

ADULT CCRN PRACTICE EXAM (SAMPLE)

STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

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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. In diabetic ketoacidosis, patients are at risk for which electrolyte disturbance during treatment?**
 - A. Hyperkalemia
 - B. Hypercalcemia
 - C. Hypokalemia
 - D. Hypermagnesemia

- 2. Mean Corpuscular Volume (MCV) is used to classify anemia into which categories?**
 - A. Microcytic, macrocytic, or normocytic.
 - B. Hypocellular and hypercellular.
 - C. Hyperglycemic and normoglycemic.
 - D. Hyperkalemic and hypokalemic.

- 3. Which statement best describes the initial management route for severe dehydration in adults?**
 - A. Oral rehydration therapy only
 - B. Intravenous fluids is the primary route
 - C. Subcutaneous saline only
 - D. Intraosseous fluids only

- 4. IAP grade IV (>25 mm Hg) is considered what?**
 - A. It can be managed with fluids and observation.
 - B. It is considered a surgical emergency.
 - C. It resolves with antibiotics alone.
 - D. It requires only vasopressor support.

- 5. What distinguishes Type I diabetes mellitus?**
 - A. An autoimmune destruction of insulin-producing beta cells of the pancreas, formerly known as juvenile diabetes.
 - B. A metabolic disorder characterized by insulin resistance with relative insulin deficiency.
 - C. Onset in older adults.
 - D. Excess insulin production.

- 6. Regarding intra-aortic balloon pump (IABP) contraindications, which statement is true?**
- A. Specific contraindications are not listed in the notes.
 - B. IABP has no contraindications.
 - C. Severe aortic regurgitation is a contraindication for IABP.
 - D. Peripheral vascular disease is a contraindication for IABP.
- 7. What are the characteristics of ethylene glycol?**
- A. Non-toxic and odorless.
 - B. Sweet to taste but bitter aftertaste.
 - C. Toxic, odorless, colorless, and sweet to taste.
 - D. Toxic, but has a strong odor.
- 8. What are the key components of brain optimization in delirium treatment?**
- A. Environmental noise without sleep change
 - B. Prolonged bed rest to conserve energy
 - C. Normal sleep cycle, adequate oxygenation, hydration, nutrition, familiar faces, pain treatment, and mobility
 - D. Aggressive sedation to improve wakefulness
- 9. What is the antidote for benzodiazepine overdose?**
- A. N-acetylcysteine (Mucomyst)
 - B. Flumazenil (Romazicon)
 - C. Naloxone (Narcan)
 - D. Activated charcoal
- 10. Which of the following can cause intestinal infarction?**
- A. Arteriosclerosis
 - B. Thrombi/emboli
 - C. Strangulated intestine
 - D. All of the above

Answers

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

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Explanations

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1. In diabetic ketoacidosis, patients are at risk for which electrolyte disturbance during treatment?

- A. Hyperkalemia
- B. Hypercalcemia
- C. Hypokalemia**
- D. Hypermagnesemia

In treating diabetic ketoacidosis, the key issue is that insulin therapy and correction of acidosis drive potassium from the extracellular space into cells, uncovering a true potassium deficit. Before treatment, potassium may appear normal or high because of insulin deficiency and acidosis, but total body potassium is actually depleted due to urinary and GI losses. As insulin is given and the patient's fluids and glucose improve, potassium shifts intracellularly and ongoing renal losses continue, so the serum potassium can fall rapidly, causing hypokalemia. This makes hypokalemia the main electrolyte disturbance to anticipate during treatment. Monitoring potassium closely and replacing it according to protocols is essential, for example, holding insulin if potassium is very low and ensuring adequate supplementation when levels are in the safe range. Hyperkalemia is more of a concern before treatment rather than during, and hypercalcemia or hypermagnesemia are not the hallmark disturbances associated with the treatment phase.

2. Mean Corpuscular Volume (MCV) is used to classify anemia into which categories?

- A. Microcytic, macrocytic, or normocytic.**
- B. Hypocellular and hypercellular.
- C. Hyperglycemic and normoglycemic.
- D. Hyperkalemic and hypokalemic.

Mean corpuscular volume measures the average size of red blood cells. This size classification splits anemia into microcytic (smaller than normal), normocytic (normal size), and macrocytic (larger than normal). The normal range is roughly 80–100 femtoliters. When the MCV is low, red cells are small, which points toward iron deficiency or thalassemia. When the MCV is high, red cells are large, as seen with B12 or folate deficiency, liver disease, or alcoholism. If the MCV is normal despite anemia, it suggests a process with normal cell size but reduced cell number, such as acute blood loss or anemia of chronic disease. This size-based grouping helps guide the subsequent diagnostic workup and targeted tests.

3. Which statement best describes the initial management route for severe dehydration in adults?

- A. Oral rehydration therapy only
- B. Intravenous fluids is the primary route**
- C. Subcutaneous saline only
- D. Intraosseous fluids only

Rapid restoration of intravascular volume with intravenous fluids is the initial management for severe dehydration in adults. When dehydration is severe, circulating blood volume is depleted, leading to reduced perfusion and potential shock, so IV fluids are started promptly to quickly restore perfusion. Oral rehydration cannot reliably address this level of fluid loss and may be poorly tolerated or too slow in severe cases. Subcutaneous saline delivers fluid more slowly and is not suitable for rapid resuscitation of hypovolemia. Intraosseous access and fluids are valuable if IV access cannot be obtained quickly, but IV fluids remain the preferred initial route when IV access is available. The typical approach uses an isotonic crystalloid given as a rapid IV bolus (for example, about 20 mL/kg), with reassessment and repeated boluses as needed until perfusion improves.

4. IAP grade IV (>25 mm Hg) is considered what?

- A. It can be managed with fluids and observation.
- B. It is considered a surgical emergency.**
- C. It resolves with antibiotics alone.
- D. It requires only vasopressor support.

Pushing intra-abdominal pressure above 25 mmHg signals a dangerous level that often correlates with abdominal compartment syndrome. At this threshold, the pressure severely compromises blood flow to the abdominal organs and can impair breathing due to elevated diaphragmatic pressures, leading to multi-organ dysfunction. This situation demands rapid relief of the pressure, typically through decompressive surgery, to prevent irreversible organ damage and death. Medical management like fluids or observation won't relieve the mechanical compression, antibiotics don't address the pressure, and vasopressors don't reduce the intra-abdominal pressure. Emergent surgical decompression is the appropriate, life-saving response.

5. What distinguishes Type I diabetes mellitus?

- A. An autoimmune destruction of insulin-producing beta cells of the pancreas, formerly known as juvenile diabetes.**
- B. A metabolic disorder characterized by insulin resistance with relative insulin deficiency.
- C. Onset in older adults.
- D. Excess insulin production.

Type I diabetes is defined by autoimmune destruction of the insulin-producing beta cells in the pancreas, leading to an absolute lack of endogenous insulin. This destruction often presents in younger individuals, hence the historical term juvenile diabetes, and is why those affected must rely on insulin for survival and are at risk for diabetic ketoacidosis if insulin is not available. This autoimmune, insulin-deficient process distinguishes Type I from other forms. The other descriptions describe Type II diabetes, which involves insulin resistance with only a relative, not absolute, insulin deficiency and typically occurs in older individuals and often with obesity. The idea of excess insulin production would not characterize Type I.

6. Regarding intra-aortic balloon pump (IABP) contraindications, which statement is true?

- A. Specific contraindications are not listed in the notes.**
- B. IABP has no contraindications.
- C. Severe aortic regurgitation is a contraindication for IABP.
- D. Peripheral vascular disease is a contraindication for IABP.

Understanding contraindications for an intra-aortic balloon pump centers on recognizing when balloon inflation could worsen a patient's condition or when access and function would be unsafe. In this particular set of notes, there isn't a listed, explicit catalog of disallowed conditions. That means the statement that specific contraindications are not listed is true within the context of those notes. In clinical practice, there are known concerns with IABP use—such as severe aortic regurgitation or significant peripheral vascular disease—that can make the procedure unsafe or ineffective. However, the question's referenced material doesn't enumerate them, so the option stating that no specific contraindications are listed best fits the context.

7. What are the characteristics of ethylene glycol?

- A. Non-toxic and odorless.
- B. Sweet to taste but bitter aftertaste.
- C. Toxic, odorless, colorless, and sweet to taste.**
- D. Toxic, but has a strong odor.

Ethylene glycol is dangerous because it is toxic while being colorless and odorless, and it tastes sweet. This combination makes ingestion easy to miss, so the statement that it is toxic, odorless, colorless, and sweet to taste is the most accurate description. Other options fail because they either imply non-toxicity, mention an odor that isn't present, or omit one of the key traits (toxicity, odorless/colorless nature, or sweetness).

8. What are the key components of brain optimization in delirium treatment?

- A. Environmental noise without sleep change
- B. Prolonged bed rest to conserve energy
- C. Normal sleep cycle, adequate oxygenation, hydration, nutrition, familiar faces, pain treatment, and mobility**
- D. Aggressive sedation to improve wakefulness

Delirium brain optimization hinges on supporting brain function with a broad, nonpharmacologic approach that covers sleep, perfusion, hydration, nutrition, orientation, comfort, and mobility. Keeping a normal sleep-wake cycle helps reset the brain's circadian rhythms and reduces confusion. Adequate oxygenation ensures the brain receives the oxygen it needs for metabolic activity and recovery from insults. Hydration and good nutrition prevent electrolyte imbalances and energy deficits that can worsen cognitive function. Familiar faces and a consistent, reassuring environment reduce disorientation and agitation, making it easier for the patient to stay oriented. Effective pain management minimizes distress and agitation that can trigger or worsen delirium. Encouraging mobility supports cerebral and systemic circulation, preserves muscle and functional status, and decreases delirium duration. Options that focus on noise reduction alone miss sleep optimization; prolonged bed rest without movement can worsen delirium risk and functional decline; and aggressive sedation to improve wakefulness often worsens delirium and delays recovery.

9. What is the antidote for benzodiazepine overdose?

- A. N-acetylcysteine (Mucomyst)
- B. Flumazenil (Romazicon)**
- C. Naloxone (Narcan)
- D. Activated charcoal

The important idea is that reversing a benzodiazepine overdose requires a specific antagonist that blocks the drug's action at the GABA-A receptor. Flumazenil binds to the benzodiazepine binding site and competes with benzodiazepines, effectively restoring normal GABA signaling and rapidly reversing the sedation and CNS depression caused by the overdose. It's given IV and titrated to the patient's response, because the duration of its action can be shorter than that of many benzodiazepines. This means the patient can become sedated again as the antidote wears off, so careful monitoring is essential and redosing may be needed. Use is cautious in people who are benzodiazepine dependent or have seizure disorders, since reversing benzodiazepines suddenly can precipitate withdrawal seizures or withdrawal-related complications. It's also not appropriate for overdoses from other depressants like barbiturates, alcohol, or opioids, and in mixed overdoses it may complicate management. The other options listed do not reverse benzodiazepine effects: one is used for acetaminophen overdose, another for opioid overdose, and another is a bowel decontaminant/absorbent rather than a true antidote.

10. Which of the following can cause intestinal infarction?

- A. Arteriosclerosis
- B. Thrombi/emboli
- C. Strangulated intestine
- D. All of the above**

Intestinal infarction happens when blood flow to a segment of bowel is disrupted long enough to cause tissue death. Arteriosclerosis narrows the mesenteric arteries, reducing baseline perfusion and making the bowel more susceptible to ischemia. A thrombus or embolus can acutely block a mesenteric vessel, abruptly stopping blood supply to a portion of the intestine. A strangulated intestine—from a hernia, volvulus, or torsion—cuts off both arterial inflow and venous outflow, leading to rapid ischemia and infarction. Because each mechanism can terminate perfusion to bowel tissue, all of these can cause intestinal infarction.

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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:

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

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