

PRACTICE EXAM 11: 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 with a severe head injury becomes increasingly somnolent and develops a new unilateral dilated pupil. Which action is the priority?

- A. Dim the lights and allow uninterrupted sleep
- B. Escalate immediately for impending herniation and support airway and perfusion
- C. Offer oral fluids and repeat the pupil check later
- D. Place the patient in Trendelenburg position

2. A patient with a Glasgow Coma Scale score of 6 has gurgling respirations after a fall. Which intervention should occur first?

- A. Wait for a family member to provide the medical history
- B. Give oral medication to reduce agitation
- C. Place the patient flat without airway support
- D. Suction the airway while maintaining cervical stabilization and oxygenation

3. A patient taking warfarin strikes the head and briefly loses consciousness. The initial neurologic examination is normal. What is the best nursing plan?

- A. Discharge immediately because the examination is normal
- B. Perform a lumbar puncture before reassessment

- C. Arrange observation with serial neurologic assessments and ordered repeat imaging
- D. Encourage vigorous activity to test balance

4. A patient with an epidural hematoma becomes briefly more alert after losing consciousness, then deteriorates. Which interpretation is most accurate?

- A. Improvement proves the injury is limited to the scalp
- B. A lucid interval can precede rapid neurologic decline from expanding arterial bleeding
- C. The patient is experiencing expected medication sedation
- D. The pattern confirms an uncomplicated concussion

5. An older adult develops progressive confusion and headache several days after a ground-level fall. Which injury should the nurse suspect?

- A. Isolated nasal contusion without intracranial risk
- B. Simple dehydration unrelated to the fall
- C. Acute otitis externa from the impact
- D. Subdural hematoma with possible slow venous bleeding

6. Clear fluid drains from a patient's nose after a facial fracture. Which nursing action is appropriate?

- A. Keep the patient upright, avoid nasal instrumentation, and notify the trauma team
- B. Pack the nostril deeply with gauze
- C. Ask the patient to blow the nose forcefully
- D. Insert a nasogastric tube through the affected nostril

7. A patient with a traumatic brain injury is restless, hypoxemic, and trying to remove the oxygen device. What should the nurse do first?

- A. Apply physical restraints without assessing the patient
- B. Administer a sedative and stop neurologic assessments

- C. Treat hypoxemia while assessing causes of agitation and maintaining safety
- D. Assume the behavior is normal and leave the patient alone

8. A patient with a suspected cervical spine injury reports new hand weakness during transfer. Which action is safest?

- A. Remove the collar to test neck range of motion
- B. Stop movement, maintain neutral alignment, and repeat a focused neurologic examination
- C. Ask the patient to walk to localize the pain
- D. Flex the neck to improve venous drainage

9. A patient has a mean arterial pressure of 78 mmHg and an intracranial pressure of 18 mmHg. What is the cerebral perfusion pressure?

- A. 42 mmHg
- B. 78 mmHg
- C. 96 mmHg
- D. 60 mmHg

10. A patient with severe head trauma begins vomiting while lying supine. Which nursing action is most appropriate?

- A. Leave the patient supine to avoid all movement
- B. Give oral water to clear the mouth
- C. Protect the airway with assisted turning while preserving spinal alignment
- D. Lower the head below the heart

11. A patient with a neck injury has arm weakness greater than leg weakness after hyperextension. Which syndrome is most likely?

- A. Central cord syndrome

- B. Anterior cord syndrome
- C. Complete spinal cord transection
- D. Isolated lumbosacral radiculopathy

12. A patient has bilateral loss of motor function, pain, and temperature below a cervical injury but retains vibration and position sense. Which pattern is suggested?

- A. Posterior cord syndrome
- B. Central cord syndrome
- C. Isolated peripheral neuropathy
- D. Anterior cord syndrome

13. A patient with a unilateral cervical cord injury has ipsilateral weakness and loss of vibration with contralateral loss of pain and temperature. Which condition is present?

- A. Neurogenic shock alone
- B. Cauda equina syndrome
- C. Brown-Sequard syndrome
- D. Diffuse axonal brain injury

14. A patient with a suspected unstable cervical injury must be moved from the floor to a stretcher. Which technique is safest?

- A. Pull the patient by the arms to save time
- B. Use a coordinated team log roll with one person controlling the head
- C. Allow the patient to sit up independently
- D. Rotate the shoulders first and bring the head around later

15. A patient with a midface fracture has mobility of the maxilla and palate with malocclusion. Which fracture pattern should the nurse recognize?

- A. Le Fort fracture with potential airway compromise
- B. Isolated nasal fracture
- C. Simple mandibular condyle sprain
- D. Closed orbital contusion only

16. A patient with a displaced mandible fracture has pooling blood and an increasing tongue obstruction. What is the priority?

- A. Offer a soft diet to reduce jaw movement
- B. Suction and prepare for a definitive airway while maintaining alignment
- C. Place the patient supine and leave the airway unmonitored
- D. Insert a blind nasopharyngeal device through the injured area

17. A patient with an orbital blowout fracture asks whether forceful nose blowing will clear congestion. Which response is best?

- A. Encourage forceful blowing every hour
- B. Pack both nostrils tightly with gauze
- C. Avoid nose blowing and report swelling or vision changes
- D. Apply pressure directly over the injured globe

18. A patient has a full-thickness laceration with visible prolapsed ocular tissue after blunt facial trauma. Which action is appropriate?

- A. Patch only the injured eye with a pressure dressing
- B. Remove visible tissue with sterile forceps
- C. Irrigate forcefully until the wound edges close
- D. Place a rigid shield without pressure and obtain urgent ophthalmic evaluation

19. A patient with blunt eye trauma has severe pain, photophobia, and blood layering in the anterior chamber. Which finding is most consistent?

- A. Traumatic hyphema
- B. Simple conjunctival irritation
- C. A superficial eyelid abrasion
- D. Isolated optic-nerve neuropathy without ocular bleeding

20. A patient with facial trauma has numbness over the cheek, diplopia, and flattening of the malar prominence. Which injury is likely?

- A. Isolated occipital scalp laceration
- B. Simple dental caries
- C. Uncomplicated cervical strain
- D. Zygomaticomaxillary complex fracture

21. A patient with a penetrating neck injury develops an expanding hematoma and stridor. Which action should the nurse prioritize?

- A. Activate an emergency airway response and prepare for early airway control
- B. Apply firm circumferential pressure around the neck
- C. Send the patient for routine radiography first
- D. Offer oral fluids to soothe the throat

22. Which finding is a hard sign of vascular injury in a patient with penetrating neck trauma?

- A. A small, nonexpanding superficial abrasion
- B. Active arterial bleeding or an expanding pulsatile hematoma
- C. Mild localized tenderness without swelling
- D. A stable bruise with an intact distal pulse

23. A patient with blunt neck trauma has hoarseness, subcutaneous emphysema, and coughing blood. Which concern is most urgent?

- A. An isolated skin contusion
- B. A routine viral sore throat
- C. Laryngotracheal injury with a potentially unstable airway
- D. A minor dental fracture without airway involvement

24. A patient arrives in a cervical collar that is visibly too loose and allows the head to tilt. What should the nurse do?

- A. Remove the collar and encourage a comfortable position
- B. Tighten it until the jaw and neck are compressed
- C. Ask the patient to hold the head still without assistance
- D. Maintain manual stabilization and obtain a correctly fitted collar

25. A patient with cervical spinal trauma develops hypotension, warm dry skin, and a heart rate of 48/min without evidence of bleeding. Which condition is most likely?

- A. Hemorrhagic shock from occult blood loss alone
- B. Neurogenic shock from loss of sympathetic vascular tone
- C. Obstructive shock from isolated pulmonary embolism
- D. Anaphylactic shock caused by a food exposure

26. A patient with an acute cervical cord injury has flaccid paralysis and absent reflexes below the lesion during the first hours. What does this suggest?

- A. Spinal shock with temporary loss of reflex activity
- B. Permanent proof of complete cord transection
- C. Isolated peripheral nerve compression
- D. A normal response to cervical immobilization

27. A patient with a high cervical spinal cord injury has increasing work of breathing and a weak cough. Which assessment is most important?

- A. Focus only on lower-extremity motor testing
- B. Restrict all repositioning to prevent any discomfort
- C. Trend respiratory effort, vital capacity, cough strength, and gas exchange
- D. Wait for cyanosis before escalating care

28. A patient develops sudden loss of vision after a blow to the orbit, but the globe appears intact. Which concern requires urgent evaluation?

- A. A minor eyelid ecchymosis
- B. Traumatic optic neuropathy
- C. A superficial conjunctival hemorrhage
- D. An uncomplicated facial bruise

29. A patient reports flashes of light and a curtain-like shadow after blunt ocular trauma. Which complication should the nurse suspect?

- A. Retinal detachment or another traumatic retinal injury
- B. Simple dry eye irritation
- C. A healed eyebrow laceration
- D. An isolated external ear contusion

30. A patient with a basilar skull fracture has bruising behind the ear and clear drainage from the ear canal. Which interpretation is best?

- A. A superficial pinna hematoma only
- B. An uncomplicated external ear infection
- C. Suspected skull-base fracture with possible CSF otorrhea
- D. A normal post-trauma drainage pattern

31. A patient with suspected increased intracranial pressure is being positioned for care. Which position generally supports venous drainage?

- A. Place the patient flat with the neck sharply flexed
- B. Turn the head toward the side of the suspected lesion
- C. Use Trendelenburg position with the hips elevated
- D. Elevate the head of the bed while keeping the neck midline

32. A patient with a traumatic brain injury develops a widened pulse pressure, bradycardia, and irregular respirations. Which concern is most urgent?

- A. A benign response to analgesia
- B. Isolated dehydration without neurologic risk
- C. Cushing response indicating dangerous intracranial pressure elevation
- D. Expected recovery from a mild concussion

33. A patient with severe brain trauma develops marked polyuria, rising serum sodium, and intense thirst. Which complication should the nurse recognize?

- A. Fluid overload from excessive antidiuretic hormone
- B. Central diabetes insipidus with dangerous free-water loss
- C. A resolved concussion requiring no monitoring
- D. An isolated facial fracture causing urinary changes

34. A patient remains comatose after high-energy acceleration-deceleration trauma, although the first CT shows little structural damage. Which injury pattern is possible?

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

35. A patient with an incomplete spinal cord injury retains perianal sensation 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

36. A patient with a severe facial injury becomes agitated and repeatedly reaches toward the mouth. Which assessment should receive priority?

- A. Assess appetite before inspecting the mouth
- B. Offer a meal to test swallowing ability
- C. Inspect for airway obstruction from blood, teeth, swelling, or soft-tissue displacement
- D. Delay oral examination until discharge planning

37. A patient with multiple rib fractures has paradoxical inward movement of one chest segment during inspiration. Which injury pattern is present?

- A. Flail chest with impaired chest-wall stability
- B. Simple pneumothorax without chest-wall disruption
- C. Isolated clavicle sprain
- D. Uncomplicated pleural effusion

38. A patient with chest trauma becomes acutely dyspneic, hypotensive, and cyanotic with absent breath sounds on the right and distended neck veins. What is the priority?

- A. Obtain a routine chest radiograph before intervening
- B. Activate immediate treatment for tension pneumothorax
- C. Place the patient flat and reassess in 30 minutes
- D. Give oral fluids for presumed dehydration

39. A patient has a sucking wound to the chest after a stabbing. Which dressing is most appropriate while definitive treatment is arranged?

- A. Pack the wound deeply with dry gauze
- B. Seal it completely on all four sides without reassessment
- C. Leave the wound uncovered during transport
- D. Apply an occlusive dressing secured on three sides and monitor for tension

40. A patient with blunt chest trauma has rapid blood loss through a thoracostomy tube and persistent shock. Which complication is most concerning?

- A. A small stable pulmonary contusion
- B. An isolated superficial rib bruise
- C. A resolved pneumothorax with no ongoing bleeding
- D. Massive hemothorax requiring urgent surgical evaluation

41. A patient with penetrating precordial trauma has hypotension, muffled heart sounds, and distended neck veins. Which condition should the nurse suspect?

- A. Cardiac tamponade from blood accumulating in the pericardial sac
- B. Uncomplicated isolated rib fracture
- C. Simple dehydration after exertion
- D. A stable pleural effusion without cardiac effect

42. A patient with blunt chest trauma has a new dysrhythmia and elevated cardiac biomarkers. Which injury should be considered?

- A. An isolated skin abrasion over the sternum
- B. A routine anxiety response with no monitoring need
- C. Blunt cardiac injury requiring rhythm and hemodynamic monitoring
- D. A simple clavicle fracture alone

43. A patient has high-speed deceleration trauma, chest pain, unequal pulses, and a widened mediastinum on imaging. Which injury is most concerning?

- A. An isolated superficial chest-wall bruise
- B. Blunt thoracic aortic injury
- C. A minor uncomplicated pleural effusion
- D. A stable distal radius fracture

44. A patient with lower chest trauma has respiratory distress, bowel sounds in the chest, and a scaphoid abdomen. Which complication is likely?

- A. Isolated pulmonary contusion without diaphragmatic injury
- B. Simple abdominal wall bruising
- C. Traumatic diaphragmatic rupture with herniation of abdominal contents
- D. Uncomplicated upper-extremity fracture

45. A patient with a chest impact has worsening hypoxemia several hours later despite a relatively clear initial radiograph. Which injury may be evolving?

- A. A superficial chest abrasion
- B. A healed clavicle injury
- C. An isolated abdominal strain
- D. Pulmonary contusion with delayed gas-exchange impairment

46. A patient with a small traumatic pneumothorax is stable but requires positive-pressure ventilation for another injury. What should the nurse anticipate?

- A. Close reassessment and definitive pleural management as ordered before or with ventilation
- B. No monitoring because the pneumothorax is already small
- C. Encouragement to ambulate immediately
- D. Routine oral fluids as the only treatment

47. A patient being transported after thoracostomy suddenly reports dyspnea, and the chest tube is found partially dislodged. What should the nurse do first?

- A. Push the contaminated tube back into the chest
- B. Apply an occlusive dressing over the site and call for immediate reassessment
- C. Clamp the tube and continue transport without notification
- D. Remove the tube completely and cover the site later

48. A chest tube drainage system shows expected tidaling but no continuous bubbling in the water-seal chamber. How should the nurse interpret this?

- A. It proves the tube is completely obstructed
- B. Expected with a patent system and no persistent air leak
- C. It requires routine clamping of the tubing
- D. It confirms a new tension pneumothorax

49. A patient with multiple rib fractures guards the chest and takes shallow breaths. Which intervention best reduces pulmonary complications?

- A. Avoid analgesia so the respiratory rate remains measurable
- B. Bind the entire chest tightly with elastic material
- C. Provide effective analgesia while encouraging supported ventilation and coughing
- D. Keep the patient supine and discourage movement

50. A patient with severe facial and chest trauma has facial petechiae, conjunctival hemorrhages, and cyanosis above the nipple line after compression. Which syndrome is suggested?

- A. Isolated carbon monoxide exposure
- B. Simple allergic facial flushing
- C. An uncomplicated clavicle fracture
- D. Traumatic asphyxia from sudden thoracic compression

51. A patient develops severe chest pain, fever, and subcutaneous emphysema after forceful vomiting followed by blunt impact. Which injury requires consideration?

- A. Esophageal rupture with mediastinal contamination
- B. A superficial abdominal abrasion
- C. An isolated ankle fracture
- D. A simple tension headache

52. A patient with a penetrating chest wound develops increasing airway pressures, falling oxygen saturation, and unilateral absent breath sounds after intubation. Which complication should be suspected?

- A. Improving pulmonary contusion
- B. Iatrogenic or traumatic tension pneumothorax
- C. Isolated lower-extremity fracture pain
- D. A resolved airway obstruction

53. A patient with unstable chest trauma has increasing oxygen needs and fatigue despite supplemental oxygen. Which assessment is most important?

- A. Measure only the patient's pain score
- B. Delay reassessment until the next scheduled vital signs
- C. Trend work of breathing, gas exchange, mental status, and readiness for ventilatory support
- D. Offer oral fluids before checking respiratory status

54. A patient with abdominal trauma is hypotensive and has a positive focused assessment with sonography for trauma in the right upper quadrant. Which action is most appropriate?

- A. Activate the hemorrhage pathway and prepare for urgent operative or procedural control
- B. Send the patient for a lengthy outpatient ultrasound
- C. Give oral food while waiting for a surgical consult
- D. Discharge if abdominal tenderness remains mild

55. A patient with blunt abdominal trauma has left upper-quadrant pain and referred pain to the left shoulder with falling blood pressure. Which injury is likely?

- A. Isolated abdominal wall bruise
- B. Simple gastroesophageal reflux
- C. A stable distal leg fracture
- D. Splenic injury with intraperitoneal hemorrhage

56. A patient with blunt right upper-quadrant trauma has abdominal tenderness, tachycardia, and falling hemoglobin. Which organ injury should be considered?

- A. A minor skin abrasion over the ribs
- B. An isolated wrist sprain
- C. Liver injury with possible intra-abdominal hemorrhage
- D. Simple constipation unrelated to trauma

57. A patient struck by a handlebar has increasing abdominal pain, guarding, and free intraperitoneal air. Which injury is most likely?

- A. Hollow-viscus perforation requiring urgent surgical evaluation
- B. An isolated superficial contusion
- C. A stable closed ankle fracture
- D. A simple tension-type headache

58. A patient has epigastric pain radiating to the back after a handlebar impact, with bruising across the abdomen. Which injury should be suspected?

- A. An isolated forearm abrasion
- B. Pancreatic or duodenal injury with possible delayed presentation
- C. A simple viral sore throat
- D. A stable nasal fracture

59. A patient with flank trauma has gross hematuria and a new expanding flank hematoma. Which action is best?

- A. Apply vigorous massage over the flank
- B. Encourage unrestricted ambulation
- C. Assume the blood is from a urinary infection
- D. Monitor perfusion and urine output while escalating for renal or retroperitoneal injury

60. A patient with a pelvic fracture has flank ecchymosis, anemia, and persistent tachycardia despite no obvious external bleeding. Which source should be considered?

- A. A superficial thigh abrasion alone
- B. A routine medication side effect
- C. Retroperitoneal hemorrhage
- D. An isolated finger fracture

61. A patient with abdominal trauma develops tense distention, oliguria, rising airway pressures, and worsening hypotension. Which complication is most likely?

- A. Abdominal compartment syndrome causing organ dysfunction
- B. A resolving abdominal wall bruise
- C. Simple hunger-related distention
- D. An isolated shoulder injury

62. A patient wearing a seat belt has a horizontal abdominal ecchymosis and increasing tenderness. Which plan is safest?

- A. Discharge because the skin is intact
- B. Apply heat and encourage a full meal
- C. Assume the mark is only cosmetic
- D. Maintain observation and serial examination for occult bowel or mesenteric injury

63. A patient with an abdominal evisceration arrives after a stabbing. Which intervention is appropriate?

- A. Push the organs back into the abdomen at the bedside
- B. Cover exposed organs with warm sterile moist dressings and avoid replacement
- C. Cover the organs with dry adhesive tape
- D. Leave the wound open for repeated inspection

64. A patient arrives with a knife embedded in the abdomen and stable vital signs. What should the nurse do?

- A. Remove the knife to inspect the wound tract
- B. Stabilize the object for controlled operating-room removal
- C. Rotate the object to determine its depth
- D. Pull it out after giving oral analgesia

65. A patient with blunt abdominal trauma initially has mild tenderness but later develops guarding and rebound. Which response is best?

- A. Document improvement because the initial pain was mild
- B. Give a meal to test gastrointestinal function
- C. Stop abdominal examinations to avoid discomfort
- D. Treat the new peritoneal signs as deterioration and notify the trauma team

66. A patient with abdominal trauma develops periumbilical ecchymosis and a falling hemoglobin level. Which interpretation is most appropriate?

- A. The finding may reflect intra-abdominal or retroperitoneal bleeding and requires escalation
- B. It confirms a harmless skin reaction
- C. It rules out internal bleeding because there is no open wound
- D. It indicates isolated allergic dermatitis

67. A patient with pelvic trauma has gross hematuria and suprapubic pain after a sudden deceleration. Which injury is most concerning?

- A. A superficial lower-abdominal abrasion
- B. A simple muscle cramp from immobility
- C. Bladder rupture requiring urinary and pelvic evaluation
- D. An isolated shoulder dislocation

68. Blood is present at the urethral meatus of a patient with a pelvic fracture. Which action is safest?

- A. Insert a catheter using firm pressure
- B. Avoid blind catheterization and notify the trauma team for urethral evaluation
- C. Ask the patient to strain repeatedly around the catheter
- D. Ignore the finding if the bladder is palpable

69. A patient with an unstable pelvic fracture is awaiting transfer. Where should a pelvic binder be positioned?

- A. Centered over the greater trochanters rather than across the iliac crests
- B. Across the upper abdomen below the ribs
- C. Around the waist at the umbilicus
- D. Over the lower thighs below the hips

70. A patient with an open-book pelvic injury has widening of the pubic symphysis and severe pelvic pain. Which intervention is appropriate?

- A. Repeatedly spring the pelvis to assess mobility
- B. Encourage walking to test weight bearing
- C. Place the patient in a wide abducted position
- D. Minimize pelvic movement, apply prescribed stabilization, and prepare for hemorrhage control

71. A patient with pelvic trauma remains hypotensive after initial blood products, and imaging suggests arterial extravasation. Which treatment may be required?

- A. Routine oral hydration alone
- B. Unrestricted ambulation to improve circulation
- C. Angiographic embolization or operative hemorrhage control
- D. Delayed outpatient follow-up without monitoring

72. A patient with a pelvic fracture develops a cool foot, absent dorsalis pedis pulse, and new paresthesia. Which response is priority?

- A. Elevate the leg and reassess at the end of the shift
- B. Escalate immediately for limb-threatening vascular compromise
- C. Apply a tight elastic wrap around the foot
- D. Encourage ankle exercises to restore the pulse

73. A patient with a pelvic fracture has perineal bruising and scrotal swelling. Which associated injury should the nurse consider?

- A. An isolated forearm fracture
- B. A routine tension headache
- C. Urethral or lower urinary tract injury
- D. A superficial chest abrasion

74. A patient with a pelvic fracture has an extraperitoneal bladder rupture. Which management principle is most appropriate?

- A. Force oral fluids until the bladder is distended
- B. Remove all urinary drainage immediately
- C. Encourage repeated Valsalva maneuvers
- D. Coordinate urinary drainage and specialist management based on the injury pattern

75. A patient with a left lower-chest impact has abdominal pain and shortness of breath that worsen when supine. Which complication is possible?

- A. Delayed recognition of a traumatic diaphragmatic hernia
- B. An isolated hand contusion
- C. A simple superficial burn
- D. An uncomplicated ear laceration

76. A patient with a seat-belt injury has persistent tachycardia and increasing pain despite stable initial imaging. Which injury may be occult?

- A. Mesenteric injury with evolving ischemia or hemorrhage
- B. A superficial belt mark with no internal significance
- C. An isolated toe fracture
- D. A routine post-trauma headache

77. A patient with blunt abdominal trauma becomes febrile and increasingly tender 24 hours after initially normal vital signs. Which concern is most important?

- A. Expected resolution of all abdominal injury
- B. Delayed hollow-viscus perforation or traumatic peritonitis
- C. A minor skin infection at the knee
- D. A simple medication-related appetite change

78. A patient develops delayed abdominal distention and pain after a high-speed crash, with bruising over the flank and a falling hematocrit. Which source is plausible?

- A. A superficial shoulder abrasion
- B. An uncomplicated migraine
- C. A stable finger dislocation
- D. Retroperitoneal or psoas-region bleeding

79. A patient with left lower-rib fractures develops worsening abdominal tenderness several hours later. Which injury should be reconsidered?

- A. A healed wrist fracture
- B. A superficial scalp abrasion
- C. Splenic injury that was initially occult
- D. An isolated foot blister

80. A patient has a traumatic abdominal-wall hernia after a handlebar impact, with localized pain but stable vital signs. Which plan is appropriate?

- A. Reduce the hernia forcefully at the bedside
- B. Protect the area and obtain evaluation for associated intra-abdominal injury
- C. Discharge without examination because vital signs are stable
- D. Apply a rigid compression board directly over the defect

81. A patient with a tibial fracture reports escalating pain despite opioids and pain with passive toe extension. Which complication is most likely?

- A. Routine fracture discomfort with no further assessment
- B. A superficial skin infection at the ankle
- C. Uncomplicated muscle soreness from repositioning
- D. Acute compartment syndrome requiring urgent surgical evaluation

82. A patient reports numb fingers after a forearm cast is applied, and the fingers are becoming cool. What should the nurse do first?

- A. Check distal perfusion and promptly notify the provider about possible constriction
- B. Wrap the cast more tightly to improve support
- C. Place the arm in a dependent position for several hours
- D. Wait for the next scheduled neurovascular check

83. A patient has an open tibial fracture with visible bone after a vehicle crash. Which intervention is the priority?

- A. Probe the wound to measure the bone exposure
- B. Close the skin at the bedside with adhesive strips
- C. Cover the wound, immobilize the limb, and prepare for antibiotics and operative care
- D. Allow weight bearing to assess fracture stability

84. A patient arrives after traumatic amputation of a hand. Which action regarding the amputated part is appropriate?

- A. Wrap in moist sterile gauze, bag it, and cool indirectly
- B. Place the part directly on ice without a barrier
- C. Immerse the part in antiseptic solution
- D. Leave the part uncovered on the stretcher

85. A patient rescued after prolonged limb compression has dark urine and weakness. Which complication should the nurse anticipate?

- A. Simple dehydration without muscle injury
- B. An isolated superficial laceration
- C. Crush syndrome with rhabdomyolysis and hyperkalemia risk
- D. A resolved ankle sprain

86. A patient with an extremity wound has brisk pulsatile bleeding that continues despite direct pressure. What should the nurse do?

- A. Release pressure repeatedly to inspect the wound
- B. Apply a proximal tourniquet per protocol and document time
- C. Elevate the limb and wait for spontaneous clotting
- D. Pack the wound loosely and delay escalation

87. A patient has an anterior shoulder dislocation and reports numbness over the lateral deltoid. Which nerve is most likely affected?

- A. Median nerve
- B. Ulnar nerve
- C. Peroneal nerve
- D. Axillary nerve

88. A patient struck in the knee has a shortened, adducted, internally rotated leg with severe hip pain. Which injury pattern is likely?

- A. Isolated ankle sprain
- B. Anterior shoulder dislocation
- C. Posterior hip dislocation with possible sciatic nerve injury
- D. Stable patellar bruise

89. A patient with a high-energy knee dislocation has a cool foot and diminished pedal pulse. Which action is the priority?

- A. Escalate for popliteal artery injury and urgent vascular assessment
- B. Apply heat and reassess after ambulation
- C. Delay pulse documentation until after reduction
- D. Massage the calf to improve circulation

90. A patient has a femur fracture and an ipsilateral unstable pelvic fracture. Which intervention should the nurse question?

- A. Checking distal pulses before and after immobilization
- B. Supporting the limb in alignment with a padded splint
- C. Monitoring for hemorrhage and neurovascular change
- D. Applying a traction splint to the injured leg

91. A patient with a long-bone fracture develops hypoxemia, confusion, and a fine petechial rash on the upper chest. Which complication is suspected?

- A. Isolated contact dermatitis
- B. Fat embolism syndrome
- C. Simple postoperative nausea
- D. A minor superficial hematoma

92. A patient with a burst fracture develops new bilateral leg weakness and urinary retention. Which concern is most urgent?

- A. Expected soreness from immobilization
- B. An isolated ankle injury
- C. Spinal canal compromise requiring urgent neurologic and surgical evaluation
- D. A harmless response to analgesia

93. A patient with a lumbar fracture develops saddle anesthesia and inability to void. Which syndrome should the nurse recognize?

- A. A simple lumbar muscle strain
- B. An isolated radial nerve injury
- C. A superficial sacral abrasion
- D. Cauda equina syndrome requiring urgent evaluation

94. A patient has a degloving injury of the forearm with a large skin flap that remains attached. Which action is appropriate?

- A. Trim the flap edges at the bedside
- B. Cover the flap with sterile moist dressings, immobilize, and obtain surgical evaluation
- C. Scrub the exposed tissue vigorously
- D. Leave the flap uncovered to observe color

95. A patient with a contaminated open wound asks for repeated peroxide cleansing. Which response is best?

- A. Use appropriate irrigation and protect viable tissue while following the wound-care plan
- B. Pour concentrated peroxide into the wound repeatedly
- C. Close the contaminated wound immediately with adhesive
- D. Avoid all cleansing until the wound dries

96. An older adult taking apixaban has a minor fall, mild headache, and a normal initial neurologic examination. Which plan is safest?

- A. Use a low threshold for observation, imaging, and serial neurologic assessment
- B. Discharge immediately because the fall was low energy
- C. Avoid imaging because the patient is older
- D. Give aspirin for headache and encourage sleep

97. An older adult with a pelvic fracture becomes confused, cool, and tachycardic while reporting little pain. Which interpretation is best?

- A. Consider confusion an expected part of aging
- B. Use the pain score alone to rule out deterioration
- C. Delay vital-sign trending until the patient is comfortable
- D. Assume significant injury is possible despite muted symptoms and escalate reassessment

98. An older patient with multiple rib fractures becomes lethargic and hypoxemic after receiving opioids. Which action is most appropriate?

- A. Stop all monitoring because sedation is expected
- B. Give another opioid dose without respiratory assessment
- C. Reassess ventilation, sedation, pain control, and pulmonary complications together
- D. Bind the chest tightly to reduce movement

99. An older adult with a ground-level fall has new back pain and kyphosis but no obvious deformity. Which concern should remain high?

- A. A normal age-related posture with no injury
- B. Osteoporotic vertebral compression or unstable spinal fracture
- C. A superficial skin bruise only
- D. An isolated hand contusion causing back pain

100. A small child with facial trauma has increasing drooling, muffled crying, and suprasternal retractions. Which action is priority?

- A. Force the child to lie flat for examination
- B. Maintain a calm environment and prepare for expert pediatric airway management
- C. Offer food to assess swallowing
- D. Delay intervention until cyanosis appears

101. A child with blunt chest trauma has increasing respiratory effort but an initially normal oxygen saturation. Which assessment is most important?

- A. Rely on oxygen saturation alone
- B. Delay reassessment until the child becomes hypotensive
- C. Trend work of breathing because children can suddenly decompensate
- D. Focus only on the visible skin bruise

102. A toddler is brought after a reported short fall with lethargy, retinal hemorrhages, and subdural bleeding. Which action is appropriate?

- A. Protect the child, document objectively, and activate the child-protection pathway
- B. Confront the caregiver and demand an admission
- C. Alter the history to make the mechanism appear consistent
- D. Discharge once the child briefly awakens

103. A child with a femur fracture becomes pale and tachycardic but still has a normal blood pressure. Which interpretation is safest?

- A. Conclude that shock is absent because pressure is normal
- B. Wait for a weak pulse before intervening
- C. Give oral fluids and reassess tomorrow
- D. Recognize compensated shock and escalate before hypotension develops

104. A child with a possible cervical injury is crying and moving the neck before imaging. Which approach is best?

- A. Allow unrestricted neck motion because the child is alert
- B. Force the head into adult-sized equipment
- C. Sedate without monitoring to stop all movement
- D. Use age-appropriate immobilization and minimize movement while maintaining a patent airway

105. A pregnant patient at 30 weeks has blunt abdominal trauma and is hypotensive while lying supine. Which positioning intervention is most appropriate?

- A. Keep the patient flat without modification
- B. Place the patient prone to relieve pressure
- C. Use left uterine displacement or lateral tilt while supporting resuscitation
- D. Elevate only the injured leg

106. A pregnant patient reports abdominal pain and vaginal bleeding after a motor-vehicle crash. Which complication should the nurse suspect?

- A. Normal pregnancy discomfort unrelated to trauma
- B. Placental abruption with risk to maternal and fetal status
- C. An isolated wrist sprain
- D. A superficial seat-belt mark without internal risk

107. A pregnant trauma patient is hemodynamically stable but has abdominal tenderness. Which monitoring plan is appropriate?

- A. Coordinate maternal reassessment with fetal monitoring and obstetric consultation
- B. Monitor the fetus only and ignore maternal vital signs
- C. Discharge when the first fetal tracing is reassuring
- D. Avoid evaluation because imaging is never permitted in pregnancy

108. A pregnant trauma patient needs diagnostic imaging to evaluate possible internal bleeding. Which principle should guide nursing support?

- A. Refuse all imaging solely because the patient is pregnant
- B. Substitute an unvalidated bedside test for needed evaluation
- C. Delay imaging until symptoms resolve spontaneously
- D. Do not delay necessary maternal evaluation; use the ordered study for the clinical need

109. An Rh-negative pregnant patient sustains abdominal trauma and has possible fetomaternal bleeding. Which action should the nurse anticipate?

- A. Give routine oral iron as the only intervention
- B. Notify the obstetric team so Rh immune globulin and evaluation can be considered
- C. Assume blood type is irrelevant after trauma
- D. Delay notification until delivery

110. A patient with a thermal burn still has a smoldering shirt after a kitchen fire. What is the first priority?

- A. Apply ointment before removing the shirt
- B. Cover the clothing with a dry blanket and wait
- C. Stop the burning process, remove hot material, and assess airway and breathing
- D. Begin detailed wound measurement before cooling or airway assessment

111. A patient rescued from an enclosed-space fire has hoarseness, facial burns, and soot in the mouth. Which concern is most urgent?

- A. Progressive inhalation injury with a potentially difficult airway
- B. A superficial hand burn only
- C. A stable ankle sprain from evacuation
- D. Routine thirst after smoke exposure

112. A patient exposed to smoke has headache, confusion, and a pulse oximeter reading of 99%. Which interpretation is correct?

- A. The reading rules out clinically important inhalation injury
- B. Carbon monoxide poisoning remains possible because standard pulse oximetry may appear normal
- C. Confusion proves only dehydration
- D. Oxygen should be withheld until a blood gas returns

113. A patient with an electrical burn has small hand wounds but severe muscle pain and dark urine. Which concern is most important?

- A. A superficial burn requiring no observation
- B. A simple contact dermatitis
- C. A healed paper cut unrelated to the exposure
- D. Deep tissue injury and rhabdomyolysis despite limited skin findings

114. A patient with a circumferential full-thickness chest burn develops increasing ventilatory restriction. Which intervention may be required?

- A. Urgent evaluation for escharotomy to relieve chest-wall constraint
- B. Apply a tighter chest dressing
- C. Encourage deep breathing without reassessment
- D. Wait for the eschar to soften naturally

115. A patient has an alkali chemical splash to the eye. Which action should occur first?

- A. Neutralize the alkali with an acid solution
- B. Patch the eye before irrigation
- C. Begin copious irrigation immediately while removing contaminated material
- D. Wait for an ophthalmologist before flushing

116. A 60-kg adult has a 25% total body surface area burn. Using the Parkland formula, how much crystalloid is calculated for the first 24 hours?

- A. 6,000 mL
- B. 3,000 mL
- C. 7,500 mL
- D. 12,000 mL

117. Using the adult Rule of Nines, what total body surface area is burned when the anterior trunk, one entire arm, and the anterior portion of one leg are involved?

- A. 27%
- B. 45%
- C. 36%
- D. 54%

118. A bariatric trauma patient must be moved after a fall, but the available stretcher is not rated for the patient's weight. Which action is safest?

- A. Move the patient with fewer staff to save time
- B. Obtain appropriately rated equipment and a coordinated transfer team
- C. Use a standard stretcher and document the risk afterward
- D. Ask the patient to walk despite pain and instability

119. A trauma patient quietly says a partner will hurt them if they return home. Which nursing response is best?

- A. Ask the partner to explain the situation at the bedside
- B. Promise confidentiality even if reporting is required
- C. Tell the patient to leave immediately without assessing barriers
- D. Arrange a private safety assessment and offer trauma-informed support and resources

120. A child has bruises in various stages on the torso and patterned marks inconsistent with the reported fall. Which action is appropriate?

- A. Photograph the injuries on a personal phone
- B. Question the child repeatedly until the story changes
- C. Ignore the pattern because bruising is common in children
- D. Document objectively, ensure safety, and follow mandated reporting procedures

121. A patient reports sexual assault during a trauma evaluation and requests evidence collection. Which action best preserves forensic integrity?

- A. Place clothing in a plastic bag and leave it unlabeled
- B. Allow several staff members to handle evidence for convenience
- C. Use the facility's trained forensic process and document transfers through chain of custody
- D. Discard items after photographs are taken

122. During the primary survey of a trauma patient, which sequence best reflects the nurse's priorities?

- A. Complete the history, then examine the airway and circulation
- B. Address airway with cervical protection, breathing, circulation, disability, and exposure
- C. Begin discharge teaching before assessing neurologic status
- D. Treat the most painful wound before checking breathing

123. A trauma patient has blood and vomitus in the mouth with a suspected cervical injury. Which airway maneuver is most appropriate initially?

- A. Suction and use a jaw-thrust maneuver while maintaining inline stabilization
- B. Use a head-tilt chin-lift without regard for the neck
- C. Give oral fluids to clear the secretions
- D. Place the patient prone without airway monitoring

124. Before rapid-sequence intubation for a deteriorating trauma patient, which preparation is most helpful?

- A. Optimize preoxygenation and continue apneic oxygenation while the team secures the airway
- B. Begin the procedure without checking suction or backup equipment
- C. Remove cervical precautions to improve visualization
- D. Withhold oxygen so the neurologic examination stays unchanged

125. A hypothermic trauma patient is receiving blood products during hemorrhage resuscitation. Which action is appropriate?

- A. Leave the patient uncovered to inspect the skin continuously
- B. Cool the blood further to reduce metabolic demand
- C. Use active warming and a blood warmer while monitoring temperature and coagulation
- D. Delay warming until surgical hemorrhage control is complete

126. During a massive transfusion, which nursing action best supports damage-control resuscitation?

- A. Give large volumes of room-temperature crystalloid before blood
- B. Wait for laboratory confirmation before communicating deterioration
- C. Use red cells alone until the operation is finished
- D. Coordinate protocol-based blood components while limiting unnecessary crystalloid

127. A patient receiving a rapid massive transfusion develops tingling, hypotension, and a prolonged QT interval. Which complication should the nurse suspect?

- A. Isolated hypernatremia from oral intake
- B. Ionized hypocalcemia related to citrate exposure
- C. A resolved blood-loss response
- D. Simple anxiety without physiologic effect

128. A bleeding trauma patient has a markedly low fibrinogen level during resuscitation. Which therapy should the nurse anticipate?

- A. Additional oral water without blood components
- B. A diuretic to remove circulating volume
- C. Targeted fibrinogen replacement with cryoprecipitate or prescribed concentrate
- D. A platelet-free crystalloid bolus as definitive treatment

129. Which intervention best represents damage-control resuscitation for a patient with uncontrolled traumatic hemorrhage?

- A. Prioritize hemorrhage control, balanced blood support, warmth, and correction of coagulopathy
- B. Normalize every laboratory value before treating the bleeding source
- C. Use crystalloid alone until the patient is fully stable
- D. Delay transport for a complete secondary history

130. Which group of abnormalities is commonly called the trauma diamond of death?

- A. Hypertension, alkalosis, thrombocytosis, and hypernatremia
- B. Fever, alkalosis, polycythemia, and hypercalcemia
- C. Bradycardia, alkalosis, dehydration, and hyperglycemia
- D. Hypothermia, acidosis, coagulopathy, and hypocalcemia

131. A patient with ongoing hemorrhagic shock remains hypotensive after two liters of crystalloid. Which action is most appropriate?

- A. Continue crystalloid alone until urine output normalizes
- B. Activate blood-based resuscitation and urgent hemorrhage-control evaluation
- C. Start a vasopressor as the only treatment for blood loss
- D. Delay escalation until the patient becomes unresponsive

132. A trauma patient has hypotension, distended neck veins, muffled heart sounds, and a narrow pulse pressure. Which shock mechanism is likely?

- A. Obstructive shock from cardiac tamponade
- B. Hypovolemic shock from isolated dehydration
- C. Neurogenic shock with loss of sympathetic tone
- D. Distributive shock from a mild allergic rash

133. A patient with chest trauma suddenly develops severe dyspnea, hypotension, unilateral absent breath sounds, and tracheal deviation. What should the nurse anticipate?

- A. Routine imaging before any treatment
- B. A diuretic for presumed pulmonary edema
- C. Immediate decompression for tension pneumothorax followed by definitive drainage
- D. Oral analgesia and observation

134. A patient with a high spinal cord injury has hypotension, warm dry skin, and relative bradycardia after trauma. Which intervention is appropriate?

- A. Assume bleeding is impossible because the skin is warm
- B. Support perfusion while continuing to exclude hemorrhage and treating loss of sympathetic tone
- C. Give a diuretic to reduce venous pooling
- D. Place the patient in a head-down position without monitoring

135. A trauma patient develops fever, worsening hypotension, rising lactate, and purulent drainage from an abdominal wound several days after surgery. Which concern is most likely?

- A. Uncomplicated postoperative fatigue
- B. Isolated chronic hypertension
- C. A stable healed fracture without infection
- D. Distributive septic shock from an evolving infection

136. A patient with blunt cardiac injury develops pulmonary edema, cool extremities, and a new low-output dysrhythmia. Which shock type should be considered?

- A. Simple hypovolemia that will resolve without assessment
- B. Neurogenic shock from isolated leg trauma
- C. Distributive shock from a minor skin abrasion
- D. Cardiogenic shock from impaired cardiac pump function

137. After a trauma intervention, which reassessment is most important before moving to the next task?

- A. Assume the intervention worked because it was completed
- B. Confirm response in airway, breathing, circulation, neurologic status, and the treated problem
- C. Record the treatment without reassessing the patient
- D. Wait for the next shift to evaluate the result

138. A patient develops acute hypoxemia and bilateral infiltrates after receiving multiple transfusions, without clear evidence of fluid overload. Which complication is possible?

- A. Transfusion-related acute lung injury
- B. A simple isolated rib bruise
- C. Chronic stable asthma with no acute change
- D. A healed abdominal incision

139. A severely injured patient develops oliguria and rising creatinine after prolonged shock and crush injury. Which complication should the nurse anticipate?

- A. A normal adaptive response requiring no monitoring
- B. An isolated eye injury causing low urine output
- C. Acute kidney injury from hypoperfusion and pigment-related tubular damage
- D. Simple urinary frequency from fluid replacement

140. A trauma patient on mechanical ventilation has worsening oxygenation, diffuse bilateral opacities, and no evidence of left-sided heart failure. Which condition is likely?

- A. A small uncomplicated skin wound
- B. An isolated wrist fracture without lung injury
- C. A resolved upper-airway obstruction
- D. Acute respiratory distress syndrome

141. Which nursing intervention helps reduce ventilator-associated pneumonia risk in an intubated trauma patient?

- A. Provide oral care, maintain appropriate head elevation, and reassess readiness to liberate
- B. Keep the patient flat after every suctioning episode
- C. Avoid oral care to prevent stimulating cough
- D. Leave secretions in place to avoid tube movement

142. Which practice is most important when accessing a central line in a trauma patient?

- A. Access the line without cleaning if the dressing looks dry
- B. Replace the dressing only after visible drainage appears
- C. Use hand hygiene and aseptic technique with an intact, monitored dressing
- D. Leave loose tape in place to avoid skin assessment

143. A trauma patient no longer needs a urinary catheter but remains unable to ambulate independently. Which action helps reduce catheter-associated infection risk?

- A. Keep it until discharge for convenience
- B. Remove when no longer indicated and use an alternative plan
- C. Disconnect the drainage bag during transfers
- D. Irrigate it routinely without a clinical indication

144. A trauma patient has a new fever, increasing incision redness, purulent drainage, and worsening pain. Which action is most appropriate?

- A. Assess the patient, notify the team, and obtain ordered cultures before or with treatment
- B. Cover the incision and wait for the next clinic visit
- C. Remove all dressings and leave the wound exposed
- D. Start leftover antibiotics without evaluation

145. A hospitalized trauma patient is disoriented at night and repeatedly tries to climb out of bed. Which intervention is best?

- A. Apply restraints immediately without assessing the cause
- B. Keep the room brightly lit all night
- C. Identify reversible causes, reorient calmly, promote sleep, and use assisted mobility
- D. Administer sedatives without safety or neurologic reassessment

146. A trauma patient who drinks heavily becomes tremulous, diaphoretic, agitated, and tachycardic during hospitalization. Which response is appropriate?

- A. Assume the findings are ordinary anxiety and leave the patient alone
- B. Give alcohol from a personal supply without an order
- C. Withhold all fluids until the tremor stops
- D. Escalate for alcohol-withdrawal assessment and protocol-based treatment

147. A weak trauma patient with orthostatic symptoms is ready to transfer from bed to chair. Which action is safest?

- A. Ask the patient to stand quickly without help
- B. Assess readiness, use assistance and equipment, and pause if symptoms occur
- C. Keep the patient immobile for the remainder of hospitalization
- D. Use restraints so the patient cannot attempt movement

148. After initial stabilization and imaging, which action is an essential part of a trauma patient's tertiary survey?

- A. Repeat only the examination of the original painful area
- B. Stop assessment once the first CT is negative
- C. Wait for the patient to identify every injury without prompting
- D. Perform a systematic repeat examination and review new information for missed injuries

149. A trauma patient has persistent tachycardia and new right upper-quadrant tenderness despite an initially reassuring examination. What should the nurse do?

- A. Repeat focused assessment and communicate the change for further evaluation
- B. Dismiss the findings because the first examination was normal
- C. Give food to see whether the pain improves
- D. Document the symptom only at discharge

150. A trauma patient becomes anxious during a dressing change and asks to stop. Which response reflects trauma-informed care?

- A. Continue without warning because the procedure is necessary
- B. Tell the patient that fear is not clinically relevant
- C. Explain the next step, offer choices when possible, and respect the patient's control
- D. Ask visitors to discuss the patient's trauma publicly

151. A trauma patient with a stable pelvic fracture is medically ready for rehabilitation. Which referral supports recovery of mobility?

- A. A dietary consult as the only rehabilitation service
- B. Physical therapy for strength, transfers, gait, and mobility progression
- C. Speech therapy for all mobility training
- D. No referral until the patient can walk independently

152. A trauma patient has a new upper-extremity amputation and needs help relearning dressing and bathing. Which referral is most appropriate?

- A. Physical therapy as the only service for all self-care tasks
- B. Occupational therapy for activities of daily living and adaptive strategies
- C. No therapy until the wound is completely healed
- D. Radiology for training in home activities

153. A trauma patient coughs with sips of water after prolonged intubation. Which action is safest?

- A. Keep the patient NPO and request a swallowing evaluation
- B. Encourage larger sips to strengthen the swallow
- C. Give thin liquids without further assessment
- D. Place food at the bedside and let the patient self-test

154. A hemodynamically stable trauma patient has a functioning gastrointestinal tract after resuscitation. Which nutrition plan is generally preferred when feasible?

- A. Keep the patient NPO indefinitely despite a usable gut
- B. Use only intravenous dextrose for full nutritional support
- C. Wait for complete wound healing before considering nutrition
- D. Begin prescribed enteral nutrition with monitoring for tolerance

155. A patient's injuries are fatal, and the family asks about organ donation. Which nursing action is appropriate?

- A. Ask the family to decide immediately without support
- B. Promise that donation will definitely be possible
- C. Notify the donation organization per policy and support family
- D. Discuss donation publicly before notifying the proper organization

156. Which statement about determination of brain death is most accurate for the trauma nurse?

- A. A nurse may declare it from a single absent reflex
- B. A family member may determine it from lack of response
- C. A normal pulse proves brain death is absent
- D. It requires a formal clinical determination by qualified practitioners using accepted criteria and policy

157. A conscious trauma patient has a valid advance directive refusing a treatment that is now being considered. What should the nurse do?

- A. Ignore it because the current family prefers treatment
- B. Destroy the document if it conflicts with the plan
- C. Communicate the directive promptly and support care consistent with the patient's expressed wishes
- D. Assume every advance directive is invalid in trauma

158. A trauma patient with life-limiting injury has pain, dyspnea, and family distress while goals of care are clarified. Which referral is appropriate?

- A. Palliative care for symptom relief, communication, and goal-concordant support
- B. Palliative care only after all treatment stops
- C. No symptom treatment until the prognosis is certain
- D. A security referral for the family's emotional response

159. A family asks to remain present during a trauma resuscitation. Which nursing approach is best when circumstances permit?

- A. Allow unrestricted access without boundaries or explanation
- B. Use a trained support person, explain what is happening, and preserve safety and team function
- C. Refuse every request regardless of clinical circumstances
- D. Ask the family to record the resuscitation for later review

160. A community trauma review identifies repeated motorcycle injuries among unhelmeted riders. Which prevention strategy is most appropriate?

- A. Provide general information without identifying the pattern
- B. Use targeted education and partnerships based on local data
- C. Wait for another fatality before acting
- D. Share identifiable patient stories without permission

161. A prehospital patient has severe chest trauma, airway compromise, and shock. Which transport decision is most appropriate?

- A. Transport to the nearest clinic regardless of capability
- B. Delay transport for a complete nonurgent history
- C. Prioritize rapid transport to the highest capable trauma resource while treating immediate threats
- D. Allow family preference to determine the destination alone

162. A patient needs transfer from a rural hospital to a trauma center for operative hemorrhage control. Which handoff element is essential?

- A. Send the patient before contacting the receiving center
- B. Provide only the patient's name and diagnosis
- C. Leave medication and blood-product information for the family
- D. Confirm acceptance, communicate current stability and treatments, and send complete records and imaging

163. A trauma patient is preparing for discharge after a repaired extremity injury. Which teaching is most important?

- A. Explain wound care, medications, activity limits, warning signs, and follow-up using teach-back
- B. Give the patient a prescription without verbal instructions
- C. Tell the family to search online for all questions
- D. Avoid discussing complications so the patient remains optimistic

164. In a mass-casualty drill, which patient should receive the highest immediate triage priority?

- A. A walking patient with minor abrasions and normal breathing
- B. A deceased patient with no spontaneous respirations after repositioning
- C. A patient with an obstructed airway who improves after a simple maneuver
- D. A patient with an isolated closed finger fracture and stable signs

165. A patient arrives after a chemical spill with powder on the clothing. Which action should occur before entry into the clean treatment area?

- A. Bring the patient directly to the resuscitation bay without precautions
- B. Isolate the patient, use appropriate PPE, remove contaminated clothing, and decontaminate
- C. Brush the powder into the air near other patients
- D. Cover the clothing with a warm blanket and postpone decontamination

166. A trauma program notices many minor injuries are sent to a high-level trauma center while several severe injuries are initially sent elsewhere. Which quality concept describes this pattern?

- A. Improved specificity with no performance concern
- B. A documentation issue unrelated to patient safety
- C. A staffing schedule problem only
- D. Overtriage and undertriage requiring review of the triage system

167. Which practice most improves the reliability of trauma-registry data used for benchmarking?

- A. Use consistent definitions, validate entries, and clarify missing or conflicting fields
- B. Remove difficult cases from the database
- C. Estimate absent values from memory without documentation
- D. Change definitions whenever a result looks unfavorable

168. A trauma team identifies delayed antibiotic administration as a recurring problem. Which performance-improvement step should follow analysis of the cause?

- A. Close the review after naming the staff member involved
- B. Implement a targeted change, assign accountability, and remeasure the outcome
- C. Publish the problem without changing the process
- D. Wait for perfect data before testing any small improvement

169. A pump programming near miss causes no patient harm. Which action should the nurse take?

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

170. A pelvic fracture patient's pain and perfusion are worsening. Which handoff format is best?

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

171. A nonclinical vendor requests the entire trauma record to evaluate equipment use. Which privacy response is most appropriate?

- A. Verify the permitted purpose and disclose only the minimum necessary information under policy
- B. Send the full record because the vendor works with the hospital
- C. Discuss the record in a public hallway
- D. Refuse every disclosure even when a valid process permits limited information

172. An uninsured patient arrives at a hospital emergency department requesting evaluation for possible internal bleeding. Which action reflects EMTALA requirements?

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

173. A visitor begins threatening staff near the trauma bay. Once immediate patient care is protected, which action should staff take?

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

174. A trauma center is preparing for designation and verification review. Which evidence best demonstrates system readiness?

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

175. After a difficult pediatric trauma resuscitation, staff members report distress and uncertainty about the event. 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

Practice Exam 11: Answer Key and Explanations

- 1. B** — A new unilateral dilated pupil with declining consciousness can signal rising intracranial pressure and impending herniation. The nurse maintains oxygenation, ventilation, cervical alignment, and adequate perfusion while activating the trauma and neurosurgical response for urgent treatment. Sleep, oral fluids, and head-down positioning delay treatment and can worsen aspiration or intracranial pressure.
- 2. D** — A very low level of consciousness and gurgling indicate impaired airway protection. The nurse suctions, uses a jaw-thrust maneuver with inline cervical stabilization, provides oxygen, and summons 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. C** — Anticoagulation increases concern for delayed intracranial bleeding after even a seemingly minor head injury. Serial examinations and prescribed imaging allow recognition of deterioration that a single normal examination cannot exclude. Immediate discharge, lumbar puncture, and vigorous activity either miss evolving hemorrhage or add risk without addressing the priority. Continue serial neurologic reassessment for change.
- 4. B** — A lucid interval is a classic warning pattern for epidural hematoma, in which bleeding can expand rapidly and compress the brain. The nurse treats renewed decline as an emergency, protects physiologic stability, and prepares for urgent neurosurgical intervention. A scalp injury, medication effect, or uncomplicated concussion does not explain the characteristic transient improvement followed by deterioration.
- 5. D** — Older adults may develop a subdural hematoma after low-energy trauma, with symptoms evolving over hours or days as venous blood accumulates. New confusion and headache require focused reassessment, imaging, and escalation rather than attribution to aging. A nasal contusion, unrelated dehydration, or external ear infection does not adequately explain progressive neurologic change after trauma.
- 6. A** — Clear rhinorrhea after facial trauma may represent cerebrospinal fluid. Upright positioning, avoidance of nose blowing and nasal instrumentation, and prompt notification reduce the risk of

worsening a skull-base defect or introducing infection. Deep packing, forceful nose blowing, and nasal tube placement can disrupt a skull-base injury and cause additional harm.

7. C — Restlessness after brain trauma can be an early sign of hypoxemia, hypercapnia, pain, or rising intracranial pressure. The nurse supports oxygenation, checks vital and neurologic status, reduces hazards, and seeks treatment for the underlying cause. Unassessed restraints, reflexive sedation, and dismissal of the behavior can obscure deterioration or worsen respiratory and neurologic compromise.

8. B — New weakness during movement may indicate spinal cord compromise or displacement. Stopping the transfer, preserving neutral alignment, and repeating motor and sensory checks help prevent secondary injury while the team evaluates the change. Removing protection, walking the patient, or flexing the neck can increase displacement and worsen an unstable cervical injury.

9. D — Cerebral perfusion pressure is calculated by subtracting intracranial pressure from mean arterial pressure. Subtracting 18 from 78 produces 60 mmHg, a value the team uses with the neurologic examination and overall physiology to judge cerebral blood-flow adequacy. Adding the values, reporting MAP alone, or subtracting MAP from ICP applies the formula incorrectly and can misdirect hemodynamic treatment.

10. C — Vomiting threatens aspiration and can increase intracranial pressure. The nurse calls for help, uses a coordinated log roll or airway maneuver that preserves spinal alignment, suctions as needed, and reassesses oxygenation and neurologic status. Leaving the patient supine, giving water, or lowering the head increases aspiration or intracranial-pressure risk. Continue serial neurologic reassessment for change.

11. A — Central cord syndrome often follows cervical hyperextension and produces greater motor impairment in the upper than lower extremities, sometimes with bladder dysfunction. The nurse maintains precautions and documents the asymmetric findings for serial comparison. The other patterns do not characteristically produce disproportionately weak arms after a cervical hyperextension mechanism. Continue serial neurologic reassessment for change.

12. D — Anterior cord involvement affects the corticospinal and spinothalamic tracts, producing motor and pain-temperature deficits while dorsal-column modalities may remain relatively preserved. Care focuses on alignment, perfusion, respiratory monitoring, and accurate neurologic trending. Posterior or central cord patterns and peripheral neuropathy do not best match the stated combination of tract findings after trauma.

13. C — Brown-Sequard syndrome reflects hemisection of the spinal cord. Dorsal-column and corticospinal deficits occur ipsilaterally, while spinothalamic loss appears contralaterally below the lesion. The nurse documents the pattern and protects the spine during evaluation. Neurogenic shock, cauda equina injury, and diffuse axonal injury do not produce this characteristic crossed sensory and motor pattern.

14. B — A coordinated log roll keeps the head, neck, trunk, and pelvis aligned while the team moves the patient. One clinician directs and controls the head so movement is deliberate and the cervical spine

remains protected. Arm pulling, independent sitting, and rotating the body before the head create uncontrolled spinal motion.

15. A — Mobility of the maxilla and palate with malocclusion suggests a Le Fort midface fracture. Swelling, bleeding, loose teeth, and instability can threaten the airway, so the nurse prepares suction, oxygenation, and specialist evaluation. An isolated nasal injury, condyle sprain, or orbital contusion does not explain mobile midface structures with malocclusion.

16. B — Mandibular disruption, bleeding, and tongue displacement can rapidly obstruct the airway. The nurse suctions, provides oxygen, maintains a position that supports airway patency, and summons experienced airway personnel for definitive control. Oral intake, unmonitored supine positioning, and blind nasal instrumentation do not protect a threatened airway and may worsen injury.

17. C — Nose blowing can force air or bacteria through an orbital fracture, increasing orbital emphysema and pressure. The nurse teaches gentle precautions, monitors vision and pain, and reports changes that could threaten ocular function. Forceful blowing, tight packing, and direct globe pressure can increase orbital or ocular injury. Continue serial neurologic reassessment for change.

18. D — Visible ocular tissue or an irregular globe suggests open-globe injury. A rigid shield prevents contact without applying pressure, while urgent ophthalmic evaluation protects remaining vision and avoids further extrusion. Pressure patches, tissue removal, and forceful irrigation can increase extrusion or cause additional damage to the injured globe. Continue serial neurologic reassessment for change.

19. A — Blood in the anterior chamber after trauma is a hyphema. It can increase intraocular pressure and impair vision, so the nurse protects the eye, limits exertion, avoids pressure, and arranges prompt ophthalmic assessment. Conjunctival irritation, an eyelid abrasion, and optic neuropathy do not explain blood layering in the anterior chamber.

20. D — Cheek numbness, diplopia, and malar flattening suggest zygomaticomaxillary complex disruption involving the infraorbital nerve and orbit. The nurse assesses vision, ocular movement, airway, and associated facial injuries while awaiting specialty care. A scalp laceration, dental caries, or cervical strain does not account for the orbital and malar findings. Continue serial neurologic reassessment for change.

21. A — An expanding neck hematoma and stridor signal a threatened airway that may become difficult to control as swelling progresses. The nurse provides oxygen, applies direct wound pressure when appropriate, and summons experienced airway and surgical teams immediately. Circumferential neck pressure, delayed imaging, and oral fluids can worsen obstruction or postpone lifesaving airway management.

22. B — Active arterial bleeding and an expanding or pulsatile hematoma are hard signs of significant vascular injury and require immediate surgical or endovascular evaluation. The nurse controls external bleeding without obstructing the airway and monitors perfusion. A small abrasion, mild tenderness, or stable bruise lacks the defining evidence of ongoing major vascular disruption.

23. C — Hoarseness, subcutaneous emphysema, and hemoptysis after neck trauma suggest laryngotracheal disruption. The airway may deteriorate rapidly, so the nurse avoids blind instrumentation, provides oxygen, and coordinates expert airway and surgical management. A skin contusion, viral sore throat, or dental fracture cannot account for these post-traumatic airway warning signs. Continue serial neurologic reassessment for change.

24. D — A poorly fitted collar fails to limit cervical motion and can create pressure injury. The nurse maintains manual stabilization while the device is resized or replaced, then reassesses alignment, skin, airway, and neurologic status. Removing the collar, excessive tightening, or relying on patient effort does not provide safe spinal protection.

25. B — Neurogenic shock can follow high spinal cord injury and is characterized by vasodilation with relative bradycardia when sympathetic tone is lost. The nurse continues a hemorrhage search while supporting perfusion, temperature, and spinal precautions. Hemorrhagic, obstructive, and anaphylactic shock do not best explain warm dry skin with bradycardia after cervical trauma.

26. A — Spinal shock is a temporary period of flaccid paralysis and areflexia below an acute cord injury. The finding does not by itself prove complete transection; serial examinations are required as reflexes and neurologic function evolve. Permanent transection, peripheral compression, and normal immobilization responses cannot be concluded from early post-injury areflexia alone.

27. C — High cervical injuries can weaken the diaphragm and accessory muscles, allowing respiratory failure to develop before obvious cyanosis. Frequent respiratory trending, assisted cough, secretion management, and early airway planning are essential. Lower-extremity testing, immobility, and waiting for cyanosis miss early ventilatory decline and delay support. Continue serial neurologic reassessment for change.

28. B — Acute vision loss after orbital trauma can reflect traumatic optic neuropathy even without an open globe. The nurse protects the eye, documents visual changes, avoids pressure, and obtains urgent ophthalmic and trauma evaluation. Eyelid bruising, conjunctival hemorrhage, and a facial bruise do not adequately explain sudden substantial vision loss. Continue serial neurologic reassessment for change.

29. A — Flashes and a curtain-like field defect are warning symptoms of retinal separation or significant retinal injury. The nurse limits activity, prevents pressure on the eye, and arranges urgent ophthalmic evaluation to preserve vision. Dry eye, a healed eyebrow wound, and an ear contusion do not cause the described visual-field warning pattern.

30. C — Postauricular ecchymosis and clear otorrhea can indicate a basilar skull fracture with cerebrospinal fluid leakage. The nurse avoids packing or probing the canal, monitors neurologic status, and notifies the trauma team. A pinna hematoma, external ear infection, or normal drainage pattern does not account for the skull-base warning signs. Continue serial neurologic reassessment for change.

31. D — Head elevation with a neutral neck can promote venous drainage and reduce avoidable increases in intracranial pressure. The nurse also avoids tight collars, hip flexion, hypoxemia, and

hypotension while following the prescribed target. A flat flexed posture, head rotation, or Trendelenburg positioning can impair venous return or increase intracranial pressure.

32. C — Widened pulse pressure, bradycardia, and irregular respirations are a late warning pattern associated with severe intracranial pressure elevation and possible herniation. The nurse escalates immediately while supporting oxygenation, ventilation, and perfusion. Analgesia, dehydration, and mild concussion do not adequately explain this dangerous combination of neurologic and cardiovascular changes. Continue serial neurologic reassessment for change.

33. B — Polyuria with rising sodium after brain trauma suggests inadequate antidiuretic hormone activity and severe free-water depletion. The nurse trends output and electrolytes, supports prescribed replacement, and reports changing neurologic or hemodynamic status. Fluid overload, a resolved concussion, and facial fracture do not explain high-volume dilute urine with hypernatremia after brain injury.

34. A — 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 eyelid laceration cannot account for persistent coma after severe acceleration-deceleration trauma. Continue serial neurologic reassessment for change.

35. D — Sacral sparing indicates that some pathways remain intact through the injured spinal cord, making the injury incomplete. The nurse documents 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.

36. C — Agitation after facial trauma may reflect hypoxia from airway contamination or obstruction rather than anxiety alone. The nurse quickly assesses the mouth and airway, suctions, provides oxygen, and escalates for definitive control when needed. Appetite assessment, oral feeding, and delayed examination fail to address a potentially rapidly worsening airway threat.

37. A — Paradoxical movement of a chest segment indicates flail chest, usually from multiple contiguous rib fractures in more than one location. The nurse supports oxygenation, provides multimodal analgesia, monitors ventilation, and watches for associated pulmonary contusion. A simple pneumothorax, clavicle sprain, or pleural effusion does not produce a free-floating chest-wall segment.

38. B — The combination of respiratory distress, hypotension, unilateral absent breath sounds, and venous distention suggests tension pneumothorax with obstructive shock. The nurse provides oxygen, summons the trauma team, and prepares for immediate decompression followed by definitive drainage. Waiting for routine imaging, flat positioning, and oral fluids delay treatment of a time-critical obstructive process.

39. D — A three-sided occlusive dressing limits air entry while allowing trapped air to escape during exhalation. The nurse monitors for worsening respiratory distress or tension physiology and prepares for

chest drainage and surgical care. Deep packing, a completely sealed dressing without monitoring, and an uncovered wound do not safely manage an open chest injury.

40. D — Large ongoing blood loss through a chest tube with shock indicates major intrathoracic hemorrhage, or massive hemothorax. The nurse supports circulation, activates the trauma pathway, tracks output, and prepares for operative or procedural hemorrhage control. A small contusion, superficial bruise, or resolved pneumothorax does not explain ongoing high-volume blood loss with shock.

41. A — Hypotension, muffled heart sounds, and venous distention after precordial trauma suggest tamponade, in which pericardial pressure restricts cardiac filling. The nurse supports oxygenation and perfusion, calls for immediate intervention, and prepares for drainage or surgery. A rib fracture, dehydration, or stable pleural effusion does not produce this obstructive shock pattern after precordial injury.

42. C — New dysrhythmia and biomarker elevation after blunt chest trauma raise concern for myocardial contusion or another blunt cardiac injury. The nurse maintains continuous monitoring, reassesses perfusion, and reports rhythm or hemodynamic changes promptly. A skin abrasion, anxiety alone, or clavicle fracture does not explain post-traumatic electrical and biomarker abnormalities. Continue serial assessment for evolving complications.

43. B — High-speed deceleration with pulse asymmetry and a widened mediastinum suggests injury to the thoracic aorta. The nurse minimizes hemodynamic surges, maintains close monitoring, and coordinates urgent vascular and trauma evaluation. A chest bruise, minor effusion, or wrist fracture cannot explain the mediastinal and perfusion findings after deceleration. Continue serial assessment for evolving complications.

44. C — Bowel sounds in the chest and an abnormal abdominal contour after blunt trauma suggest diaphragmatic rupture with herniation. The nurse supports ventilation, avoids unnecessary positive pressure changes, and prepares for urgent imaging and surgical management. A pulmonary contusion, abdominal bruise, or arm fracture does not explain abdominal viscera within the thorax.

45. D — Pulmonary contusion can worsen over time as alveolar bleeding and edema develop, so an initially reassuring image does not exclude progression. The nurse trends oxygenation and work of breathing and prepares support as prescribed. A chest abrasion, healed clavicle injury, or abdominal strain does not account for delayed hypoxemia after thoracic impact.

46. A — Positive-pressure ventilation can enlarge a traumatic pneumothorax and precipitate tension physiology. The nurse communicates the finding, monitors respiratory and hemodynamic trends, and prepares for pleural drainage when ordered. Ignoring the finding, ambulation, and oral fluids do not prevent pressure-related expansion or treat respiratory deterioration. Continue serial assessment for evolving complications.

47. B — A partially dislodged chest tube can allow air entry and lose pleural drainage. The nurse protects the site with an occlusive dressing, supports oxygenation, avoids reinsertion, and summons the

trauma team for reassessment and replacement if needed. Pushing a contaminated tube inward, unreported clamping, or delayed coverage can worsen an air leak and respiratory compromise.

48. B — Tidal volume with absent continuous bubbling can indicate pressure changes are transmitted through a patent system without a persistent air leak. The nurse still checks tubing, connections, drainage, respiratory status, and prescribed expectations. Absent bubbling alone does not prove obstruction, justify routine clamping, or confirm tension physiology. Continue serial assessment for evolving complications.

49. C — Pain-limited ventilation promotes atelectasis and secretion retention. Analgesia combined with supported deep breathing, coughing, mobilization as safe, and pulmonary hygiene improves ventilation while the nurse monitors for respiratory fatigue. Withholding analgesia, circumferential binding, and prolonged supine immobility increase splinting and pulmonary risk. Continue serial assessment for evolving complications. Reassess promptly when new findings change risk or response.

50. D — Facial petechiae and conjunctival hemorrhage with upper-body cyanosis after chest compression reflect venous backflow associated with traumatic asphyxia. The nurse prioritizes airway, breathing, circulation, and evaluation for associated thoracic injuries. Carbon monoxide exposure, allergy, and clavicle fracture do not explain this pressure-related distribution of petechiae and cyanosis. Continue serial assessment for evolving complications.

51. A — Severe chest pain, subcutaneous emphysema, and systemic illness after vomiting can indicate esophageal rupture, which permits contamination of the mediastinum. The nurse keeps the patient NPO, supports physiology, and alerts the trauma and surgical teams. An abdominal abrasion, ankle fracture, or tension headache does not explain thoracic symptoms with subcutaneous air after vomiting.

52. B — Sudden ventilatory deterioration with unilateral absent breath sounds and rising airway pressures suggests tension physiology, potentially worsened by positive pressure. The nurse supports oxygenation, checks the system, and activates immediate decompression and trauma evaluation. An improving contusion, leg pain, or resolved obstruction cannot explain abrupt unilateral thoracic and ventilatory changes.

53. C — Increasing oxygen needs and fatigue may precede respiratory failure from contusion, flail chest, or pneumothorax. The nurse integrates work of breathing, gas exchange, mental status, and hemodynamics to escalate support early. Pain alone, delayed reassessment, and oral fluids do not identify evolving ventilatory failure. Continue serial assessment for evolving complications.

54. A — Hemodynamic instability with free intraperitoneal fluid after trauma suggests active internal bleeding. The nurse supports circulation, activates the trauma response, maintains NPO status, and prepares for definitive hemorrhage control. Outpatient imaging, oral food, and discharge delay resuscitation and are unsafe when internal bleeding is likely. Continue serial assessment for evolving complications.

55. D — Left upper-quadrant pain, referred shoulder pain, and shock after blunt trauma are concerning for splenic bleeding irritating the diaphragm. The nurse reassesses perfusion, keeps the patient NPO, and

prepares for urgent imaging or intervention. An abdominal bruise, reflux, or leg fracture does not explain hemorrhagic shock with referred shoulder pain after abdominal impact.

56. C — The liver is vulnerable to right upper-quadrant blunt trauma, and tenderness with tachycardia and falling hemoglobin suggests ongoing bleeding. The nurse monitors perfusion, abdominal findings, and laboratory trends while preparing for definitive evaluation. A skin abrasion, wrist sprain, or constipation does not account for the hemodynamic and laboratory pattern after abdominal trauma.

57. A — Guarding and free intraperitoneal air after blunt trauma strongly suggest perforation of a hollow organ. The nurse keeps the patient NPO, supports circulation, monitors for sepsis, and prepares for urgent surgical management. A superficial contusion, ankle fracture, or headache cannot explain free air and peritoneal irritation. Continue serial assessment for evolving complications.

58. B — Handlebar compression can injure the pancreas or duodenum, and symptoms may evolve as inflammation or leakage develops. The nurse maintains observation, serial abdominal assessment, NPO status as ordered, and timely imaging or surgical consultation. A forearm abrasion, sore throat, or nasal fracture does not explain post-traumatic epigastric pain radiating to the back.

59. D — Gross hematuria and an expanding flank hematoma after trauma suggest renal or adjacent retroperitoneal injury. The nurse tracks perfusion, urine output, pain, and laboratory trends and prepares for imaging and specialist evaluation. Massage, ambulation, and attribution to infection can increase bleeding or delay recognition of traumatic urinary injury. Continue serial assessment for evolving complications.

60. C — The retroperitoneum can hold substantial blood without obvious external loss. Ecchymosis, anemia, and persistent tachycardia after pelvic trauma warrant hemorrhage-focused reassessment, blood-product preparation, and urgent source control. A thigh abrasion, medication effect, or finger fracture does not explain ongoing occult blood loss after pelvic injury. Continue serial assessment for evolving complications.

61. A — Tense abdominal distention with oliguria, ventilatory pressure increase, and hypotension suggests elevated intra-abdominal pressure impairing organ function. The nurse urgently reports the pattern, measures pressure as ordered, and prepares for decompression or source control. A bruise, hunger, or shoulder injury cannot explain combined renal, respiratory, and circulatory deterioration. Continue serial assessment for evolving complications.

62. D — A seat-belt sign indicates energy transmission and raises concern for bowel, mesenteric, or spinal injury even when external skin damage is limited. Serial examination and appropriate imaging help detect delayed complications. Discharge, heat with oral intake, and a cosmetic interpretation can delay diagnosis of occult intra-abdominal injury. Continue serial assessment for evolving complications.

63. B — Exposed abdominal organs should be protected from drying and contamination with warm sterile moist dressings. The nurse avoids pressure or replacement, keeps the patient NPO, supports circulation, and prepares for urgent operative evaluation. Manual replacement, dry adhesive material, and an uncovered wound can cause tissue injury, desiccation, contamination, or heat loss.

64. B — An impaled object may be tamponading major bleeding or damaging organs. Stabilizing it prevents movement, while controlled removal with surgical resources allows hemorrhage control and direct management of the tract. Bedside removal, rotation, and oral analgesia can release tamponade and worsen hemorrhage or organ injury. Continue serial assessment for evolving complications.

65. D — New guarding and rebound can indicate peritoneal irritation from bleeding, perforation, or ischemia. The nurse repeats vital and abdominal assessments, maintains NPO status, and promptly escalates the change. The initial mild pain, oral feeding, and stopping examinations do not explain or safely manage evolving peritoneal signs. Continue serial assessment for evolving complications.

66. A — Periumbilical or flank ecchymosis after trauma can accompany internal hemorrhage, although the sign is not diagnostic alone. Falling hemoglobin and clinical trends determine urgency, so the nurse reassesses perfusion and reports the pattern. A harmless skin reaction, absence of an open wound, or allergy does not rule out concealed abdominal bleeding.

67. C — Gross hematuria and suprapubic pain after pelvic trauma suggest bladder disruption. The nurse monitors output and perfusion, avoids unplanned instrumentation, and coordinates imaging or specialist evaluation to distinguish injury patterns. An abrasion, muscle cramp, or shoulder dislocation does not explain blood in the urine with suprapubic pain after deceleration. Continue serial assessment for evolving complications.

68. B — Blood at the meatus after pelvic trauma suggests urethral injury. Blind catheterization can convert a partial injury to a complete disruption, so the nurse maintains urinary monitoring and seeks imaging or specialist guidance first. Forceful catheterization, straining, and ignoring the sign can worsen urethral damage and delay urinary tract protection.

69. A — A properly positioned pelvic binder applies circumferential support at the level of the greater trochanters, helping reduce pelvic volume and motion. The nurse reassesses skin, distal perfusion, pain, and neurologic status after application. Upper-abdominal, umbilical, or thigh placement does not stabilize the pelvic ring and may impair breathing or circulation.

70. D — An open-book pattern represents pelvic-ring disruption with substantial bleeding risk. The nurse avoids repeated manipulation, stabilizes the pelvis as ordered, monitors perfusion, and prepares for blood products and definitive control. Springing, walking, and wide abduction increase pelvic motion and can worsen bleeding or tissue injury. Continue serial assessment for evolving complications.

71. C — Persistent shock with arterial extravasation indicates ongoing pelvic hemorrhage requiring definitive source control. Depending on the patient's condition and resources, angiographic embolization or surgery may be necessary alongside resuscitation. Oral hydration, ambulation, and delayed follow-up cannot control active arterial bleeding or stabilize shock. Continue serial assessment for evolving complications. Reassess promptly when new findings change risk or response.

72. B — A cool pulseless foot with paresthesia indicates acute neurovascular compromise that can threaten limb viability. The nurse documents the change, maintains safe alignment, avoids constriction, and activates urgent vascular and trauma evaluation. Delayed reassessment, tight wrapping, and exercise

can worsen ischemia or postpone revascularization. Continue serial assessment for evolving complications.

73. C — Perineal ecchymosis and scrotal swelling after pelvic trauma can indicate extravasation from urethral or lower urinary tract injury. The nurse avoids blind instrumentation, monitors urine output, and seeks focused urologic evaluation. A forearm fracture, headache, or chest abrasion does not explain traumatic perineal and scrotal findings. Continue serial assessment for evolving complications.

74. D — Extraperitoneal bladder injuries are commonly associated with pelvic fractures and require coordinated urinary drainage and specialist decisions. The nurse monitors output, pain, infection, and abdominal or pelvic changes without increasing bladder pressure. Forced fluids, removing drainage, and Valsalva can increase urinary leakage and delay appropriate repair or drainage. Continue serial assessment for evolving complications.

75. A — Diaphragmatic injuries may be occult initially and later allow abdominal contents to herniate into the chest, causing pain or respiratory compromise. The nurse reports changing symptoms and prepares for imaging and surgical evaluation. Hand contusion, superficial burn, and ear laceration do not account for combined thoracoabdominal symptoms after impact. Continue serial assessment for evolving complications.

76. A — Mesenteric injury can be subtle early and may progress to ischemia, bleeding, or bowel perforation. Persistent tachycardia and pain require serial examination, laboratory trending, and reassessment of imaging or surgical need. A superficial mark, toe fracture, or headache does not explain persistent systemic and abdominal changes after high-energy compression. Continue serial assessment for evolving complications.

77. B — Some bowel injuries declare themselves later as leakage, inflammation, and peritonitis develop. Fever, increasing tenderness, or guarding after trauma requires repeat assessment, prompt escalation, NPO status, and preparation for definitive evaluation. Expected recovery, a knee infection, or appetite change does not explain evolving abdominal signs after blunt trauma. Continue serial assessment for evolving complications.

78. D — The retroperitoneum and psoas region can conceal significant bleeding, producing flank bruising, pain, distention, and declining hematocrit. The nurse supports circulation, trends abdominal and neurologic findings, and escalates for imaging and source control. A shoulder abrasion, migraine, or finger dislocation cannot account for occult blood loss with post-traumatic flank findings.

79. C — Lower left-rib fractures can accompany splenic injury, and bleeding may become apparent only after observation. New tenderness or hemodynamic change prompts repeated abdominal and perfusion assessment and urgent team notification. Wrist fracture, scalp abrasion, and foot blister do not explain delayed abdominal deterioration after left thoracic trauma. Continue serial assessment for evolving complications.

80. B — Traumatic abdominal-wall hernia indicates substantial force and may coexist with bowel or mesenteric injury. The nurse avoids forceful reduction, performs serial assessment, maintains

precautions, and coordinates imaging or surgical evaluation. Forceful reduction, discharge, and rigid direct compression can injure tissue or miss a concealed intra-abdominal complication. Continue serial assessment for evolving complications.

81. D — Pain out of proportion and pain with passive stretch are early warning signs of compartment syndrome. The nurse loosens constrictive materials, keeps the limb at heart level, repeats neurovascular checks, and urgently alerts the surgical team. Routine pain, superficial infection, and muscle soreness do not explain the escalating pressure-related symptoms after fracture.

82. A — Numbness and cool fingers after casting suggest impaired circulation or rising compartment pressure. The nurse performs an immediate neurovascular assessment, elevates appropriately, removes or loosens external constriction per protocol, and escalates without delay. Tightening the cast, prolonged dependency, and delayed reassessment can worsen ischemia and threaten the limb. Repeat neurovascular checks as swelling evolves.

83. C — An open fracture communicates with the environment and carries contamination, infection, and neurovascular risks. The nurse covers the wound, avoids probing or closure, immobilizes the limb, assesses perfusion, and prepares for timely antibiotics and debridement. Probing, bedside closure, and weight bearing increase contamination or tissue injury and delay definitive management.

84. A — The amputated part should be protected from drying and direct freezing. Sterile moist gauze, a sealed bag, and cooling around the bag preserve tissue while the patient receives priority resuscitation and rapid surgical consultation. Direct ice, antiseptic immersion, and uncovered storage can cause freezing, chemical injury, desiccation, or contamination. Repeat neurovascular checks as swelling evolves.

85. C — Prolonged compression can cause muscle breakdown, releasing myoglobin and potassium when pressure is relieved. Dark urine and weakness require cardiac monitoring, renal surveillance, careful fluid management, and prompt treatment of electrolyte abnormalities. Dehydration, superficial laceration, and ankle sprain do not explain pigmenturia and systemic risk after entrapment. Repeat neurovascular checks as swelling evolves.

86. B — Life-threatening extremity hemorrhage that does not respond to direct pressure requires rapid tourniquet application according to local protocol. The nurse records the application time, reassesses perfusion and bleeding, and continues broader resuscitation. Repeated release, elevation alone, and loose delayed packing allow ongoing blood loss and can worsen shock. Repeat neurovascular checks as swelling evolves.

87. D — The axillary nerve travels near the shoulder and can be injured with an anterior dislocation, causing numbness over the lateral deltoid and weakness with abduction. The nurse documents neurovascular status before and after reduction. Median, ulnar, and peroneal nerve distributions do not match the lateral shoulder sensory change. Repeat neurovascular checks as swelling evolves.

88. C — A shortened, adducted, internally rotated limb after dashboard-type trauma is characteristic of posterior hip dislocation. The nurse assesses distal pulses and sciatic function, avoids movement, and

prepares for urgent reduction. An ankle sprain, shoulder dislocation, or patellar bruise cannot produce the described hip and limb position. Repeat neurovascular checks as swelling evolves.

89. A — Knee dislocation can injure the popliteal artery even when the joint appears reduced. A cool foot and diminished pulse require immediate vascular evaluation, repeated checks, and protection of the limb while definitive care is arranged. Heat, delayed documentation, and calf massage can worsen ischemia or postpone recognition of an arterial injury.

90. D — Traction splints may be contraindicated with an ipsilateral pelvic injury because traction can worsen pelvic disruption or associated damage. The nurse follows the trauma plan, supports alignment, and repeatedly checks perfusion and sensation. Neurovascular checks, supported alignment, and hemorrhage monitoring are appropriate protective measures for the combined injuries. Repeat neurovascular checks as swelling evolves.

91. B — The combination of respiratory decline, neurologic change, and petechiae after a long-bone fracture suggests fat embolism syndrome. The nurse supports oxygenation, monitors neurologic and respiratory status, and reports deterioration while definitive treatment is coordinated. Dermatitis, nausea, and a superficial hematoma do not explain the multisystem post-fracture pattern. Repeat neurovascular checks as swelling evolves.

92. C — New weakness and urinary retention after a burst fracture suggest compression of neural structures. The nurse maintains spinal precautions, documents the change, reassesses motor and sensory function, and urgently notifies the spine and trauma teams. Immobilization soreness, ankle injury, and analgesia do not explain new bilateral neurologic and bladder dysfunction.

93. D — Saddle anesthesia and urinary retention are red flags for cauda equina compression. The nurse maintains alignment, measures bladder status, documents the neurologic deficit, and seeks urgent surgical evaluation to limit permanent dysfunction. Muscle strain, radial nerve injury, and superficial abrasion do not explain the sacral sensory and bladder findings. Repeat neurovascular checks as swelling evolves.

94. B — A degloving injury disrupts skin perfusion and exposes tissue to desiccation and contamination. Sterile moist coverage, immobilization, pain control, and urgent surgical evaluation protect potentially viable tissue and identify deeper injury. Bedside trimming, vigorous scrubbing, and uncovered observation can destroy viable tissue and increase contamination. Repeated neurovascular checks matter because swelling, constriction, and ischemia can progress after the initial intervention.

95. A — Traumatic wounds require removal of contamination while preserving viable tissue; harsh repeated antiseptic exposure can injure healing tissue. The nurse uses prescribed irrigation, covers the wound, assesses neurovascular status, and prepares for debridement when indicated. Concentrated peroxide, immediate closure, and avoiding cleansing can cause tissue injury, trap contamination, or increase infection risk.

96. A — Older adults may have cerebral atrophy and anticoagulant-related bleeding risk, allowing serious intracranial injury to present subtly. The nurse emphasizes serial assessment and timely imaging

or observation based on the trauma plan. Low-energy mechanism, avoidance of imaging, and aspirin do not safely exclude delayed hemorrhage or medication-related bleeding. Individualize care and reassess changing needs.

97. D — Older adults may have altered pain expression, blunted physiologic reserve, and atypical manifestations of shock. New confusion and cool skin after pelvic trauma require a renewed hemorrhage and perfusion assessment. Age-related assumptions, pain score alone, and delayed vital signs can miss serious bleeding and evolving shock. Individualize care and reassess changing needs.

98. C — Older adults are vulnerable to opioid-related hypoventilation and pneumonia after painful chest injury. The nurse reassesses respiratory effort and gas exchange, balances analgesia with safety, and supports pulmonary hygiene. Stopping monitoring, adding opioid without assessment, and tight binding can worsen respiratory failure or secretion retention. Individualize care and reassess changing needs.

99. B — Osteoporosis can permit significant vertebral injury after low-energy mechanisms, and new pain or kyphosis warrants careful spinal assessment. The nurse maintains precautions until injury is evaluated rather than relying on mechanism alone. Age-related posture, skin bruising, and hand injury do not safely explain new traumatic back pain and shape change.

100. B — Children have smaller airways and can deteriorate quickly with edema or blood. Keeping the child calm, supporting oxygenation, avoiding unnecessary agitation, and preparing experienced airway help reduce the risk of sudden obstruction. Forced positioning, oral feeding, and waiting for cyanosis can worsen obstruction or delay a difficult airway response. Individualize care and reassess changing needs.

101. C — Children may maintain oxygen saturation and blood pressure until physiologic reserve is exhausted. Increasing effort is an early warning, so the nurse trends ventilation, mental status, perfusion, and fatigue rather than one number. Oxygen saturation alone, delayed reassessment, and skin inspection can miss impending pediatric respiratory failure. Individualize care and reassess changing needs.

102. A — The injury pattern and history may be inconsistent with the reported mechanism and require evaluation for abusive head trauma. The nurse ensures safety, documents statements and findings verbatim, and follows mandatory reporting policy. Confrontation, altered documentation, and discharge can compromise safety, evidence, and timely multidisciplinary investigation. Individualize care and reassess changing needs.

103. D — Children can preserve blood pressure through vasoconstriction until substantial blood loss has occurred. Pallor and tachycardia may therefore indicate compensated shock, requiring prompt perfusion assessment and resuscitation planning. Normal pressure, waiting for a weak pulse, and delayed oral hydration can miss rapidly worsening pediatric hemorrhage. Individualize care and reassess changing needs.

104. D — Children require appropriately sized support and careful airway attention because their anatomy differs from adults. The nurse minimizes movement, reassures the child, and reassesses fit,

skin, breathing, and neurologic status. Unrestricted motion, poorly fitted equipment, and unmonitored sedation can cause injury or airway compromise. Individualize care and reassess changing needs.

105. C — The gravid uterus can reduce venous return when it compresses major vessels in the supine position. Left uterine displacement or lateral tilt supports maternal circulation while the team evaluates both patient and fetus. Unmodified supine, prone, or isolated leg positioning does not relieve aortocaval compression during resuscitation. Individualize care and reassess changing needs.

106. B — Pain and vaginal bleeding after trauma can signal placental separation, which may cause concealed hemorrhage, uterine irritability, and fetal compromise. The nurse supports maternal resuscitation, monitors fetal status as indicated, and escalates promptly. Normal discomfort, wrist injury, and a superficial mark do not explain post-traumatic bleeding and abdominal pain. Individualize care and reassess changing needs.

107. A — Maternal stability and fetal well-being are linked, and a reassuring early tracing does not eliminate risk from evolving abruption or other injury. The nurse coordinates serial maternal and fetal assessment with obstetric expertise. Fetal-only monitoring, immediate discharge, and avoidance of all evaluation can miss maternal or fetal deterioration. Individualize care and reassess changing needs.

108. D — Necessary trauma evaluation should not be withheld solely because of pregnancy. The team selects the appropriate study, minimizes exposure consistent with the clinical need, and continues maternal and fetal monitoring. Refusal, unvalidated substitution, and delay can allow serious hemorrhage or injury to progress without diagnosis. Individualize care and reassess changing needs.

109. B — Trauma can permit fetal red-cell transfer into an Rh-negative patient's circulation. The nurse communicates the blood type and mechanism promptly so obstetric clinicians can determine testing and prophylaxis needs. Iron, ignoring blood type, and delayed notification do not address possible alloimmunization after traumatic fetomaternal hemorrhage. Individualize care and reassess changing needs.

110. C — The first priority is to stop ongoing thermal exposure and then address airway, breathing, and circulation. Hot or smoldering material continues tissue injury, while airway edema may progress after an enclosed-space fire. Ointment, delayed removal, and wound measurement before physiologic assessment leave ongoing exposure or life threats untreated. Individualize care and reassess changing needs.

111. A — Hoarseness, facial burns, and soot suggest inhalation injury; edema can increase over time and make later airway control difficult. The nurse provides oxygen, prepares early expert airway evaluation, and monitors for deterioration. Hand burn, ankle sprain, and thirst do not explain the airway warning pattern after an enclosed-space fire. Individualize care and reassess changing needs.

112. B — Carbon monoxide can cause tissue hypoxia while standard pulse oximetry cannot reliably distinguish carboxyhemoglobin from oxyhemoglobin. The nurse administers high-concentration oxygen as ordered and escalates for co-oximetry and toxicology evaluation. A normal saturation, dehydration

assumption, and withholding oxygen can delay treatment of smoke-related hypoxic injury. Individualize care and reassess changing needs.

113. D — Electrical current can travel through deep tissues and cause muscle necrosis, dysrhythmia, and pigmenturia even when skin injury is small. The nurse obtains cardiac monitoring, assesses compartments and urine, and escalates care. Small skin wounds, dermatitis, and a paper cut do not exclude serious internal electrical injury. Individualize care and reassess changing needs.

114. A — A rigid circumferential eschar can restrict chest expansion and worsen ventilation. Increasing ventilatory difficulty requires urgent burn-team assessment and possible escharotomy while oxygenation and airway support continue. Tighter dressings, unsupported breathing exercises, and waiting can worsen restriction and delay decompression. Trauma care must be individualized because age, pregnancy, burns, body habitus, and social context can change usual presentations.

115. C — Alkali can penetrate ocular tissues rapidly, so immediate copious irrigation limits ongoing chemical injury. The nurse removes contacts or contaminated material when possible, continues flushing, and obtains urgent ophthalmic evaluation. Chemical neutralization, patching before irrigation, and waiting permit continued tissue destruction and can worsen the injury. Individualize care and reassess changing needs.

116. A — The Parkland calculation is 4 mL multiplied by body weight in kilograms and burn percentage: 4 times 60 times 25 equals 6,000 mL in the first 24 hours. Half is generally given during the first eight hours from the time of injury, with ongoing titration to clinical response. The alternatives delay protection or ignore population-specific risk.

117. C — For an adult, the anterior trunk represents 18%, one entire arm represents 9%, and the anterior portion of one leg represents 9%. Adding those regions gives 36% total body surface area, which helps guide resuscitation and burn-center planning. The other percentages omit or double-count one of the specified regions and therefore do not match the stated adult body-surface estimates.

118. B — Bariatric transfer requires equipment that can safely support the patient's weight, adequate personnel, and a rehearsed plan. The nurse protects staff and patient from falls, shear, equipment failure, and delayed rescue. Fewer staff, unrated equipment, and forced walking increase injury risk and do not constitute a safe transfer plan. Individualize care and reassess changing needs.

119. D — A private, nonjudgmental assessment supports safety planning and allows disclosure without the suspected abuser present. The nurse explains limits of confidentiality, follows policy and law, and connects the patient with appropriate resources. Bedside questioning, an absolute confidentiality promise, and unplanned departure can increase danger or undermine required protections. Individualize care and reassess changing needs.

120. D — Unusual distribution, patterned injury, and an inconsistent history require objective documentation and child-protection evaluation. The nurse preserves privacy, uses approved documentation tools, and follows reporting and evidence procedures. Personal photography, repeated

leading questioning, and dismissal can compromise evidence, safety, and the child's trust. Individualize care and reassess changing needs. Reassess promptly when new findings change risk or response.

121. C — Forensic evidence is collected, packaged, labeled, secured, and transferred using an established process. Accurate chain-of-custody documentation shows who handled each item and helps preserve its legal reliability. Plastic storage, untracked handling, and discarding items can degrade evidence or make its origin and integrity impossible to establish. Individualize care and reassess changing needs.

122. B — The primary survey rapidly identifies immediate threats through airway with cervical protection, breathing, circulation, disability, and exposure. The nurse treats life threats as they are found and repeats the survey after each intervention. History, discharge teaching, and pain-focused sequencing delay assessment of airway, breathing, circulation, or neurologic danger. Continue reassessment as trauma physiology evolves.

123. A — Suction removes contamination, and a jaw thrust can open the airway while minimizing cervical movement. The nurse maintains inline stabilization, provides oxygen, and prepares for definitive airway control if protection remains inadequate. Head tilt, oral fluids, and unmonitored prone positioning can worsen spinal movement, aspiration, or hypoxemia. Continue reassessment as trauma physiology evolves.

124. A — Preoxygenation increases oxygen reserve, and apneic oxygenation can extend the safe period during laryngoscopy. The nurse also checks suction, medications, monitoring, and backup plans while maintaining cervical precautions. Skipping preparation, removing precautions, and withholding oxygen increase hypoxemia and airway or spinal injury risk. Ongoing reassessment is essential because trauma physiology and treatment effects can change quickly during the care transition.

125. C — Hypothermia worsens coagulopathy and metabolic instability during hemorrhage. Active patient warming and warmed blood products help interrupt this cycle while the nurse monitors temperature, perfusion, electrolytes, and response to source control. Leaving the patient uncovered, cooling blood, and delaying warming perpetuate heat loss and can worsen bleeding. Continue reassessment as trauma physiology evolves.

126. D — Hemorrhagic shock care emphasizes rapid source control and balanced blood-component therapy according to the local protocol, with attention to temperature, calcium, and coagulation. The nurse tracks response and communicates laboratory or clinical changes. Excess crystalloid, delayed communication, and red cells alone can worsen dilutional coagulopathy or fail to replace needed components.

127. B — Citrate in blood products binds calcium, and rapid transfusion can produce clinically important ionized hypocalcemia with hypotension or dysrhythmia. The nurse obtains ordered laboratory testing, maintains monitoring, and prepares replacement as prescribed. Oral intake, a resolved response, and anxiety do not explain the timing and cardiovascular findings during rapid transfusion.

128. C — Fibrinogen is essential for clot formation, and severe trauma-associated depletion can impair hemostasis. The nurse prepares prescribed cryoprecipitate or fibrinogen replacement while continuing component therapy, temperature control, and source-control efforts. Water, diuresis, and crystalloid do not replace depleted fibrinogen or correct traumatic coagulopathy. Ongoing reassessment is essential because trauma physiology and treatment effects can change quickly during the care transition.

129. A — Damage-control resuscitation links early hemorrhage control with blood-component support, avoidance of excessive dilution, warming, and correction of coagulopathy, acidosis, and electrolyte problems. The nurse coordinates these actions without delaying definitive source control. Laboratory perfection, crystalloid alone, and a delayed history do not stop life-threatening bleeding or its physiologic spiral. Continue reassessment as trauma physiology evolves.

130. D — The trauma diamond expands the classic lethal triad by adding hypocalcemia to hypothermia, acidosis, and coagulopathy. These abnormalities reinforce one another during severe hemorrhage, so resuscitation addresses all four while controlling the source. The alternative clusters describe unrelated or opposite abnormalities and do not represent the recognized trauma resuscitation spiral.

131. B — Persistent hypotension after crystalloid suggests continuing blood loss and inadequate circulating oxygen-carrying capacity. The nurse activates the hemorrhage pathway, prepares blood products, reassesses perfusion, and supports rapid source control. More crystalloid alone, vasopressor-only treatment, and delayed escalation do not replace lost blood or control the bleeding source. Continue reassessment as trauma physiology evolves.

132. A — The pattern suggests impaired cardiac filling from pericardial pressure, producing obstructive shock. The nurse supports oxygenation and perfusion, avoids delays for nonessential testing, and prepares for urgent drainage or surgical management. Dehydration, neurogenic shock, and mild allergy do not explain venous distention with obstructed cardiac filling after trauma. Continue reassessment as trauma physiology evolves.

133. C — This combination indicates tension physiology, in which pleural pressure compromises ventilation and venous return. The nurse provides oxygen, calls for immediate decompression, and prepares for chest drainage while monitoring response. Routine imaging, diuresis, and observation delay treatment of a rapidly fatal obstructive emergency. Ongoing reassessment is essential because trauma physiology and treatment effects can change quickly during the care transition.

134. B — Neurogenic shock may follow loss of sympathetic tone, but occult bleeding must still be excluded. The nurse supports circulation, maintains spinal precautions, monitors temperature and rhythm, and titrates prescribed therapy to response. Warm skin does not rule out bleeding, and diuresis or unmonitored head-down positioning can worsen instability. Continue reassessment as trauma physiology evolves.

135. D — Fever, purulent drainage, worsening perfusion, and elevated lactate suggest infection-associated distributive shock. The nurse obtains cultures and prescribed treatment without delaying resuscitation, monitors organ function, and escalates for source control. Fatigue, hypertension, and a

healed fracture do not explain systemic hypoperfusion with a purulent traumatic wound. Continue reassessment as trauma physiology evolves.

136. D — Pulmonary edema, cool perfusion, dysrhythmia, and low output after cardiac trauma suggest pump failure. The nurse monitors rhythm and hemodynamics, avoids assuming fluid will help, and coordinates cardiology and trauma management. Hypovolemia, leg trauma, and skin abrasion do not best explain pulmonary congestion with post-traumatic pump dysfunction. Continue reassessment as trauma physiology evolves.

137. B — Trauma care is iterative: every intervention can help, fail, or create a new problem. The nurse repeats focused primary-survey elements, compares objective trends, and escalates when the expected response does not occur. Completion, documentation alone, and delayed reassessment cannot establish whether life threats improved or progressed. Continue reassessment as trauma physiology evolves.

138. A — Acute hypoxemia and noncardiogenic pulmonary edema after transfusion raise concern for transfusion-related acute lung injury. The nurse stops the transfusion, maintains support, notifies the team and blood bank, and differentiates it from circulatory overload. A rib bruise, stable asthma, or healed incision does not explain abrupt post-transfusion respiratory failure with new infiltrates.

139. C — Shock reduces renal perfusion, while rhabdomyolysis can add pigment-mediated tubular injury. The nurse trends urine output, creatinine, potassium, and fluid response and coordinates renal-protective treatment with the trauma team. Normal adaptation, eye injury, and urinary frequency do not explain oliguria with rising creatinine after shock or crush injury. Continue reassessment as trauma physiology evolves.

140. D — Worsening oxygenation with diffuse infiltrates not explained by cardiac failure is consistent with acute respiratory distress syndrome, which can follow shock, aspiration, or severe inflammation. The nurse supports lung-protective management and monitors trends. Skin wounds, wrist fractures, and resolved upper-airway obstruction do not produce diffuse noncardiogenic respiratory failure. Continue reassessment as trauma physiology evolves.

141. A — Oral hygiene, appropriate head elevation, secretion management, and daily assessment for liberation reduce aspiration and ventilator-associated infection risk. The nurse follows the unit bundle and monitors for new respiratory findings. Flat positioning, avoided oral care, and retained secretions increase aspiration and bacterial burden. Ongoing reassessment is essential because trauma physiology and treatment effects can change quickly during the care transition.

142. C — Hand hygiene, aseptic access, and reliable dressing care reduce central-line bloodstream infection risk. The nurse inspects the site, follows disinfecting and replacement policy, and reports redness, drainage, fever, or line malfunction. Skipping cleaning, waiting for drainage, and leaving loose tape compromise line protection and delay recognition of infection. Continue reassessment as trauma physiology evolves.

143. B — The safest catheter is one that is no longer needed. Removing it reduces infection risk, while a planned alternative addresses mobility or output monitoring needs. The nurse reassesses retention risk

and documents the plan. Convenience retention, disconnection, and routine unneeded irrigation increase infection or contamination risk. Continue reassessment as trauma physiology evolves.

144. A — Fever, purulence, redness, and worsening pain suggest a surgical-site infection or deeper complication. The nurse assesses for sepsis, communicates promptly, obtains ordered cultures, and supports prescribed antimicrobial and source-control treatment. Delayed follow-up, unprotected exposure, and unsupervised antibiotics can worsen infection or obscure its cause. Continue reassessment as trauma physiology evolves.

145. C — Delirium prevention and treatment include evaluating hypoxia, pain, infection, medications, and withdrawal; providing orientation and sleep support; and mobilizing safely. The nurse reduces hazards and reassesses mental status rather than relying on restraint. Unassessed restraints, continuous bright light, and unmonitored sedation can worsen delirium, injury, or respiratory compromise. Continue reassessment as trauma physiology evolves.

146. D — Tremor, diaphoresis, agitation, and tachycardia after reduced alcohol intake may indicate withdrawal, which can progress to seizures or delirium tremens. The nurse uses the facility protocol, monitors airway and autonomic status, and gives prescribed therapy. Dismissal, personal alcohol, and withholding fluids do not safely treat withdrawal and can delay prevention of severe complications.

147. B — Falls are prevented by checking strength, symptoms, and hemodynamic tolerance; using adequate staff and equipment; and progressing activity gradually. The nurse encourages safe mobility while avoiding unnecessary immobility. Unassisted standing, prolonged immobility, and restraints increase fall, deconditioning, and injury risk. Ongoing reassessment is essential because trauma physiology and treatment effects can change quickly during the care transition.

148. D — The tertiary survey is a deliberate reassessment after immediate threats are addressed. It integrates history, new symptoms, examination, laboratory results, and imaging to identify injuries missed during early resuscitation. A single body area, negative study, or patient-led recall alone cannot reliably detect all evolving or occult injuries. Continue reassessment as trauma physiology evolves.

149. A — Missed injuries can declare themselves as bleeding, edema, or inflammation evolves. New tachycardia and localized tenderness require reassessment, trend review, NPO status as appropriate, and prompt trauma-team communication. A reassuring first examination, oral feeding, and delayed documentation can postpone diagnosis of an occult injury. Continue reassessment as trauma physiology evolves.

150. C — Trauma-informed care emphasizes safety, transparency, collaboration, choice, and avoidance of retraumatization. The nurse pauses when safe, explains what will happen, obtains consent within the care process, and supports the patient's voice. Unannounced continuation, dismissing fear, and public discussion undermine trust, dignity, and psychological safety. Continue reassessment as trauma physiology evolves.

151. B — Physical therapy addresses strength, balance, transfers, gait, and safe progression after injury. Early coordinated rehabilitation can reduce deconditioning and improve function while respecting

weight-bearing and surgical restrictions. Dietary and speech services may be valuable for other needs, but they do not replace mobility-focused therapy or justify delay. Continue reassessment as trauma physiology evolves.

152. B — Occupational therapy focuses on self-care, adaptive equipment, upper-extremity function, and meaningful daily activities. Coordinated referral supports independence while the wound and prosthetic plan continue to evolve. Physical therapy alone, delayed therapy, and radiology do not address the patient's self-care and adaptation needs. Ongoing reassessment is essential because trauma physiology and treatment effects can change quickly during the care transition.

153. A — Coughing with liquids suggests dysphagia and aspiration risk after intubation or neurologic injury. The nurse stops oral intake, maintains airway precautions, and obtains speech-language evaluation before advancing diet. Larger sips, unassessed thin liquids, and self-testing can cause aspiration and respiratory complications. Ongoing reassessment is essential because trauma physiology and treatment effects can change quickly during the care transition.

154. D — When feasible, enteral nutrition supports gut function and provides protein and energy during recovery. The nurse verifies the plan, monitors aspiration and intolerance, and coordinates timing with operations and hemodynamic status. Indefinite NPO status, dextrose alone, and waiting for wound healing can worsen malnutrition and delay recovery. Continue reassessment as trauma physiology evolves.

155. C — Donation referral follows institutional policy and allows trained specialists to evaluate eligibility and approach the family appropriately. The nurse provides compassionate support, protects privacy, and avoids promises about donation outcomes. Pressuring the family, promising eligibility, and public discussion can cause harm and bypass the required donation process. Continue reassessment as trauma physiology evolves.

156. D — Brain death is a formal medical determination that requires an appropriate examination, prerequisites, and documented criteria by qualified practitioners according to law and policy. The nurse supports testing, observes, documents, and communicates changes. One reflex, family observation, or presence of a pulse cannot independently establish or exclude brain death. Continue reassessment as trauma physiology evolves.

157. C — Advance directives communicate a patient's preferences and should be incorporated into decision-making when applicable. The nurse verifies the document, informs the team, advocates for the patient, and follows policy for any conflict. Family preference alone, destruction of records, and blanket invalidation disregard patient autonomy and safe legal-ethical process. Continue reassessment as trauma physiology evolves.

158. A — Palliative care can be provided alongside disease-directed treatment to relieve symptoms, clarify goals, and support patients and families. It is not limited to the final hours or to withholding all treatment. Waiting for treatment to stop, withholding symptoms care, and security referral do not meet the patient's clinical and psychosocial needs.

159. B — Family presence may be supported when safe and when a trained staff member explains the process and protects privacy. The nurse balances family needs with patient care, infection control, and team functioning. Unrestricted access, blanket refusal, and recording can compromise safety, confidentiality, and coordinated resuscitation. Continue reassessment as trauma physiology evolves.

160. B — Injury prevention is strongest when it responds to local patterns and combines education, protective behaviors, policy or community partnerships, and evaluation. The nurse protects confidentiality while translating trauma data into prevention. Generic messaging, delayed action, and identifiable stories without permission are less effective or violate privacy. Continue reassessment as trauma physiology evolves.

161. C — Severe injury with airway, breathing, and circulatory threats requires timely transport to a resource capable of definitive trauma care. Prehospital teams treat immediate threats while communicating the patient's condition and destination rationale. Nearest location, delayed history, and family preference alone may place the patient where definitive care is unavailable. Continue reassessment as trauma physiology evolves.

162. D — Safe interfacility transfer requires receiving-center acceptance, an appropriate transport plan, and accurate communication of injuries, trends, interventions, medications, blood products, and pending needs. Unconfirmed transfer, minimal identification, and family-dependent information create dangerous gaps in continuity and treatment. Ongoing reassessment is essential because trauma physiology and treatment effects can change quickly during the care transition.

163. A — Discharge teaching must prepare the patient to manage care and recognize complications. Demonstration or teach-back verifies understanding of wound care, medications, restrictions, follow-up, and symptoms requiring urgent contact. A prescription alone, internet referral, and avoidance of risk discussion leave preventable gaps in home readiness and safety. Continue reassessment as trauma physiology evolves.

164. C — Mass-casualty triage prioritizes patients who are likely to benefit from rapid, limited intervention. An airway obstruction relieved by a simple maneuver represents an immediate treatment priority, while walking minor injuries and obviously nonsurvivable findings are categorized differently. Minor ambulatory injury, death after repositioning, and a stable finger fracture do not have the same immediate lifesaving potential.

165. B — External contamination can expose staff, other patients, and the facility. The nurse follows the incident plan, establishes a controlled zone, uses appropriate PPE, removes contaminated material, and supports decontamination before routine care proceeds. Unprotected entry, aerosolizing powder, and delayed decontamination spread hazardous material and create secondary exposure. Document actions and reassess system performance.

166. D — Overtriage uses high-level resources for patients who may not need them, while undertriage sends patients with serious injuries to less capable resources. Both patterns affect safety and system capacity and should prompt performance review. The pattern is not simply specificity, documentation, or staffing; it reflects whether destination decisions match injury severity and capability.

167. A — Reliable registry data require standardized definitions, complete documentation, validation, and transparent handling of missing or conflicting information. Accurate data allow meaningful comparison, performance improvement, and feedback across the trauma system. Selective removal, undocumented estimates, and changing definitions introduce bias and make comparisons unreliable. Reliable trauma systems depend on clear communication, documented actions, and timely follow-through across teams and settings.

168. B — Performance improvement links a defined problem to root-cause analysis, a targeted intervention, assigned responsibility, and repeat measurement. Reassessment shows whether the change improved care and whether further adjustment is needed. Blame, publication without action, and indefinite delay do not create a measurable improvement cycle or safer process. Document actions and reassess system performance.

169. 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 without punitive assumptions. Ignoring, altering records, and public blame conceal risk, undermine learning, and may create additional safety or legal problems.

170. D — 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.

171. A — For a non-treatment request, the covered entity should verify the purpose, apply its privacy procedures, and limit disclosure to the minimum necessary unless an exception or authorization applies. The nurse uses approved channels and documents the response. A business relationship alone does not justify the full record, public discussion risks disclosure, and blanket refusal can block a permitted limited request.

172. B — A Medicare-participating hospital with emergency services must provide an appropriate medical screening examination and stabilizing treatment for an emergency medical condition regardless of insurance status or ability to pay. Transfer decisions must meet applicable requirements. Payment-first delay, financially motivated transfer, and self-care instructions do not replace emergency screening or stabilization.

173. D — 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.

174. C — 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 system capability and undermine patient safety and valid review. Document actions and reassess system performance.

175. 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.