alignment, and continue hemorrhage-focused resuscitation
- B. Force the leg into normal alignment without analgesia
- C. Ask the patient to stand for a neurovascular test
- D. Apply a traction splint without assessing the pelvis

65. A patient with abdominal trauma develops increasing pain, fever, and guarding after an initially reassuring examination. What should the nurse do?

- A. Document the first examination as definitive
- B. Repeat the assessment and notify the team about possible delayed perforation
- C. Give a meal to see whether pain improves
- D. Use a heating pad and postpone reassessment

66. A patient with suspected pelvic hemorrhage becomes increasingly restless and cool despite initial fluids. Which response is best?

- A. Continue crystalloid alone until the hemoglobin result returns
- B. Place the patient in a chair to improve comfort
- C. Reassess perfusion and activate blood-based resuscitation with hemorrhage control
- D. Stop all monitoring to reduce stimulation

67. A patient with blunt abdominal injury has a distended abdomen and decreasing bowel sounds after resuscitation. Which concern is greatest?

- A. A healed superficial abrasion
- B. A stable isolated shoulder bruise
- C. A routine medication side effect without other findings
- D. Evolving ileus, bleeding, or abdominal compartment physiology

68. A patient with a pelvic fracture reports numbness in the perineum and cannot void. Which complication should the nurse suspect?

- A. Simple anxiety about hospitalization
- B. An isolated finger fracture
- C. Sacral or pelvic nerve and urinary-tract injury
- D. A minor skin abrasion

69. A patient has a penetrating flank wound with stable vital signs and mild hematuria. Which nursing plan is appropriate?

- A. Probe the wound to determine its depth
- B. Apply a circumferential belt tightly around the abdomen
- C. Discharge after the bleeding at the skin stops
- D. Keep the patient NPO, monitor trends, and prepare for focused renal and abdominal evaluation

70. A patient with severe chest trauma has rising carbon dioxide levels, fatigue, and shallow breathing despite oxygen. Which next step is most appropriate?

- A. Escalate ventilatory support and prepare for a controlled airway
- B. Increase oral fluids and encourage sleep
- C. Remove oxygen to stimulate deeper breathing
- D. Wait for a normal chest radiograph before acting

71. A patient with a chest tube suddenly has increased dyspnea and no tidaling in the system. What should the nurse do first?

- A. Clamp the tube routinely for transport
- B. Assess the patient and tubing for obstruction or disconnection while escalating deterioration
- C. Strip the tubing forcefully toward the patient
- D. Ignore the system if the dressing is dry

72. A patient with a traumatic diaphragmatic injury has severe shortness of breath and worsening gastric distention. Which supportive action is appropriate?

- A. Prepare for gastric decompression and urgent surgical management
- B. Give carbonated fluids to relieve pressure
- C. Place the patient flat and delay imaging
- D. Apply an abdominal binder over the upper abdomen

73. A patient with suspected bladder rupture has pelvic trauma, gross hematuria, and abdominal distention. Which evaluation should the nurse anticipate?

- A. A routine oral contrast meal only
- B. Cystographic evaluation before or with urinary drainage planning
- C. Blind repeated Foley insertion
- D. A lumbar puncture for abdominal pain

74. A trauma patient has severe abdominal pain, a rigid abdomen, and worsening tachycardia after a delay in transfer. What should the nurse emphasize?

- A. Routine discharge instructions before imaging
- B. Oral analgesia as the only intervention
- C. Immediate reassessment, resuscitation, and surgical source-control consultation
- D. A warm bath to relax the abdominal muscles

75. A patient with a tibial fracture has pain out of proportion, tense swelling, and increasing pain with passive toe movement. What is the priority?

- A. Elevate the limb high above the heart and wait
- B. Apply a tighter circumferential cast
- C. Give oral fluids and reassess tomorrow
- D. Escalate immediately for compartment-pressure evaluation and possible fasciotomy

76. A patient with a crushed lower leg has dark urine, muscle pain, and rising serum potassium. Which intervention should the nurse anticipate?

- A. Cardiac monitoring, rapid assessment, and treatment of crush-related rhabdomyolysis
- B. Restrict all fluids until the urine clears
- C. Massage the injured compartment vigorously
- D. Discharge after applying a compression sleeve

77. A patient has an open femur fracture with visible contamination. Which action is appropriate before definitive repair?

- A. Scrub the bone aggressively at the bedside
- B. Close the wound tightly with adhesive strips
- C. Cover with sterile material, give ordered antibiotics, and update tetanus protection
- D. Delay treatment until swelling completely resolves

78. A patient has life-threatening bleeding from a mangled forearm and direct pressure is ineffective. What should the nurse anticipate?

- A. Loosen the tourniquet every few minutes
- B. Apply a tourniquet proximal to the wound and document the application time
- C. Cover the wound with a small adhesive bandage
- D. Elevate the limb and wait for spontaneous clotting

79. A patient with a midshaft femur fracture has severe pain and a cool foot. What should the nurse do before applying a traction splint?

- A. Apply traction immediately without a baseline examination
- B. Ask the patient to walk to confirm the fracture
- C. Place the limb in a tight circumferential cast
- D. Reassess pulses, sensation, and movement and evaluate for associated pelvic injury

80. A traumatic hand wound has visible tendon ends and loss of finger flexion. Which action is appropriate?

- A. Test the tendon repeatedly against resistance
- B. Close the wound tightly before imaging
- C. Encourage active gripping to prevent stiffness
- D. Cover and splint the hand for specialist repair

81. A patient has an amputated finger after an industrial injury. How should the part be preserved?

- A. Wrap moist sterile gauze, bag it, and cool indirectly
- B. Place it directly on ice
- C. Immerse it in disinfectant
- D. Leave it uncovered at room temperature

82. After an anterior shoulder dislocation, the patient's hand is cool and the radial pulse cannot be palpated. Which priority action is appropriate?

- A. Apply heat and reassess at the end of the shift
- B. Urgently reassess neurovascular status and obtain reduction and vascular evaluation
- C. Encourage active shoulder exercises
- D. Discharge after placing the arm in a sling

83. A patient with a posterior hip dislocation after a dashboard impact has severe pain and a shortened internally rotated leg. Which intervention is appropriate?

- A. Force the hip into full extension at the bedside
- B. Encourage walking to test joint stability
- C. Immobilize the leg and prepare for prompt reduction with sedation support
- D. Apply a traction splint without assessing the pelvis

84. A knee was dislocated and spontaneously reduced before arrival. Which assessment remains essential?

- A. Assessing only skin color at discharge
- B. Encouraging jogging to test stability
- C. Repeated distal pulses and vascular evaluation for popliteal injury
- D. Applying heat before checking perfusion

85. A patient with a thoracolumbar fracture has new leg weakness during transfer. Which action is safest?

- A. Continue moving quickly to finish the transfer
- B. Stop the transfer, maintain alignment, and repeat the neurologic examination
- C. Flex the spine to reduce muscle spasm
- D. Remove all supports to test independent movement

86. A patient with a suspected unstable vertebral fracture must be turned for skin inspection. Which technique is best?

- A. Twist the shoulders first and pull the hips after
- B. Ask the patient to roll independently
- C. Lift one leg sharply to rotate the pelvis
- D. Use a coordinated logroll with the spine aligned and enough staff

87. A patient with a degloving injury has a large flap of skin attached by a narrow bridge. Which action is appropriate?

- A. Cover the flap gently, preserve perfusion, and obtain urgent surgical evaluation
- B. Trim the flap at the bedside
- C. Apply a tight pressure wrap over the entire limb
- D. Leave the wound open and dry

88. A deep hand laceration causes loss of finger extension and visible tendon ends. What should the nurse do?

- A. Suture the tendon ends in the emergency bay
- B. Ask the patient to exercise the fingers repeatedly
- C. Splint the hand, cover the wound, and arrange urgent hand-surgery evaluation
- D. Apply an ice pack directly to the open wound

89. An older adult on a beta blocker has a serious fall, cool skin, and delayed capillary refill but only a modest heart rate. What should the nurse recognize?

- A. The medication proves the patient is hemodynamically stable
- B. Shock may be present despite a blunted tachycardic response
- C. A normal pulse rate excludes blood loss
- D. Older adults cannot develop occult hemorrhage

90. An older adult taking an anticoagulant has a head strike and a normal initial neurologic examination. Which plan is safest?

- A. Discharge immediately because the patient feels well
- B. Encourage unassisted walking to test balance
- C. Give aspirin to prevent delayed thrombosis
- D. Continue protocol-based observation and serial neurologic assessment

91. An older adult with fragile skin must be moved from a trauma stretcher. Which technique is best?

- A. Drag the patient across the sheet by the arms
- B. Pull firmly on the ankles to reposition the body
- C. Use adhesive tape to secure the skin during movement
- D. Use lift equipment and coordinated handling that limits shear

92. A child after blunt trauma is pale, anxious, and tachycardic with a normal blood pressure. Which interpretation is most appropriate?

- A. Compensated shock is possible and requires immediate reassessment
- B. The normal blood pressure rules out shock
- C. Anxiety is the only likely explanation
- D. Children do not lose significant blood internally

93. A child with facial trauma has a relatively large tongue and becomes increasingly fatigued while breathing. What should the nurse anticipate?

- A. Waiting for complete obstruction before calling the airway team
- B. Giving a large drink to clear secretions
- C. Early airway support with age-appropriate equipment and expert assistance
- D. Using adult equipment without checking fit

94. A child has bruises inconsistent with the caregiver's explanation. Which nursing response is best?

- A. Accuse the caregiver before assessing the child
- B. Separate the history when safe, document objectively, and report concerns
- C. Promise the child absolute secrecy
- D. Wait until the next clinic appointment

95. A child with a large burn is shivering during transfer. Which nursing action is most appropriate?

- A. Prevent hypothermia with warming measures while coordinating burn resuscitation

- B. Apply ice directly to the burned skin
- C. Leave the child uncovered to inspect the wounds
- D. Give unrestricted water before airway assessment

96. A child with head and neck trauma has a prominent occiput and needs spinal protection. Which positioning principle is important?

- A. Maintain neutral alignment with padding that accounts for body proportions
- B. Force the head flat against an adult-sized board
- C. Flex the neck to match the chest contour
- D. Remove all support so the child can self-position

97. A young child cannot describe pain after a fracture. Which assessment approach is best?

- A. Assume no pain because the child is quiet
- B. Ask only yes-or-no questions about a numeric score
- C. Use developmentally appropriate behavioral and caregiver-informed pain assessment
- D. Delay analgesia until the child can explain the injury

98. A pregnant trauma patient has facial swelling, hoarseness, and increasing oxygen needs. Which airway principle is important?

- A. Wait for complete obstruction before preparing equipment
- B. Anticipate earlier airway intervention because pregnancy can worsen edema and reduce reserve
- C. Use a blind nasal airway without imaging
- D. Avoid oxygen because fetal exposure is harmful

99. A pregnant patient with trauma becomes hypotensive while supine. Which intervention should the nurse perform?

- A. Place the patient prone

- B. Apply a tight abdominal binder
- C. Delay treatment until fetal imaging is complete
- D. Maintain left uterine displacement while continuing maternal resuscitation

100. A pregnant trauma patient beyond the threshold for viable fetal monitoring has abdominal pain but stable maternal vital signs. What should the nurse anticipate?

- A. Continuous or serial fetal monitoring with obstetric consultation
- B. No fetal assessment unless the mother becomes hypotensive
- C. Immediate discharge after one fetal heart-rate check
- D. A pelvic examination before maternal stabilization

101. A pregnant patient with trauma has unknown Rh status and possible fetomaternal bleeding. Which plan is appropriate?

- A. Assume Rh status is positive without testing
- B. Obtain type and screen and involve obstetrics about Rh immune globulin
- C. Withhold all blood products until delivery
- D. Give an anticoagulant automatically

102. A bariatric trauma patient arrives with suspected spinal injury. Which preparation is most important?

- A. Use standard equipment until it fails
- B. Transfer the patient with minimal staff to reduce embarrassment
- C. Use weight-capable equipment and a coordinated plan for airway, transfer, and positioning
- D. Avoid analgesia because assessment is more important

103. A bariatric patient with chest trauma becomes dyspneic when supine. Which position may improve ventilation while precautions are maintained?

- A. A flat position without head support
- B. A prone position over the injured chest
- C. A dangling position at the stretcher edge
- D. A ramped or reverse-Trendelenburg position with appropriate support

104. A bariatric patient has prolonged immobilization after trauma and new calf tenderness. What should concern the nurse?

- A. A normal expected response to the stretcher
- B. Venous thromboembolism risk requiring prompt assessment
- C. An indication to massage the calf
- D. A reason to remove all compression devices

105. A burn patient has facial burns, hoarseness, and soot around the nares. Which action is the priority?

- A. Prepare for early airway control and close respiratory reassessment
- B. Apply ointment inside the airway
- C. Wait for a chest film before calling for help
- D. Give oral fluids to wash away soot

106. A patient has a circumferential full-thickness burn of the chest and worsening ventilatory restriction. Which intervention should the nurse anticipate?

- A. A tighter chest wrap to support the burn
- B. Ice packs over the entire torso
- C. Delayed airway assessment until wound healing begins
- D. Escharotomy evaluation to release restrictive chest-wall eschar

107. A patient touched a live electrical source and has small entry and exit wounds. Which monitoring is essential?

- A. Reassurance based only on the small external burns
- B. Immediate discharge after washing the skin
- C. Cardiac rhythm and deep tissue assessment despite limited skin findings
- D. Direct ice over the electrical pathway

108. A patient spills dry powdered cement on the skin and reports burning. What should the nurse do first?

- A. Irrigate immediately without removing visible powder
- B. Brush off the dry chemical before copious irrigation
- C. Neutralize it with an acidic household liquid
- D. Cover it tightly with an occlusive dressing

109. A patient has hydrofluoric acid exposure to a hand with severe pain that seems greater than the skin findings. Which treatment should the nurse anticipate?

- A. A warm oil soak alone
- B. Delayed irrigation until laboratory results return
- C. A tight tourniquet around the wrist
- D. Immediate decontamination and calcium-based therapy under burn or toxicology guidance

110. A trauma patient discloses a recent sexual assault and wants only essential staff involved. Which response is trauma-informed?

- A. Ask the patient to repeat the story to every staff member
- B. Promise that no report will ever be required
- C. Offer privacy, explain choices, obtain consent, and preserve evidence according to policy
- D. Collect clothing in plastic bags and discard personal items

111. A patient accompanied by a controlling person gives vague answers and repeatedly looks toward the door. Which action is appropriate?

- A. Arrange a private safety assessment for possible violence
- B. Allow the companion to answer every question
- C. Confront the companion publicly
- D. Discharge the patient without resources

112. A patient with a substance use disorder is admitted after trauma and becomes tremulous, agitated, and diaphoretic. What should the nurse anticipate?

- A. Sedating the patient without monitoring
- B. Restricting all fluids and stimulation
- C. Withdrawal assessment, seizure precautions, and protocol-based treatment
- D. Assuming the behavior is drug-seeking and withholding care

113. During the primary survey, a patient has spurting femoral bleeding and a patent airway. What should the nurse do first?

- A. Obtain a complete medical history before touching the wound
- B. Control the catastrophic hemorrhage while continuing the primary survey
- C. Send the patient for a routine radiograph
- D. Wait for a hemoglobin result before applying pressure

114. After initial stabilization, which activity belongs in the secondary survey?

- A. A systematic head-to-toe examination with focused history
- B. Discharging before reassessment
- C. Removing all monitoring to improve comfort
- D. Repeating only the first vital sign

115. During a trauma resuscitation, several clinicians begin overlapping tasks and no one confirms medication doses. Which team action is best?

- A. Allow every clinician to choose tasks independently
- B. Stop all communication until the patient is stable
- C. Ask the family to coordinate the team
- D. Use a designated leader, closed-loop communication, and clearly assigned roles

116. A bleeding trauma patient is receiving blood components and becomes cold with worsening acidosis. Which resuscitation principle is important?

- A. Give only room-temperature crystalloid
- B. Stop all blood support until the temperature normalizes
- C. Warm the patient and products while monitoring calcium, coagulation, and acid-base status
- D. Cover the patient with ice to control inflammation

117. A patient with uncontrolled traumatic hemorrhage has received initial blood products and remains unstable. Which action is appropriate?

- A. Continue small crystalloid boluses without reassessment
- B. Delay blood because the hemoglobin is not yet reported
- C. Send the patient to a quiet room for observation
- D. Activate the massive-transfusion pathway and coordinate hemorrhage control

118. A patient with traumatic bleeding arrives early after injury and has no contraindication identified by the trauma team. What therapy may be considered according to protocol?

- A. Timely antifibrinolytic therapy when indicated by the bleeding pathway
- B. Routine antifibrinolytic treatment for every minor bruise
- C. Delaying all hemorrhage care until a CT scan is complete
- D. Replacing blood control with oral iron

119. A trauma patient has hypothermia, acidosis, coagulopathy, and worsening bleeding. Which concept describes this interaction?

- A. An isolated medication allergy
- B. The trauma diamond of death
- C. A stable recovery loop
- D. A benign response to analgesia

120. Before rapid-sequence intubation of a hypoxemic trauma patient, which preparation can improve safety?

- A. Induce anesthesia before applying oxygen
- B. Remove suction so the airway field stays uncluttered
- C. Use one device without a rescue plan
- D. Optimize preoxygenation, position appropriately, and prepare backup airway equipment

121. A trauma intubation attempt fails and oxygen saturation is falling. Which team response is safest?

- A. Reoxygenate and use the planned rescue pathway
- B. Repeat the same attempt indefinitely
- C. Remove all monitoring to improve access
- D. Continue sedatives without ventilation

122. A trauma patient has hypotension, distended neck veins, and absent breath sounds on one side. Which shock mechanism is most likely?

- A. Hypovolemic shock from a superficial abrasion
- B. Obstructive shock from tension pneumothorax
- C. Cardiogenic shock from an isolated toe fracture
- D. Distributive shock from mild anxiety

123. A patient with blunt myocardial injury has hypotension, crackles, and poor perfusion despite no major external bleeding. Which support is appropriate?

- A. Give unlimited fluid rapidly without cardiac reassessment
- B. Treat only the skin wounds
- C. Support oxygenation and circulation while evaluating cardiac pump failure
- D. Encourage ambulation to improve circulation

124. A trauma patient develops fever, hypotension, and increasing vasopressor needs several days after bowel contamination. Which priority is most important?

- A. Stop all antibiotics until discharge
- B. Treat the fever with blankets only
- C. Ignore cultures because trauma explains every fever
- D. Identify infection and obtain timely source-control and sepsis management

125. A patient with spinal cord injury has persistent hypotension and bradycardia after hemorrhage is excluded. Which treatment should the nurse anticipate?

- A. Large oral fluid intake as the only therapy
- B. Vasopressor and chronotropic support guided by the trauma team
- C. A tight abdominal binder without monitoring
- D. Discharge because the skin is warm

126. After a chest tube is placed for traumatic pneumothorax, which reassessment is most important?

- A. Repeat respiratory, hemodynamic, breath-sound, and tube-function assessment
- B. Document the procedure and end all observation
- C. Check only the insertion-site dressing
- D. Allow ambulation before confirming lung response

127. A patient develops acute hypoxemia, fever, and bilateral noncardiogenic pulmonary edema during a blood transfusion. What should the nurse do?

- A. Increase the transfusion rate to correct hypoxemia
- B. Give oral fluids and continue observation
- C. Stop the transfusion, maintain support, and notify the transfusion and medical teams
- D. Assume fluid overload without reporting the event

128. A trauma patient develops hypertension, jugular venous distention, crackles, and hypoxemia during a transfusion. Which complication is concerning?

- A. An isolated finger fracture
- B. A simple allergic rash without respiratory change
- C. Transfusion-associated circulatory overload
- D. A resolved pneumothorax

129. A ventilated trauma patient meets criteria for acute respiratory distress syndrome. Which ventilator strategy should the nurse anticipate?

- A. Very large tidal volumes to normalize every blood gas
- B. Routine fluid loading to open the lungs
- C. Supine positioning without reassessment
- D. Lung-protective ventilation with careful pressure and oxygen monitoring

130. A patient with a prolonged crush injury has oliguria and rising creatinine. Which monitoring is essential?

- A. Stop all prescribed fluids without assessment
- B. Trend urine output, renal function, potassium, and cardiac rhythm
- C. Measure only the wound circumference
- D. Assume dark urine means adequate kidney function

131. A trauma patient develops sudden facial droop and unilateral weakness after an initially stable course. Which action is the priority?

- A. Activate urgent neurologic evaluation and brain imaging
- B. Attribute the deficit to fatigue and reassess tomorrow
- C. Give oral fluids before calling the team
- D. Massage the weak side of the face

132. A ventilated trauma patient is at risk for ventilator-associated pneumonia. Which prevention bundle element is appropriate?

- A. Keep the patient completely flat
- B. Avoid oral care to prevent stimulation
- C. Change antibiotics daily without indication
- D. Elevate head and provide oral care per protocol

133. Which practice helps reduce central-line-associated bloodstream infection risk in a trauma patient?

- A. Access the line without hand hygiene if gloves are worn
- B. Leave every line in place through discharge
- C. Use aseptic access, scrub the hub, and remove the line when no longer needed
- D. Use the same contaminated dressing until it falls off

134. A catheterized trauma patient has no ongoing urinary indication and can void independently. Which action is best?

- A. Remove the catheter and monitor voiding according to the care plan
- B. Keep it indefinitely for convenience
- C. Disconnect the bag and leave the catheter open
- D. Irrigate it routinely without an indication

135. A hospitalized trauma patient becomes inattentive at night and pulls at lines. Which intervention is appropriate first?

- A. Apply restraints immediately without assessment
- B. Reorient, assess reversible causes, promote sleep, and use sensory aids
- C. Keep the room brightly lit all night
- D. Administer sedatives without checking oxygenation

136. A patient with heavy alcohol use becomes tremulous, diaphoretic, and hallucinating after admission. Which response is safest?

- A. Leave the patient alone in a dark room
- B. Withhold all medication until the behavior stops
- C. Encourage walking to reduce agitation
- D. Initiate the withdrawal protocol with seizure and airway precautions

137. A stable trauma patient is being transferred from the emergency department to the ward. Which activity is a tertiary survey?

- A. A quick glance at the original triage note
- B. A deliberate repeat examination after stabilization to identify missed injuries
- C. Removing the cervical collar without reassessment
- D. Skipping the examination because imaging was completed

138. A frightened trauma patient asks why each procedure is necessary. Which response reflects trauma-informed care?

- A. Tell the patient to stop asking questions
- B. Perform procedures without explanation to save time
- C. Explain, offer choices, and preserve patient control
- D. Promise that no discomfort will occur

139. A family asks to remain present during resuscitation, and the patient previously expressed that preference. Which action is appropriate?

- A. Follow facility policy while supporting safe, informed family presence
- B. Remove the family automatically from every resuscitation
- C. Allow unrestricted access around the airway
- D. Ask the family to direct clinical decisions

140. A trauma patient has new difficulty swallowing and weak cough after a prolonged intubation. Which team referral is most appropriate?

- A. Speech-language pathology evaluation with airway and nutrition reassessment
- B. Physical therapy only for leg strength
- C. Unrestricted oral intake to test swallowing
- D. No referral until a second aspiration event occurs

141. A patient with severe traumatic injury has an advance directive refusing a treatment now under consideration. What should the nurse do?

- A. Ignore the document because the family requests treatment
- B. Destroy the directive after copying it
- C. Notify the team, locate the directive, and advocate for the patient's expressed wishes
- D. Make an independent legal decision without the team

142. A ventilated trauma patient may be an organ donor after death is determined by authorized clinicians. Which nursing action is appropriate?

- A. Approach the family independently before referral
- B. Stop all support before a formal determination
- C. Promise donation will occur
- D. Notify donation services per policy and support family

143. A family asks whether a patient is brain dead because the patient has no visible response. Which response is best?

- A. Confirm brain death based on bedside appearance alone
- B. Explain that authorized clinicians must complete the formal determination using required criteria
- C. Ask the family to decide whether testing is needed
- D. Promise recovery if the ventilator remains in place

144. A patient with metastatic cancer and a new traumatic fracture asks for better pain control while continuing treatment. Which referral is appropriate?

- A. Palliative care only after every treatment stops
- B. No pain treatment because the injury is expected
- C. Palliative care for symptom relief and goal-concordant support
- D. Immediate discharge without discussing goals

145. A prehospital team arrives with a patient who has a tourniquet and a suspected pelvic injury. Which receiving-nurse action is most useful?

- A. Obtain a focused handoff, verify interventions and times, and continue reassessment
- B. Remove the tourniquet without examining the wound
- C. Repeat every procedure without listening to the report
- D. Delay assessment until paperwork is complete

146. A trauma center is sending a patient with ongoing oxygen needs to another facility. Which transfer action is essential?

- A. Send the patient once a bed is mentioned
- B. Confirm acceptance, stability, equipment, records, and qualified transport support
- C. Remove oxygen for the ambulance loading period
- D. Leave the receiving team to obtain the medication list

147. A patient with a cervical fracture is moved from imaging back to the trauma bay. Which nursing action is essential?

- A. Assume the patient is unchanged because imaging is complete
- B. Disconnect all lines before moving
- C. Ask the patient to sit up independently
- D. Repeat the handoff and verify airway, lines, alignment, and monitoring during movement

148. A trauma patient is preparing for discharge with a splint and wound dressing. Which teaching approach is best?

- A. Provide written instructions without discussion
- B. Use teach-back for wound care, medications, activity limits, and warning signs
- C. Tell the patient to search online if problems occur
- D. Ask only whether the patient understands

149. A patient is medically ready for discharge but has no transportation, limited health literacy, and no safe place to store medications. What should the nurse do?

- A. Discharge immediately because the vital signs are normal
- B. Give extra medication without teaching
- C. Ask the patient to solve transportation independently
- D. Coordinate case management and address barriers before final discharge

150. A trauma patient with a new spinal cord injury asks what rehabilitation will involve. Which explanation is accurate?

- A. Only strength training is needed
- B. Rehabilitation begins only after all wounds are healed
- C. Rehabilitation integrates physical, occupational, speech, nursing, dietary, and psychosocial goals
- D. The family performs therapy without professional guidance

151. A patient recovering from trauma has weakness, poor balance, and fear of falling during transfer. Which plan is appropriate?

- A. Use an individualized mobility plan with therapy, assistance, and fall precautions
- B. Keep the patient on bed rest indefinitely
- C. Ask the patient to walk alone to build confidence
- D. Remove the call light to reduce dependence

152. A patient with traumatic amputation expresses hopelessness and says life is not worth living. Which action is the priority?

- A. Tell the patient to focus on being grateful
- B. Leave the patient alone to regain privacy
- C. Promise that the feelings will disappear quickly
- D. Complete a suicide-risk assessment and maintain immediate safety precautions

153. A community trauma program wants to reduce bicycle-related head injuries. Which intervention is most consistent with injury prevention?

- A. Provide education only after each injury occurs
- B. Use data to target helmet education, safe-road changes, and community partnerships
- C. Publish fear-based messages without measuring outcomes
- D. Focus exclusively on treating emergency department symptoms

154. A trauma patient with opioid use disorder requests medication for withdrawal and pain. Which response is appropriate?

- A. Withhold analgesia to discourage substance use
- B. Assume every symptom is drug-seeking behavior
- C. Use nonjudgmental screening and coordinate evidence-based withdrawal and analgesia care
- D. Discharge without discussing treatment resources

155. A patient with multiple injuries has completed surgery but develops a new pressure injury at the sacrum. Which system response is best?

- A. Reassess turning, support surfaces, moisture control, and handoff processes
- B. Blame the last nurse without reviewing the process
- C. Delete the event from the record
- D. Stop all mobility until discharge

156. A family member reports that a trauma patient is having nightmares and avoiding care after discharge. Which referral is appropriate?

- A. Tell the family to ignore the behavior
- B. Offer behavioral-health support and trauma-focused follow-up
- C. Cancel all follow-up until symptoms resolve
- D. Use restraints during outpatient visits

157. An earthquake produces more injured patients than the trauma center can immediately treat. Which triage principle applies?

- A. Prioritize patients who are most likely to benefit from immediate lifesaving resources
- B. Treat patients strictly in arrival order
- C. Treat the loudest or most distressed patient first
- D. Use the same priority for every patient

158. A patient exposed to an unknown industrial chemical arrives before decontamination. Which action is appropriate?

- A. Bring the patient directly into the main treatment bay
- B. Handle clothing with bare hands for faster care
- C. Isolate the patient, use required PPE, remove contaminated clothing, and decontaminate
- D. Delay notification until symptoms become severe

159. A trauma center discovers that several severely injured patients were initially assigned a low-acuity triage category. Which quality action is best?

- A. Delete the cases because the patients eventually survived
- B. Blame one triage nurse without examining the process
- C. Stop collecting triage data
- D. Review the under-triage cases for system factors and corrective education

160. A review identifies repeated delays in diagnosing cervical spine injuries during shift changes. Which performance-improvement response is most useful?

- A. Add a poster without measuring the problem
- B. Punish every clinician involved in a delay
- C. Map the handoff process, identify failure points, and test a corrective change
- D. Stop reviewing missed injuries

161. A trauma registry abstractor finds missing injury-severity fields and inconsistent definitions across cases. What should happen next?

- A. Estimate missing values from memory
- B. Exclude difficult cases from the registry
- C. Report the data without noting limitations
- D. Validate data against source records and correct the collection process

162. After a pediatric trauma death, staff members report distress and uncertainty about the resuscitation. Which support is appropriate?

- A. Hold a structured, psychologically safe debrief with referral options
- B. Require public blame statements from each staff member
- C. Avoid discussion so the team forgets the event
- D. Share details casually on social media

163. Which handoff statement best follows SBAR for a patient with a worsening pelvic fracture?

- A. List every chart entry without a clear concern
- B. State the situation, relevant background, assessment, and requested action
- C. Give only the patient's room number
- D. Report the problem after the transfer is finished

164. A nurse discovers that a medication pump was programmed incorrectly but the patient was not harmed. Which action is appropriate?

- A. Ignore it because no harm occurred
- B. Alter the record to remove evidence of the error
- C. Report the near miss objectively and participate in system review
- D. Publicly identify the colleague responsible

165. A family member requests detailed trauma information about an adult patient by telephone. Which action follows privacy principles?

- A. Share the entire record because the caller knows the patient's name
- B. Verify identity and authorization, then disclose only permitted minimum information
- C. Discuss the case in a public hallway
- D. Refuse every request even after authorization is confirmed

166. An emergency department receives an uninsured patient with a possible internal hemorrhage. Which statement reflects emergency-access requirements?

- A. Delay evaluation until payment is arranged
- B. Transfer immediately because the patient lacks insurance
- C. Offer only written self-care instructions
- D. Provide an appropriate medical screening examination and stabilizing treatment

167. During a threatening visitor incident, which action should trauma staff prioritize once immediate patient care is protected?

- A. Activate safety procedures, create distance, and request trained assistance
- B. Confront the visitor alone to demonstrate authority
- C. Continue treatment without notifying anyone
- D. Physically restrain the visitor without trained support

168. A trauma center is undergoing designation and verification review. Which evidence best demonstrates system readiness?

- A. Maintain required resources, qualified leadership, reliable data, and performance improvement
- B. Prepare marketing material without reviewing clinical outcomes
- C. Limit review to the emergency department's first hour
- D. Remove difficult cases that could lower performance statistics

169. A patient with a traumatic brain injury develops marked polyuria, rising sodium, and worsening thirst. Which complication should the nurse recognize?

- A. Simple fluid overload from excessive antidiuretic hormone
- B. Possible diabetes insipidus with risk for severe free-water loss
- C. A resolved concussion with no need for monitoring
- D. An isolated facial fracture causing urinary changes

170. A patient remains comatose after high-energy trauma, although the initial CT shows little structural damage. Which injury pattern should the nurse anticipate?

- A. An isolated scalp abrasion without intracranial concern
- B. A simple nasal fracture with expected alertness
- C. Diffuse axonal injury requiring neurocritical monitoring and supportive care
- D. A superficial eye laceration causing coma

171. A patient with an incomplete spinal cord injury has preserved sensation around the anus and voluntary toe movement. What does this finding indicate?

- A. Complete cord transection with no preserved pathways
- B. An isolated wrist nerve injury
- C. A normal examination without spinal concern
- D. Sacral sparing and an incomplete cord injury

172. A patient with blunt thoracic trauma develops increasing dyspnea and a new air-fluid level in the pleural space. Which complication should the nurse suspect?

- A. A stable superficial chest bruise
- B. An isolated abdominal muscle strain
- C. Hemopneumothorax requiring chest drainage and continued reassessment
- D. A healed clavicle fracture without thoracic injury

173. A patient with a splenic injury becomes stable after initial care but develops renewed left upper-quadrant pain and shock later. Which concern is most important?

- A. A routine response to oral analgesia
- B. Delayed splenic rupture with recurrent intra-abdominal hemorrhage
- C. An isolated shoulder strain
- D. A superficial abdominal rash

174. A patient with pelvic trauma has new lower-abdominal pain, inability to void, and suprapubic fullness after catheter removal. What should the nurse do?

- A. Encourage repeated straining to void
- B. Apply a tight pelvic belt over the bladder
- C. Discharge because the catheter was already removed
- D. Assess for urinary retention or bladder injury and notify the trauma team

175. A patient undergoes limb revascularization after an ischemic injury and then develops severe swelling and pain with passive stretch. What is the priority?

- A. Escalate for reperfusion-related compartment syndrome and urgent surgical evaluation
- B. Apply a tighter dressing to control the swelling
- C. Elevate the limb high and wait for the pain to resolve
- D. Encourage exercise to improve circulation

Practice Exam 10: Answer Key and Explanations

1. **C** — A worsening focal deficit after a head injury suggests an expanding intracranial process, and anticoagulation increases bleeding concern. The nurse should protect airway and cervical alignment, obtain urgent imaging, notify the trauma and neurosurgical teams, and prepare for reversal or intervention as ordered. The alternatives delay neurologic protection or add injury.
2. **A** — A very low level of consciousness and gurgling indicate loss of airway protection. The nurse should suction, use jaw-thrust and oxygenation while maintaining inline cervical stabilization, and summon the airway team for definitive management. History collection, oral medication, and unsupported positioning do not correct obstruction and may increase aspiration or spinal injury risk.
3. **B** — Post-traumatic seizure activity can impair ventilation and may signal evolving brain injury or a reversible metabolic problem. The nurse protects the airway, checks glucose, prevents injury, documents the event, and promptly involves the trauma and neurologic teams. Restraints, oral intake, and unattended recovery increase aspiration or injury risk and do not evaluate the cause of persistent altered consciousness.
4. **B** — Cerebral perfusion pressure is calculated by subtracting intracranial pressure from mean arterial pressure. Subtracting 22 from 84 produces 62 mmHg, which helps the team judge whether cerebral blood flow may be threatened. Adding the values, reporting MAP alone, or subtracting MAP from ICP applies the formula incorrectly and could misdirect hemodynamic treatment.
5. **A** — New paresthesias may indicate spinal cord or nerve-root compromise. Neutral alignment, careful immobilization, and serial motor and sensory examinations reduce secondary movement while allowing the team to detect deterioration. Removing protection, walking the patient, or flexing the neck can increase displacement and worsen an unstable cervical injury. Continue serial neurologic reassessment for change.
6. **C** — Central cord syndrome commonly produces greater motor impairment in the upper extremities than the lower extremities after cervical hyperextension, especially in a narrowed canal. Care includes spinal protection, detailed neurologic assessment, and urgent specialist evaluation. Cauda equina, lumbar disease, and peripheral neuropathy do not explain this acute upper-extremity-predominant deficit after cervical trauma.
7. **D** — Anterior cord injury affects the corticospinal and spinothalamic tracts, causing motor and pain-temperature loss while posterior column modalities may remain intact. The pattern requires spinal

precautions, serial examination, and specialist assessment for evolving cord compromise. Posterior column injury, a single dorsal root lesion, and cerebellar disease do not create this combined acute sensory and motor pattern.

8. A — Spinal shock is the early period of transient flaccidity and areflexia below an acute cord lesion. It differs from neurogenic shock, which is a hemodynamic loss of sympathetic tone. The nurse documents the baseline and watches for reflex and autonomic changes. Autonomic dysreflexia, pulmonary edema, and contractures are not the expected explanation for immediate areflexic paralysis after acute cord trauma.

9. C — A basilar skull fracture can disrupt the cribriform plate and create a pathway for blind nasal instrumentation to enter the cranial vault. If decompression is necessary, the team should select a safer route and use specialist guidance. The oral, intravenous, and rectal routes do not pass through the fractured skull base and do not create the same instrumentation hazard.

10. D — Blood, teeth, edema, and unstable facial structures can rapidly obstruct the airway. Suction, manual stabilization, oxygenation, and early preparation for a controlled airway address the immediate threat while limiting additional trauma. Waiting, blind nasal instrumentation, and oral medication allow obstruction or aspiration to progress and may be unsafe with a skull-base injury.

11. B — Le Fort III injuries separate the midface from the cranial base and may destabilize the airway, orbit, and facial support structures. The nurse protects the airway, avoids unnecessary manipulation, and coordinates urgent trauma and maxillofacial evaluation. An isolated nasal, mandibular, or orbital injury does not account for mobility of the entire midface with severe occlusion change.

12. B — Proptosis, tense lids, and acute vision loss suggest retrobulbar pressure threatening the optic nerve and retinal circulation. This is an emergency requiring immediate specialist treatment while the nurse avoids pressure and monitors vision and pupil changes. Tight patching, direct pressure, and vigorous irrigation can increase pressure or delay decompression of a vision-threatening injury.

13. C — An open globe requires protection from pressure, contamination, and further movement while urgent ophthalmic evaluation is arranged. A rigid shield and NPO status support safe operative care and reduce the chance of extrusion. Pressure, fragment removal, and repeated manipulation can worsen tissue loss, increase contamination, or delay definitive repair. Continue serial neurologic reassessment for change.

14. A — Alkaline chemicals can penetrate ocular tissue quickly, so immediate irrigation limits contact time and tissue damage. Contacts should be removed, the pH reassessed during care, and ophthalmology involved after irrigation begins. Waiting, tight covering, and chemical neutralization delay dilution or can cause an additional reaction and worsen the ocular injury.

15. D — Penetrating neck trauma can injure the airway, carotid system, or esophagus even when the first airway assessment is normal. Controlled pressure, airway readiness, and rapid surgical evaluation limit hemorrhage while avoiding blind exploration. Finger exploration, deep blind packing, and clot removal can disrupt a tamponade, worsen bleeding, or injure vital structures.

16. C — Progressive swelling with hoarseness and stridor signals threatened airway obstruction, and distortion can make later intubation difficult. Early expert airway control, oxygenation, and surgical backup are safer than waiting for complete obstruction. Supine observation, oral intake, and an unaccompanied routine study can allow a rapidly deteriorating airway to become inaccessible.

17. B — Focal neurologic findings after blunt cervical trauma raise concern for blunt cerebrovascular injury, including dissection. Timely vascular imaging and neurologic monitoring help identify ischemia before a completed stroke occurs. An ankle film, gastric study, or skin culture cannot evaluate a traumatic neck-vessel injury or explain new focal neurologic signs. Continue serial neurologic reassessment for change.

18. A — Fractures that involve the transverse foramen can injure the vertebral artery, so the trauma team may request vascular imaging even before symptoms emerge. The nurse maintains precautions and reports any new neurologic change immediately. Minor skin injury, a finger sprain, and a shin bruise do not carry the same direct risk of traumatic cervical-vessel disruption.

19. D — A collar that is too loose or too tight can fail to stabilize the spine or cause pressure injury. The nurse reassesses fit, skin, airway access, and neurologic findings without removing protection or rotating the neck. Permanent removal, excessive tightening, and neck rotation can create instability, airway difficulty, or additional tissue damage.

20. B — New vomiting and agitation can signal rising intracranial pressure, aspiration risk, or neurologic deterioration. Reassessment, airway protection, head and neck alignment, and prompt escalation allow treatment before further secondary injury occurs. Attributing the change to expected discomfort, offering oral fluids, or using a prone position does not address the evolving neurologic and airway threats.

21. C — Hypotension and hypoxemia reduce oxygen delivery to injured brain tissue, while a new dilated pupil may indicate herniation. The nurse supports airway and circulation, maintains alignment, and activates immediate trauma and neurosurgical management. Withholding support, lumbar puncture, or waiting can worsen cerebral ischemia, precipitate herniation, or delay lifesaving intervention. Continue serial neurologic reassessment for change.

22. A — High cervical injury can impair diaphragm and accessory-muscle function, producing fatigue and secretion retention. The nurse supports ventilation, suctions safely, monitors gas exchange, and prepares for an expert airway plan before exhaustion occurs. Hydration, unsupervised exercises, and one normal reading do not correct progressive ventilatory weakness or impaired airway protection.

23. D — The combination suggests autonomic dysreflexia, an emergency caused by a noxious stimulus below the injury. Upright positioning lowers blood pressure while the nurse searches for and relieves triggers such as bladder distention. Flat positioning, a tight binder, and straining can worsen blood pressure or intensify the stimulus instead of treating the cause.

24. C — Neurogenic shock follows disruption of sympathetic pathways and produces vasodilation with relative bradycardia and warm skin. Hemorrhage still must be excluded, but the pattern supports a

distributive mechanism requiring perfusion support and close reassessment. Dehydration, a small effusion, and an uncomplicated wrist fracture do not explain hypotension with bradycardia and warm vasodilated skin.

25. A — Children may show subtle behavioral changes before obvious neurologic decline. Persistent irritability and vomiting after head trauma warrant repeated assessment, glucose and airway review, and prompt escalation for imaging or observation. Attributing the change to temperament, giving food, or vigorous play can delay recognition of rising intracranial pressure or aspiration risk.

26. D — Clear rhinorrhea after skull-base trauma may represent cerebrospinal fluid leakage. A light dressing preserves observation, while avoiding packing and nose blowing reduces pressure and contamination until specialist evaluation occurs. Firm packing, nasal instrumentation, and forceful blowing can increase pressure, introduce infection, or worsen a skull-base defect. Continue serial neurologic reassessment for change.

27. B — An open depressed fracture can expose brain tissue and create contamination or pressure risk. Loose sterile coverage protects the wound while avoiding manipulation; the patient needs urgent neurosurgical assessment and infection prevention. Pushing bone, vigorous scrubbing, or tight wrapping can force contamination inward, increase pressure, or injure exposed tissue. Continue serial neurologic reassessment for change.

28. D — An embedded ocular or periocular fragment may involve the globe or orbit. Stabilization, shielding, pain and nausea control, and urgent specialist evaluation reduce movement and prevent additional tissue damage. Bedside removal, direct pressure, and adhesive closure can dislodge the object or compress injured ocular structures. Continue serial neurologic reassessment for change.

29. B — Facial burns and soot suggest inhalation injury, and edema can progress rapidly despite an initially normal saturation. Early airway assessment and controlled intubation planning are safer before swelling makes access difficult. Waiting for desaturation, oral fluids, or a tight mask can delay airway control and increase aspiration or obstruction risk.

30. A — Delayed intracranial bleeding or post-concussive deterioration can appear after discharge. The patient and caregiver need clear warning signs, supervision instructions, medication guidance, and a reliable pathway for urgent reassessment. Alcohol, immediate driving, and ignoring neurologic symptoms can mask deterioration or increase injury risk after a concussion. Continue serial neurologic reassessment for change.

31. C — Anticoagulation and age increase concern for delayed intracranial bleeding even when the initial examination and scan are reassuring. Observation, medication review, and serial neurologic assessments support early detection of change. Immediate discharge, lumbar puncture, and vigorous exercise can miss or worsen a delayed bleed and do not replace structured reassessment.

32. B — Inconsistent history and patterned injuries raise concern for abuse. The nurse protects the child, documents observable findings and statements, preserves evidence, and activates the facility's reporting and social-work process. Confrontation, deleting records, or waiting for a revised story can increase

danger, destroy evidence, and delay required protection. Continue serial neurologic reassessment for change.

33. D — Cervical cord injury can weaken respiratory muscles and cough, allowing atelectasis, secretion retention, and fatigue. Assisted airway clearance and prompt respiratory support reduce hypoxemia while the team evaluates the need for a definitive airway. Whispering, removing monitoring, and oral intake do not clear secretions and can delay recognition of respiratory failure or increase aspiration risk.

34. C — Paradoxical motion with respiratory distress indicates flail-chest physiology and impaired ventilation. Oxygenation, multimodal analgesia, pulmonary hygiene, and preparation for positive-pressure support address the underlying respiratory failure risk. Tight binding restricts ventilation, painful coughing worsens fatigue, and prone observation delays support for an unstable chest injury. Continue serial assessment for evolving complications.

35. A — Sudden respiratory and circulatory compromise with unilateral absent breath sounds after ventilation is classic for tension physiology. Immediate decompression is lifesaving and should not wait for imaging when the clinical picture is compelling. More airway pressure, oral fluids, or delayed imaging can worsen intrathoracic pressure and postpone treatment of obstructive shock.

36. C — The stated formula uses the systolic pressure once and the diastolic pressure twice. Substituting 90 and 48 gives $(90 + 96)$ divided by 3, or 62 mmHg, which helps trend perfusion during resuscitation. Using the systolic value alone, averaging the two pressures, or adding without dividing produces an incorrect estimate of arterial pressure.

37. A — The combination indicates obstructed cardiac filling from pericardial blood. The nurse supports oxygenation and circulation, obtains urgent bedside evaluation, and prepares for drainage or operative management while monitoring for pulseless deterioration. A rib fracture, dehydration, or pulmonary contusion does not explain the obstructive pattern of venous distention, muffled sounds, and impaired filling.

38. B — Persistent high-volume thoracic drainage with shock suggests major vascular or pulmonary bleeding that may require operative control. The nurse maintains airway and circulation, quantifies output, preserves warming, and alerts the trauma surgeon. Clamping, discharge, or oral fluids can conceal ongoing hemorrhage, worsen respiratory compromise, and delay definitive source control. Continue serial assessment for evolving complications.

39. D — Blunt myocardial injury can produce dysrhythmias or pump failure after the initial impact. Continuous ECG and serial hemodynamic assessment allow rapid treatment if ectopy progresses or cardiac output falls. A single pressure, warming, hydration, or ambulation cannot detect or manage evolving electrical or mechanical cardiac complications. Continue serial assessment for evolving complications.

40. C — High-energy deceleration with chest pain and pulse asymmetry raises concern for great-vessel injury. The nurse limits exertion, supports perfusion, avoids unnecessary hypertension, and prepares the

patient for urgent vascular imaging and specialist management. Minor skin or extremity injuries do not explain pulse asymmetry and the potentially fatal vascular consequences of high-energy deceleration.

41. A — An open pneumothorax needs a seal that limits air entry while allowing trapped air to escape or be recognized. Oxygenation, reassessment for tension physiology, and definitive chest drainage follow the initial dressing. A fully sealed unvented dressing can convert the injury to tension physiology, while packing or circumferential wrapping interferes with ventilation.

42. B — Pulmonary contusions can evolve as edema and hemorrhage increase after injury. Oxygenation, analgesia, pulmonary hygiene, and carefully titrated support improve gas exchange while avoiding fluid excess that worsens lung injury. Large fluid loads, suppressing pulmonary hygiene, and early discharge can increase edema, secretion retention, and delayed respiratory failure. Continue serial assessment for evolving complications.

43. C — A persistent large air leak and failure of lung expansion suggest tracheobronchial injury. Bronchoscopy can localize the lesion, while surgical or advanced airway management may be required to restore ventilation. Incentive spirometry, tube removal, or antibiotics alone cannot identify or repair a major airway disruption. Continue serial assessment for evolving complications.

44. D — Esophageal disruption can contaminate the mediastinum and progress rapidly to sepsis. The nurse keeps the patient NPO, supports airway and circulation, monitors for deterioration, and obtains urgent surgical and diagnostic evaluation. A chest bruise, wrist sprain, or scalp wound cannot explain the combination of thoracic symptoms, subcutaneous air, and systemic deterioration.

45. B — A torn diaphragm can allow abdominal organs to move into the chest, causing abnormal thoracic sounds and respiratory compromise. The nurse supports breathing, avoids delays in imaging, and prepares for surgical repair. A skin contusion or extremity or nasal fracture does not place bowel in the thorax or explain the chest and abdominal findings.

46. D — PEA with venous distention after penetrating chest trauma suggests pericardial blood obstructing cardiac filling. The team must continue high-quality resuscitation while rapidly addressing reversible traumatic causes through emergency procedures. Anxiety, an ankle injury, and mild dehydration do not produce the obstructive arrest pattern or explain the mechanism and neck-vein distention.

47. A — Exposed abdominal contents need protection from drying, contamination, and pressure. Sterile moist coverage preserves tissue while the nurse supports circulation, prevents hypothermia, and prepares for urgent operative evaluation. Replacing, tightly drying, or chemically irrigating the organs can cause additional tissue injury, contamination, or loss of viable tissue. Continue serial assessment for evolving complications.

48. A — A properly positioned pelvic binder reduces pelvic volume and may limit hemorrhage from an unstable ring injury. It should be centered at the greater trochanters while movement is minimized and resuscitation continues. An upper-abdominal binder, repeated rolling, or walking can fail to stabilize the pelvis and may increase bleeding or displacement.

49. B — The retroperitoneum can hold significant blood with little external evidence. Flank bruising and shock require ongoing resuscitation, serial assessment, and diagnostic imaging when the patient is stable enough for it. A superficial abrasion, shoulder dislocation, or scalp contusion does not explain concealed blood loss with progressive shock. Continue serial assessment for evolving complications.

50. C — Left upper-quadrant bleeding can irritate the diaphragm and refer pain to the left shoulder while shock develops. The nurse monitors perfusion, limits oral intake, and prepares for imaging, blood support, or operative management. An ankle fracture, skin abrasion, or ear wound cannot explain the referred shoulder pain and evolving signs of intra-abdominal hemorrhage.

51. D — The liver is vulnerable to right upper-quadrant blunt force, and bleeding may progress after the initial examination. Serial abdominal and perfusion assessments guide imaging, blood preparation, and operative or nonoperative management. Extremity, facial, and toe injuries do not explain guarding, tachycardia, and the risk of concealed abdominal hemorrhage. Continue serial assessment for evolving complications.

52. B — Free air with peritoneal irritation suggests perforation of a hollow organ and contamination of the abdominal cavity. The nurse keeps the patient NPO, supports sepsis prevention, and prepares for urgent surgical source control. A rib fracture, superficial bruise, or leg strain does not create free intraperitoneal air or diffuse peritoneal signs.

53. A — Pancreatic and duodenal injuries can be initially subtle because much of the injury is retroperitoneal. Worsening pain and tachycardia require repeat examination, imaging, NPO status, and specialist consultation. Minor extremity, skin, or ear injuries do not explain progressive epigastric symptoms after a focused handlebar impact. Continue serial assessment for evolving complications.

54. C — Blood at the meatus after pelvic trauma raises concern for urethral disruption. Blind catheterization can convert a partial tear into a complete injury, so the team should evaluate the urethra before selecting bladder drainage. Forceful catheterization, repeated straining, and clamping can worsen tissue disruption, bleeding, or urinary obstruction. Continue serial assessment for evolving complications.

55. D — Flank tenderness and hematuria suggest renal or collecting-system trauma. In a stable patient, contrast imaging helps define the injury and guide observation, embolization, or surgery while serial perfusion and urine output are monitored. A throat culture, lumbar puncture, or hearing test does not evaluate traumatic renal bleeding or urinary tract disruption.

56. B — A tense abdomen with oliguria and rising airway pressures suggests increased intra-abdominal pressure impairing renal, respiratory, and cardiovascular function. The nurse reports the pattern urgently and prepares for pressure measurement and decompressive treatment. An ankle injury, nausea, or scalp wound cannot explain simultaneous abdominal tension, renal hypoperfusion, and ventilatory deterioration.

57. D — The gravid uterus can compress major vessels when the patient is supine, reducing venous return. Left displacement or tilt improves circulation while maintaining trauma precautions and allowing

maternal and fetal assessment. Leg elevation, prone positioning, or unsupported turning can worsen venous obstruction, disrupt injuries, or interfere with resuscitation. Continue serial assessment for evolving complications.

58. A — Fetomaternal blood exposure can occur after trauma even when external bleeding is absent. Obstetric evaluation determines the need for Rh immune globulin and fetal monitoring while maternal stabilization remains the first priority. Withholding indicated care, routine anticoagulation, and laxatives do not prevent Rh sensitization or evaluate maternal and fetal injury.

59. C — Trauma can separate the placenta from the uterine wall, causing uterine tenderness, contractions, maternal bleeding that may be concealed, and fetal compromise. The nurse supports maternal oxygenation and circulation while obtaining urgent obstetric care. Extremity or scalp injury and chronic heartburn do not explain uterine irritability or an acute fetal heart-rate change after trauma.

60. B — In maternal arrest, fetal and maternal survival depend on rapid coordinated resuscitation and obstetric planning when circulation does not return. The team prepares without interrupting essential maternal support or waiting for nonessential information. Stopping compressions, prone positioning, or waiting for family delays time-critical resuscitation and can worsen both maternal and fetal outcomes.

61. C — A seat-belt sign indicates force across the abdominal wall and may accompany delayed hollow-organ or mesenteric injury. Serial examination and appropriate imaging are important even when early vital signs and pain are reassuring. Immediate discharge, heat, and oral challenge can delay recognition of perforation, ischemia, or bleeding that develops after the initial evaluation.

62. A — Protruding omentum indicates violation of the abdominal wall and possible internal injury. Sterile coverage and prompt operative evaluation protect tissue and limit contamination while circulation and airway are supported. Pushing, clamping, or walking can traumatize tissue, increase contamination, and worsen bleeding or organ injury. Continue serial assessment for evolving complications.

63. D — Selected stable renal injuries can be managed nonoperatively with serial perfusion, hemoglobin, urine output, and abdominal assessment. The plan changes if bleeding, pain, or hemodynamic instability develops. Unrestricted discharge, blind instrumentation, and compression can miss worsening hemorrhage or injure the urinary tract. Continue serial assessment for evolving complications. Reassess promptly when new findings change risk or response.

64. A — The deformity suggests unstable pelvic or proximal femoral injury with bleeding risk. Movement should be minimized, alignment supported as found, perfusion monitored, and pelvic stabilization applied when indicated by the trauma team. Forceful manipulation, standing, or unassessed traction can worsen displacement, bleeding, nerve injury, or an associated pelvic fracture. Continue serial assessment for evolving complications.

65. B — Hollow-organ injury and peritoneal contamination can evolve after the initial assessment. New pain, fever, and guarding require repeat examination, laboratory and imaging evaluation, NPO status, and timely source-control planning. A prior normal examination, oral intake, or heat does not exclude a

delayed perforation and can postpone surgical treatment. Continue serial assessment for evolving complications.

66. C — Restlessness and cool skin may be early signs of inadequate oxygen delivery during concealed pelvic bleeding. The nurse reassesses airway and circulation, alerts the trauma team, and supports balanced blood resuscitation and mechanical hemorrhage control. Crystalloid-only delay, chair positioning, and removal of monitoring can worsen dilutional coagulopathy or conceal rapid deterioration.

67. D — Distention and altered bowel sounds after trauma can accompany bleeding, edema, ileus, or rising intra-abdominal pressure. The nurse compares trends, measures perfusion and urine output, and escalates changes rather than dismissing them. Superficial or isolated bruises do not explain progressive abdominal distention, and a presumed medication effect should not override trauma reassessment.

68. C — Perineal numbness and urinary retention after pelvic trauma suggest injury to pelvic nerves, bladder, or urethra. The nurse protects alignment, documents the neurologic finding, avoids blind catheterization, and obtains urgent specialist evaluation. Anxiety, finger injury, and skin abrasion do not explain acute saddle sensory loss or urinary dysfunction after pelvic trauma.

69. D — A flank wound can involve kidney, colon, vessels, or retroperitoneal structures even when initial vital signs are stable. NPO status, serial assessment, and imaging or operative evaluation protect against missed internal injury. Probing, tight belts, and discharge based only on skin bleeding can introduce contamination, worsen pressure, or miss concealed hemorrhage.

70. A — Rising carbon dioxide and fatigue indicate ventilatory failure, not simply low oxygen concentration. The nurse supports ventilation, alerts the airway team, and prepares for controlled intubation while continuing cervical and hemodynamic precautions. Fluids, oxygen removal, and radiograph delay do not correct inadequate ventilation and may allow respiratory arrest. Continue serial assessment for evolving complications.

71. B — A change in chest-tube function matters only in the context of the patient's respiratory status and possible obstruction, kinking, or disconnection. Assessment and rapid correction prevent recurrent pneumothorax or tension physiology. Routine clamping, forceful stripping, and ignoring symptoms can increase intrathoracic pressure or delay treatment of a deteriorating patient. Continue serial assessment for evolving complications.

72. A — Herniated abdominal viscera can compress the lung, and gastric distention can worsen thoracic compromise. Decompression with an appropriate route, respiratory support, and urgent surgical evaluation address the mechanical problem. Carbonated fluids, flat positioning, and upper-abdominal compression can increase pressure and delay repair of the diaphragmatic defect. Continue serial assessment for evolving complications.

73. B — Pelvic trauma with hematuria and distention can indicate bladder disruption. Imaging that evaluates the bladder helps distinguish injury patterns and prevents blind instrumentation from worsening urethral or bladder trauma. An oral meal, repeated blind catheterization, or lumbar puncture

does not define urinary tract disruption and can delay appropriate treatment. Continue serial assessment for evolving complications.

74. C — A rigid abdomen and worsening tachycardia suggest peritoneal contamination or hemorrhage and require rapid stabilization and source-control planning. Analgesia may be provided, but it never replaces repeated examination and escalation. Discharge, analgesia alone, and a bath delay evaluation of a potentially time-critical abdominal catastrophe. Continue serial assessment for evolving complications.

75. D — Pain out of proportion, tense swelling, and pain with passive stretch are warning signs of acute compartment syndrome. The nurse removes external constriction when ordered, preserves perfusion, and obtains urgent surgical evaluation. High elevation, tighter casting, and delayed reassessment can reduce arterial inflow or allow irreversible muscle and nerve ischemia.

76. A — Crush injury can release myoglobin and potassium, causing kidney injury and lethal dysrhythmias. The nurse monitors ECG and urine output, supports prescribed fluid therapy, and prepares for electrolyte and renal management. Fluid restriction, vigorous massage, and discharge can worsen pigment nephropathy, tissue injury, or cardiac instability. Repeat neurovascular checks as swelling evolves.

77. C — Open fractures carry contamination and infection risk. Sterile coverage, timely antibiotics, tetanus assessment, splinting, and surgical debridement protect tissue while preserving the neurovascular examination. Aggressive bedside scrubbing, tight closure, and delay can drive contamination deeper, trap bacteria, or allow further tissue and vascular damage. Repeated neurovascular checks matter because swelling, constriction, and ischemia can progress after the initial intervention.

78. B — When severe extremity bleeding is not controlled by direct pressure, a properly applied tourniquet can prevent exsanguination. The nurse records the time, reassesses perfusion and pain, and prepares the patient for definitive hemorrhage control. Intermittent loosening, a small bandage, or waiting allows continued blood loss and can convert a controllable injury into shock.

79. D — Femur fractures can bleed substantially and may coexist with pelvic or knee injury. A neurovascular baseline and assessment for contraindications are required before traction so the device does not worsen an unrecognized injury. Unassessed traction, walking, and tight casting can increase displacement, ischemia, or bleeding and eliminate a useful baseline examination.

80. D — Visible tendon injury with lost flexion requires protection from retraction and contamination. A sterile dressing, functional splint, pain control, and hand-surgery evaluation preserve repair options and limit further tissue damage. Repeated resistance, tight closure, and active gripping can worsen tendon separation, contamination, or tissue injury. Repeated neurovascular checks matter because swelling, constriction, and ischemia can progress after the initial intervention.

81. A — The amputated part should be protected from drying and direct freezing while the patient receives hemorrhage control and urgent replantation evaluation. Moist sterile gauze and indirect cooling preserve tissue viability during transport. Direct ice, disinfectant, and uncovered room-temperature

storage can cause freezing, chemical injury, desiccation, or accelerated tissue loss. Repeat neurovascular checks as swelling evolves.

82. B — An absent pulse after dislocation may reflect arterial compression or injury and threatens limb viability. The nurse documents the baseline, immobilizes safely, and escalates for urgent reduction and vascular assessment. Heat, exercise, discharge, and a sling alone do not restore perfusion or address a potentially limb-threatening vascular injury. Repeat neurovascular checks as swelling evolves.

83. C — Posterior hip dislocation can compromise the sciatic nerve and femoral head circulation, so prompt reduction is needed. Immobilization, neurovascular assessment, analgesia, and procedural preparation reduce additional damage. Forceful extension, walking, or unassessed traction can worsen the dislocation, injure the nerve, or obscure associated pelvic injury. Repeated neurovascular checks matter because swelling, constriction, and ischemia can progress after the initial intervention.

84. C — Knee dislocation can injure the popliteal artery even after apparent reduction, and pulses may change over time. Serial vascular checks and appropriate imaging or consultation are required before disposition. Skin color alone, jogging, and heat do not exclude occult arterial injury or protect an unstable knee. Repeat neurovascular checks as swelling evolves.

85. B — New weakness during movement may indicate spinal cord or nerve compromise. Stopping, preserving alignment, and repeating the examination allow the team to identify deterioration and prevent additional displacement. Continuing, flexing the spine, or removing supports can worsen an unstable vertebral injury and make neurologic damage irreversible. Repeat neurovascular checks as swelling evolves.

86. D — A coordinated logroll keeps the head, trunk, and pelvis moving together, limiting flexion and rotation. Adequate staff, communication, and equipment protect the injured spine during necessary care. Segmental twisting, independent rolling, and sharp pelvic movement can increase displacement and worsen cord or nerve injury. Repeated neurovascular checks matter because swelling, constriction, and ischemia can progress after the initial intervention.

87. A — Degloving injuries disrupt skin perfusion and expose tissue to contamination. Gentle sterile coverage, limb support, hemorrhage control, and urgent surgical assessment preserve viable tissue and guide repair. Bedside trimming, excessive pressure, and dry exposure can destroy marginal blood supply or increase contamination and tissue loss. Repeated neurovascular checks matter because swelling, constriction, and ischemia can progress after the initial intervention.

88. C — Loss of extension with visible tendon ends indicates a complex injury requiring specialist repair. Splinting and sterile coverage limit movement and contamination while preserving function and the neurovascular examination. Bedside tendon suturing, repeated exercise, and direct ice can worsen tissue damage, obscure anatomy, or injure exposed structures. Repeat neurovascular checks as swelling evolves.

89. B — Beta blockade and age can blunt tachycardia, while cool skin and delayed refill indicate poor peripheral perfusion. The nurse uses the entire trend, mental status, urine output, and laboratory data

rather than relying on heart rate alone. Medication use does not prove stability, a normal pulse does not exclude bleeding, and older adults remain vulnerable to concealed hemorrhage.

90. D — Age and anticoagulation increase concern for delayed intracranial bleeding after a head strike. Observation, medication review, and repeated neurologic checks support early recognition even when the first examination is normal. Immediate discharge, unassisted walking, and aspirin can increase injury or bleeding risk and do not replace structured reassessment. Individualize care and reassess changing needs.

91. D — Aging skin tears easily and has reduced reserve for pressure and shear. Lift equipment, adequate staff, padding, and coordinated movement reduce skin injury while preserving spinal and fracture precautions. Dragging, pulling on limbs, and adhesive tape can cause skin tears, nerve injury, or displacement of fractures. Individualize care and reassess changing needs.

92. A — Children can maintain blood pressure until compensation fails, so tachycardia, pallor, cool skin, and behavior change may precede hypotension. The nurse reassesses airway, perfusion, bleeding, and trends without false reassurance. Normal pressure, anxiety, and age do not exclude serious hemorrhage or the early compensated phase of pediatric shock. Individualize care and reassess changing needs.

93. C — Children have smaller airways and can deteriorate quickly when edema, blood, or secretions increase resistance. Early skilled airway support and correctly sized equipment reduce the risk of sudden complete obstruction. Waiting, oral intake, and improperly sized equipment can delay oxygenation or worsen aspiration and airway trauma. Individualize care and reassess changing needs.

94. B — Possible abuse requires safety-focused assessment, objective documentation, and activation of the required reporting pathway. Private history may reveal risk while avoiding promises or confrontation that could increase danger. Accusation, absolute secrecy, and delay can compromise safety, evidence, and the required protective response. Trauma care must be individualized because age, pregnancy, burns, body habitus, and social context can change usual presentations.

95. A — Children lose heat quickly after burns, and hypothermia worsens coagulopathy and physiologic stress. Warming, sterile coverage, airway assessment, and weight-based resuscitation support safe transfer to burn care. Direct ice causes tissue injury, uncovered exposure increases heat loss, and unrestricted oral water can be unsafe with airway or operative needs. Individualize care and reassess changing needs.

96. A — A child's larger occiput can force neck flexion on flat adult equipment. Padding and age-appropriate immobilization maintain neutral alignment and reduce airway or spinal compromise. Forcing the head flat, flexing the neck, or removing support can worsen alignment and increase secondary injury. Trauma care must be individualized because age, pregnancy, burns, body habitus, and social context can change usual presentations.

97. C — Children communicate pain through behavior, physiologic signs, developmental tools, and caregiver observations. Repeated age-appropriate assessment supports timely analgesia without

requiring adult verbal descriptions. Quiet behavior, an unsuitable numeric question, and delayed analgesia can underestimate pain and worsen fear and physiologic stress. Trauma care must be individualized because age, pregnancy, burns, body habitus, and social context can change usual presentations.

98. B — Pregnancy can increase airway vascularity and edema while reducing respiratory reserve. Facial trauma adds obstruction risk, so early expert airway planning and oxygenation are safer than delayed rescue attempts. Waiting, blind nasal instrumentation, and withholding oxygen can make a difficult airway or maternal hypoxemia more dangerous. Individualize care and reassess changing needs.

99. D — Left uterine displacement improves venous return when the gravid uterus compresses major vessels. Maternal airway, breathing, and circulation remain the priority while fetal assessment occurs in parallel. Prone positioning, tight abdominal compression, and delayed maternal resuscitation can worsen venous obstruction and hypoxemia. Trauma care must be individualized because age, pregnancy, burns, body habitus, and social context can change usual presentations.

100. A — Maternal vital signs can remain stable while placental or fetal injury evolves. Fetal monitoring, maternal reassessment, and obstetric consultation help identify contractions, abruption, or fetal compromise. Waiting for maternal shock, early discharge, or an invasive examination can miss evolving pregnancy complications and interrupt stabilization. Individualize care and reassess changing needs.

101. B — Trauma can expose fetal red cells to maternal circulation, making blood type and obstetric evaluation important. Rh immune globulin is considered when indicated while maternal stabilization and hemorrhage control proceed. Assumption, withholding necessary blood, and automatic anticoagulation do not evaluate sensitization risk or treat traumatic bleeding. Individualize care and reassess changing needs.

102. C — Bariatric patients may exceed equipment limits and have increased airway, pressure, and transfer risks. Planning equipment, staffing, positioning, and monitoring protects the patient and team while preserving a reliable examination. Overloaded equipment, inadequate staffing, and withheld analgesia increase fall, airway, pressure, and movement-related injury. Individualize care and reassess changing needs.

103. D — Ramped or reverse-Trendelenburg positioning can improve diaphragmatic excursion and airway access in a patient with increased abdominal mass. The team maintains spinal and injury precautions while titrating respiratory support. Flat, prone, or dangling positions can worsen ventilation, destabilize injuries, or create a fall during an acute respiratory problem. Individualize care and reassess changing needs.

104. B — Immobility, inflammation, and body habitus increase venous thromboembolism risk. New unilateral calf findings require assessment and escalation rather than massage, which could dislodge a clot. Dismissing symptoms, massaging the calf, or removing prescribed devices without assessment can delay treatment or increase embolic risk. Individualize care and reassess changing needs. Reassess promptly when new findings change risk or response.

105. A — Hoarseness and facial soot suggest inhalation injury, which can progress as airway edema develops. Early airway preparation, oxygenation, and frequent reassessment are safer before swelling makes intubation difficult. Ointment, imaging delay, and oral fluids do not prevent progressive airway obstruction and may complicate urgent airway management. Individualize care and reassess changing needs.

106. D — Rigid circumferential eschar can restrict chest expansion and impair ventilation. Escharotomy may restore excursion when clinically indicated, while oxygenation, analgesia, warming, and burn-center management continue. Tighter wrapping, ice, and delayed assessment worsen restriction, tissue injury, or heat loss and do not restore chest-wall compliance. Individualize care and reassess changing needs.

107. C — Electrical energy can travel through deep tissue and disrupt cardiac conduction even when the skin injury looks small. The nurse ensures power is disconnected, monitors rhythm, assesses the full path, and coordinates specialty care. Small surface burns do not exclude deep injury, and discharge or direct ice can miss dysrhythmia, muscle damage, or compartment syndrome.

108. B — Dry powders can continue reacting when wetted, so visible material should be gently brushed away before irrigation. Protective equipment, prolonged decontamination, pH reassessment, and burn consultation follow. Immediate wetting, household neutralization, or tight covering can spread the chemical, create a reaction, or trap the agent against tissue. Individualize care and reassess changing needs.

109. D — Hydrofluoric acid can cause deep tissue injury and dangerous systemic calcium shifts, often with severe pain that exceeds visible damage. Decontamination and calcium-based treatment require urgent specialist-guided care and cardiac monitoring. Oil, delayed irrigation, and a tourniquet do not remove the chemical or correct the potential systemic toxicity and may worsen tissue injury.

110. C — Trauma-informed care restores safety and control through privacy, clear explanations, consent, and choice while following reporting and evidence rules. Clothing and other evidence are handled in a manner that preserves chain of custody. Repeated retelling, absolute promises, and plastic storage can increase distress, violate policy, or compromise evidence preservation. Individualize care and reassess changing needs.

111. A — Controlled communication and fear cues may indicate trafficking or interpersonal violence. A private, respectful assessment with an interpreter or advocate when needed allows safety screening, medical care, and resource connection. Allowing the companion to control the interview, public confrontation, or unsupported discharge can increase danger and prevent accurate assessment. Individualize care and reassess changing needs.

112. C — Autonomic symptoms after reduced alcohol or sedative exposure may progress to seizures or delirium. Structured assessment, monitoring, prescribed treatment, hydration, and a nonjudgmental approach improve safety. Unmonitored sedation, fluid restriction, and stigmatizing care can worsen complications or delay treatment of dangerous withdrawal. Trauma care must be individualized because age, pregnancy, burns, body habitus, and social context can change usual presentations.

113. B — Exsanguinating external hemorrhage can cause death within minutes and requires immediate control while airway, breathing, and circulation are reassessed. A tourniquet or direct pressure is used according to the injury and protocol. History, routine imaging, and laboratory delay allow preventable blood loss to continue during a time-critical resuscitation. Continue reassessment as trauma physiology evolves.

114. A — The secondary survey identifies injuries not found during the immediate life-threat assessment. A systematic examination, history, medication review, and reassessment are performed after priorities are addressed. Discharge, removal of monitoring, and a single vital sign do not identify occult injuries or changes after the primary survey. Continue reassessment as trauma physiology evolves.

115. D — A defined leader and closed-loop communication reduce omissions, duplication, and medication errors during high cognitive load. Roles should be assigned, read-backs confirmed, and changes announced as the patient's condition evolves. Uncoordinated work, silence, or family-led coordination increases confusion and removes the safety checks needed during resuscitation. Continue reassessment as trauma physiology evolves.

116. C — Hypothermia, acidosis, hypocalcemia, and coagulopathy amplify one another during severe bleeding. Active warming, balanced blood support, laboratory monitoring, and correction of physiologic derangements improve hemostasis. Room-temperature crystalloid, stopping needed blood, and cooling the patient worsen the trauma physiology that impairs clot formation and perfusion. Continue reassessment as trauma physiology evolves.

117. D — Persistent instability from major bleeding requires coordinated blood delivery, warming, laboratory monitoring, and rapid mechanical or operative source control. A protocol helps the team act before laboratory confirmation catches up. Crystalloid-only treatment, laboratory delay, and observation do not stop hemorrhage and can worsen dilutional coagulopathy or shock. Continue reassessment as trauma physiology evolves.

118. A — Early antifibrinolytic therapy may help selected bleeding trauma patients when used within the local protocol and clinical context. It supplements, rather than replaces, direct hemorrhage control, blood support, and definitive care. Automatic use for minor injuries, imaging delay, and oral iron do not address the time-critical source of traumatic blood loss.

119. B — Hypothermia, acidosis, coagulopathy, and hypocalcemia reinforce one another and make hemorrhage increasingly difficult to control. Recognizing the trauma diamond of death prompts early warming, balanced resuscitation, calcium monitoring, and source control. An allergy, recovery loop, or analgesic response does not explain the mutually worsening physiologic derangements seen in exsanguinating trauma.

120. D — Pre-intubation optimization increases oxygen reserve and anticipates difficult airway failure. Preoxygenation, apneic oxygenation when appropriate, suction, positioning, medication readiness, and backup plans reduce desaturation and delays. Induction without oxygen, absent suction, and a single-device plan remove key safeguards during a high-risk airway procedure. Ongoing reassessment is essential because trauma physiology and treatment effects can change quickly during the care transition.

121. A — A failed airway requires honest recognition, reoxygenation, and a predefined rescue strategy. Repeated unsuccessful attempts cause edema, bleeding, and delay, while monitoring and oxygenation guide the next intervention. Indefinite repetition, absent monitoring, and sedation without ventilation can convert a difficult airway into a catastrophic one. Continue reassessment as trauma physiology evolves.

122. B — Tension pneumothorax increases intrathoracic pressure, limits venous return, and produces obstructive shock with respiratory compromise. Immediate decompression and continued reassessment address the mechanical cause. A superficial abrasion, toe fracture, or anxiety does not explain unilateral absent breath sounds with venous obstruction and shock. Ongoing reassessment is essential because trauma physiology and treatment effects can change quickly during the care transition.

123. C — Blunt cardiac injury can impair contractility and cause cardiogenic shock. The nurse supports oxygenation, obtains ECG and echocardiographic evaluation, titrates therapy carefully, and watches for pulmonary edema. Unlimited fluid, skin-only care, and ambulation can worsen congestion or delay recognition of cardiac pump failure. Ongoing reassessment is essential because trauma physiology and treatment effects can change quickly during the care transition.

124. D — Delayed fever and shock after contamination suggest infection or sepsis and require cultures, antibiotics when indicated, source control, perfusion support, and reassessment. Trauma history does not exclude a new disease process. Stopping treatment, using blankets alone, or attributing all fever to trauma can delay control of a life-threatening infection. Continue reassessment as trauma physiology evolves.

125. B — Neurogenic shock results from loss of sympathetic tone and may require vasoactive support, chronotropic treatment, and careful monitoring after hemorrhage is excluded. Warm skin does not mean perfusion is adequate. Oral fluids, an unmonitored binder, and discharge do not correct distributive hypotension or bradycardia after cord injury. Continue reassessment as trauma physiology evolves.

126. A — Chest-tube placement changes the patient's physiology and can be complicated by obstruction, malposition, recurrent pneumothorax, bleeding, or reexpansion problems. Repeated clinical and system assessment confirms response. Documentation alone, a dressing check, or early ambulation cannot identify recurrent respiratory or circulatory compromise. Ongoing reassessment is essential because trauma physiology and treatment effects can change quickly during the care transition.

127. C — Acute hypoxemia and noncardiogenic edema during or soon after transfusion suggest TRALI. The transfusion is stopped, the line is managed per policy, respiratory support begins, and the reaction is reported for evaluation. Increasing blood, oral fluids, or assuming TACO without assessment can worsen lung injury and delay the required transfusion-reaction response.

128. C — Hypertension, venous congestion, pulmonary crackles, and hypoxemia suggest excess intravascular volume rather than isolated lung injury. The nurse stops the transfusion, supports breathing, elevates the patient, and alerts the team for treatment. A finger fracture, mild rash, or resolved pneumothorax does not explain acute volume-overload signs during transfusion. Continue reassessment as trauma physiology evolves.

129. D — ARDS care limits ventilator-induced injury through lung-protective settings, appropriate oxygen targets, positioning, and fluid strategy. The nurse monitors synchrony, pressures, gas exchange, and signs of worsening organ dysfunction. Large tidal volumes, unnecessary fluid loading, and unmonitored supine positioning can intensify alveolar injury and hypoxemia. Continue reassessment as trauma physiology evolves.

130. B — Crush-related rhabdomyolysis can cause pigment nephropathy, hyperkalemia, acidosis, and dysrhythmia. Urine output, renal labs, electrolytes, and ECG trends guide treatment and escalation. Stopping therapy, wound-only measurement, and interpreting dark urine as adequate output can delay renal or cardiac rescue. Ongoing reassessment is essential because trauma physiology and treatment effects can change quickly during the care transition.

131. A — A new focal deficit may represent traumatic vascular injury, intracranial bleeding, or acute stroke. Time-sensitive neurologic assessment and imaging identify treatable causes while airway and glucose are checked. Fatigue attribution, oral fluids, and massage delay recognition of a potentially reversible neurologic emergency. Ongoing reassessment is essential because trauma physiology and treatment effects can change quickly during the care transition.

132. D — Head elevation, oral care, suction, sedation review, and timely liberation from ventilation reduce aspiration and ventilator-associated infection risk. Prevention is a coordinated bundle rather than a single medication. Flat positioning, absent oral care, and unnecessary antibiotic changes do not prevent aspiration and can create additional complications. Continue reassessment as trauma physiology evolves.

133. C — Aseptic technique, hub disinfection, dressing care, and prompt removal of unnecessary lines reduce bloodstream infection risk. The nurse also monitors the site and reports fever or local inflammation. Gloves do not replace hand hygiene, unnecessary lines increase risk, and contaminated dressings require timely attention. Continue reassessment as trauma physiology evolves.

134. A — Removing an unnecessary urinary catheter reduces infection, trauma, and mobility barriers. The nurse confirms the plan, removes it using proper technique, and monitors for retention or difficulty voiding. Convenience-based continuation, an open system, and routine irrigation increase infection or trauma risk without treating a defined problem. Continue reassessment as trauma physiology evolves.

135. B — Acute fluctuating inattention suggests delirium, which may arise from hypoxia, infection, pain, medications, withdrawal, or sleep disruption. Reorientation, cause assessment, safety measures, and nonpharmacologic support are first-line. Immediate restraints, all-night light, and unassessed sedation can worsen agitation, immobility, respiratory depression, and delirium. Ongoing reassessment is essential because trauma physiology and treatment effects can change quickly during the care transition.

136. D — Alcohol withdrawal can progress to seizures, delirium, autonomic instability, and respiratory compromise. Protocol-based assessment and treatment, monitoring, hydration, and safety precautions reduce preventable deterioration. Isolation without assessment, medication withholding, and walking do

not control withdrawal and may increase injury or seizure risk. Ongoing reassessment is essential because trauma physiology and treatment effects can change quickly during the care transition.

137. B — The tertiary survey is a structured re-examination after initial stabilization and early treatment. It incorporates new symptoms, trends, imaging review, and an updated head-to-toe assessment to find missed injuries. A glance at notes, unplanned collar removal, or reliance on imaging alone does not provide the systematic reassessment needed after trauma.

138. C — Trauma-informed communication emphasizes safety, transparency, choice, collaboration, and control. Clear explanations and consent reduce retraumatization while allowing urgent care to continue when immediate life threats require action. Dismissal, unexplained procedures, and unrealistic promises undermine trust and can increase fear, refusal, or psychological distress. Ongoing reassessment is essential because trauma physiology and treatment effects can change quickly during the care transition.

139. A — Family presence may support the patient and family when consistent with patient preference, safety, staffing, and policy. A designated staff member explains events and preserves a clear treatment area. Automatic exclusion, unrestricted access, and family-directed clinical decisions can violate preference, safety, or professional roles. Continue reassessment as trauma physiology evolves.

140. A — Dysphagia and weak cough increase aspiration risk after trauma and airway support. Speech-language pathology can assess swallowing while nursing and medical teams coordinate nutrition, secretion management, and respiratory safety. Leg therapy, unrestricted intake, and delayed referral do not evaluate airway protection or prevent aspiration-related complications. Continue reassessment as trauma physiology evolves.

141. C — Advance directives communicate the patient's preferences and should guide care when applicable. The nurse verifies the document, informs the treating team, supports discussion with the surrogate, and documents actions. Ignoring, destroying, or independently overriding the directive undermines autonomy and can create ethical and legal harm. Continue reassessment as trauma physiology evolves.

142. D — Donation referral follows institutional policy and separates donation discussions from the treating team's death determination. The nurse supports physiologic care, privacy, and the family's questions without making promises. Independent approaches, stopping support early, and promises bypass required processes and can damage trust or interfere with legal determination. Continue reassessment as trauma physiology evolves.

143. B — Brain death is a formal medical determination requiring an authorized examination and institutional or legal criteria. Nurses provide clear support, communicate observations, and avoid declaring or predicting the outcome independently. Appearance, family choice, and ventilator continuation alone cannot establish brain death or guarantee recovery. Continue reassessment as trauma physiology evolves.

144. C — Palliative care can be integrated at any stage to address pain, symptoms, communication, and goals alongside disease-directed or trauma treatment. It is not limited to the final hours of life. Waiting

until treatment stops, withholding analgesia, or discharging without goals discussion leaves important suffering and planning unaddressed. Continue reassessment as trauma physiology evolves.

145. A — Prehospital information about mechanism, findings, treatments, times, and response guides immediate priorities. The receiving nurse verifies devices and reassesses the patient without creating gaps during transfer of care. Unexamined removal, repetitive work, and paperwork delay can cause renewed hemorrhage or lose critical information about the patient's trajectory. Continue reassessment as trauma physiology evolves.

146. B — Safe interfacility transfer requires communication between clinicians, confirmation of acceptance, appropriate transport capability, current records, medications, monitoring, and contingency planning for deterioration. A bed mention, oxygen interruption, and incomplete records do not establish a safe handoff or support the patient's ongoing needs. Ongoing reassessment is essential because trauma physiology and treatment effects can change quickly during the care transition.

147. D — Intrafacility transfers can cause loss of airway support, line disconnection, pressure injury, or spinal movement. A structured handoff and equipment check preserve continuity while the patient moves between departments. Assumption, line disconnection, and independent sitting can cause preventable deterioration or secondary spinal injury. Ongoing reassessment is essential because trauma physiology and treatment effects can change quickly during the care transition.

148. B — Teach-back verifies what the patient can actually explain and do, including wound care, medications, restrictions, follow-up, and red flags. It identifies literacy, language, transportation, or caregiver barriers before discharge. Written material alone, online referral, and a yes-or-no question can miss misunderstanding and unsafe home conditions. Continue reassessment as trauma physiology evolves.

149. D — Home readiness includes safe housing, transportation, medication access, comprehension, follow-up, and caregiver support. Case management and the interdisciplinary team can address barriers that otherwise cause harm or return visits. Normal vital signs do not resolve social barriers, extra medication can increase risk, and unsupported problem-solving leaves the transition unsafe. Continue reassessment as trauma physiology evolves.

150. C — Trauma rehabilitation addresses mobility, self-care, communication, swallowing, nutrition, bowel and bladder function, coping, and discharge planning. Interdisciplinary goals begin early and adapt as medical stability changes. Strength alone, delayed rehabilitation, and untrained family therapy omit important functional, safety, and psychosocial needs. Ongoing reassessment is essential because trauma physiology and treatment effects can change quickly during the care transition.

151. A — Safe mobility balances early rehabilitation with injury restrictions and fall risk. Therapy, assistive equipment, supervision, and clear goals restore function while preventing another injury. Indefinite bed rest, unassisted walking, and removal of the call light increase deconditioning, falls, and loss of independence. Ongoing reassessment is essential because trauma physiology and treatment effects can change quickly during the care transition.

152. D — Hopelessness after traumatic loss may signal suicide risk and requires direct assessment, removal of hazards, observation, and mental-health support. The nurse responds without judgment and documents the safety plan. Dismissal, isolation, and unrealistic promises can increase danger and prevent timely intervention for self-harm risk. Continue reassessment as trauma physiology evolves.

153. B — Effective injury prevention combines surveillance data, risk-focused education, environmental change, and evaluation. Community partnerships extend prevention beyond the bedside and allow the program to measure whether injuries decline. Reactive education, fear without evaluation, and treatment-only focus do not address the upstream causes of preventable trauma. Continue reassessment as trauma physiology evolves.

154. C — Patients with substance use disorders deserve safe analgesia, withdrawal prevention, respectful assessment, and linkage to treatment. Coordinated care reduces untreated withdrawal, unsafe self-medication, and stigma. Withholding care, assuming motives, and unsupported discharge increase suffering and may worsen overdose or withdrawal risk. Trauma care must be individualized because age, pregnancy, burns, body habitus, and social context can change usual presentations.

155. A — A new pressure injury warrants patient treatment and a systems review of risk assessment, repositioning, equipment, nutrition, moisture, and communication. Improvement focuses on contributing conditions rather than individual blame. Blame, deletion, and immobility do not heal the injury or identify reliable prevention changes. Ongoing reassessment is essential because trauma physiology and treatment effects can change quickly during the care transition.

156. B — Nightmares and avoidance can reflect acute stress or post-traumatic symptoms that benefit from early support, screening, education, and follow-up. Respectful referral promotes safety and recovery. Ignoring symptoms, canceling follow-up, and restraints increase isolation and do not address psychological injury. Trauma care must be individualized because age, pregnancy, burns, body habitus, and social context can change usual presentations.

157. A — Mass-casualty triage allocates limited resources to maximize lives saved and functional benefit. Categories are based on physiologic need, survivability, and available resources rather than arrival order or emotional intensity. Arrival order, volume of distress, and identical priority ignore resource constraints and can divert lifesaving care from patients most likely to benefit.

158. C — Decontamination protects staff, other patients, and the facility while limiting ongoing exposure. The response follows the emergency plan, uses PPE, contains clothing, irrigates as indicated, and communicates with hazardous-material resources. Main-bay entry, bare-hand handling, and delayed notification can spread contamination and expose additional people. Reliable trauma systems depend on clear communication, documented actions, and timely follow-through across teams and settings.

159. D — Under-triage can delay lifesaving care and should trigger a structured review of criteria, staffing, education, communication, and system conditions. Corrective action is based on evidence and follow-up measurement. Deletion, individual blame, and stopping data collection prevent learning and do not reduce recurrence. Reliable trauma systems depend on clear communication, documented actions, and timely follow-through across teams and settings.

160. C — A process review should identify where information, assessment, or escalation fails, then implement and measure a targeted change. This approach addresses system reliability and tests whether delays actually decrease. An unmeasured poster, punishment, and stopping review do not reveal the cause or demonstrate improvement. Reliable trauma systems depend on clear communication, documented actions, and timely follow-through across teams and settings.

161. D — Registry data support benchmarking only when fields are complete, accurate, and consistently defined. Source validation, clarification, staff education, and monitoring improve reliability and make outcomes more interpretable. Memory estimates, selective case removal, and unreported limitations introduce bias and weaken the registry's value for quality improvement. Document actions and reassess system performance.

162. A — A structured debrief can identify safety lessons, acknowledge emotional impact, and connect staff with peer or professional support. It should be respectful, confidential, and separate from punitive judgment. Blame, avoidance, and public disclosure harm psychological safety, reduce reporting, and violate confidentiality. Reliable trauma systems depend on clear communication, documented actions, and timely follow-through across teams and settings.

163. B — SBAR makes a handoff actionable by identifying the immediate situation, relevant background, focused assessment, and recommendation or request. It reduces ambiguity and helps the receiving clinician act on the risk. A chart dump, room number, or delayed report omits the interpretation and action needed for safe continuity. Document actions and reassess system performance.

164. C — Near misses reveal hazards before harm occurs and support prevention when reported promptly and objectively. The nurse ensures patient assessment, follows reporting policy, and helps identify contributing system factors. Ignoring, altering records, and public blame conceal risk, undermine learning, and may create additional safety or legal problems. Document actions and reassess system performance.

165. B — Privacy practice requires reasonable verification, authorization when applicable, a private setting, and disclosure limited to the information needed for the permitted purpose. Documentation and policy guide the response. Name recognition does not establish authorization, public discussion risks disclosure, and blanket refusal can block properly authorized communication. Document actions and reassess system performance.

166. D — Emergency-access rules require an appropriate screening examination and stabilizing treatment for an emergency medical condition without using payment status as the reason to delay care. Any transfer must meet clinical and regulatory requirements. Payment-first delay, financially motivated transfer, and self-care instructions do not replace required emergency evaluation and stabilization. Document actions and reassess system performance.

167. A — Immediate safety takes priority during a workplace-violence threat. Staff should use the facility alert process, protect patients, create distance, and request trained security or law-enforcement assistance according to policy. Solo confrontation, silence, and untrained restraint increase injury risk.

and can escalate the situation. Reliable trauma systems depend on clear communication, documented actions, and timely follow-through across teams and settings.

168. A — Trauma designation and verification depend on sustained resources, trained personnel, reliable data, performance improvement, and coordination across the trauma system. Readiness is demonstrated by actual processes and outcomes. Marketing, a narrow time window, and selective case removal obscure the system's capability and undermine patient safety and valid review. Document actions and reassess system performance.

169. B — Polyuria with rising sodium after brain injury suggests loss of antidiuretic hormone activity and dangerous free-water depletion. The nurse trends urine output and electrolytes, supports prescribed replacement, and promptly reports changing neurologic or hemodynamic status. Fluid overload, a resolved concussion, and facial fracture do not explain concentrated sodium loss with high urine output after brain trauma.

170. C — Diffuse axonal injury can cause profound or prolonged unconsciousness after acceleration-deceleration forces while early CT findings are limited. The nurse protects oxygenation and perfusion, prevents secondary injury, and coordinates advanced neurologic evaluation. A scalp abrasion, nasal fracture, or superficial eye laceration cannot account for persistent coma after severe acceleration-deceleration trauma.

171. D — Sacral sparing indicates that some pathways remain intact through the injured spinal cord, making the injury incomplete. The nurse documents the exact sensory and motor findings and protects alignment while the team plans further management. Complete transection, wrist nerve injury, and a normal examination do not explain preserved sacral sensation and voluntary movement after spinal trauma.

172. C — An air-fluid level after chest trauma suggests both air and blood in the pleural space. The nurse supports oxygenation, monitors for shock and tension physiology, verifies chest-drain function, and escalates for definitive treatment. A bruise, muscle strain, or healed clavicle fracture cannot explain pleural air and blood with progressive respiratory distress.

173. B — Splenic bleeding can temporarily tamponade and then recur, producing renewed pain and shock after an apparently stable interval. The nurse reassesses perfusion, limits oral intake, alerts the trauma team, and prepares for urgent imaging or surgery. Analgesia, shoulder strain, and rash do not explain recurrent shock after known splenic trauma.

174. D — New urinary difficulty and suprapubic fullness after pelvic trauma may reflect retention, obstruction, or bladder injury. The nurse assesses, avoids traumatic instrumentation, monitors output, and obtains timely evaluation. Straining, tight compression, and discharge can worsen pain or urinary injury and delay recognition of a potentially serious pelvic complication. Continue serial assessment for evolving complications.

175. A — Reperfusion can cause edema within closed fascial compartments, producing acute compartment syndrome. Severe pain and passive-stretch pain require immediate pressure assessment

and surgical intervention while limb perfusion is protected. Tighter dressings, high elevation, and exercise can reduce inflow or worsen tissue injury while delaying decompression. Repeated neurovascular checks matter because swelling, constriction, and ischemia can progress after the initial intervention.