

AACN Essentials of Critical Care Nursing Practice Test (Sample)

Study Guide



Everything you need from our exam experts!

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Introduction

Preparing for a certification exam can feel overwhelming, but with the right tools, it becomes an opportunity to build confidence, sharpen your skills, and move one step closer to your goals. At Examzify, we believe that effective exam preparation isn't just about memorization, it's about understanding the material, identifying knowledge gaps, and building the test-taking strategies that lead to success.

This guide was designed to help you do exactly that.

Whether you're preparing for a licensing exam, professional certification, or entry-level qualification, this book offers structured practice to reinforce key concepts. You'll find a wide range of multiple-choice questions, each followed by clear explanations to help you understand not just the right answer, but why it's correct.

The content in this guide is based on real-world exam objectives and aligned with the types of questions and topics commonly found on official tests. It's ideal for learners who want to:

- Practice answering questions under realistic conditions,
- Improve accuracy and speed,
- Review explanations to strengthen weak areas, and
- Approach the exam with greater confidence.

We recommend using this book not as a stand-alone study tool, but alongside other resources like flashcards, textbooks, or hands-on training. For best results, we recommend working through each question, reflecting on the explanation provided, and revisiting the topics that challenge you most.

Remember: successful test preparation isn't about getting every question right the first time, it's about learning from your mistakes and improving over time. Stay focused, trust the process, and know that every page you turn brings you closer to success.

Let's begin.

How to Use This Guide

This guide is designed to help you study more effectively and approach your exam with confidence. Whether you're reviewing for the first time or doing a final refresh, here's how to get the most out of your Examzify study guide:

1. Start with a Diagnostic Review

Skim through the questions to get a sense of what you know and what you need to focus on. Your goal is to identify knowledge gaps early.

2. Study in Short, Focused Sessions

Break your study time into manageable blocks (e.g. 30 - 45 minutes). Review a handful of questions, reflect on the explanations.

3. Learn from the Explanations

After answering a question, always read the explanation, even if you got it right. It reinforces key points, corrects misunderstandings, and teaches subtle distinctions between similar answers.

4. Track Your Progress

Use bookmarks or notes (if reading digitally) to mark difficult questions. Revisit these regularly and track improvements over time.

5. Simulate the Real Exam

Once you're comfortable, try taking a full set of questions without pausing. Set a timer and simulate test-day conditions to build confidence and time management skills.

6. Repeat and Review

Don't just study once, repetition builds retention. Re-attempt questions after a few days and revisit explanations to reinforce learning. Pair this guide with other Examzify tools like flashcards, and digital practice tests to strengthen your preparation across formats.

There's no single right way to study, but consistent, thoughtful effort always wins. Use this guide flexibly, adapt the tips above to fit your pace and learning style. You've got this!

Questions

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- 1. Which scenario best illustrates moral distress at the bedside?**
 - A. A nurse knows the right action to take but cannot due to institutional constraints.**
 - B. A nurse agrees with the care plan and acts accordingly.**
 - C. A nurse refuses care due to personal beliefs unrelated to patient needs.**
 - D. A nurse is praised for advocating for patient autonomy.**

- 2. Which of the following is NOT considered an unintentional distraction when caring for an unresponsive ventilated patient?**
 - A. Talking to a colleague**
 - B. Singing**
 - C. Humming**
 - D. Joking**

- 3. Which statement demonstrates respect for patient autonomy?**
 - A. The patient has the right to refuse care and it must be honored**
 - B. The patient must always follow the physician's orders**
 - C. Consent is not required for routine care**
 - D. The nurse decides the treatment**

- 4. In critical care, resiliency refers to which characteristic?**
 - A. Motivation to reduce anxiety through positive self-talk**
 - B. Ability to bounce back quickly after an insult**
 - C. Physical strength to endure extreme physical stressors**
 - D. Ability to return to a state of equilibrium**

- 5. In ICU pain management, which approach reduces opioid requirements and improves respiratory outcomes?**
 - A. Sedation-based approach only**
 - B. Increased basal opioid dosing**
 - C. Multimodal analgesia and opioid-sparing strategies**
 - D. Delayed analgesia until mechanical ventilation is complete**

- 6. For the A - Assessment component of SBAR, which statement belongs?**
- A. I would like you to ...**
 - B. The patient's vital signs are...**
 - C. I think the problem is...**
 - D. The patient's treatments are...**
- 7. When a nurse uses conscientious refusal to participate in care, a potential consequence is:**
- A. Dismissal from a nursing position.**
 - B. Employer sanction.**
 - C. The patient will support the nurse's decision.**
 - D. State boards protect the nurse in this situation.**
- 8. Which action best aligns with reducing safety risks due to language barriers in critical care?**
- A. Use interpreter services to communicate with patients who have limited English proficiency.**
 - B. Rely on family members to translate.**
 - C. Use only written materials.**
 - D. Assume patient understands medical terminology.**
- 9. A nurse is administering haloperidol (Haldol) via IV push to a delirious patient. What is most important for the nurse to monitor?**
- A. Heart rate**
 - B. PR interval**
 - C. QT interval**
 - D. Respiratory rate**

10. Which observation would most strongly support readiness for an interruption of sedation in a mechanically ventilated patient?

- A. Had a MAP of 75 and heart rate of 76**
- B. Was sleeping but awakened with verbal stimuli**
- C. Frowned when turned but otherwise showed no muscular tension**
- D. Activated the ventilator alarms but the alarms stopped spontaneously**

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Answers

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1. A
2. A
3. A
4. B
5. C
6. B
7. B
8. A
9. C
10. B

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Explanations

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1. Which scenario best illustrates moral distress at the bedside?

- A. A nurse knows the right action to take but cannot due to institutional constraints.**
- B. A nurse agrees with the care plan and acts accordingly.**
- C. A nurse refuses care due to personal beliefs unrelated to patient needs.**
- D. A nurse is praised for advocating for patient autonomy.**

Moral distress happens when a nurse knows the ethically appropriate action to take but is blocked from taking it by external barriers such as institutional policies, staffing shortages, or other constraints. In this scenario, the nurse recognizes the right action yet cannot implement it because of those constraints, leading to ethical discomfort and emotional strain at the bedside. This tension—knowing what should be done but being unable to do it due to system factors—is the hallmark of moral distress. The other situations don't involve feeling constrained from acting on what's ethically right: simply agreeing with and carrying out the plan isn't distressing, acting on personal beliefs unrelated to patient needs changes the dynamic but isn't about an external barrier to the right action, and being praised for advocating autonomy is positive reinforcement, not distress.

2. Which of the following is NOT considered an unintentional distraction when caring for an unresponsive ventilated patient?

- A. Talking to a colleague**
- B. Singing**
- C. Humming**
- D. Joking**

Minimizing environmental stimuli is essential when caring for an unresponsive ventilated patient because extraneous noises can increase arousal, agitation, and respiratory stress, complicating sedation and recovery. Talking to a colleague is a purposeful, necessary part of clinical care and safety—coordinating tasks, confirming ventilator settings, or sharing critical observations—so it's not considered an unintentional distraction. In contrast, singing, humming, or joking around create nonessential sounds that the patient may hear and that do not contribute to care, making them inappropriate distractions in this setting. The goal is to maintain a calm, controlled bedside environment, using quiet tones and concise communication whenever possible to protect the patient's rest and safety.

3. Which statement demonstrates respect for patient autonomy?

- A. The patient has the right to refuse care and it must be honored**
- B. The patient must always follow the physician's orders**
- C. Consent is not required for routine care**
- D. The nurse decides the treatment**

Honoring patient autonomy means recognizing the patient's right to make their own health care decisions, including the choice to accept or refuse treatment, as long as they have the capacity to decide and are adequately informed. Saying that the patient has the right to refuse care and that this decision must be honored is the clearest demonstration of autonomy in practice, because it centers the patient as the decision-maker and requires the clinician to respect that choice, provide full information, assess capacity, and document the refusal while still offering support and alternatives. Paternalistic approaches—acting as if the physician's orders must always be followed without considering the patient's preferences—undermine autonomy. Assuming consent for routine care without explicit discussion also disrespects the patient's right to participate, and having the nurse decide the treatment removes the patient's voice from the decision-making process.

4. In critical care, resiliency refers to which characteristic?

- A. Motivation to reduce anxiety through positive self-talk**
- B. Ability to bounce back quickly after an insult**
- C. Physical strength to endure extreme physical stressors**
- D. Ability to return to a state of equilibrium**

Resiliency in critical care means the capacity to recover and adapt after a health insult, returning toward baseline function and stability as quickly as possible. It reflects both physiological and psychological recovery, and the ability to regain balance after stressors like infection, injury, or invasive treatments. The description that best fits this is the ability to bounce back quickly after an insult, because it conveys rapid recovery and return toward baseline in the face of acute illness or trauma. While coping strategies like positive self-talk or simply having physical endurance describe related skills, they don't fully capture the dynamic process of bouncing back after disruption. Returning to equilibrium is related, but resiliency emphasizes the speed and completeness of recovery following adversity.

5. In ICU pain management, which approach reduces opioid requirements and improves respiratory outcomes?

A. Sedation-based approach only

B. Increased basal opioid dosing

C. Multimodal analgesia and opioid-sparing strategies

D. Delayed analgesia until mechanical ventilation is complete

Using multiple pain-control strategies that tackle different ways pain is felt and processed lets us achieve meaningful relief with much less opioid use. Multimodal analgesia combines non-opioid medications (such as acetaminophen and, when appropriate, NSAIDs), regional or neuraxial techniques, and adjuvants like ketamine, lidocaine, gabapentinoids, or dexmedetomidine. When several modalities contribute to analgesia, the total opioid need drops, so patients remain more responsive to their own breathing and maintain better ventilatory drive. Reducing opioid exposure is directly linked to improved respiratory outcomes in the ICU. Less opioid-induced respiratory depression means better respiratory effort, more reliable ventilator synchrony, and a smoother path to weaning from mechanical ventilation. It also tends to lessen sedation depth and delirium, supporting earlier mobilization and recovery. By comparison, relying on a sedation-focused approach without adequate analgesia, increasing basal opioids, or delaying analgesia until after airway management can lead to insufficient pain control, greater respiratory compromise, and longer dependence on ventilation.

6. For the A - Assessment component of SBAR, which statement belongs?

A. I would like you to ...

B. The patient's vital signs are...

C. I think the problem is...

D. The patient's treatments are...

In SBAR, the Assessment part communicates how you interpret the data and what is going on with the patient right now. It's where you move from raw information to clinical judgment about the patient's status and potential problems. Saying "The patient's vital signs are ..." fits here because vital signs are the core objective data you use to gauge stability or deterioration. This kind of statement invites you to interpret what those numbers mean for the patient's condition, and it sets up your clinical conclusion or concern (for example, that the patient may be slipping toward instability or that perfusion is adequate). In practice, you'd follow with the interpretation of those vitals and what you think the problem could be. Other options are more about making a request (what you want done) or detailing what has already been done (treatments), rather than articulating your current interpretation of the patient's status based on data. While phrases like "I think the problem is..." can express assessment, the strongest SBAR assessment centers on the objective data and its implications, such as vital signs, to justify the concern and guide next steps.

7. When a nurse uses conscientious refusal to participate in care, a potential consequence is:

- A. Dismissal from a nursing position.**
- B. Employer sanction.**
- C. The patient will support the nurse's decision.**
- D. State boards protect the nurse in this situation.**

When a nurse invokes conscientious refusal, the focus is on balancing personal values with patient safety and the need for uninterrupted care. Even if a nurse declines to participate in a specific procedure or aspect of care, the employer must ensure that patients still receive timely, safe treatment. Because of that, a realistic and common consequence is disciplinary action or sanctions by the employer. These sanctions can range from formal counseling or reassignment to more formal disciplinary measures like suspension or termination, depending on the organization's policies and the impact on patient care. Patients may not always align with the nurse's stance, and state boards regulate practice to protect the public; they may recognize conscientious objection but do not automatically shield a nurse from workplace consequences. The important point is that the employer has a responsibility to maintain patient access to care, which is why employer sanctions are a likely consequence in these situations.

8. Which action best aligns with reducing safety risks due to language barriers in critical care?

- A. Use interpreter services to communicate with patients who have limited English proficiency.**
- B. Rely on family members to translate.**
- C. Use only written materials.**
- D. Assume patient understands medical terminology.**

The essential idea is ensuring accurate, real-time communication for patients with limited English proficiency to prevent safety risks in critical care. In this setting, precise understanding of symptoms, treatment plans, medication instructions, consent, and discussion of goals of care is crucial. Professional interpreter services provide real-time translation by trained individuals who know medical terminology, which helps ensure that both the patient and the care team share an accurate understanding of risks, benefits, and procedures. This also allows for effective clarification and confirmation through teach-back, helping to verify that the patient truly understands what is being communicated. Interpreter use also preserves confidentiality and reduces the risk of miscommunication that can lead to medication errors, incorrect procedures, or incomplete informed consent. Relying on family members to translate introduces several problems: potential inaccuracies, incomplete information, and bias, plus issues with confidentiality and the emotional strain on families during critical moments. Relying solely on written materials ignores literacy, cognitive status, and the need for timely, interactive discussion, especially when medical decisions are urgent or complex. Assuming the patient understands medical terminology is unsafe and can mask significant gaps in comprehension. Using professional interpreters best aligns with safe, patient-centered care by ensuring accurate understanding, informed consent, and appropriate responses to patient needs in a high-stakes environment.

9. A nurse is administering haloperidol (Haldol) via IV push to a delirious patient. What is most important for the nurse to monitor?

- A. Heart rate**
- B. PR interval**
- C. QT interval**
- D. Respiratory rate**

The key issue here is the risk of QT interval prolongation with haloperidol when given intravenously. Haloperidol can affect cardiac repolarization by blocking potassium channels, which lengthens the QT interval on an ECG. A prolonged QT increases the risk of torsades de pointes, a potentially fatal ventricular arrhythmia. Because of this, ECG monitoring to assess the QT interval before and during IV haloperidol administration is essential. Correct any electrolyte disturbances (potassium, magnesium), avoid other QT-prolonging drugs, and consider giving the medication slowly to minimize risk. If the QT interval becomes markedly prolonged, the medication should be reassessed and, if needed, withheld. While other vital signs like heart rate, PR interval, or respiratory rate are important for overall patient safety and assessment, they do not address the specific, potentially life-threatening cardiac risk associated with haloperidol's effect on myocardial repolarization as directly as monitoring the QT interval.

10. Which observation would most strongly support readiness for an interruption of sedation in a mechanically ventilated patient?

- A. Had a MAP of 75 and heart rate of 76**
- B. Was sleeping but awakened with verbal stimuli**
- C. Frowned when turned but otherwise showed no muscular tension**
- D. Activated the ventilator alarms but the alarms stopped spontaneously**

The main idea is that readiness to interrupt sedation depends on the patient being awake enough to participate in assessment and potential weaning from the ventilator. When a patient can be sleeping yet easily awakened by verbal stimuli, it shows they are not deeply sedated and can respond to external cues. This responsiveness is essential for safely performing a spontaneous awakening trial and for evaluating readiness to reduce or stop sedation. It suggests the patient can follow commands and participate in the next steps of weaning, rather than remaining in a deeply sedated state. Hemodynamic stability alone doesn't prove readiness to awaken, and mild discomfort during turning without clear arousal doesn't demonstrate the ability to engage with the assessment. Ventilator alarms that are activated but then stop spontaneously don't confirm readiness either and could reflect agitation or other factors that complicate an interruption.

Next Steps

Congratulations on reaching the final section of this guide. You've taken a meaningful step toward passing your certification exam and advancing your career.

As you continue preparing, remember that consistent practice, review, and self-reflection are key to success. Make time to revisit difficult topics, simulate exam conditions, and track your progress along the way.

If you need help, have suggestions, or want to share feedback, we'd love to hear from you. Reach out to our team at hello@examzify.com.

Or visit your dedicated course page for more study tools and resources:

<https://aacnessentialsofccnursing.examzify.com>

We wish you the very best on your exam journey. You've got this!

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