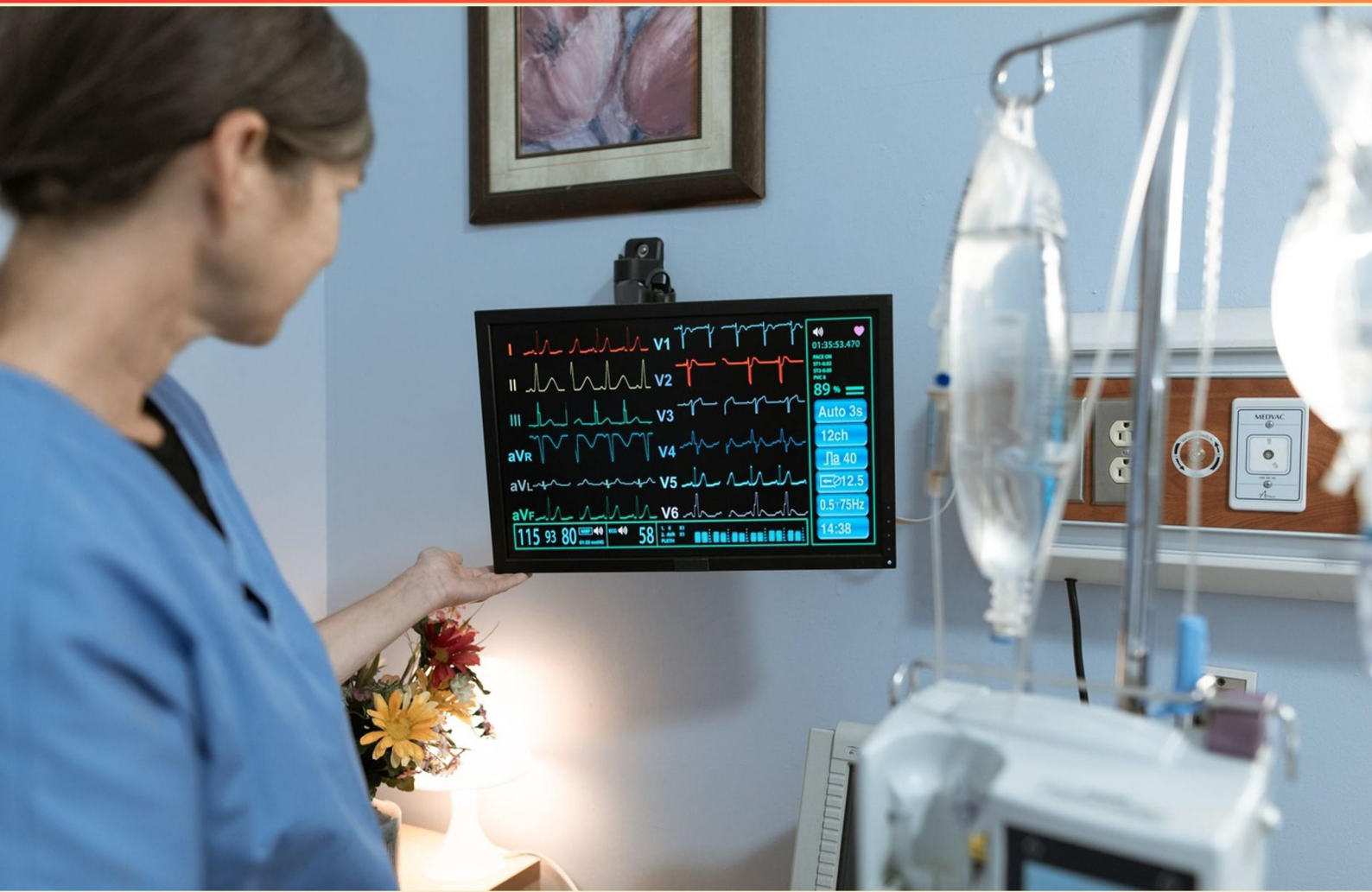


AACN ESSENTIALS OF CRITICAL CARE NURSING PRACTICE TEST (SAMPLE)

STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

VISIT US ONLINE FOR
THE FULL VERSION STUDY GUIDE

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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 device is used to confirm airway placement and assess ventilation efficiency at the bedside?**
 - A. End-tidal CO2 detector
 - B. Pulse oximeter
 - C. Thermometer
 - D. Stethoscope
- 2. Which statement most strongly indicates a patient has decision-making capacity?**
 - A. Asks questions about identified treatments
 - B. Is being medicated for severe pain
 - C. Has been diagnosed with septic shock
 - D. Does not understand the medical condition
- 3. To demonstrate informed consent for a dressing change, which action is appropriate?**
 - A. A consent form to sign to have dressings changed
 - B. An explanation of a dressing to be changed
 - C. A consent form to sign to receive medications
 - D. A consent form to sign to be turned in bed
- 4. In nutritional assessment, which data would be used to estimate energy expenditure?**
 - A. Food allergies
 - B. Use of nutritional supplements
 - C. If can swallow
 - D. Height and weight
- 5. Which statement about oxygen saturation (SpO2) is correct?**
 - A. SpO2 reflects the percentage of dissolved oxygen in plasma
 - B. SpO2 equals PaO2
 - C. SpO2 represents the percentage of hemoglobin bound with oxygen
 - D. SpO2 is unaffected by hemoglobin status

- 6. 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
- 7. In septic shock, what is the recommended initial fluid resuscitation volume and timeframe?**
- A. 10 mL/kg within 1 hour
 - B. 30 mL/kg isotonic crystalloids within the first 3 hours
 - C. 50 mL/kg within 6 hours
 - D. 5 mL/kg within 30 minutes
- 8. In SBAR communication, which phrase is an appropriate initial statement?**
- A. The patient's immediate history is...
 - B. I would like you to ...
 - C. I am concerned about...
 - D. I think the problem is...
- 9. Which scenario best represents a patient at risk for nutritional imbalance requiring monitoring?**
- A. Stable Post-MI
 - B. Renal Failure
 - C. Slightly Elevated Liver Enzymes
 - D. Intubated and Sedated
- 10. Elevation of serum lactate in critically ill patients most commonly indicates which condition?**
- A. Dehydration
 - B. Efficient oxygen delivery
 - C. Hemolysis
 - D. Poor perfusion

Answers

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

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Explanations

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1. Which device is used to confirm airway placement and assess ventilation efficiency at the bedside?

A. End-tidal CO2 detector

B. Pulse oximeter

C. Thermometer

D. Stethoscope

Using capnography to confirm airway placement and monitor ventilation. An end-tidal CO2 detector measures the CO2 level in exhaled air and provides a waveform that shows CO2 is being delivered from the lungs. After securing the airway, a consistent end-tidal CO2 waveform with normal values confirms tracheal placement and effective ventilation. If CO2 is not detected or the waveform is absent, it raises concern for esophageal intubation or tube dislodgement, prompting immediate reassessment and repositioning. Capnography also helps track ventilation efficiency over time by showing trends in CO2 elimination; rising CO2 can indicate hypoventilation or rebreathing, while very low CO2 may reflect hyperventilation or poor perfusion. In contrast, a pulse oximeter only shows oxygen saturation and does not verify placement or provide immediate ventilation data, a thermometer is unrelated, and a stethoscope alone cannot reliably confirm airway placement or quantify ventilation.

2. Which statement most strongly indicates a patient has decision-making capacity?

A. Asks questions about identified treatments

B. Is being medicated for severe pain

C. Has been diagnosed with septic shock

D. Does not understand the medical condition

Being able to participate in decisions means engaging with information, understanding what's being offered, and weighing options. When a patient asks questions about identified treatments, it shows they are actively seeking clarification, evaluating what is presented, and considering potential consequences. That active information-processing and inquiry demonstrates decision-making capacity in that moment. Medicating for severe pain can cloud thinking and judgment, making it hard to understand information or reason about choices. A diagnosis like septic shock can bring delirium or cognitive impairment, which undermines capacity. Not understanding the medical condition similarly signals limited understanding necessary to make informed choices. Remember, capacity is task- and time-specific, so a person can have it for some decisions and not others.

3. To demonstrate informed consent for a dressing change, which action is appropriate?

A. A consent form to sign to have dressings changed

B. An explanation of a dressing to be changed

C. A consent form to sign to receive medications

D. A consent form to sign to be turned in bed

Informed consent is a process where the clinician explains what will be done, what to expect, potential risks and benefits, and available alternatives, and then confirms the patient understands and agrees voluntarily. For a dressing change, the appropriate action is to provide a clear explanation of what will be done, how it will feel, any risks or discomfort, how long it will take, and any aftercare steps, and to answer questions. This conversational approach demonstrates understanding and voluntary agreement more than signing a form. Signing a consent form for a dressing change isn't typically required, and forms to receive medications or to be turned in bed aren't relevant to this procedure. The patient should also be allowed to ask questions and to decline if they choose.

4. In nutritional assessment, which data would be used to estimate energy expenditure?

- A. Food allergies
- B. Use of nutritional supplements
- C. If can swallow

D. Height and weight

Estimating energy expenditure relies on formulas that convert body size into metabolic needs. Height and weight are fundamental inputs because they reflect the body's mass and surface area, which drive metabolic rate. By using height and weight, you can estimate basal energy needs (BMR) and, when combined with an activity factor, total energy expenditure. The other data—food allergies, use of nutritional supplements, or ability to swallow—don't inform how many calories the body requires; they relate to dietary restrictions, intake feasibility, or nutrition management rather than energy needs.

5. Which statement about oxygen saturation (SpO₂) is correct?

- A. SpO₂ reflects the percentage of dissolved oxygen in plasma
- B. SpO₂ equals PaO₂

C. SpO₂ represents the percentage of hemoglobin bound with oxygen

- D. SpO₂ is unaffected by hemoglobin status

SpO₂ reflects the percentage of hemoglobin binding sites that are occupied by oxygen, measured noninvasively with pulse oximetry. It does not measure the amount of dissolved oxygen in plasma (that's PaO₂), and it is not the same as PaO₂, even though they relate through the oxygen–hemoglobin dissociation curve. SpO₂ can be influenced by hemoglobin status—low hemoglobin, or abnormal forms like carboxyhemoglobin or methemoglobin can affect readings—so it isn't independent of Hb status. Therefore, the statement that SpO₂ represents the percentage of hemoglobin bound with oxygen is the correct interpretation.

6. 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.

7. In septic shock, what is the recommended initial fluid resuscitation volume and timeframe?

- A. 10 mL/kg within 1 hour
- B. 30 mL/kg isotonic crystalloids within the first 3 hours**
- C. 50 mL/kg within 6 hours
- D. 5 mL/kg within 30 minutes

Septic shock requires rapid restoration of circulating volume to improve tissue perfusion and oxygen delivery. The recommended initial fluid resuscitation is 30 mL/kg of isotonic crystalloids (such as normal saline or a balanced solution like Lactated Ringer's) administered within the first 3 hours. This amount, scaled to body weight, aims to promptly raise preload and cardiac output, supporting perfusion while you reassess response. After giving fluids, reevaluate hemodynamics; if hypotension persists, initiate vasopressor support (typically norepinephrine) to maintain mean arterial pressure ≥ 65 mmHg and continue to monitor for fluid responsiveness to avoid overload. Using a smaller volume or stretching the timeframe would delay restoration of perfusion, whereas too large an or too rapid a bolus can increase the risk of fluid overload and edema.

8. In SBAR communication, which phrase is an appropriate initial statement?

- A. The patient's immediate history is...
- B. I would like you to ...
- C. I am concerned about...**
- D. I think the problem is...

In SBAR, the first statement should clearly present the situation that requires attention, without jumping to conclusions. Saying "I am concerned about..." does just that: it flags that there is an issue needing the team's awareness and prompts a focused follow-up with Background, then Assessment, and finally Recommendation. It conveys urgency and invites discussion rather than assuming a diagnosis or issuing a directive. The other phrasings tend to place the focus on background details, a request, or a premature conclusion. Beginning with background ("The patient's immediate history is...") shifts to what happened rather than what needs attention now. A request ("I would like you to...") moves into a directive before the issue is clearly stated. Stating a conclusion about what the problem is ("I think the problem is...") editorializes the issue and fits better in Assessment rather than the opening Situation. So starting with "I am concerned about..." aligns with SBAR by front-loading the concern that kicks off a concise, action-oriented handoff.

9. Which scenario best represents a patient at risk for nutritional imbalance requiring monitoring?

- A. Stable Post-MI
- B. Renal Failure**
- C. Slightly Elevated Liver Enzymes
- D. Intubated and Sedated

The main idea here is that kidneys play a central role in balanced nutrition, particularly in handling protein metabolism, electrolytes, and acid-base status. When the kidneys are failing, these processes become unstable. Nutritional status becomes closely tied to how well nutrition can be managed under these conditions. In renal failure, several pieces converge to create a high risk for nutritional imbalance. The body often enters a catabolic state, and dialysis can wash out amino acids and other nutrients, which can lead to a negative nitrogen balance if intake isn't carefully adjusted. Electrolyte and mineral disturbances are common—hyperkalemia, hyperphosphatemia, hypocalcemia—which directly affect metabolic stability and feeding plans. Metabolic acidosis can impair protein synthesis and overall energy use. Plus, uremia can dampen appetite, further reducing intake. Because of all this, patients with renal failure require close nutritional monitoring and tailored support that accounts for altered protein needs, energy requirements, fluid status, and potential dialysis-related nutrient losses. While other scenarios can involve nutritional concerns, they don't as consistently entail the combination of catabolic state, dialysis-related nutrient losses, and multi system electrolyte/acid-base disturbances seen with renal failure, which makes this scenario the one that most clearly signals a need for proactive nutritional monitoring.

10. Elevation of serum lactate in critically ill patients most commonly indicates which condition?

- A. Dehydration
- B. Efficient oxygen delivery
- C. Hemolysis
- D. Poor perfusion**

Elevated serum lactate in critically ill patients most often reflects inadequate tissue perfusion and resultant anaerobic metabolism. When oxygen delivery to tissues falls below demand, cells switch from aerobic to anaerobic glycolysis. In that state, pyruvate is converted to lactate to regenerate NAD⁺, allowing glycolysis to continue despite insufficient oxygen. The accumulating lactate then appears in the bloodstream, making lactate a practical marker of perfusion status and the severity of shock or hypoperfusion. Dehydration can contribute to reduced circulating volume and hypoperfusion, but it's a broader trigger for poor perfusion rather than the direct signal lactate most specifically represents. Efficient oxygen delivery would tend to prevent lactate buildup, not cause it. Hemolysis doesn't directly cause a primary rise in lactate levels; it affects other parameters without explaining the common lactate elevation seen with tissue hypoxia.

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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