

PRACTICE EXAM 9: 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 are established through Angoff and statistical-equating procedures. Select the single best answer for each question.

1. A patient struck the temporal region and briefly lost consciousness. After a lucid interval, the patient develops a unilateral fixed dilated pupil and worsening lethargy. Which action is the priority?
 - A. Place the patient in routine observation and recheck in four hours
 - B. Escalate immediately for emergent neuroimaging and neurosurgical evaluation
 - C. Perform a lumbar puncture before contacting the trauma team
 - D. Administer oral analgesia and reassess after the medication takes effect

2. A patient with severe traumatic brain injury becomes progressively less responsive. Which nursing goal best reduces the risk of secondary brain injury?
 - A. Keep the patient deeply sedated without checking neurologic responses
 - B. Restrict all fluids even when perfusion indicators deteriorate
 - C. Delay airway intervention until a definitive intracranial diagnosis is made
 - D. Maintain adequate oxygenation and cerebral perfusion while preventing hypotension

3. Following a cervical spinal cord injury, a patient has hypotension, bradycardia, warm dry skin, and no obvious external hemorrhage. Which condition is most likely?
 - A. Hypovolemic shock caused by isolated dehydration
 - B. Obstructive shock caused by a small pleural effusion

- C. Neurogenic shock caused by loss of sympathetic vascular tone
- D. Cardiogenic shock caused by an uncomplicated extremity fracture

4. A patient opens the eyes to voice, speaks in confused sentences, and withdraws from painful stimulation. What is the patient's Glasgow Coma Scale score?

- A. 9
- B. 13
- C. 11
- D. 15

5. A patient with a traumatic intracranial hemorrhage has an oxygen saturation of 86% and a falling blood pressure. Which intervention should the nurse prioritize?

- A. Correct hypoxemia and hypotension while maintaining cervical spine precautions
- B. Obtain a detailed family history before supporting ventilation
- C. Lower the head of the bed flat and withhold oxygen
- D. Encourage oral fluids while waiting for repeat imaging

6. A patient has bruising behind the ear and clear drainage from the ear after a high-energy head injury. Which action is appropriate?

- A. Pack the ear firmly to stop cerebrospinal fluid leakage
- B. Insert a nasogastric tube through the nostril without imaging
- C. Irrigate the ear canal vigorously with sterile saline
- D. Cover the drainage lightly and avoid inserting anything into the ear or nose

7. A patient with suspected basilar skull fracture requires gastric decompression. Which route should the nurse avoid until the injury is excluded?

- A. The oral route

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

8. A patient with midface trauma has gurgling respirations, loose teeth, and rapidly increasing work of breathing. What should the nurse do first?

- A. Apply a nonrebreather mask and leave the patient unattended
- B. Push displaced teeth farther into the oral cavity
- C. Place the patient supine without suctioning to protect the spine
- D. Suction the airway and prepare for a definitive airway while stabilizing the cervical spine

9. A patient with blunt orbital trauma has severe eye pain, proptosis, decreased vision, and a tense eyelid. Which complication should the nurse suspect?

- A. Uncomplicated conjunctival irritation suitable for routine drops
- B. A superficial eyelid abrasion requiring pressure dressing
- C. Orbital compartment syndrome requiring emergent decompression evaluation
- D. A stable refractive error that can be reviewed at discharge

10. A patient with a penetrating neck wound develops an expanding hematoma, stridor, and increasing respiratory effort. Which plan is most appropriate?

- A. Secure the airway early with expert assistance and prepare for operative management
- B. Explore the wound blindly at the bedside
- C. Apply a tight circumferential neck dressing and observe
- D. Send the patient for routine outpatient imaging

11. A patient with blunt neck trauma has hoarseness, subcutaneous emphysema, and persistent air leakage despite a chest tube. Which injury is most concerning?

- A. An isolated superficial neck contusion
- B. A laryngotracheal or tracheobronchial disruption
- C. A simple closed clavicle fracture
- D. A mild sore throat from oxygen therapy

12. A patient with a high cervical spinal cord injury has weak diaphragmatic movement and pooling secretions. Which assessment is most important?

- A. Trend respiratory effort, vital capacity, cough strength, and gas exchange
- B. Measure only urine output every eight hours
- C. Assess skin color once per shift without respiratory trending
- D. Wait for oxygen saturation to fall before calling the provider

13. A patient with traumatic brain injury begins generalized convulsions. Which nursing priority is most appropriate during the event?

- A. Force the jaw open with a rigid object
- B. Protect the airway and oxygenation while preventing additional injury
- C. Restrain all extremities tightly against the bed
- D. Leave the patient alone to avoid stimulation

14. A patient develops new unilateral weakness and aphasia several hours after a head injury. What is the nurse's best response?

- A. Attribute the findings to anxiety until the next shift
- B. Offer food and reassess after the meal
- C. Activate urgent neurologic evaluation and prepare for repeat brain imaging
- D. Document the change without notifying the trauma team

15. A patient with a suspected spinal injury must be moved from the stretcher to the CT table. Which technique is safest?

- A. Ask the patient to twist independently toward the table
- B. Pull the patient by the arms in one quick motion
- C. Remove all motion restriction before the move
- D. Use a coordinated team logroll or lift while maintaining neutral spinal alignment

16. A patient taking a direct oral anticoagulant has a minor fall with a normal initial neurologic examination. Which plan is most appropriate?

- A. Discharge immediately because the first examination is normal
- B. Give aspirin to prevent a delayed clot
- C. Continue observation and follow the trauma team's plan for imaging or repeat evaluation
- D. Perform a lumbar puncture to rule out bleeding

17. A patient has a scalp laceration over a depressed open skull fracture. Which dressing approach is appropriate while awaiting surgery?

- A. Pack the wound tightly with gauze over the fracture
- B. Apply a sterile nonadherent dressing without pressing on the depressed area
- C. Scrub the exposed bone vigorously with antiseptic
- D. Close the wound with adhesive strips at the bedside

18. A patient with an acute cervical cord injury develops worsening weakness after an episode of hypotension. Which nursing goal is most important?

- A. Support spinal cord perfusion and prevent further hypoxemia or hypotension
- B. Keep the patient hypotensive to reduce bleeding from all injuries
- C. Delay reassessment until pain medication is completed
- D. Encourage ambulation to assess the neurologic deficit

19. A patient rescued from an enclosed fire has facial burns, soot around the mouth, hoarseness, and increasing anxiety. Which action is best?

- A. Wait for complete airway obstruction before intubating
- B. Give oral fluids to soothe the throat
- C. Apply a tight facial dressing over the mouth and nose
- D. Prepare for early controlled intubation before airway edema progresses

20. A patient has a penetrating eye injury with tissue protruding from the globe. Which intervention should the nurse perform?

- A. Remove the protruding material with sterile forceps
- B. Patch only the injured eye firmly with gauze
- C. Irrigate the eye repeatedly until the material comes out
- D. Place a rigid eye shield without applying pressure and obtain urgent ophthalmic help

21. A patient splashes an unknown alkaline cleaner into both eyes. What should the nurse do first?

- A. Wait for the product label before starting irrigation
- B. Begin copious irrigation immediately and continue while arranging ocular evaluation
- C. Neutralize the chemical with an acid solution
- D. Cover both eyes and transport without rinsing

22. A patient has blunt eye trauma, an irregular pupil, and a dark defect at the corneal surface. Which action is appropriate?

- A. Measure intraocular pressure with a handheld device
- B. Apply a pressure patch to control swelling
- C. Protect the eye with a rigid shield and avoid pressure, drops, or manipulation
- D. Remove the visible tissue with a cotton swab

23. A patient with traumatic subarachnoid blood reports a sudden severe headache and repeated vomiting. Which nursing action is most appropriate?

- A. Reassess airway and neurologic status promptly and notify the trauma team
- B. Give oral medication and allow the patient to sleep
- C. Place the patient flat without monitoring
- D. Encourage coughing to clear cerebral blood

24. A patient has a sensory level and new hand weakness after a high-energy crash but denies neck pain. Which action is appropriate?

- A. Remove the cervical collar because pain is absent
- B. Ask the patient to rotate the neck through full range
- C. Clear the spine based only on a normal pulse examination
- D. Maintain spinal motion restriction and obtain formal clearance by the trauma team

25. Immediately after a spinal cord injury, a patient has flaccid paralysis and absent reflexes below the lesion. Which condition does this describe?

- A. Neurogenic shock
- B. Cardiogenic shock
- C. Spinal shock
- D. Obstructive shock

26. A patient with a C6 spinal cord injury has a weak cough and thick secretions. Which intervention is most appropriate?

- A. Limit repositioning to prevent all movement
- B. Use assisted coughing, suction readiness, and aggressive pulmonary hygiene
- C. Give sedatives to suppress the cough reflex
- D. Wait for fever before starting respiratory care

27. A patient with a traumatic subdural hematoma becomes increasingly agitated and develops a worsening headache. Which finding would most strongly indicate deterioration?

- A. A new decline in level of consciousness or pupil asymmetry
- B. Mild thirst with stable neurologic findings
- C. A small bruise on the forearm
- D. A request for a quieter room

28. A patient is found unresponsive after blunt trauma and is vomiting. Which airway maneuver is preferred while cervical injury remains possible?

- A. Use forceful head tilt and chin lift
- B. Hyperextend the neck to open the airway
- C. Turn the head sharply to the side
- D. Use a jaw-thrust maneuver with manual cervical stabilization

29. A patient has clear fluid draining from the nose after facial trauma. Which nursing action is appropriate?

- A. Insert nasal packing to stop all drainage
- B. Place sterile gauze beneath the nose without packing and notify the trauma team
- C. Ask the patient to blow the nose forcefully
- D. Suction deeply through the nostril with a rigid catheter

30. A patient with a depressed skull fracture has worsening lethargy but stable vital signs. Which action is the priority?

- A. Repeat the neurologic assessment and urgently escalate the change to the trauma team
- B. Offer reassurance because vital signs remain stable
- C. Remove all monitoring to reduce stimulation
- D. Delay communication until the next scheduled rounding time

31. A patient with mild traumatic brain injury is discharged after initial evaluation. Which instruction is most important for the caregiver?

- A. Allow the patient to drive if feeling slightly better
- B. Give sedatives routinely so the patient sleeps deeply
- C. Return immediately for worsening headache, repeated vomiting, confusion, seizure, or weakness
- D. Ignore new symptoms unless fever also develops

32. A cervical collar causes chin pressure and partially obstructs the patient's airway. What should the nurse do?

- A. Remove the collar and leave the neck unsupported
- B. Tighten the collar until the airway is fully compressed
- C. Rotate the head away from the collar's pressure point
- D. Maintain manual stabilization while the team reassesses collar size and positioning

33. A patient with a high-energy mechanism has severe neck pain and possible craniocervical instability. Which action is safest?

- A. Avoid forced extension or flexion and maintain meticulous neutral alignment
- B. Test active neck rotation before imaging
- C. Remove all support to observe spontaneous posture
- D. Place a pillow beneath the neck to exaggerate extension

34. A patient with severe traumatic brain injury receives hyperosmolar therapy. Which parameter should the nurse monitor closely?

- A. Only the patient's appetite and bowel sounds
- B. Skin turgor once daily without laboratory trends
- C. Serum sodium, fluid balance, renal function, and neurologic response
- D. Visual acuity as the sole marker of treatment effect

35. A patient with a severe head injury demonstrates abnormal flexion of the arms in response to pain. What does this finding indicate?

- A. A normal response to painful stimulation
- B. Severe central nervous system dysfunction requiring urgent escalation
- C. An isolated peripheral nerve injury
- D. Improved neurologic function after resuscitation

36. A patient has an embedded metal fragment in the eye after an industrial injury. Which intervention is appropriate?

- A. Pull the object out quickly with hemostats
- B. Apply pressure directly over the fragment
- C. Flush forcefully until the object loosens
- D. Stabilize the object with a protective shield and avoid removing it

37. A patient with multiple rib fractures has paradoxical chest movement, shallow respirations, and increasing fatigue. Which intervention is most appropriate?

- A. Provide oxygen, analgesia, pulmonary support, and prepare for positive-pressure ventilation
- B. Bind the entire chest tightly with an elastic wrap
- C. Encourage unassisted deep breathing despite severe pain
- D. Place the patient flat and withhold analgesia

38. A patient has an open chest wound with a sucking sound and severe dyspnea. Which intervention should the nurse anticipate?

- A. Pack the wound deeply with dry gauze
- B. Apply an occlusive chest dressing and prepare for definitive pleural drainage
- C. Seal all four edges without monitoring for tension
- D. Remove the dressing whenever the patient inhales

39. A trauma patient has a blood pressure of 84/48 mmHg. Using the standard mean arterial pressure approximation, what is the MAP?

- A. 44 mmHg
- B. 72 mmHg
- C. 60 mmHg
- D. 96 mmHg

40. A patient after blunt chest trauma has severe respiratory distress, absent breath sounds on one side, distended neck veins, and worsening hypotension. What should the nurse do?

- A. Wait for a portable chest radiograph before treatment
- B. Place the patient in Trendelenburg and observe
- C. Activate immediate decompression for suspected tension pneumothorax
- D. Administer oral fluids and reassess in thirty minutes

41. A patient with blunt chest trauma is pale, hypotensive, and has markedly decreased breath sounds on the injured side. Which treatment should the nurse anticipate?

- A. Needle decompression alone with no further drainage
- B. Chest tube placement with rapid evaluation for operative hemorrhage control
- C. Routine oral analgesia and discharge teaching
- D. A tight abdominal binder around the thorax

42. A chest tube patient develops sudden respiratory distress, and the drainage system shows no tidaling. What should the nurse do first?

- A. Assess the patient and inspect the tubing for kinks, disconnection, or obstruction
- B. Strip the entire tube forcefully toward the collection chamber
- C. Clamp the tube routinely for one hour
- D. Remove the tube immediately without notifying the team

43. A chest tube has continuous bubbling in the water-seal chamber. Which interpretation is most appropriate?

- A. The lung is definitely fully reexpanded
- B. The collection chamber is overfilled with blood
- C. The suction regulator should always be increased
- D. There is an air leak; trace it from the patient outward

44. A patient with a pulmonary contusion develops worsening hypoxemia several hours after a crash. Which plan is best?

- A. Give large unmonitored fluid boluses to clear the lungs
- B. Provide prophylactic antibiotics for every contusion
- C. Restrict oxygen because the injury is self-limited
- D. Support oxygenation and ventilation while avoiding unnecessary fluid overload

45. An older adult with multiple rib fractures has shallow respirations because of pain. Which intervention should the nurse emphasize?

- A. Avoid analgesia so respiratory depression cannot occur
- B. Apply circumferential chest binding throughout the day
- C. Use multimodal analgesia and coached pulmonary hygiene with frequent reassessment
- D. Encourage bed rest without lung-expansion exercises

46. After a blunt chest injury, a patient has muffled heart sounds, distended neck veins, narrow pulse pressure, and shock. Which condition is most likely?

- A. Simple isolated rib fracture
- B. Cardiac tamponade causing obstructive shock
- C. Uncomplicated pulmonary contusion
- D. Neurogenic shock from a minor wrist injury

47. A patient with blunt cardiac injury develops frequent ventricular ectopy. Which action is appropriate?

- A. Maintain continuous ECG monitoring and report dysrhythmia or hemodynamic change
- B. Remove the monitor once the first ECG is completed
- C. Encourage strenuous activity to test cardiac reserve
- D. Treat the rhythm as anxiety without reassessing perfusion

48. A patient after a high-speed deceleration crash has chest pain, unequal arm blood pressures, and a widened mediastinum. What should the nurse anticipate?

- A. Routine discharge after a normal pulse oximeter reading
- B. Forceful chest compression to narrow the mediastinum
- C. Immediate oral feeding before imaging
- D. Urgent evaluation for blunt great-vessel injury with controlled transport and monitoring

49. A patient after a high-speed crash has respiratory distress, abdominal pain, and bowel sounds in the left chest. Which injury is most likely?

- A. An isolated superficial abdominal abrasion
- B. A simple closed humerus fracture
- C. Traumatic diaphragmatic rupture with herniation of abdominal contents
- D. Uncomplicated viral bronchitis

50. A patient with blunt thoracic trauma has a persistent large air leak, pneumomediastinum, and failure of the lung to reexpand despite a chest tube. Which injury should be suspected?

- A. Tracheobronchial injury requiring bronchoscopy or surgical evaluation
- B. A small uncomplicated skin laceration
- C. Isolated abdominal muscle strain
- D. A resolved pneumothorax with no further concern

51. A patient with an abdominal evisceration after penetrating trauma arrives alert but pale. Which dressing should the nurse apply?

- A. Push the organs back into the abdominal cavity
- B. Cover the exposed organs with warm sterile moist dressings without replacing them
- C. Cover the organs with dry adhesive tape
- D. Apply direct pressure over the exposed bowel

52. A patient has an impaled metal rod through the upper abdomen. Which intervention is appropriate?

- A. Stabilize the object in place and prepare for controlled operative removal
- B. Remove the rod immediately to inspect the wound
- C. Twist the rod to determine its path
- D. Push the rod farther inward to stop bleeding

53. A patient with blunt left upper-quadrant trauma initially improves after fluids, then develops tachycardia and increasing abdominal tenderness. Which concern is most important?

- A. A resolved injury requiring no further assessment
- B. An isolated ankle sprain causing referred pain
- C. Delayed hemorrhage from splenic injury
- D. A routine medication side effect

54. A patient with a deep right upper-quadrant injury has hypotension, abdominal distention, and worsening pallor. Which priority is appropriate?

- A. Give oral fluids and wait for pain to settle
- B. Continue hemorrhage-focused resuscitation and prepare for definitive liver injury control
- C. Apply a splint to the lower leg
- D. Discontinue monitoring because the bleeding is internal

55. A patient with a penetrating abdominal wound develops a rigid abdomen, rebound tenderness, and worsening shock. What should the nurse anticipate?

- A. Routine oral intake and outpatient follow-up
- B. A heating pad over the abdomen
- C. Discharge after a single negative urine test
- D. Urgent operative evaluation for hollow-viscus injury and peritonitis

56. A patient with a pelvic fracture has flank bruising, abdominal distention, and persistent shock without obvious external bleeding. Which injury should remain high on the differential?

- A. Occult retroperitoneal hemorrhage
- B. A superficial forearm abrasion
- C. A mild tension headache
- D. An isolated nasal fracture

57. A patient with an unstable pelvic fracture is hypotensive. Where should a pelvic binder be positioned?

- A. Across the upper abdomen below the ribs
- B. Around the waist above the iliac crests
- C. Centered over the greater trochanters
- D. Across the mid-thighs below the pelvis

58. A pelvic binder is found positioned around a patient's waist after pelvic trauma. What should the nurse do?

- A. Tighten it higher around the lower ribs
- B. Remove it and encourage the patient to walk
- C. Place a second binder across the chest
- D. Reposition it over the greater trochanters while maintaining alignment

59. A patient with a pelvic fracture has blood at the urethral meatus. Which action is appropriate?

- A. Insert the catheter gently until urine appears
- B. Avoid blind urethral catheterization and notify the trauma team for evaluation
- C. Use repeated catheter attempts with increasing pressure
- D. Ask the patient to void into a container and discharge

60. A patient with pelvic trauma has perineal ecchymosis and scrotal swelling. Which concern should guide nursing care?

- A. Simple bruising requiring vigorous massage
- B. A minor skin rash requiring topical powder
- C. A routine urinary infection requiring delayed testing
- D. Possible urethral injury requiring avoidance of blind catheter insertion

61. A patient with lower abdominal trauma has suprapubic pain, distention, and gross hematuria. Which injury is most concerning?

- A. A superficial abdominal wall contusion only
- B. An isolated shoulder dislocation
- C. Traumatic bladder injury
- D. A mild medication-related urinary change

62. A patient with pelvic trauma is diagnosed with intraperitoneal bladder rupture. Which treatment should the nurse anticipate?

- A. Operative repair with urinary drainage and ongoing abdominal assessment
- B. Foley catheter drainage alone in every case
- C. Oral hydration and unrestricted activity
- D. Compression of the lower abdomen with a binder

63. A patient with blunt renal trauma has hematuria but stable perfusion and no peritonitis. Which plan is most appropriate?

- A. Perform immediate nephrectomy without further assessment
- B. Continue monitoring and obtain trauma-directed imaging to grade the renal injury
- C. Insert a urethral catheter despite suspected urethral injury
- D. Discharge because hematuria is expected after any fall

64. After massive fluid and blood resuscitation, a trauma patient has a tense abdomen, rising airway pressures, oliguria, and worsening hypotension. What should the nurse suspect?

- A. Simple constipation without physiologic effect
- B. Abdominal compartment syndrome
- C. A resolved abdominal injury
- D. An isolated wrist fracture

65. A trauma patient has confirmed abdominal compartment syndrome with progressive organ dysfunction. Which intervention should the nurse anticipate?

- A. Increase abdominal pressure with tight external binding
- B. Encourage oral intake to restore organ volume
- C. Urgent decompressive management directed by the trauma and surgical teams
- D. Delay intervention until bowel sounds disappear

66. A patient with a lower chest wound has left shoulder pain and respiratory distress, but the first radiograph is inconclusive. Which principle is most important?

- A. Maintain suspicion for occult diaphragmatic injury and arrange reassessment
- B. Assume the diaphragm is intact after one unclear image
- C. Clear the patient for unrestricted activity
- D. Treat the shoulder pain as an isolated musculoskeletal problem

67. A patient struck by a bicycle handlebar develops delayed epigastric pain and rising pancreatic enzymes. Which plan is appropriate?

- A. Offer a full meal to test gastrointestinal tolerance
- B. Discharge because the skin bruise is small
- C. Apply a pelvic binder to the upper abdomen
- D. Continue serial assessment and imaging for pancreatic or duodenal injury

68. A patient has a pronounced seatbelt sign but minimal abdominal tenderness after a motor vehicle crash. Which action is most appropriate?

- A. Discharge immediately because tenderness is minimal
- B. Continue evaluation and serial reassessment for occult bowel injury
- C. Give laxatives to prevent obstruction
- D. Apply a tight abdominal binder and stop examination

69. A patient with a penetrating abdominal gunshot wound is hypotensive and confused. Which plan is most appropriate?

- A. Delay definitive care for a lengthy outpatient history
- B. Offer oral contrast and wait for symptom progression
- C. Discharge after applying a dry dressing
- D. Proceed rapidly toward operative hemorrhage and contamination control

70. A hemodynamically stable patient has a superficial abdominal stab wound without peritonitis. Which approach may be appropriate under trauma-team direction?

- A. Immediate discharge without wound evaluation
- B. Blind exploration with a bedside instrument
- C. Selective imaging and serial examination rather than automatic laparotomy
- D. Forced oral intake to provoke pain

71. A patient receiving a massive transfusion develops paresthesias, hypotension, and a prolonged QT interval. Which problem should the nurse suspect?

- A. Ionized hypocalcemia related to citrate in transfused blood products
- B. Hypercalcemia caused by excessive oral calcium
- C. A simple anxiety response without physiologic change
- D. Isolated dehydration from a missed meal

72. A trauma patient has a heart rate of 126 beats/min and a systolic blood pressure of 84 mmHg. What is the shock index?

- A. 0.67
- B. 1.00
- C. 1.50
- D. 2.10

73. A patient initially stable after blunt abdominal trauma develops fever, guarding, and increasing pain the next day. Which concern is most important?

- A. Normal healing that needs no reassessment
- B. A missed hollow-viscus injury with delayed contamination
- C. A minor bruise unrelated to the abdomen
- D. A resolved injury caused by temporary anxiety

74. A patient with a lower chest stab wound becomes hypotensive and develops abdominal tenderness. Which principle should guide care?

- A. Treat the wound as potentially thoracoabdominal and escalate for combined injury evaluation
- B. Limit assessment to the skin entry point
- C. Assume the wound cannot affect the diaphragm
- D. Encourage walking to determine whether pain is muscular

75. A chest tube is accidentally pulled out of the patient's chest but remains attached to the drainage tubing. What should the nurse do?

- A. Push the tube back through the skin
- B. Leave the site open so air can escape
- C. Clamp the patient's airway and wait for a radiograph
- D. Apply an occlusive dressing to the insertion site, provide oxygen, and call the trauma team

76. A patient with a pelvic fracture remains hypotensive despite a correctly placed binder and blood-product resuscitation. Which next concern is most important?

- A. A need to loosen the binder for comfort
- B. A resolved hemorrhage with anxiety-related tachycardia
- C. Ongoing arterial pelvic bleeding requiring advanced hemorrhage-control intervention
- D. An isolated skin injury at the hip

77. A patient with flank trauma develops delayed hematuria and persistent pain despite stable blood pressure. Which evaluation should the nurse anticipate?

- A. Immediate unrestricted oral intake without imaging
- B. Renal and ureteral imaging with urologic or trauma consultation
- C. A pressure dressing over the flank
- D. Routine treatment for an uncomplicated urinary infection

78. A patient with blunt thoracic trauma develops severe chest pain, fever, subcutaneous emphysema, and pain with swallowing. Which injury should the nurse suspect?

- A. An isolated uncomplicated rib bruise
- B. A superficial shoulder strain
- C. A resolved pulmonary contusion
- D. Keep NPO and obtain urgent surgical review

79. A patient with a pelvic fracture develops an expanding groin hematoma and a newly diminished femoral pulse. Which action is the priority?

- A. Escalate for urgent vascular assessment and hemorrhage-control intervention
- B. Apply a warm compress and reassess tomorrow
- C. Encourage walking to improve circulation
- D. Remove the pelvic binder without a replacement plan

80. A patient with a penetrating lower chest wound has worsening abdominal pain, fever, and free air near the diaphragm on imaging. Which complication is most concerning?

- A. A simple isolated skin infection
- B. A hollow-viscus injury with contamination requiring urgent source-control planning
- C. A resolved chest-wall contusion
- D. A minor ankle sprain

81. A patient with a tibial fracture reports escalating pain despite opioids and pain with passive toe extension. Which action is the priority?

- A. Elevate the leg high above the level of the heart
- B. Apply a tighter compression wrap to reduce swelling
- C. Reassure the patient that severe pain is expected
- D. Notify the surgical team immediately for suspected compartment syndrome

82. A patient with a swollen forearm after a crush injury has increasing paresthesia and pain with passive finger extension. What should the nurse do?

- A. Apply an additional rigid splint over the swelling
- B. Wait until the radial pulse is absent
- C. Remove external constriction if ordered and prepare for urgent pressure-relieving treatment
- D. Massage the compartment vigorously

83. A patient rescued after prolonged limb compression has dark urine and a markedly elevated creatine kinase level. Which intervention should the nurse anticipate?

- A. Aggressive isotonic fluid therapy with close renal and electrolyte monitoring
- B. Fluid restriction until the urine clears
- C. Routine potassium replacement without laboratory review
- D. Compression of the affected limb to stop muscle breakdown

84. A patient has an open tibial fracture with gross contamination. Which nursing intervention is appropriate while awaiting surgery?

- A. Push the bone back beneath the skin
- B. Scrub the wound aggressively at the bedside
- C. Apply a sterile dressing and prepare antibiotics, tetanus care, and debridement
- D. Close the wound with adhesive strips

85. A patient has an isolated midshaft femur fracture with no pelvic, knee, or ankle injury. Which prehospital device may be appropriate?

- A. A traction splint applied according to protocol with repeated neurovascular checks
- B. A pelvic binder placed around the upper abdomen
- C. A rigid collar applied only to the injured leg
- D. A circumferential cast applied before imaging

86. A patient with severe pelvic pain and hypotension has suspected pelvic ring disruption. Which device should the nurse anticipate first?

- A. A traction splint applied to one leg
- B. A compression wrap around the upper abdomen
- C. A soft ankle brace
- D. A pelvic binder centered over the greater trochanters

87. A traumatic lower-leg amputation has been controlled with a tourniquet. How should the amputated part be handled?

- A. Place the part directly on dry ice
- B. Wrap in moist gauze, seal in a bag, and cool it indirectly
- C. Immerse the part in disinfectant solution
- D. Leave the part uncovered at room temperature

88. A patient has life-threatening arterial bleeding from a mangled forearm, and direct pressure is ineffective. Which intervention should the nurse anticipate?

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

89. A patient with an anterior shoulder dislocation has a cool hand and an absent radial pulse. What is the priority?

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

90. A patient has a posterior hip dislocation after a dashboard injury. Which intervention is appropriate?

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

91. A deep hand laceration has visible tendon ends and loss of finger flexion. Which nursing action is appropriate?

- A. Cover the wound, preserve alignment, and obtain urgent hand or surgical consultation
- B. Force the finger through repeated range-of-motion testing
- C. Close the wound tightly with household adhesive
- D. Apply heat and delay examination until swelling resolves

92. A patient has a degloving injury in which skin is separated from the underlying tissue over the thigh. What should the nurse anticipate?

- A. Routine lotion and outpatient observation
- B. Aggressive massage to reattach the skin
- C. Protect wound, preserve tissue, and obtain urgent surgical review
- D. Immediate disposal of the separated tissue

93. A patient with a thoracolumbar fracture develops new bilateral leg weakness and urinary retention. Which action is the priority?

- A. Encourage ambulation to improve bladder function
- B. Remove all immobilization because the pain is reduced
- C. Treat the findings as a routine urinary infection
- D. Maintain spinal alignment and escalate urgently for neurologic and imaging evaluation

94. A patient with a circumferential forearm cast develops worsening pain, numb fingers, and coolness. Which action should the nurse take first?

- A. Elevate the arm above the head for several hours
- B. Notify the provider immediately and prepare for cast splitting or removal of constrictive dressings
- C. Apply another elastic wrap over the cast
- D. Wait until the next scheduled neurovascular check

95. A patient with a femur fracture develops sudden hypoxemia, confusion, and a fine petechial rash on the upper chest. Which complication should the nurse suspect?

- A. Suspect fat embolism; support breathing and neurologic status
- B. An isolated superficial skin reaction
- C. A resolved fracture with expected soreness
- D. A simple urinary infection

96. An older adult taking a beta blocker has a pelvic fracture, cool skin, delayed capillary refill, and new confusion, but the heart rate is 82 beats/min. Which interpretation is best?

- A. The normal heart rate rules out clinically important blood loss
- B. Beta blockers reliably protect older adults from hypoperfusion
- C. Confusion is expected and does not require reassessment
- D. The patient may be in shock despite the absence of marked tachycardia

97. An anticoagulated older adult falls and has a normal initial neurologic examination. Which plan is most appropriate?

- A. Discharge immediately because the patient is awake
- B. Use trauma-directed imaging and observation with serial neurologic reassessment
- C. Give aspirin to prevent delayed intracranial bleeding
- D. Avoid all imaging because radiation risk is the only concern

98. A dependent older adult has patterned bruising, poor hygiene, and a caregiver who refuses to leave the room. What should the nurse do?

- A. Ask the caregiver to explain the bruises in front of the patient
- B. Document only the caregiver's explanation
- C. Provide private assessment and follow the facility's suspected-elder-abuse reporting process
- D. Ignore the pattern because bruising is common in older adults

99. A child after a motor vehicle crash is anxious, tachycardic, pale, and has delayed capillary refill, but the blood pressure is normal. Which interpretation is best?

- A. Recognize compensated shock and continue rapid evaluation for occult blood loss
- B. Conclude that shock is impossible while blood pressure is normal
- C. Give oral fluids and return the child to the waiting room
- D. Attribute the findings only to fear

100. A small child with facial trauma has a large tongue, swollen airway tissues, and increasing stridor. Which preparation is most appropriate?

- A. Prepare for early expert airway management using appropriately sized equipment
- B. Wait until complete obstruction develops
- C. Use adult-sized equipment because it is easier to locate
- D. Force the neck into extension during every attempt

101. A pediatric trauma patient needs medication and fluid resuscitation. Which principle should guide preparation?

- A. Use the adult dose because the injury is severe
- B. Estimate doses from the caregiver's height
- C. Delay all therapy until exact weight is confirmed later
- D. Use the child's current weight or a validated length-based tool for dosing and equipment

102. A caregiver reports that a child fell from a low couch, but the child has bruises in different healing stages and a metaphyseal fracture. What is the priority?

- A. Accept the history and discharge the child after analgesia
- B. Ask the child to confront the caregiver immediately
- C. Ensure safety, document objectively, and activate the child-protection process
- D. Clean the bruises and omit them from the record

103. An infant has altered consciousness, retinal hemorrhages, and subdural bleeding without a compatible history. Which action is appropriate?

- A. Assume the injuries are caused by ordinary crying
- B. Treat the findings as possible abusive head trauma and activate safeguarding evaluation
- C. Discharge after the infant becomes briefly alert
- D. Delay documentation until the caregiver remembers more details

104. A pregnant trauma patient beyond mid-pregnancy becomes dizzy and hypotensive while lying supine. Which intervention should the nurse anticipate?

- A. Use left uterine displacement or lateral positioning while supporting maternal resuscitation
- B. Place the patient flat and elevate both legs only
- C. Apply direct pressure over the uterus
- D. Delay resuscitation until fetal imaging is completed

105. A pregnant patient is hemodynamically stable after abdominal trauma, but fetal monitoring shows recurrent decelerations. Which action is appropriate?

- A. Stop monitoring because maternal vital signs are normal
- B. Discharge if fetal movement returns once
- C. Continue maternal assessment and obtain urgent obstetric and trauma-team evaluation
- D. Treat the fetal tracing without reassessing the mother

106. A pregnant patient involved in a high-speed crash has abdominal pain, uterine tenderness, vaginal bleeding, and frequent contractions. Which complication is most concerning?

- A. Uncomplicated round-ligament discomfort
- B. Simple cystitis without trauma relevance
- C. A minor ankle sprain
- D. Placental abruption

107. A pregnant patient who is Rh-negative sustains blunt abdominal trauma. Which plan should the nurse anticipate?

- A. Assume no treatment is needed unless fetal movement stops
- B. Notify obstetrics about anti-D and fetomaternal-hemorrhage evaluation
- C. Administer Rh-positive blood without compatibility review
- D. Avoid all laboratory testing during pregnancy

108. A patient has dry powdered alkali on the forearm after an industrial accident. What should the nurse do first?

- A. Irrigate immediately without removing visible powder
- B. Neutralize the alkali with an acid
- C. Brush off the dry chemical with appropriate protection before copious irrigation
- D. Cover the powder with an occlusive dressing

109. A patient splashes liquid alkali into the eyes. Which intervention is the priority?

- A. Wait for an exact chemical concentration before rinsing
- B. Apply an eye patch and reassess later
- C. Use an acidic solution to neutralize the alkali
- D. Begin immediate copious irrigation and continue during urgent ophthalmic evaluation

110. A patient after an electrical injury has entry and exit wounds but initially reports feeling well. Which assessment is important?

- A. Assess only the visible skin wounds
- B. Obtain cardiac monitoring and evaluate for occult deep tissue injury
- C. Discharge if the patient denies pain
- D. Apply lotion and cover the burns without monitoring

111. A patient with a high-voltage injury develops dark urine and muscle pain. Which complication should the nurse suspect?

- A. Rhabdomyolysis with risk for acute kidney injury and electrolyte disturbance
- B. A harmless change from increased oral hydration
- C. An isolated superficial sunburn
- D. A resolved electrical exposure with no systemic effects

112. A patient with a circumferential full-thickness chest burn develops rising airway pressures and poor chest expansion. Which intervention should the nurse anticipate?

- A. Tighten the dressing around the chest
- B. Wait for spontaneous eschar separation
- C. Urgent escharotomy evaluation to release restrictive burn eschar
- D. Apply ice directly to the burned skin

113. A patient with a circumferential extremity burn develops increasing pain, numbness, and absent distal Doppler signals. Which action is the priority?

- A. Elevate the limb and reassess tomorrow
- B. Apply a tighter compression bandage
- C. Massage the burned tissue vigorously
- D. Escalate immediately for escharotomy and vascular reassessment

114. A patient rescued from an enclosed fire has soot, facial burns, hoarseness, and stridor. Which intervention is most appropriate?

- A. Prepare for early definitive airway management before edema makes intubation difficult
- B. Wait until oxygen saturation becomes critically low
- C. Offer oral fluids for throat comfort
- D. Apply a tight mask over the burned face

115. A patient exposed to smoke in an enclosed fire has headache, confusion, and a normal pulse-oximeter reading. Which action is appropriate?

- A. Rule out poisoning because the pulse oximeter is normal
- B. Administer high-concentration oxygen and obtain co-oximetry as directed
- C. Give only room air while awaiting symptoms
- D. Treat the finding as uncomplicated dehydration

116. For a practice calculation, use the adult Rule of Nines values of 9% for one entire arm and 18% for the anterior trunk. What TBSA is involved when both areas are burned?

- A. 9%
- B. 18%
- C. 27%
- D. 36%

117. Using a prescribed formula of 4 mL/kg/%TBSA, how much fluid is calculated for the first 8 hours for a 70-kg patient with a 30% burn, assuming no fluid was given before arrival?

- A. 2,100 mL
- B. 4,200 mL
- C. 8,400 mL
- D. 12,600 mL

118. A bariatric trauma patient requires CT transfer. Which preparation is most important?

- A. Move the patient with one staff member to reduce crowding
- B. Use any stretcher if the patient appears stable
- C. Delay all monitoring because equipment is difficult to transport
- D. Verify equipment weight limits, use adequate staff, and protect airway, skin, and lines

119. A trauma patient may be experiencing intimate partner violence. Which nursing approach is best?

- A. Screen privately using a nonjudgmental approach and assess immediate safety

- B. Ask the accompanying partner to answer all questions
- C. Confront the partner in the treatment area
- D. Document that the patient is responsible for the injuries

120. After a suspected sexual assault, which handling of clothing is appropriate?

- A. Place all clothing together in one sealed plastic bag
- B. Dry, separately package clothing in paper, and document chain of custody
- C. Discard clothing after photographs are taken
- D. Send evidence without recording transfers between handlers

121. A patient has injuries suggestive of human trafficking, and an accompanying person refuses to leave. What should the nurse do?

- A. Ask the accompanying person to translate sensitive questions
- B. Confront the person publicly before assessing the patient
- C. Discharge the patient without documenting concerns
- D. Arrange a private, trauma-informed interview with a qualified interpreter when needed

122. A trauma patient arrives with uncontrolled external hemorrhage, airway obstruction, and altered mental status. Which action takes priority in the initial survey?

- A. Complete a detailed head-to-toe history before treating bleeding
- B. Obtain routine laboratory results before applying pressure
- C. Control the immediately life-threatening hemorrhage while managing airway and breathing in parallel
- D. Transport the patient to CT before any bedside intervention

123. After initial stabilization of a trauma patient, which activity belongs in the secondary survey?

- A. A systematic head-to-toe examination with focused history and repeat vital signs

- B. Delaying all reassessment until the patient reaches the ward
- C. Removing monitoring so the patient can rest
- D. Performing only a radiograph of the painful extremity

124. A patient has undergone resuscitation and operative repair but develops new abdominal tenderness and a subtle neurologic change the next day. Which action is appropriate?

- A. Assume all injuries were identified during the primary survey
- B. Discontinue precautions because surgery was completed
- C. Perform a tertiary examination and reassess for missed or evolving injuries
- D. Treat the findings as expected postoperative discomfort

125. A severely injured patient is cold, acidotic, and coagulopathic during ongoing hemorrhage. Which concept best explains the concern?

- A. The trauma diamond: hypothermia, acidosis, coagulopathy, and hypocalcemia reinforce bleeding
- B. A benign response that improves with continued crystalloid alone
- C. A pulmonary-only complication unrelated to bleeding
- D. A neurologic syndrome caused by mild dehydration

126. Which resuscitation strategy best reflects damage-control principles in a patient with traumatic hemorrhagic shock?

- A. Give repeated large crystalloid boluses without reassessing perfusion
- B. Delay blood products until the hemoglobin result returns
- C. Correct temperature only after surgery is complete
- D. Prioritize hemorrhage control and balanced blood products while limiting unnecessary crystalloid

127. A trauma patient remains hypotensive with suspected internal hemorrhage despite initial access and monitoring. Which action should the nurse anticipate?

- A. Wait for a complete blood count before requesting blood products
- B. Activate the institution's massive-transfusion and hemorrhage-control pathway
- C. Give oral fluids while observing the abdomen
- D. Transfer the patient without a resuscitation plan

128. During massive transfusion, a trauma patient becomes cold and develops prolonged coagulation tests and ventricular ectopy. Which intervention should the nurse anticipate?

- A. Stop all blood products permanently and provide only dextrose
- B. Apply ice packs to prevent fever
- C. Warm the patient and monitor or replace calcium and coagulation factors per protocol
- D. Ignore laboratory changes until bleeding stops

129. A trauma patient has persistent oozing from lines and abnormal viscoelastic testing during hemorrhage. Which action is appropriate?

- A. Give aspirin to improve platelet flow
- B. Withhold all replacement until the operating room
- C. Use a heating pad as the only treatment
- D. Administer targeted coagulation therapy or blood components according to the resuscitation protocol

130. Before emergency intubation, a hypotensive trauma patient is poorly preoxygenated and has copious facial blood. Which preparation is most appropriate?

- A. Proceed without suction because intubation must be fast
- B. Suction the airway, optimize oxygenation and perfusion, and prepare backup airway equipment
- C. Give a large sedative dose before checking blood pressure
- D. Remove cervical precautions to improve visualization

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

- A. Obstructive shock from tension pneumothorax
- B. Distributive shock from an isolated superficial wound
- C. Cardiogenic shock from a healed ankle fracture
- D. Hypovolemic shock from mild nausea

132. A patient with a high thoracic spinal cord injury has hypotension, relative bradycardia, and warm dry skin after major trauma. Which shock type should the nurse recognize?

- A. Hypovolemic shock from confirmed external hemorrhage
- B. Neurogenic shock due to loss of sympathetic vascular tone
- C. Obstructive shock from a small pleural effusion
- D. Cardiogenic shock from an uncomplicated finger injury

133. A patient with blunt myocardial injury develops hypotension, pulmonary congestion, and a new ventricular dysrhythmia. Which shock mechanism is most likely?

- A. Neurogenic shock from isolated skin trauma
- B. Hypovolemic shock caused only by a superficial laceration
- C. Cardiogenic shock from impaired cardiac pump function
- D. Obstructive shock from mild constipation

134. A trauma patient with a contaminated open fracture develops fever, worsening perfusion, and rising lactate after several days. Which process should the nurse suspect?

- A. Septic shock from infection requiring antibiotics, cultures, and source control
- B. Normal postoperative inflammation requiring no escalation
- C. Isolated anxiety without physiologic effect
- D. Resolved hypovolemia that cannot recur

135. After a fluid or blood intervention, which reassessment best evaluates whether a trauma patient's perfusion is improving?

- A. Rely on a single heart-rate value only
- B. Assess pain score without checking circulation
- C. Wait for the next day's weight
- D. Trend perfusion, mental status, urine output, breathing, and laboratory data

136. A patient develops acute hypoxemia and bilateral pulmonary infiltrates during a transfusion, without evidence of circulatory overload. Which complication is most likely?

- A. Simple atelectasis caused by a missed meal
- B. Transfusion-associated circulatory overload
- C. An uncomplicated extremity bruise
- D. Transfusion-related acute lung injury

137. During a transfusion, a patient develops hypertension, jugular venous distention, and pulmonary edema. Which complication should the nurse suspect?

- A. Transfusion-related acute lung injury without volume excess
- B. An isolated airway abrasion
- C. Transfusion-associated circulatory overload
- D. A resolved hemorrhagic shock state

138. A mechanically ventilated trauma patient meets criteria for acute respiratory distress syndrome. Which ventilator principle should the nurse expect?

- A. Use very large tidal volumes to fully expand every alveolus
- B. Use lung-protective ventilation with careful monitoring of oxygenation and airway pressures
- C. Avoid all positive pressure despite severe hypoxemia
- D. Increase ventilator pressure without reassessing the patient

139. A crush-injury patient has dark urine, rising potassium, and decreasing urine output. Which complication is the priority?

- A. Acute kidney injury with potentially life-threatening electrolyte disturbance
- B. A harmless effect of muscle soreness
- C. An isolated dermatologic reaction
- D. Improved renal function from concentrated urine

140. A patient with blunt neck trauma develops sudden aphasia and right-sided weakness. Which action is most appropriate?

- A. Assume the deficit is medication-related and wait
- B. Activate urgent stroke and vascular evaluation while maintaining trauma stabilization
- C. Give oral food before obtaining imaging
- D. Remove all monitoring to reduce anxiety

141. A patient with a contaminated abdominal wound develops fever, hypotension, and worsening abdominal pain. Which treatment principle is essential?

- A. Begin prescribed antimicrobial therapy and achieve timely source control
- B. Treat fever only with a cooling blanket
- C. Delay antibiotics until the wound is completely closed
- D. Avoid cultures because they may delay discharge

142. Which practice best reduces central-line-associated bloodstream infection risk in a trauma patient?

- A. Access the line routinely to keep it active
- B. Change dressings only after visible drainage appears
- C. Leave every line in place through discharge
- D. Use aseptic technique and remove the line when no longer needed

143. Which intervention is most effective for reducing catheter-associated urinary tract infection risk after trauma?

- A. Irrigate the catheter routinely without an indication
- B. Keep the drainage bag above the bladder
- C. Remove the catheter as soon as it is no longer necessary
- D. Disconnect the closed system each shift

144. A mechanically ventilated trauma patient is at risk for ventilator-associated pneumonia. Which nursing practice is appropriate?

- A. Keep the patient flat after every suctioning episode
- B. Maintain head elevation as ordered, provide oral care, and assess readiness to reduce ventilation
- C. Skip oral care because the tube bypasses the mouth
- D. Continue deep sedation without daily reassessment

145. An older trauma patient is disoriented at night, pulls at lines, and has fluctuating attention. Which intervention is best?

- A. Apply physical restraints as the sole treatment
- B. Keep the room brightly lit throughout the night
- C. Withhold analgesia to keep the patient alert
- D. Assess reversible causes and use reorientation, sleep support, sensory aids, and safe mobility

146. A patient with a history of heavy alcohol use becomes tremulous, hypertensive, hallucinating, and increasingly agitated after admission. Which action is appropriate?

- A. Initiate the withdrawal protocol, provide prescribed benzodiazepine therapy, and institute seizure precautions
- B. Dismiss the symptoms as ordinary postoperative anxiety
- C. Restrict fluids and stimulation without medication
- D. Give alcohol from the patient's personal supply

147. A patient with opioid use disorder has a painful fracture and takes maintenance medication at home. Which plan is most appropriate?

- A. Withhold all analgesia to avoid reinforcing drug use
- B. Assume every pain report is medication seeking
- C. Continue coordinated treatment for opioid use disorder while providing multimodal, adequately monitored analgesia
- D. Stop maintenance therapy without consulting the treating team

148. A patient with intentional self-inflicted lacerations is medically stabilized but remains guarded and reports access to weapons at home. What is the priority?

- A. Discharge once the wounds are sutured
- B. Promise confidentiality about the weapons
- C. Leave the patient alone to encourage independence
- D. Maintain immediate safety, remove accessible means, and obtain urgent behavioral-health evaluation

149. Which intervention best reduces fall risk for a weak trauma patient who becomes dizzy during mobilization?

- A. Keep the patient restrained in bed continuously
- B. Use an individualized mobility plan with assistance, environmental safety, and reassessment of causes
- C. Ask the patient to walk alone to build confidence
- D. Remove nonslip footwear to improve sensation

150. A trauma survivor becomes distressed when staff approach quickly for a painful procedure. Which nursing approach reflects trauma-informed care?

- A. Explain the procedure, ask permission when possible, offer choices, and preserve control and privacy
- B. Proceed without warning because speed is the only priority
- C. Tell the patient that distress is an overreaction
- D. Use several staff members without explaining their roles

151. A family asks why a patient with devastating injuries is being treated urgently while prognosis remains uncertain. Which response is best?

- A. Promise that the patient will recover
- B. Avoid the family until every test is complete
- C. Acknowledge uncertainty, explain current priorities plainly, and invite questions with appropriate support
- D. Use unexplained technical terms to limit discussion

152. A patient with a spinal injury is medically stable but has impaired mobility and difficulty with self-care. Which referral is most appropriate?

- A. Delay rehabilitation until all follow-up appointments are finished
- B. Encourage bed rest to preserve energy
- C. Coordinate physical and occupational therapy with nursing goals and discharge planning
- D. Use restraints to prevent unsafe movement

153. A patient with facial trauma coughs during sips of water and has a wet voice. Which action should the nurse take?

- A. Offer thicker liquids without an assessment
- B. Encourage rapid drinking to clear the throat
- C. Place the patient flat during meals
- D. Stop oral intake and obtain a speech-language swallowing evaluation

154. A critically injured patient is hemodynamically stable and has a functioning gastrointestinal tract. Which nutritional plan should the nurse anticipate?

- A. Avoid nutrition until the wound is completely healed
- B. Early enteral nutrition when clinically appropriate, with monitoring of tolerance and metabolic needs
- C. Use parenteral nutrition first in every trauma patient
- D. Provide only clear liquids indefinitely

155. A capacitated trauma patient has a documented advance directive refusing a specific life-sustaining treatment. Which action is appropriate?

- A. Communicate the directive and support the patient's stated wishes
- B. Ignore it because family members request every intervention
- C. Destroy the document after scanning it
- D. Ask an unrelated staff member to override it

156. A patient with catastrophic brain injury meets clinical triggers for possible organ donation. Which action should the nurse anticipate?

- A. Notify the designated organ-donation organization through the established referral pathway
- B. Ask the family to contact a transplant center independently
- C. Discuss donation as a condition of continued treatment
- D. Stop all supportive care before referral

157. Which statement about brain death assessment is correct?

- A. A bedside nurse may declare brain death from an absent pupil response alone
- B. Family agreement substitutes for the clinical examination
- C. It is determined through a formal clinical process by qualified practitioners using required prerequisites and testing
- D. One low Glasgow Coma Scale score is sufficient

158. A patient with injuries that are no longer curable has pain, dyspnea, and anxiety while the family requests continued support. Which service is appropriate?

- A. Withhold all symptom treatment until death is imminent
- B. Use palliative care for symptoms, communication, and goals alongside active treatment
- C. Avoid family meetings to prevent difficult decisions

D. Use restraints as the primary anxiety treatment

159. A trauma center notes a high rate of motorcycle injuries among local young adults. Which injury-prevention activity is most appropriate?

- A. Offer the same untargeted brochure to every patient
- B. Wait for national data before acting locally
- C. Focus only on treating injuries after they occur
- D. Use local data to design targeted community education and evaluate whether outcomes improve

160. A prehospital team arrives for a patient with life-threatening extremity bleeding and possible spinal injury. Which principle should guide early care?

- A. Delay hemorrhage control until arrival at the hospital
- B. Control bleeding, support ABCs, limit motion, and choose the destination
- C. Transport without communicating mechanism or interventions
- D. Remove all precautions so the patient can sit upright

161. Before transferring a ventilated trauma patient to another facility, which information is most important to communicate?

- A. Only the patient's name and admission time
- B. A brief statement that the patient is stable
- C. The receiving team's parking instructions
- D. Airway status, ventilator settings, injuries, interventions, medications, trends, and anticipated complications

162. A trauma patient is moved from the emergency department to the operating room. Which preparation is essential?

- A. Confirm monitoring, oxygen, medications, access, equipment, destination readiness, and a verbal handoff
- B. Disconnect all infusions to simplify the move
- C. Transport without a clinician because the distance is short
- D. Leave emergency airway supplies behind

163. Which action best supports safe discharge for a trauma patient with a new wound, medication changes, and limited transportation?

- A. Give written instructions without checking understanding
- B. Tell the patient to arrange all follow-up independently
- C. Use teach-back, review warning signs and follow-up, reconcile medications, and address transportation barriers
- D. Omit wound teaching because the dressing is intact

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

- A. A patient with minor injuries who can walk independently
- B. A patient with injuries incompatible with survival using available resources
- C. A patient who arrived first but has stable vital signs
- D. A patient with a correctable life threat who can benefit from immediate intervention

165. A patient arrives contaminated with an unknown industrial chemical. Which action should the trauma team take first?

- A. Bring the patient directly into the main treatment bay
- B. Ask family members to remove the chemical without protection
- C. Isolate the patient, don appropriate PPE, remove contaminated clothing, and begin decontamination
- D. Cover the contamination with blankets and delay notification

166. A trauma program has an under-triage rate that is increasing while over-triage remains low. Which quality-improvement response is best?

- A. Review missed high-risk patients and modify triage criteria, education, or feedback processes
- B. Ignore the trend because low over-triage proves the system is efficient
- C. Reduce trauma activation for all older adults
- D. Stop collecting triage data to avoid misleading rates

167. A trauma center discovers that several patients had delayed diagnoses of cervical spine injury. Which performance-improvement action is most appropriate?

- A. Blame the last nurse who documented the collar
- B. Conduct a multidisciplinary review and implement a measurable corrective plan
- C. Delete the cases from the trauma registry
- D. Change the policy without examining contributing factors

168. Which practice improves the reliability of trauma-registry data?

- A. Use standardized definitions, complete fields accurately, and validate data against source records
- B. Enter only outcomes that make the program look successful
- C. Allow each reviewer to define injuries differently
- D. Omit cases with incomplete early documentation

169. After a difficult resuscitation involving a patient death, which team-support action is most appropriate?

- A. Require staff to discuss the event publicly in front of visitors
- B. Avoid any discussion so distress will disappear
- C. Use the debrief to assign blame before reviewing facts
- D. Conduct a structured debrief focused on learning, emotional support, and available resources

170. Which information is most important in an SBAR handoff for a deteriorating trauma patient?

- A. Only the patient's room number and diagnosis
- B. A chronological list of every routine task completed
- C. The current assessment, relevant history, response to treatment, and a clear recommendation
- D. An assurance that the next nurse can read the chart

171. A medication error reaches a trauma patient but causes no apparent harm. Which action should the nurse take?

- A. Avoid reporting because no injury is visible
- B. Assess, notify, disclose as required, document, and file an objective report
- C. Alter the record to prevent concern
- D. Discuss the error casually with coworkers only

172. A family member asks for a trauma patient's diagnosis while standing in a crowded hallway. Which response is appropriate?

- A. State the diagnosis loudly so the family can hear
- B. Speak privately and disclose only authorized minimum information
- C. Provide the entire chart because the person is related
- D. Refuse all communication even after authorization is verified

173. An uninsured patient with an emergency medical condition arrives at a hospital that is capable of stabilization. Which principle applies?

- A. Refuse evaluation until insurance is verified
- B. Transfer the patient immediately for financial reasons
- C. Provide a medical screening exam and stabilizing treatment regardless of payment
- D. Offer only written self-care instructions

174. A visitor threatens staff and blocks the trauma-bay exit. Which action is the priority when it is safe to do so?

- 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, move people away, and request trained security

175. A trauma center is preparing for a designation review. Which activity best demonstrates system readiness?

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

Practice Exam 9: Answer Key and Explanations

1. B — A lucid interval followed by rapid neurologic decline and an ipsilateral dilated pupil suggests expanding epidural bleeding with herniation risk. The nurse should protect oxygenation, maintain cervical alignment, notify the trauma and neurosurgical teams, and prepare for immediate imaging and intervention. Routine observation, lumbar puncture, and oral analgesia delay treatment and may worsen intracranial pressure or compromise an unstable airway.

2. D — Primary injury occurs at impact, whereas secondary injury can be amplified by hypoxemia, hypotension, hypercarbia, fever, seizures, or abnormal glucose. Supporting oxygenation and perfusion while coordinating definitive management limits avoidable physiologic insults during the vulnerable period. Sedation, fluid restriction, or diagnostic delay cannot substitute for preserving airway, breathing, circulation, and serial neurologic assessment.

3. C — High spinal cord disruption can interrupt sympathetic outflow, producing vasodilation, relative bradycardia, and warm skin. Neurogenic shock is a distributive process, but occult hemorrhage must still be actively excluded because more than one shock mechanism may coexist after trauma. Dehydration, a

small effusion, and an extremity fracture do not explain this characteristic combination of hypotension, bradycardia, and vasodilation.

4. C — The Glasgow Coma Scale combines eye, verbal, and motor responses. Eye opening to voice scores 3, confused verbal speech scores 4, and withdrawal from pain scores 4. Adding those components gives a total score of 11, which indicates clinically important altered consciousness. The alternatives delay neurologic protection or add injury.

5. A — Hypoxemia and hypotension reduce oxygen delivery to injured brain tissue and increase secondary injury. Immediate support of airway, breathing, and circulation takes priority, while the nurse preserves spinal alignment and coordinates definitive treatment for the intracranial lesion. History collection, withholding oxygen, or oral fluids cannot correct an immediate threat to cerebral oxygen delivery and may delay lifesaving support.

6. D — Retroauricular ecchymosis and clear otorrhea raise concern for a basilar skull fracture with cerebrospinal fluid leakage. A light sterile dressing allows observation while avoiding pressure, instrumentation, and contamination. The trauma team should be notified and neurologic status monitored closely. Packing, blind nasal instrumentation, and vigorous irrigation can injure tissue, introduce infection, or obscure the character and amount of drainage.

7. B — A basilar skull fracture may disrupt the cribriform plate, creating a pathway for a nasogastric tube to enter the cranial vault. When gastric access is necessary, the team should select a safer route and use imaging or specialist guidance as indicated. The alternatives delay neurologic protection or add injury. Continue serial neurologic reassessment for change.

8. D — Facial trauma can rapidly obstruct the airway with blood, secretions, teeth, and edema. Suction, manual stabilization, high-flow oxygen, and early preparation for a definitive airway address the immediate threat while preventing cervical movement. Oxygen alone does not clear obstruction, manipulating teeth can worsen aspiration, and an unprotected supine airway increases obstruction risk.

9. C — Proptosis, tense eyelids, vision loss, and severe pain indicate rising orbital pressure that can compress the optic nerve and retinal circulation. This is an emergency; the nurse should avoid pressure on the globe and urgently involve ophthalmology and the trauma team. Routine drops, pressure dressings, or discharge planning fail to address threatened vision and may increase pressure or delay decompression.

10. A — An expanding neck hematoma and stridor indicate threatened airway obstruction. Edema and bleeding can progress quickly, and distorted anatomy makes blind exploration hazardous. Early controlled airway management with surgical backup and urgent operative evaluation are safer than waiting. Blind exploration, circumferential compression, and outpatient imaging can worsen injury, obstruct venous return, or delay treatment of a rapidly evolving airway emergency.

11. B — Hoarseness, subcutaneous emphysema, and a persistent large air leak suggest disruption of the laryngotracheal or tracheobronchial tree. The nurse should minimize airway manipulation, provide oxygen, and prepare for bronchoscopy or surgical airway management by an experienced team. A

contusion, clavicle fracture, or sore throat does not account for extensive air in tissue and continuing escape through the thoracic drainage system.

12. A — High cervical injuries can weaken the diaphragm and accessory muscles, causing fatigue, secretion retention, and delayed respiratory failure. Serial respiratory mechanics, cough effectiveness, mental status, and gas exchange identify deterioration before oxygen saturation becomes an isolated late warning. Urine output, infrequent color checks, and waiting for desaturation do not adequately detect progressive ventilatory failure after cervical cord injury.

13. B — Seizures increase oxygen demand and can cause hypoxemia, aspiration, and additional trauma. The nurse should protect the head, maintain a safe position when possible, provide oxygen and suction readiness, and administer prescribed therapy without placing objects in the mouth. Jaw forcing, tight restraint, and abandonment create injury or aspiration risk and do not control the underlying seizure or airway threat.

14. C — New focal deficits after trauma may indicate expanding hemorrhage, cerebral edema, ischemia, or vascular injury. The change is time-sensitive and requires immediate escalation, airway and perfusion support, and repeat diagnostic evaluation rather than routine observation. Anxiety, food, or passive documentation cannot safely explain away a new focal neurologic deficit or prevent irreversible secondary brain injury.

15. D — Patients with possible spinal instability require coordinated movement, clear commands, and continuous alignment of the head, neck, and torso. The team should use an approved transfer method and reassess neurologic status afterward. Independent twisting, arm pulling, and unplanned removal of motion restriction can produce displacement, pain, or worsening neurologic injury.

16. C — Anticoagulation can increase the risk of intracranial bleeding after seemingly minor trauma, and early findings may be subtle. The nurse should maintain observation, trend neurologic findings, and coordinate imaging or repeat evaluation according to the clinical plan. Immediate discharge, aspirin, or lumbar puncture is not a safe substitute for serial assessment and appropriate imaging of an anticoagulated trauma patient.

17. B — An open depressed skull fracture may communicate with the environment and can be associated with dural or brain injury. A sterile, gentle covering limits contamination while avoiding pressure, manipulation, or bedside closure before specialist evaluation. Tight packing, vigorous scrubbing, and adhesive closure can push fragments inward, damage tissue, or conceal the injury from the operative team.

18. A — The injured spinal cord is vulnerable to secondary ischemia. Prompt correction of hypotension and hypoxemia, careful alignment, and frequent neurologic reassessment help preserve remaining function while the team investigates reversible causes. Permissive hypotension is not a universal goal in spinal cord injury, delayed reassessment loses time, and ambulation is unsafe before stability is established.

19. D — Inhalation injury can cause progressive supraglottic edema, making later intubation difficult or impossible. Hoarseness, soot, facial burns, and respiratory change justify early expert airway management while oxygenation and cervical precautions are maintained. Waiting, oral fluids, or a tight dressing delays airway control and may worsen aspiration or obstruct already threatened airflow.

20. D — A suspected open-globe injury requires protection from pressure and further contamination. A rigid shield prevents contact with the eye, and urgent ophthalmology involvement is needed. The patient should remain NPO if operative management is anticipated. Removal, pressure patching, and irrigation can extrude ocular contents or worsen structural damage and therefore are unsafe.

21. B — Alkaline substances can penetrate ocular tissues rapidly, so irrigation is the time-critical intervention. The nurse should remove contact lenses when feasible during irrigation, check pH as directed, and continue until the treating team determines that adequate decontamination has occurred. Waiting, chemical neutralization, or transport without rinsing prolongs tissue exposure and can create a second chemical injury.

22. C — An irregular pupil and visible corneal defect suggest an open-globe injury. Pressure, tonometry, drops, and manipulation can worsen extrusion of ocular contents. The nurse should use a rigid shield, control nausea and pain as ordered, and obtain urgent specialist evaluation. The alternatives delay neurologic protection or add injury. Continue serial neurologic reassessment for change.

23. A — Sudden headache, vomiting, and declining alertness may signal rising intracranial pressure or rebleeding. The nurse should reassess airway, breathing, pupils, motor responses, and vital trends while escalating for urgent evaluation and treatment. Oral medication, unmonitored flat positioning, and coughing do not address a possible intracranial emergency and may increase aspiration or intracranial pressure.

24. D — Neurologic findings are evidence of possible spinal cord injury even when pain is absent. Motion restriction should continue until an appropriate clinical assessment and imaging process clears the cervical spine. Absence of pain, self-directed neck movement, and a normal pulse examination do not exclude unstable spinal or neurologic injury. Continue serial neurologic reassessment for change.

25. C — Spinal shock is a temporary loss of motor, sensory, and reflex activity below an acute cord lesion. Neurogenic shock is a hemodynamic syndrome involving loss of sympathetic tone, so the two conditions may occur together but are not interchangeable. Neurogenic, cardiogenic, and obstructive shock describe circulation problems rather than the acute neurologic areflexia and flaccidity of spinal shock.

26. B — Cervical cord injury weakens abdominal and intercostal muscles, reducing cough effectiveness and increasing atelectasis and secretion retention. Assisted coughing, positioning, suction, lung expansion, and close respiratory monitoring support airway clearance. Immobility, unnecessary sedation, and waiting for fever allow preventable respiratory complications to develop and do not protect the injured cord.

27. A — A change in consciousness or new anisocoria can reflect increasing mass effect, cerebral edema, or herniation. These findings require immediate reassessment and escalation because neurologic deterioration can progress quickly after traumatic bleeding. Thirst, a peripheral bruise, and environmental preference do not directly indicate worsening intracranial pressure or focal neurologic compromise.

28. D — Jaw thrust opens the airway while minimizing cervical movement when spinal injury is possible. The team should suction, provide oxygen, and prepare for advanced airway management if the patient cannot protect the airway. Head tilt, hyperextension, and sharp rotation can worsen cervical displacement and do not provide a safe initial approach in trauma.

29. B — Clear rhinorrhea after facial trauma may represent cerebrospinal fluid leakage from a skull-base fracture. Gentle collection on sterile gauze permits observation while avoiding pressure, nose blowing, and instrumentation that could introduce infection or worsen injury. Packing, forceful nose blowing, and deep suction can increase pressure, damage tissue, or create a route for contamination.

30. A — Neurologic deterioration can precede hemodynamic change in intracranial injury. Worsening lethargy should trigger an immediate repeat assessment, airway and perfusion review, and urgent communication for imaging or surgical management. Stable vital signs do not make a declining mental status benign, and reassurance, removing monitoring, or delay can miss impending herniation.

31. C — Delayed intracranial bleeding or swelling can present after an initially reassuring assessment. Clear return precautions for worsening neurologic symptoms help caregivers recognize deterioration and obtain timely emergency care. Driving, routine sedatives, and waiting for fever can obscure symptoms or delay treatment of a potentially expanding intracranial lesion. Continue serial neurologic reassessment for change.

32. D — A poorly fitted collar can obstruct the airway or cause pressure injury, but removing support without a replacement risks cervical movement. Manual stabilization allows the team to correct the device while preserving alignment and airway access. Unsupervised removal, excessive tightening, and head rotation trade one preventable hazard for another and do not maintain safe spinal protection.

33. A — Craniocervical instability can worsen with manipulation, particularly forced flexion or extension. Neutral alignment, careful transfers, and specialist-directed imaging reduce the risk of converting an unstable injury into a catastrophic neurologic event. Active rotation, unsupported posture, and exaggerated extension apply unnecessary motion to a potentially unstable junction. Continue serial neurologic reassessment for change.

34. C — Hyperosmolar therapy shifts water from swollen brain tissue but can produce electrolyte disturbance, volume changes, and renal stress. Trending laboratory data, urine output, hemodynamics, neurologic findings, and treatment response supports safe titration. Appetite, isolated skin turgor, or visual acuity cannot detect the important systemic and neurologic effects of hyperosmolar therapy.

35. B — Abnormal flexion, or decorticate posturing, reflects serious dysfunction of pathways above the brainstem and can signal rising intracranial pressure or worsening injury. The nurse should protect the

airway, repeat the neurologic examination, and escalate immediately. This posture is not normal, not explained by a single peripheral nerve lesion, and does not represent neurologic improvement.

36. D — An embedded object may penetrate the globe or orbit, and removal can cause uncontrolled bleeding or extrusion of ocular contents. Stabilization, a rigid shield, pain and nausea control, and urgent ophthalmic evaluation are the safest priorities. Pulling, pressing, or forceful flushing can enlarge the wound and convert a contained injury into irreversible structural damage.

37. A — Flail chest causes impaired ventilation and often coexists with pulmonary contusion. Oxygenation, effective analgesia, lung expansion, and timely ventilatory support reduce fatigue and atelectasis while the team evaluates the underlying injuries. Circumferential binding restricts ventilation, painful unsupported breathing is ineffective, and withholding analgesia worsens splinting and respiratory failure. Continue serial assessment for evolving complications.

38. B — An open pneumothorax permits air to enter through the wound and compromises ventilation. A properly applied occlusive dressing with a venting strategy, oxygen, and prompt chest tube placement helps restore intrathoracic pressure while limiting conversion to tension physiology. Deep packing, an unvented four-sided seal, or repeated removal fails to control the wound safely and can worsen respiratory compromise.

39. C — The mean arterial pressure approximation is calculated as systolic pressure plus twice the diastolic pressure, divided by three. With 84 systolic and 48 diastolic, the calculation is $(84 + 96)$ divided by 3, producing 60 mmHg. 44 is the pulse pressure, 72 incorrectly treats systolic and diastolic pressure equally, and 96 is the sum of the two values without averaging.

40. C — The combination of respiratory distress, unilateral absent breath sounds, obstructive shock, and possible neck-vein distention is highly concerning for tension pneumothorax. Decompression should occur immediately according to trauma protocol, without waiting for confirmatory imaging. Radiography, positioning, and oral fluids delay relief of intrathoracic pressure and cannot reverse an immediately life-threatening obstructive process.

41. B — Shock plus unilateral decreased breath sounds after trauma suggests a large hemothorax or combined thoracic injury. Tube thoracostomy allows drainage and assessment while the trauma team determines whether surgery or another hemorrhage-control procedure is required. Needle decompression alone does not drain blood, discharge is unsafe, and an abdominal binder can restrict ventilation without controlling intrathoracic bleeding.

42. A — Loss of tidaling may result from lung reexpansion, obstruction, disconnection, or patient deterioration. The nurse should assess the patient first, then inspect the system systematically and correct simple mechanical problems while escalating respiratory change. Forceful stripping can generate dangerous pressure, routine clamping can precipitate tension, and removal without a plan creates another airway and pleural risk.

43. D — Continuous bubbling in the water seal suggests air entering the drainage system, commonly from the patient, connections, or tubing. The nurse should assess the patient and trace the system from

the insertion site outward to locate the leak. Bubbling does not prove reexpansion or blood volume, and increasing suction without finding the source can worsen the leak.

44. D — Pulmonary contusions can worsen as edema and hemorrhage evolve, impairing gas exchange. Treatment is supportive, with oxygen, ventilation when needed, analgesia, and careful fluid management guided by perfusion and respiratory status. Excess fluid can intensify pulmonary edema, antibiotics do not treat uncomplicated contusion, and oxygen restriction worsens tissue hypoxia. Continue serial assessment for evolving complications.

45. C — Pain causes splinting, atelectasis, and secretion retention. Multimodal analgesia, positioning, coughing support, and coached lung expansion improve ventilation while limiting opioid exposure and identifying respiratory decline early. Untreated pain, chest binding, and prolonged immobility reduce ventilation and increase complications rather than protecting the patient. Continue serial assessment for evolving complications.

46. B — Muffled heart sounds, venous distention, and hypotension suggest blood or fluid compressing the heart and limiting filling. This obstructive physiology requires immediate trauma-team involvement and preparation for pericardial or operative decompression. Rib fracture, pulmonary contusion, and a wrist injury do not produce this characteristic obstructive pattern without another major thoracic process.

47. A — Myocardial contusion can cause dysrhythmias or impaired contractility, sometimes after an initially normal assessment. Continuous monitoring, serial ECGs, electrolyte review, and perfusion assessment help detect deterioration and guide treatment. A single ECG, exertion, or attribution to anxiety can miss evolving electrical or mechanical cardiac injury. Continue serial assessment for evolving complications.

48. D — Deceleration, pulse or pressure asymmetry, and mediastinal widening raise concern for traumatic aortic or other great-vessel injury. The patient requires monitored transport, avoidance of unnecessary shear or hypertension, and urgent imaging and surgical consultation. Pulse oximetry, chest compression, and feeding do not diagnose or stabilize a potentially lethal vascular injury.

49. C — Bowel sounds in the chest after blunt trauma suggest abdominal organs have passed through a disrupted diaphragm. The nurse should support breathing, avoid unnecessary positive-pressure complications, and prepare the patient for urgent imaging and surgical repair. A superficial abrasion, humerus fracture, or bronchitis cannot explain intrathoracic bowel sounds and combined thoracoabdominal symptoms.

50. A — Persistent air leakage and pneumomediastinum despite appropriate pleural drainage suggest a tear in the trachea or bronchus. The team may need bronchoscopy to define the injury and surgical repair to restore airway integrity. Skin injury, abdominal strain, and a resolved pneumothorax do not account for ongoing air escape and mediastinal air.

51. B — Eviscerated organs should be protected from drying and contamination while avoiding manipulation. Warm sterile moist dressings preserve tissue and reduce evaporative heat loss until operative evaluation can occur. Replacing organs, using dry adhesive material, or applying direct

pressure can tear tissue, impair perfusion, and worsen contamination or injury. Continue serial assessment for evolving complications.

52. A — An impaled object may be tamponading bleeding or injuring major structures. Stabilization prevents movement during transport, while operative control permits visualization and hemorrhage management before removal. Bedside removal, twisting, or further insertion can release tamponade, enlarge injury, and cause uncontrolled hemorrhage. Serial examinations and trend data matter because bleeding, respiratory compromise, and abdominal pressure can worsen after the initial assessment.

53. C — Splenic injury can bleed intermittently or rupture after an initially reassuring period. Recurrent tachycardia, tenderness, or perfusion change requires repeated assessment, laboratory and imaging review, and prompt trauma-team escalation. Initial improvement does not exclude delayed bleeding, and ankle injury or medication effects do not explain evolving left upper-quadrant findings. Continue serial assessment for evolving complications.

54. B — The liver is highly vascular, and abdominal distention with shock suggests ongoing internal hemorrhage. The nurse should support perfusion, activate blood and trauma resources, and prepare for operative, endovascular, or other definitive control. Oral fluids, a leg splint, and removal of monitoring neither restore circulating volume nor control potentially lethal internal bleeding.

55. D — Rigidity, rebound, and shock suggest contamination, inflammation, or hemorrhage from a hollow-organ injury. The patient should remain NPO, receive resuscitation and prescribed antimicrobial therapy, and undergo urgent trauma-surgical evaluation. Oral intake, heat, or a urine test cannot exclude intra-abdominal catastrophe and would delay source control. Continue serial assessment for evolving complications.

56. A — Retroperitoneal bleeding may accumulate without obvious external blood loss and can produce flank ecchymosis, abdominal distention, anemia, and shock. Continued resuscitation, serial examination, imaging, and trauma consultation are essential. Superficial abrasions, headaches, and nasal fractures do not explain progressive circulatory compromise with flank or abdominal findings. Continue serial assessment for evolving complications.

57. C — A pelvic binder works by reducing pelvic volume and stabilizing the ring when centered over the greater trochanters. Correct placement supports hemorrhage control and reduces further movement while the patient is transported for definitive management. Upper abdominal, waist-level, or mid-thigh placement does not adequately compress the pelvic ring and may impair breathing or cause pressure injury.

58. D — Waist-level placement is too high to stabilize the pelvic ring and may restrict abdominal or respiratory movement. The binder should be corrected over the greater trochanters with coordinated handling and continued assessment for bleeding and perfusion. Higher tightening, walking, and chest placement do not stabilize the pelvis and can add injury or compromise breathing.

59. B — Blood at the meatus suggests urethral injury, especially with pelvic trauma. Blind catheterization can extend a tear or create a false passage. The team should evaluate the urethra and

choose an appropriate drainage strategy. Urine return does not prove an intact urethra, repeated attempts worsen injury, and voiding does not exclude serious pelvic or urinary damage.

60. D — Perineal bruising and scrotal swelling can accompany urethral disruption. The nurse should inspect for meatal blood, monitor output, maintain privacy, and notify the team before any urethral instrumentation. Massage, powder, and delayed infection testing do not address possible structural urinary injury and may worsen tissue damage. Continue serial assessment for evolving complications.

61. C — Suprapubic pain, abdominal distention, and hematuria after trauma raise concern for bladder rupture or associated pelvic injury. The nurse should monitor output, avoid unsafe catheterization, and coordinate imaging and urologic or trauma evaluation. A wall contusion, shoulder injury, or medication effect does not adequately explain acute hematuria with distention after blunt force.

62. A — Intraperitoneal bladder rupture allows urine to enter the peritoneal cavity and commonly requires surgical repair, along with controlled urinary drainage and monitoring for infection or abdominal complications. Catheter drainage alone may be insufficient, and hydration, activity, or external compression does not close an intraperitoneal tear. Continue serial assessment for evolving complications.

63. B — Stable patients with renal trauma are often evaluated with appropriate imaging and serial monitoring to determine the degree of injury and need for intervention. Hematuria is important but does not alone dictate immediate surgery. Unnecessary nephrectomy, unsafe catheterization, and discharge ignore the need to define injury severity and watch for delayed bleeding or complications.

64. B — A tense abdomen with oliguria, increased ventilatory pressures, and hemodynamic deterioration suggests pressure within the abdomen is impairing organ function. This is a time-sensitive complication requiring immediate team notification and objective pressure assessment. Constipation, a resolved injury, or a wrist fracture does not explain simultaneous renal, respiratory, and circulatory compromise.

65. C — When elevated intra-abdominal pressure causes organ dysfunction, decompression may be necessary to restore ventilation, venous return, and renal perfusion. The nurse supports resuscitation, monitors pressures and output, and prepares for urgent procedural or operative management. External compression, oral intake, and waiting for absent bowel sounds worsen pressure or delay treatment of established organ compromise.

66. A — Diaphragmatic injuries can be subtle on initial imaging, particularly with small tears or overlapping structures. Persistent thoracoabdominal symptoms require serial examination and additional imaging or surgical review. A single inconclusive image and shoulder pain do not exclude a diaphragmatic tear or herniation risk. Continue serial assessment for evolving complications. Reassess promptly when new findings change risk or response.

67. D — Handlebar trauma can compress the pancreas or duodenum against the spine, and symptoms may evolve over time. Serial examinations, laboratory trends, imaging, and trauma consultation help

detect delayed retroperitoneal injury. Feeding, discharge, and pelvic compression do not evaluate or treat a possible pancreatic or duodenal injury. Continue serial assessment for evolving complications.

68. B — A seatbelt sign indicates substantial force and can accompany bowel or mesenteric injury even when early symptoms are mild. The patient needs trauma-directed imaging, serial examination, and clear escalation for increasing pain or peritoneal findings. Minimal initial tenderness, laxatives, and an abdominal binder do not exclude evolving hollow-viscus injury and may delay recognition.

69. D — Hemodynamic instability after penetrating abdominal trauma suggests ongoing hemorrhage, contamination, or both. Rapid resuscitation and operative evaluation are prioritized over time-consuming studies that will not change the need for immediate source control. Outpatient history, oral contrast, and discharge delay treatment of potentially lethal intra-abdominal injury. Continue serial assessment for evolving complications.

70. C — Stable patients without peritonitis may be candidates for a selective evaluation pathway using wound assessment, imaging, and serial examinations. The decision remains protocol-driven and requires rapid escalation if pain, tenderness, or perfusion changes. Discharge, blind exploration, and forced intake are unsafe because they either miss injury or create additional tissue damage.

71. A — Citrate in blood products can bind ionized calcium during rapid transfusion, contributing to hypotension, dysrhythmia, and neuromuscular symptoms. The nurse should obtain laboratory assessment and administer calcium according to the massive-transfusion protocol. Hypercalcemia, anxiety, and missed meals do not explain this pattern during rapid blood-product administration. Continue serial assessment for evolving complications.

72. C — Shock index is calculated by dividing heart rate by systolic blood pressure. Dividing 126 by 84 yields 1.50, a value that supports concern for significant circulatory stress in the context of trauma and should be interpreted with the complete clinical picture. 0.67 reverses the division, 1.00 ignores the actual values, and 2.10 is not produced by the stated calculation.

73. B — Delayed peritonitis after blunt trauma can reflect a missed bowel perforation or mesenteric injury. New fever, guarding, and increasing pain require immediate reassessment, imaging, antimicrobial therapy as ordered, and surgical consultation. Normal healing, a minor bruise, and anxiety do not explain evolving peritoneal signs after significant abdominal force. Continue serial assessment for evolving complications.

74. A — Wounds near the lower chest can cross the diaphragm and injure lung, liver, spleen, stomach, or bowel. Combined assessment and timely imaging or operative evaluation are necessary when shock or abdominal findings appear. Skin inspection, assumptions about anatomy, and walking tests can miss internal injury and worsen instability. Continue serial assessment for evolving complications.

75. D — A displaced chest tube can create an open pathway into the pleural space and allow recurrent pneumothorax. The site should be covered, the patient assessed and oxygenated, and definitive tube replacement or other management arranged promptly. Reinsertion by the nurse, leaving the wound open, or clamping the airway is unsafe and does not control pleural air entry.

76. C — Persistent shock despite mechanical stabilization and resuscitation suggests continued bleeding, including arterial pelvic hemorrhage. The patient may require pelvic packing, angioembolization, or another trauma-center intervention while perfusion support continues. Loosening the binder, attributing shock to anxiety, or focusing on skin injury delays control of life-threatening hemorrhage. Continue serial assessment for evolving complications.

77. B — Delayed hematuria and flank pain after trauma can indicate renal or ureteral injury even when initial perfusion is stable. Imaging and specialist review help identify obstruction, leakage, vascular injury, or bleeding that requires intervention. Food, external pressure, and routine infection treatment do not define or control structural urinary tract trauma.

78. D — Chest pain, subcutaneous emphysema, systemic deterioration, and odynophagia after major trauma can indicate esophageal disruption with mediastinal contamination. The patient should remain NPO, receive support and prescribed antimicrobials, and undergo urgent specialty evaluation. A rib bruise, shoulder strain, or resolved contusion does not explain mediastinal air, swallowing pain, and systemic risk.

79. A — An expanding groin hematoma and diminished femoral pulse suggest pelvic or iliac-vessel injury with threatened limb perfusion and ongoing hemorrhage. The nurse should maintain stabilization, support circulation, and obtain urgent vascular or trauma intervention. Warmth, walking, and unplanned binder removal can increase bleeding or delay treatment of a vascular emergency.

80. B — Free air and systemic or abdominal findings after a thoracoabdominal wound suggest perforation of stomach or bowel with contamination. The patient should remain NPO, receive resuscitation and prescribed therapy, and undergo urgent trauma-surgical evaluation. A skin infection, resolved contusion, or ankle sprain cannot account for free intraperitoneal air and evolving abdominal illness.

81. D — Pain out of proportion and pain with passive stretch are early warning signs of acute compartment syndrome. Prompt surgical evaluation is required because irreversible muscle and nerve ischemia can develop before pulses disappear. High elevation can reduce arterial inflow, added compression worsens pressure, and reassurance delays treatment of a limb-threatening emergency.

82. C — Neurologic symptoms and passive-stretch pain suggest rising compartment pressure. The nurse should assess the full neurovascular status, loosen removable constriction according to protocol, and prepare for urgent fasciotomy or other definitive treatment. Added splinting, waiting for pulselessness, and vigorous massage increase tissue pressure or delay care; pulses can remain present until late.

83. A — Crush-related rhabdomyolysis releases myoglobin and electrolytes, increasing the risk of acute kidney injury and dysrhythmia. Isotonic fluids, urine-output trending, renal assessment, and electrolyte monitoring support clearance and detect complications. Fluid restriction, unverified potassium replacement, and added compression can worsen renal injury, hyperkalemia risk, or local tissue damage. Repeat neurovascular checks as swelling evolves.

84. C — An open fracture communicates with the environment and has high contamination and infection risk. Sterile coverage protects tissue while timely antimicrobial prophylaxis, tetanus assessment, operative irrigation, and debridement are arranged. Replacing bone, aggressive bedside scrubbing, and closure can introduce deeper contamination, damage tissue, or trap bacteria before definitive debridement. Repeat neurovascular checks as swelling evolves.

85. A — Traction splinting can align and stabilize an isolated midshaft femur fracture and reduce pain and bleeding when contraindications are absent. Distal pulses, sensation, and movement must be checked before and after application. A pelvic binder, cervical collar, or circumferential cast does not provide the appropriate controlled traction or safe monitoring for this injury.

86. D — Pelvic ring disruption can cause major hemorrhage. A correctly positioned pelvic binder reduces movement and pelvic volume while the patient is transported for definitive hemorrhage control. A single-leg traction splint, upper abdominal wrap, or ankle brace cannot stabilize the pelvic ring or address pelvic bleeding. Repeated neurovascular checks matter because swelling, constriction, and ischemia can progress after the initial intervention.

87. B — The amputated part should be protected from drying and contamination, cooled without freezing, and transported with the patient. Sterile moist gauze, a sealed bag, and an ice-water environment preserve tissue viability for possible replantation. Direct dry ice can freeze tissue, disinfectant damages cells, and leaving the part warm and exposed accelerates desiccation and contamination.

88. B — A tourniquet is appropriate for uncontrolled, life-threatening extremity hemorrhage when direct pressure fails. It should be placed proximal to the injury, tightened until bleeding stops, and left in place for trained clinicians to manage while the time is recorded. Periodic loosening can restart fatal bleeding, a small bandage is inadequate, and elevation alone cannot control a severed or damaged artery.

89. D — Absent distal perfusion after dislocation suggests arterial compromise or severe neurovascular compression. The limb requires urgent specialist evaluation, prompt reduction when appropriate, and repeated pulse, motor, and sensory checks. Heat, exercise, discharge, and delayed reassessment can worsen ischemia or miss a vascular injury threatening limb viability. Repeat neurovascular checks as swelling evolves.

90. C — Posterior hip dislocation is painful and can compromise the femoral head blood supply or sciatic nerve. The limb should be supported in position, neurovascular status documented, and reduction performed promptly by the appropriate team. Forceful extension, walking, and unconsidered traction can worsen fracture-dislocation, nerve injury, or vascular compromise. Repeat neurovascular checks as swelling evolves.

91. A — Visible tendon injury with loss of function requires careful protection and specialist repair planning. A sterile dressing, splinting in a functional position, analgesia, and neurovascular assessment reduce additional damage. Forceful testing, unsterile closure, and delayed evaluation can enlarge the wound, contaminate tendon ends, and impair final function. Repeat neurovascular checks as swelling evolves.

92. C — Degloving disrupts blood supply and creates dead space, contamination, and tissue-loss risk. The wound requires sterile protection, careful assessment of viability, pain control, and prompt surgical or reconstructive planning. Lotion, massage, and discarding tissue ignore the risk of ischemia and contamination and may eliminate tissue that could be useful for reconstruction.

93. D — New weakness and urinary retention after a vertebral injury suggest spinal cord or cauda equina compromise. Maintaining alignment and urgent escalation may prevent further neurologic damage while imaging and specialist treatment are arranged. Ambulation, removal of support, and infection treatment do not address possible acute compression or instability. Repeat neurovascular checks as swelling evolves.

94. B — Pain, paresthesia, and coolness beneath a cast suggest compromised perfusion or rising compartment pressure. The nurse should escalate immediately, document findings, and prepare for rapid release of external constriction and definitive treatment. High elevation can reduce arterial inflow, added wrapping increases pressure, and delayed reassessment risks irreversible ischemia. Repeat neurovascular checks as swelling evolves.

95. A — Fat embolism syndrome can follow long-bone trauma and present with respiratory compromise, neurologic change, and petechiae after a delay. Treatment is supportive, with oxygenation, ventilatory assistance when needed, hemodynamic monitoring, and prevention of further embolization. A skin reaction, expected soreness, or urinary infection does not explain the combined pulmonary, neurologic, and petechial findings.

96. D — Beta blockade and age can blunt tachycardia, so perfusion, mental status, skin findings, urine output, and blood pressure trends may reveal shock earlier. The nurse should escalate concern and assess for occult hemorrhage. A seemingly normal heart rate does not exclude shock, beta blockers do not protect perfusion, and new confusion is not a benign aging change.

97. B — Older adults may sustain significant intracranial injury from low-energy mechanisms, and anticoagulation can increase delayed bleeding risk. Serial examinations and appropriate imaging are needed even when the first neurologic assessment is reassuring. Immediate discharge, aspirin, and avoidance of imaging can delay recognition or worsen bleeding and do not account for anticoagulation.

98. C — Patterned injuries, neglect, and controlling behavior are red flags for abuse. Private, trauma-informed assessment protects disclosure, while objective documentation and mandated reporting procedures support patient safety and further investigation. Confronting the caregiver in front of the patient, recording only one account, or normalizing patterned bruising can increase danger and suppress disclosure.

99. A — Children can preserve blood pressure through vasoconstriction until substantial circulating volume is lost. Tachycardia, pallor, delayed refill, anxiety, and altered behavior may therefore indicate compensated shock requiring immediate evaluation. Normal blood pressure, oral fluids, and fear alone do not safely explain a cluster of poor perfusion findings after trauma. Individualize care and reassess changing needs.

100. A — Children have smaller, more easily obstructed airways, and edema can progress rapidly after facial trauma or burns. Early preparation with weight- or length-appropriate equipment and experienced airway support reduces the risk of a failed late airway. Waiting, using mismatched equipment, and forced extension increase the chance of hypoxemia, trauma, or inability to ventilate.

101. D — Pediatric medication doses, fluid volumes, and equipment sizes depend on body size. A measured weight or validated length-based system supports rapid, safer preparation when a scale is unavailable, while clinical response is continuously reassessed. Adult dosing, caregiver height, and delaying urgent treatment can cause medication error, inadequate support, or preventable deterioration.

102. C — Injury patterns inconsistent with the reported mechanism raise concern for inflicted trauma. The nurse should protect the child, separate interviews appropriately, document exact findings and statements, and follow mandated safeguarding and reporting procedures. Accepting an implausible history, confrontation, or omission can leave the child in danger and compromise the investigation.

103. B — The combination of neurologic injury, retinal findings, and an inconsistent history is concerning for abusive head trauma. Stabilization comes first, followed by objective documentation, multidisciplinary evaluation, and protection from further harm. Ordinary crying does not explain serious injury, transient alertness does not ensure safety, and delayed documentation can lose critical evidence.

104. A — The gravid uterus can compress major vessels when the patient is supine, reducing venous return. Left uterine displacement or lateral positioning helps support maternal circulation while airway, breathing, hemorrhage control, and fetal assessment proceed. Remaining flat, pressing on the uterus, or delaying maternal stabilization can worsen venous obstruction and threaten both patient and fetus.

105. C — Fetal heart-rate abnormalities may be an early sign of placental injury, uterine compromise, or maternal deterioration. Maternal stabilization remains the priority, with continuous monitoring and urgent obstetric-trauma collaboration. Normal maternal vital signs, transient movement, or isolated fetal treatment cannot exclude evolving maternal or placental injury. Individualize care and reassess changing needs.

106. D — Pain, uterine tenderness, bleeding, and contractions after trauma are concerning for separation of the placenta from the uterine wall. Abruptio can impair fetal oxygenation and cause maternal hemorrhage, so urgent obstetric evaluation is required. Round-ligament pain, cystitis, and an ankle sprain do not explain the combined uterine and fetal-risk findings after significant trauma.

107. B — Trauma can expose an Rh-negative pregnant patient to fetal red blood cells. Obstetric evaluation determines the need for anti-D immune globulin and testing, while maternal resuscitation and fetal monitoring continue. Waiting for fetal movement loss, incompatible blood, and avoidance of testing can miss preventable alloimmunization or delay treatment. Individualize care and reassess changing needs.

108. C — Dry chemicals may continue reacting when water is added. After protecting staff, the nurse should remove loose powder and then irrigate thoroughly, preventing spread to unaffected skin and eyes.

Immediate water over powder, chemical neutralization, or occlusion can intensify the reaction or prolong tissue exposure. Individualize care and reassess changing needs.

109. D — Alkali can penetrate ocular tissues quickly, making immediate irrigation the critical treatment. Contact lenses should be removed when feasible, and irrigation should continue while pH and eye injury are assessed by the treating team. Waiting, patching, and chemical neutralization delay removal and may create additional ocular injury. Individualize care and reassess changing needs.

110. B — Electrical current can travel through deep tissue and affect the heart, muscles, nerves, and kidneys despite limited skin findings. Cardiac monitoring, neurovascular assessment, and evaluation for internal injury are therefore important. Visible wounds, absence of pain, and skin care alone do not exclude dysrhythmia, muscle necrosis, or occult internal damage.

111. A — Electrical current can cause deep muscle necrosis and release myoglobin, producing dark urine and increasing the risk of acute kidney injury and dysrhythmias. The nurse should support fluids as ordered and trend renal and electrolyte data. Hydration color changes, sunburn, and a resolved exposure do not explain myoglobin-related urine change and muscle injury.

112. C — Rigid circumferential eschar can restrict chest-wall excursion and impair ventilation. Escharotomy may be required when respiratory mechanics deteriorate, while airway support and burn-center management continue. Tightening dressings, waiting, and direct ice worsen restriction or tissue injury and do not restore ventilation. Trauma care must be individualized because age, pregnancy, burns, body habitus, and social context can change usual presentations.

113. D — Circumferential eschar can impair venous return and arterial flow, producing ischemia. Pain, paresthesia, and absent distal signals require urgent burn-surgical evaluation and release of constricting eschar when indicated. Delay, added compression, and massage can worsen pressure, disrupt fragile tissue, and risk irreversible limb injury. Individualize care and reassess changing needs.

114. A — Inhalation injury can cause progressive airway edema and obstruction after an initially acceptable examination. Early expert airway control is safer than attempting intubation after swelling worsens, while oxygenation and burn-center care continue. Waiting, oral fluids, and a tight mask do not secure the airway and may increase aspiration or obstruction.

115. B — Carbon monoxide can interfere with standard pulse-oximeter interpretation, so a normal reading does not exclude toxic exposure. High-concentration oxygen and co-oximetry help address and evaluate impaired oxygen carriage. A normal pulse-oximeter value, room air, and dehydration treatment do not reliably assess or correct carbon-monoxide toxicity. Individualize care and reassess changing needs.

116. C — The stated practice values are added: 9% for one entire arm plus 18% for the anterior trunk equals 27% total body surface area. The estimate supports initial planning but should be refined by burn specialists when needed. 9% counts only the arm, 18% counts only the trunk, and 36% doubles the correct combined area.

117. B — The prescribed 24-hour calculation is 4 multiplied by 70 kg and 30%, which equals 8,400 mL. Half of that amount, 4,200 mL, is assigned to the first eight hours under the stated assumption. 2,100 mL is one quarter, 8,400 mL is the full calculated day, and 12,600 mL uses an incorrect multiplier.

118. D — Bariatric care requires safe handling equipment, sufficient personnel, and attention to pressure injury, ventilation, positioning, and line security. Planning prevents staff injury and patient deterioration during transfers. Understaffing, unverified equipment, and stopping monitoring increase fall, airway, pressure, and device-dislodgement risks. Trauma care must be individualized because age, pregnancy, burns, body habitus, and social context can change usual presentations.

119. A — Private screening improves safety and the chance of disclosure. Neutral language, interpreter access when needed, documentation of objective findings, and safety planning support patient autonomy and reduce retaliation risk. Partner-led questioning, confrontation, and blaming language can increase danger, suppress disclosure, and compromise trauma-informed care. Individualize care and reassess changing needs.

120. B — Separate paper packaging reduces moisture retention and cross-contamination. Accurate labeling, secure storage, complete documentation, and witnessed transfers preserve evidentiary integrity and help the patient retain control of the investigative process. Plastic can promote degradation, discarding destroys evidence, and undocumented transfers make chain of custody vulnerable to challenge. Individualize care and reassess changing needs.

121. D — Private communication is essential because an accompanying controller may prevent disclosure or pose danger. A qualified interpreter, nonjudgmental questions, safety assessment, and discreet documentation support patient protection. Using the companion as interpreter, public confrontation, or silent discharge can increase risk and prevent accurate assessment. Individualize care and reassess changing needs.

122. C — The contemporary trauma primary survey prioritizes catastrophic hemorrhage along with airway, breathing, circulation, disability, and exposure. Life-threatening bleeding must be controlled immediately while the team continues simultaneous resuscitation rather than waiting for a complete history or imaging. History, laboratory testing, and CT are secondary to immediate hemorrhage control and stabilization of the airway, breathing, and circulation.

123. A — The secondary survey searches for injuries not found during the immediate life-threat assessment. It includes a systematic physical examination, focused history, repeated vital signs, review of mechanism, and integration of imaging or laboratory data. Ward delay, removal of monitoring, and a single extremity radiograph cannot identify occult injuries or evolving physiologic deterioration.

124. C — A tertiary survey is a deliberate repeat evaluation after initial stabilization to identify missed injuries or new findings. New pain and neurologic change should trigger focused reassessment, review of trends, and escalation. The primary survey and surgery do not guarantee that every injury was found, and postoperative assumptions can delay recognition of a new emergency.

125. A — Hypothermia, acidosis, coagulopathy, and hypocalcemia interact to worsen bleeding and impair resuscitation. Recognizing this cycle supports warming, hemorrhage control, balanced blood products, calcium monitoring, and rapid definitive treatment. Crystalloid alone, a pulmonary explanation, or dehydration does not account for the mutually reinforcing physiologic deterioration of severe hemorrhage. Continue reassessment as trauma physiology evolves.

126. D — Damage-control resuscitation emphasizes rapid hemorrhage control, prevention of dilutional coagulopathy, balanced blood-component therapy, warming, and targeted correction of physiologic derangements. The strategy is adjusted to the patient's response and local protocol. Unmeasured crystalloid, delayed blood, and postponed warming can worsen dilution, hypothermia, acidosis, and bleeding. Continue reassessment as trauma physiology evolves.

127. B — Persistent shock with suspected major bleeding requires rapid, protocolized access to blood products, warming, laboratory monitoring, and definitive hemorrhage control. Activation should not depend on a delayed hemoglobin result because early values may be misleading. Oral fluids, waiting for laboratory confirmation, and transport without coordinated resources delay life-saving resuscitation. Continue reassessment as trauma physiology evolves.

128. C — Rapid blood replacement can worsen hypothermia, citrate-related hypocalcemia, and coagulopathy. Active warming, ionized-calcium monitoring, coagulation testing, and protocol-directed replacement support effective clotting and cardiac function while hemorrhage control continues. Stopping resuscitation, cooling the patient, or ignoring trends allows the trauma diamond of death to intensify. Continue reassessment as trauma physiology evolves.

129. D — Diffuse oozing and abnormal coagulation testing suggest trauma-associated coagulopathy. Targeted component or factor therapy, warming, calcium correction, and hemorrhage control should be guided by laboratory or viscoelastic results and institutional protocol. Aspirin can worsen bleeding, withholding therapy delays correction, and warming alone cannot replace deficient clotting components. Continue reassessment as trauma physiology evolves.

130. B — Pre-intubation optimization reduces peri-intubation hypoxemia, hypotension, and failed-airway risk. Suction, effective preoxygenation, hemodynamic support, manual cervical control, and backup equipment should be organized before induction whenever the situation permits. Ignoring blood, excessive sedation, and removing precautions create preventable airway, hemodynamic, or spinal risks. Ongoing reassessment is essential because trauma physiology and treatment effects can change quickly during the care transition.

131. A — Tension pneumothorax raises intrathoracic pressure, obstructs venous return, and impairs ventilation, producing obstructive shock. Immediate decompression and pleural management are required while oxygenation and circulation are supported. Superficial wounds, an ankle fracture, and nausea do not explain unilateral absent breath sounds with venous obstruction and respiratory collapse. Continue reassessment as trauma physiology evolves.

132. B — Neurogenic shock is a distributive state caused by interruption of sympathetic tone, leading to vasodilation and relative bradycardia. The nurse must still search for occult hemorrhage because mixed

shock is possible after trauma. External bleeding, a small effusion, and a finger injury do not explain the characteristic hemodynamic pattern without another major process.

133. C — Blunt cardiac injury can impair contractility and electrical stability, causing pulmonary congestion, dysrhythmia, and low output. Continuous monitoring, perfusion assessment, echocardiographic evaluation, and cardiology or trauma involvement are appropriate. Skin trauma, a superficial laceration, or constipation cannot produce this pattern of myocardial dysfunction and pulmonary congestion. Continue reassessment as trauma physiology evolves.

134. A — Fever, worsening perfusion, and increasing lactate after contaminated injury suggest infection with organ dysfunction and possible septic shock. Prompt cultures, antimicrobial therapy, source control, and hemodynamic support are required. Normal inflammation, anxiety, and resolved hypovolemia do not explain progressive perfusion failure after a contaminated wound. Continue reassessment as trauma physiology evolves.

135. D — Trauma perfusion is dynamic, and no single vital sign is sufficient. Trending mental status, pressure, peripheral perfusion, urine output, respiratory effort, and laboratory data shows response and identifies ongoing shock or treatment complications. Heart rate, pain, or daily weight alone can be misleading and cannot characterize the patient's immediate response to resuscitation.

136. D — Acute hypoxemia and noncardiogenic pulmonary edema during or soon after transfusion suggest transfusion-related acute lung injury. The transfusion is stopped, respiratory support begins, and the reaction is reported and evaluated promptly. Atelectasis, circulatory overload, and a bruise do not best fit acute noncardiogenic respiratory deterioration without volume-overload findings. Continue reassessment as trauma physiology evolves.

137. C — Hypertension, venous distention, and pulmonary edema indicate excessive intravascular volume or limited cardiac reserve, consistent with transfusion-associated circulatory overload. Stop the transfusion, support breathing, notify the provider, and prepare prescribed diuresis. TRALI is noncardiogenic, an airway abrasion is local, and resolved hemorrhage does not explain new volume-overload signs. Continue reassessment as trauma physiology evolves.

138. B — Lung-protective ventilation limits ventilator-induced injury while supporting gas exchange. The nurse monitors oxygenation, pressures, synchrony, hemodynamics, and response, and collaborates on individualized adjustments. Large tidal volumes, withholding necessary support, or unmonitored pressure increases can worsen alveolar injury and hemodynamic compromise. Ongoing reassessment is essential because trauma physiology and treatment effects can change quickly during the care transition.

139. A — Myoglobin release and electrolyte shifts after muscle injury can cause acute kidney injury and dysrhythmia. The nurse should support ordered fluids, trend urine output and renal markers, monitor the ECG, and escalate hyperkalemia. Muscle soreness, skin reaction, and concentrated urine do not explain oliguria with rising potassium after crush injury.

140. B — Blunt neck trauma can injure the carotid or vertebral arteries and cause ischemic stroke. New focal deficits require immediate neurologic escalation, vascular imaging, glucose and airway

assessment, and continued trauma precautions. Waiting, oral intake, and removing monitoring delay time-sensitive treatment and do not explain away a new focal deficit. Continue reassessment as trauma physiology evolves.

141. A — Sepsis after contaminated trauma requires prompt recognition, cultures when feasible without harmful delay, antimicrobial therapy, perfusion support, and source control such as drainage or surgery. Cooling alone, delayed antibiotics, and avoiding cultures fail to address infection, organ dysfunction, or the anatomic source. Ongoing reassessment is essential because trauma physiology and treatment effects can change quickly during the care transition.

142. D — Hand hygiene, aseptic access, appropriate dressing care, and daily evaluation of line necessity reduce infection risk. Removing an unnecessary central line eliminates a potential route for bloodstream infection. Unnecessary access, delayed dressing changes, and prolonged line use increase contamination opportunities rather than preventing infection. Continue reassessment as trauma physiology evolves.

143. C — The duration of urinary-catheter exposure is a major modifiable risk. Daily necessity review, closed-system maintenance, unobstructed drainage, and prompt removal reduce infection risk. Routine irrigation, an elevated bag, and repeated disconnection can introduce contamination or impair drainage. Ongoing reassessment is essential because trauma physiology and treatment effects can change quickly during the care transition.

144. B — Head elevation, oral hygiene, secretion management, and assessment for sedation reduction or ventilator liberation help reduce aspiration and ventilator-associated complications. The plan must be individualized to injury and hemodynamic status. Flat positioning, omitted oral care, and unnecessary deep sedation increase secretion retention, aspiration, and prolonged ventilation. Continue reassessment as trauma physiology evolves.

145. D — Fluctuating attention and disorientation suggest delirium. The nurse should assess pain, hypoxia, infection, medications, withdrawal, and metabolic causes while supporting sleep, orientation, hearing, vision, hydration, and mobility. Restraints, continuous bright light, and untreated pain can worsen agitation and do not correct the underlying cause. Continue reassessment as trauma physiology evolves.

146. A — Alcohol withdrawal can progress to seizures and delirium tremens. Protocol-based symptom assessment, prescribed benzodiazepines, thiamine or other ordered therapy, electrolyte review, and close monitoring reduce complications. Anxiety labeling, fluid restriction, and personal alcohol use are unsafe and do not provide controlled treatment or seizure prevention. Continue reassessment as trauma physiology evolves.

147. C — Acute trauma pain and opioid withdrawal can coexist. Coordinated continuation or adjustment of maintenance treatment, nonopioid modalities, and monitored supplemental analgesia support humane care and reduce destabilization. Withholding analgesia, stigmatizing reports, or abruptly stopping maintenance treatment can worsen pain, withdrawal, distrust, and unsafe self-treatment. Continue reassessment as trauma physiology evolves.

148. D — Intentional injury plus access to lethal means indicates ongoing safety risk. Constant observation as indicated, environmental safety, respectful suicide assessment, and behavioral-health evaluation are required after immediate medical stabilization. Suturing alone, secrecy about weapons, and unobserved independence do not address imminent self-harm risk. Ongoing reassessment is essential because trauma physiology and treatment effects can change quickly during the care transition.

149. B — Falls are prevented through assessment of orthostasis, medications, pain, strength, environment, and cognition, followed by assisted mobility and appropriate equipment. Restriction alone can worsen deconditioning and agitation. Restraints, unassisted walking, and unsafe footwear increase risk and do not correct the cause of dizziness or weakness. Continue reassessment as trauma physiology evolves.

150. A — Trauma-informed care recognizes that procedures can reactivate fear and loss of control. Clear explanation, consent-oriented language, choices, privacy, and predictable touch improve trust while necessary treatment continues. Unannounced action, dismissive language, and unexplained staff presence can intensify distress and impair cooperation or disclosure. Ongoing reassessment is essential because trauma physiology and treatment effects can change quickly during the care transition.

151. C — Families need honest, compassionate communication that distinguishes current treatment goals from uncertain outcomes. The nurse should use plain language, check understanding, provide updates, and involve the treating team and support services. False reassurance, silence, and unexplained jargon undermine trust and prevent informed participation. Ongoing reassessment is essential because trauma physiology and treatment effects can change quickly during the care transition.

152. C — Early interdisciplinary rehabilitation addresses strength, mobility, activities of daily living, equipment, caregiver skills, and safe discharge. Therapy goals should be coordinated with precautions and the patient's medical stability. Delaying therapy, bed rest, and restraints promote deconditioning and do not teach safe function. Ongoing reassessment is essential because trauma physiology and treatment effects can change quickly during the care transition.

153. D — Coughing and wet voice after swallowing suggest aspiration risk. Oral intake should be held until swallowing is assessed, and the patient should receive appropriate positioning, suction readiness, and alternate nutrition planning if needed. Changing liquid consistency without evaluation, rapid drinking, and flat positioning can increase aspiration and pulmonary complications. Continue reassessment as trauma physiology evolves.

154. B — When the gut is usable and the patient is adequately resuscitated, enteral nutrition supports intestinal function and recovery. The team monitors tolerance, aspiration risk, glucose, electrolytes, and changing energy or protein needs. Prolonged starvation, routine early parenteral nutrition, and indefinite clear liquids fail to meet recovery needs without a specific indication.

155. A — A capacitated patient's informed preferences guide care, and a valid advance directive communicates preferences if capacity changes. The nurse should verify the document, notify the team, clarify conflicts, and continue appropriate comfort and supportive care. Family preference, document

destruction, and an unrelated override do not replace the patient's expressed choices or proper clinical review.

156. A — Potential donation cases should be referred through the designated organization so trained specialists can evaluate eligibility and support the family. The treating team continues appropriate care and separates donation discussions from bedside treatment decisions. Independent family calls, conditional language, and stopping support before referral undermine ethical, legal, and clinical processes.

157. C — Brain death determination requires a formal, jurisdictionally appropriate process that establishes prerequisites and evaluates absent brain function and brainstem reflexes. Nurses support the examination and care but do not independently make the declaration. A single pupil finding, family agreement, or low coma score cannot replace the required qualified examination and testing.

158. B — Palliative care can be provided alongside disease-directed treatment and focuses on symptom relief, communication, decision support, and quality of life. It is appropriate whenever serious illness creates substantial physical or emotional burden. Delaying symptom relief, avoiding communication, and relying on restraints do not address suffering or clarify goals. Continue reassessment as trauma physiology evolves.

159. D — Effective injury prevention uses local surveillance to identify patterns, selects a targeted intervention, partners with the community, and evaluates outcomes. Trauma programs can then refine outreach based on measured results. Untargeted material, waiting for national data, and treatment alone do not address the specific local risk or demonstrate prevention impact.

160. B — Prehospital care prioritizes immediate life threats, appropriate motion restriction, rapid transport, destination selection, and clear notification. Early interventions and accurate handoff improve continuity and help the receiving team prepare resources. Delayed bleeding control, poor communication, and unnecessary movement increase preventable risk before definitive care. Continue reassessment as trauma physiology evolves.

161. D — Safe interfacility transfer requires a complete, structured handoff that communicates current physiology, airway and ventilator needs, lines, medications, injuries, response, pending results, and contingency plans. Identity and a vague stability statement omit critical information, while logistical details do not substitute for clinical handoff. Ongoing reassessment is essential because trauma physiology and treatment effects can change quickly during the care transition.

162. A — Intrafacility transfers can cause deterioration if monitoring, oxygen, medication infusions, access, or airway equipment is interrupted. The sending and receiving teams should confirm readiness and exchange a concise, complete handoff. Disconnected infusions, unstaffed transport, and absent airway supplies create avoidable risk during movement. Ongoing reassessment is essential because trauma physiology and treatment effects can change quickly during the care transition.

163. C — Discharge planning must connect treatment instructions with the patient's ability to carry them out. Teach-back, medication reconciliation, warning signs, follow-up coordination, and barrier reduction

reduce preventable return visits and complications. Unverified written instructions, unsupported follow-up, and omitted wound teaching leave safety gaps even when the dressing looks intact. Continue reassessment as trauma physiology evolves.

164. D — Mass-casualty triage allocates limited resources to patients most likely to benefit from immediate lifesaving intervention. Categories are based on physiologic need, survivability, and resource availability rather than arrival order or emotional urgency. Walking wounded, expectant patients, and stable patients do not receive the same immediate priority when resources are constrained.

165. C — Decontamination protects staff, other patients, and the facility while reducing ongoing exposure. Isolation, PPE, clothing removal, appropriate irrigation, and communication with hazardous-material resources should occur according to the substance and emergency plan. Main-bay entry, unprotected family assistance, and delayed notification spread contamination and expose additional people. Document actions and reassess system performance.

166. A — Under-triage means seriously injured patients may not receive the needed trauma response. A structured review of cases, criteria, education, and EMS feedback can identify system causes while preserving appropriate access. Low over-triage does not make missed injury acceptable, broad age restrictions are unsupported, and stopping data collection prevents improvement. Document actions and reassess system performance.

167. B — Missed injuries require a systems-focused review of assessment, imaging, handoff, staffing, and workflow. The team should identify contributing factors, implement corrective actions, assign accountability, and monitor whether delays decrease. Individual blame, deleting records, and changing policy without analysis do not identify reliable prevention strategies. Reliable trauma systems depend on clear communication, documented actions, and timely follow-through across teams and settings.

168. A — Trauma registries support benchmarking and performance improvement only when data are complete, accurate, and consistently defined. Validation against source documentation improves reliability and reveals where collection processes need correction. Selective reporting, inconsistent definitions, and omitted cases introduce bias and weaken the registry's value. Reliable trauma systems depend on clear communication, documented actions, and timely follow-through across teams and settings.

169. D — A facilitated debrief can identify safety lessons, support staff, and connect clinicians with peer or professional resources. Psychological safety and objective review are more useful than public disclosure or blame. Public discussion, avoidance, and premature blame can increase harm, inhibit reporting, and obscure system learning. Document actions and reassess system performance.

170. C — SBAR is effective when the receiver understands the situation, relevant background, focused assessment, and requested action. A recommendation makes the handoff actionable and reduces ambiguity during deterioration. Location, routine task lists, and reliance on chart review omit the urgency, interpretation, and action needed for safe transfer. Document actions and reassess system performance.

171. B — Near misses and errors without immediate harm still provide safety information and may precede delayed effects. Patient assessment, timely notification, accurate documentation, and institutional reporting support treatment and system improvement. Silence, altered records, and informal discussion conceal risk, compromise integrity, and prevent corrective action. Reliable trauma systems depend on clear communication, documented actions, and timely follow-through across teams and settings.

172. B — Privacy requires protecting health information from unnecessary disclosure. The nurse should verify identity and authorization, use a private setting, and share only the minimum information needed for the permitted purpose. Public disclosure, unrestricted chart access, and blanket refusal each fail to balance confidentiality with authorized communication. Document actions and reassess system performance.

173. C — Emergency-access law requires an appropriate screening examination and stabilizing treatment for an emergency medical condition, regardless of ability to pay. Any transfer must meet applicable clinical and regulatory requirements. Insurance verification, financially motivated transfer, and self-care instructions cannot replace required emergency evaluation and stabilization. Reliable trauma systems depend on clear communication, documented actions, and timely follow-through across teams and settings.

174. D — Immediate safety takes priority during a workplace-violence threat. Staff should use the facility alert process, create distance, protect patients, and request trained security or law-enforcement assistance according to policy. Solo confrontation, silence, and untrained restraint increase injury risk and may escalate the situation. Reliable trauma systems depend on clear communication, documented actions, and timely follow-through across teams and settings.

175. A — Trauma designation and verification depend on sustained resources, trained personnel, reliable data, performance improvement, and coordination across the trauma system. Readiness is demonstrated by actual processes and outcomes, not presentation alone. Marketing, a narrow time window, and selective case removal obscure the system's true capability and undermine patient safety. Document actions and reassess system performance.