ADVANCED TRAUMA CARE FOR NURSES (ATCN) PRACTICE EXAM (SAMPLE)

STUDY GUIDE

SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

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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

1. **After a primary survey, the stable patient who fell from a height and has bilateral calcaneal fractures should receive imaging of which spinal regions?**

   A. Spine radiographs including cervical, thoracic, lumbar, and sacral vertebra

   B. Only cervical spine X-ray

   C. MRI of spine

   D. No imaging initially

2. **Which symptom is a classic sign of compartment syndrome, indicating high severity?**

   A. Pain out of proportion to the injury

   B. Swelling

   C. Nausea

   D. Dizziness

3. **In the adult Rule of Nines, what percentage is attributed to one arm (including both anterior and posterior surfaces)?**

   A. 4.5%

   B. 7%

   C. 9%

   D. 18%

4. **After applying a pelvic binder, what is the recommended next step in management?**

   A. Reevaluate with imaging and plan for definitive stabilization; remove only under guidance

   B. Remove binder immediately

   C. Leave binder in place without reassessment

   D. Replace with a larger binder

5. **What is the purpose of a pelvic binder in traumatic pelvic fracture, and when should it be reassessed?**

   A. To decrease pelvic volume and control pelvic hemorrhage; reevaluate with imaging and plan for definitive stabilization; remove only under guidance

   B. To immobilize the leg

   C. To limit chest movement

   D. To secure the head

6. To select an appropriate C-collar size, measurement is taken from the bottom of the chin to the top of which landmark?

A. Shoulder

B. Ear

C. Nose

D. Clavicle

7. Which lab pattern suggests ongoing intra-abdominal bleeding?

A. Increasing hematocrit and decreasing lactate

B. Decreasing hematocrit and rising lactate

C. Normal hematocrit and normal lactate

D. Decreased lactate with increased perfusion

8. During the primary survey, which component focuses on preventing hypothermia and exposing the patient safely?

A. Airway management

B. Exposure and environmental control

C. Breathing

D. Circulation

9. Urine output and hypovolemic shock: What is the target urine output for infants (babies)?

A. 2 ml/kg/hr

B. 1 ml/kg/hr

C. 0.5 ml/kg/hr

D. 3 ml/kg/hr

10. In distinguishing tension pneumothorax from cardiac tamponade, what assessment finding is paramount?

A. Blood pressure measurement

B. Jugular venous distention

C. Breath sounds assessment

D. Cardiac auscultation

Answers

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

Explanations

1. After a primary survey, the stable patient who fell from a height and has bilateral calcaneal fractures should receive imaging of which spinal regions?

A. Spine radiographs including cervical, thoracic, lumbar, and sacral vertebra

B. Only cervical spine X-ray

C. MRI of spine

D. No imaging initially

A high-energy fall with bilateral calcaneal fractures signals a significant axial load through the spine, so injuries can be present at multiple levels. In the secondary survey of a stable trauma patient, the safest approach is to image the entire spine—cervical, thoracic, lumbar, and sacral—to avoid missing a fracture that could alter management or transfer decisions. Cervical imaging alone could miss thoracic, lumbar, or sacral injuries, and while MRI can reveal soft-tissue or cord concerns, it's not the first-line screen for acute bony injuries. No imaging would risk overlooking a potentially unstable spinal fracture.

2. Which symptom is a classic sign of compartment syndrome, indicating high severity?

A. Pain out of proportion to the injury

B. Swelling

C. Nausea

D. Dizziness

The situation involves a limb-threatening rise in pressure within a closed muscle compartment that reduces tissue perfusion and risks ischemia. The clearest, earliest warning that the injury has become severely compromised is pain that is out of proportion to the exam, especially pain that worsens with passive stretching of the affected muscles. This intense, disproportionate pain reflects neural and muscular ischemia from the high compartment pressure and signals escalating severity even before other signs appear. Swelling can occur but is non-specific and not by itself a reliable indicator of severity. Nausea or dizziness aren't typical signs of compartment syndrome and don't indicate the same urgent ischemic process. If suspected, prompt evaluation and pressure assessment, and surgical consultation for fasciotomy, are essential to prevent irreversible damage.

3. In the adult Rule of Nines, what percentage is attributed to one arm (including both anterior and posterior surfaces)?

A. 4.5%

B. 7%

C. 9%

D. 18%

Estimating burn size quickly relies on the Rule of Nines, which assigns percentages to large body regions to approximate total body surface area. An arm, counting both anterior and posterior surfaces, accounts for nine percent because each surface is 4.5% (front 4.5% plus back 4.5%), totaling 9% for the entire arm. This quick breakdown helps guide fluid resuscitation and initial management. For reference, the head is 9%, each leg is 18%, the trunk is 18% anterior and 18% posterior (together 36%), and the perineum is 1%. In children, proportions differ, so pediatric methods like Lund and Brower are used for more accuracy.

4. After applying a pelvic binder, what is the recommended next step in management?

A. Reevaluate with imaging and plan for definitive stabilization; remove only under guidance

B. Remove binder immediately

C. Leave binder in place without reassessment

D. Replace with a larger binder

The main idea is that a pelvic binder is a temporary measure, and the next step is to rapidly reassess the patient with imaging to guide definitive stabilization. The binder helps reduce pelvic volume and tamponade bleeding, buying time, but it is not a final fix. After application, obtain pelvic imaging (such as AP pelvic radiographs and CT if the patient is stable enough) to define the fracture pattern and any associated injuries, then plan definitive stabilization (external fixation, pelvic packing, or ORIF as indicated) and arrange the appropriate interventions. The binder stays in place until definitive stabilization is secured or removal is guided by the surgical team; removing it immediately could lead to renewed bleeding and instability. Keeping the binder without reassessment risks missing injuries that would change management. Replacing with a larger binder does not constitute definitive care and delays proper stabilization.

5. What is the purpose of a pelvic binder in traumatic pelvic fracture, and when should it be reassessed?

A. To decrease pelvic volume and control pelvic hemorrhage; reevaluate with imaging and plan for definitive stabilization; remove only under guidance

B. To immobilize the leg

C. To limit chest movement

D. To secure the head

The purpose of a pelvic binder is to compress the pelvis to decrease pelvic volume and help tamponade bleeding from a pelvic fracture, providing temporary stabilization to support resuscitation while definitive care is arranged. This reduction in space helps limit venous bleeding and reduces pelvic motion that can worsen hemorrhage. Reassessment should occur after initial stabilization and imaging. Once the patient has been resuscitated and pelvic imaging (X-ray or CT) has been reviewed, plan definitive stabilization such as external fixation for the pelvic ring or angiographic embolization for arterial bleeding. The binder is a temporary measure and should be removed only under guidance from the trauma team or surgical team, typically once definitive stabilization is in place or bleeding is controlled, with ongoing assessment for skin integrity and limb perfusion.

6. To select an appropriate C-collar size, measurement is taken from the bottom of the chin to the top of which landmark?

A. Shoulder

B. Ear

C. Nose

D. Clavicle

Choosing the right cervical-collar size is all about neck length. The measurement is taken from the bottom of the chin to the top of the shoulder to determine how long the collar must be to properly immobilize the cervical spine. This distance ensures the collar extends from under the chin to the upper chest area, providing secure stabilization without riding up under the chin or leaving the lower neck exposed. A collar that reaches the top of the shoulder fits the design of standard collars and allows for proper alignment and fixation during immobilization, transfer, and imaging. Landmarks like the ear or nose don't reflect how far down the neck needs to extend, and measuring to the clavicle can misjudge the necessary length for effective immobilization.

7. Which lab pattern suggests ongoing intra-abdominal bleeding?

A. Increasing hematocrit and decreasing lactate

B. Decreasing hematocrit and rising lactate

C. Normal hematocrit and normal lactate

D. Decreased lactate with increased perfusion

Intra-abdominal bleeding that is still ongoing tends to show a fall in hematocrit along with a rise in lactate. The hematocrit drop reflects blood loss, but it often lags behind the actual bleed because early bleeding can be compensated and fluids can dilute blood. Lactate increases when tissues don't receive enough oxygen due to reduced perfusion, signaling ongoing hypoperfusion from active bleeding. Together, these trends point to continued hemorrhage with shock, guiding urgent escalation of care. If hematocrit were rising, that would argue against active ongoing bleed. Normal hematocrit and lactate don't indicate active bleeding either, and a decreasing lactate with better perfusion would suggest improving perfusion rather than ongoing hemorrhage.

8. During the primary survey, which component focuses on preventing hypothermia and exposing the patient safely?

A. Airway management

B. Exposure and environmental control

C. Breathing

D. Circulation

Exposure and environmental control is the part of the primary survey that focuses on safely exposing the patient to inspect for injuries while actively preventing heat loss. After you briefly uncover the patient to perform a rapid head-to-toe assessment, you must protect against hypothermia by using warming blankets, warmed IV fluids, and keeping the environment warm. Hypothermia worsens coagulopathy and shock, so maintaining body temperature is central to this step. In contrast, airway management, breathing, and circulation address airway patency and ventilation, oxygenation, and bleeding/perfusion, respectively, while disability assesses neurologic status.

9. Urine output and hypovolemic shock: What is the target urine output for infants (babies)?

A. 2 ml/kg/hr

B. 1 ml/kg/hr

C. 0.5 ml/kg/hr

D. 3 ml/kg/hr

In hypovolemic shock, watching urine output helps gauge how well renal perfusion and overall circulation are being maintained. For infants, the target is about 2 mL/kg per hour. This higher rate reflects their greater relative need for renal perfusion to support glomerular filtration and fluid balance as they resuscitate. Why this fits best: 2 mL/kg/hr provides a practical, age-appropriate goal that signals adequate perfusion without assuming fluid overload. It translates to roughly 10 mL/hour for a 5 kg infant, which aligns with maintaining kidney function during shock resuscitation. Why the other options aren't preferred here: 0.5 mL/kg/hr is a lower benchmark more typical of adults and would underrepresent an infant's needs, risking undetected oliguria and worsening renal injury. 1 mL/kg/hr is a common pediatric target but is on the low side for infants, who usually require closer to 2 mL/kg/hr. 3 mL/kg/hr could push toward fluid overload in tiny patients and isn't the standard target in infant resuscitation. Remember to use urine output alongside other perfusion indicators (heart rate, cap refill, mental status, lactate) to guide fluid resuscitation.

10. In distinguishing tension pneumothorax from cardiac tamponade, what assessment finding is paramount?

A. Blood pressure measurement

B. Jugular venous distention

C. Breath sounds assessment

D. Cardiac auscultation

Breath sounds on the injured side provide the quickest, most reliable clue when distinguishing tension pneumothorax from cardiac tamponade in an unstable patient. In a tension pneumothorax, air has trapped under pressure and the affected lung collapses, so auscultation reveals absent or markedly diminished breath sounds on that side (often with hyperresonance on percussion and possible tracheal deviation). In cardiac tamponade, the lungs themselves are not collapsed; breath sounds are typically present and equal because the primary problem is fluid around the heart, not air in the pleural space. This distinction matters because it directs urgent treatment. Diminished or absent breath sounds consistent with a tension pneumothorax calls for immediate decompression with needle thoracostomy followed by chest tube placement. If breath sounds are normal and other signs point to impaired cardiac filling, tamponade becomes the leading consideration, guiding pericardiocentesis and hemodynamic management. While signs like hypotension and neck vein findings can appear in both, the presence or absence of breath sounds most directly reflects pleural system involvement and drives the rapid, life-saving intervention.

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://atcn.examzify.com

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