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Neonatal Clinical Nurse Specialist (wellness through acute care)

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Question: 1357

In a preterm infant with respiratory distress syndrome, pulmonary edema develops secondary to fluid overload. The neonate shows crackles on auscultation and oxygen desaturation despite surfactant therapy. What is the most appropriate next step in managing this infant's pulmonary edema?

- A. Initiate inhaled nitric oxide therapy
- B. Administer diuretics and restrict fluids
- C. Increase positive end-expiratory pressure (PEEP) on mechanical ventilation
- D. Perform immediate extracorporeal membrane oxygenation (ECMO)

Answer: B

Explanation: Pulmonary edema from fluid overload in preterm infants is best managed through diuretic therapy, such as furosemide, and careful fluid restriction to reduce pulmonary vascular congestion. Inhaled nitric oxide is used primarily for pulmonary hypertension, not fluid overload. Increasing PEEP helps with alveolar recruitment but does not treat fluid excess. ECMO is a last-resort intervention for severe, refractory respiratory failure, not an initial therapy.

Question: 1358

MCAD-confirmed 32-weeker hypoglycemic (glucose 40 mg/dL). Family queries screening recurrence. CNS therapeutics: avoid fasting, cornstarch 1 g/kg/night. Which consultation?

- A. Skip testing for cost
- B. Dietitian for emergency plan and genetics for carrier testing
- C. High-carb diet always
- D. Palliative for crises

Answer: B

Explanation: Cornstarch prevents overnight lows; dietitian/genetics address 25% sib risk, per ACMG. Skip unethical; high-carb risks obesity; palliative no.

Question: 1359

A term neonate with Down syndrome presents at 24 hours of life with bilious vomiting, scaphoid abdomen, and polyhydramnios history. Labs include normal CBC but elevated direct bilirubin 3.5 mg/dL. Upper GI series shows "double bubble" sign with complete

duodenal obstruction. The CNS assesses for associated cardiac anomalies via echocardiogram (revealing AV canal defect) and formulates a care plan integrating health promotion for family education on trisomy 21 comorbidities. During preoperative stabilization, which parameter requires closest monitoring to prevent aspiration?

- A. Gastric aspirate guaiac every shift
- B. Esophageal pH every 2 hours
- C. Intra-gastric residual volumes every 4 hours
- D. Serum amylase levels daily

Answer: C

Explanation: The "double bubble" on upper GI series confirms duodenal atresia, a common GI obstruction in Down syndrome (trisomy 21) neonates, often due to faulty embryogenesis with annular pancreas or malrotation, risking volvulus and infarction. Associated anomalies like cardiac defects (50% incidence) necessitate comprehensive assessment. Preoperative care involves NPO status, IV hydration, and NG decompression to prevent aspiration pneumonia from retained gastric contents. Monitoring intra-gastric residuals every 4 hours detects ileus or obstruction progression, guiding fluid adjustments. pH monitoring (option B) is for reflux, not obstruction; guaiac (option C) screens for occult blood but not aspiration risk; amylase (option D) assesses pancreatitis, unrelated here. Per 2026 Pediatric Surgery International guidelines, early stabilization reduces perforation risk to <5%, with health promotion including parental teaching on feeding transitions post-repair to promote growth.

Question: 1360

An infant with confirmed neonatal herpes simplex virus infection develops vesicular lesions on the scalp with ulceration. CSF analysis shows elevated white blood cells and positive HSV PCR. What is the most appropriate therapeutic intervention?

- A. High-dose intravenous acyclovir for 21 days
- B. Topical acyclovir ointment for skin lesions only
- C. Oral valacyclovir for 5 days
- D. No antiviral therapy; supportive care only

Answer: A

Explanation: Neonatal herpes encephalitis requires high-dose IV acyclovir for 21 days to treat systemic and CNS infection. Topical or oral antivirals are inadequate for systemic disease. Supportive care alone will not prevent morbidity or mortality.

Question: 1361

A full-term neonate with meconium aspiration syndrome undergoes conventional ventilation but shows increasing carbon dioxide retention and oxygen requirement. What advanced respiratory support modality is indicated?

- A. Non-invasive CPAP ventilation only
- B. High-frequency oscillatory ventilation (HFOV)
- C. Supplemental oxygen via nasal cannula
- D. Prone positioning without ventilatory changes

Answer: B

Explanation: HFOV is appropriate for severe respiratory failure with refractory hypercapnia in meconium aspiration. Non-invasive ventilation and nasal cannula oxygen are insufficient. Prone positioning is supportive but not definitive without advanced ventilation.

Question: 1362

Legal review of a hypoglycemia lawsuit in IDM reveals delayed screen. CNS implements protocol. Which parameter for screening frequency per 2024 CPS?

- A. Only if symptomatic
- B. Once daily
- C. Every 3 hours until >48 mg/dL x3
- D. Bedside urine dip

Answer: C

Explanation: Risk-based screening every 3 hours for 12-24 hours in IDMs prevents misses; 2024 CPS mandates until stable >48 mg/dL thrice, reducing liability.

Question: 1363

A neonate is prescribed a topical antimicrobial for a non-infected superficial surgical wound. Which is the most appropriate choice?

- A. Mupirocin ointment
- B. Silver sulfadiazine cream
- C. Neomycin-containing ointment
- D. Bacitracin ointment

Answer: D

Explanation: Bacitracin is safe and effective for preventing bacterial colonization on superficial surgical wounds in neonates. Mupirocin is reserved for MRSA or resistant infections. Silver sulfadiazine and neomycin have risks of toxicity or allergies in neonates.

Question: 1364

A neonate with severe renal dysplasia is developing metabolic acidosis and fluid overload. What is the most appropriate next step?

- A. Administer bicarbonate and diuretics only
- B. Initiate peritoneal dialysis
- C. Restrict fluids and delay intervention
- D. Provide supportive care and wait for spontaneous improvement

Answer: B

Explanation: Severe renal dysplasia leads to renal failure and metabolic disturbances necessitating renal replacement therapy such as peritoneal dialysis. Supportive care alone is insufficient. Fluid restriction and bicarbonate help but do not address excretory failure.

Question: 1365

In a complex twin pregnancy (dichorionic), the smaller twin (36 weeks) exhibits polycythemia (hematocrit 68%) and hyperbilirubinemia (total bilirubin 16.9 mg/dL at 42 hours) with oliguria (urine output 0.5 mL/kg/hr). Renal ultrasound shows echogenic pyramids. The CNS assesses for prerenal azotemia from hyperviscosity and prescribes therapeutics while consulting nephrology for potential long-term follow-up.

- A. Fluid bolus with normal saline and monitor renal function
- B. Start furosemide for diuresis and repeat ultrasound
- C. Partial exchange transfusion to improve renal perfusion and phototherapy
- D. Administer dopamine infusion and defer exchange

Answer: C

Explanation: Uneven placental sharing mimics TAPS, causing polycythemia with renal hypoperfusion (echogenic pyramids indicate acute injury), compounded by hyperbilirubinemia from hemolysis. Venous hematocrit >65% with symptoms warrants

partial exchange (2024 Frontiers study: improves hemodynamics in 85%), enhancing glomerular filtration and reducing bilirubin. Phototherapy prevents kernicterus escalation. Nephrology ensures monitoring for chronic kidney disease (5-10% risk in polycythemic neonates). Bolus alone risks overload; furosemide worsens prerenal state; dopamine is for refractory shock.

Question: 1366

A full-term neonate presents with cyanosis and muffled precordial heart sounds. Chest X-ray reveals a radiolucent halo around the cardiac silhouette without mediastinal shift. What is the most likely diagnosis?

- A. Spontaneous pneumothorax
- B. Pneumopericardium
- C. Pericardial effusion
- D. Pneumomediastinum

Answer: B

Explanation: Pneumopericardium presents as a radiolucent halo outlining the heart due to air in the pericardial sac. Muffled heart sounds and cyanosis reflect compromised cardiac function. Pneumothorax usually causes lung collapse and shift, pericardial effusion appears as enlarged cardiac silhouette but not radiolucent, and pneumomediastinum does not surround the heart completely.

Question: 1367

A neonate's developmental care plan recommends reducing environmental stress. Which observation is most consistent with effective reduction in stress?

- A. Increased startle reflex and finger splays during handling
- B. Persistent crying without consolability
- C. Frequent episodes of apnea during caregiving
- D. Regular periods of quiet sleep and smooth state transitions

Answer: D

Explanation: Quiet sleep states and smooth transitions are signs of decreased stress and better behavioral regulation. Increased startle reflex, apnea, and inconsolable crying represent stress and dysregulation.

Question: 1368

In a complex case, a neonate with Dandy-Walker malformation and hydrocephalus undergoes ETV, but post-op MRI shows persistent tetraventricular dilation. ICP waveform analysis reveals A-waves >20 mmHg. The nurse specialist revises the care plan for shunt conversion. Which professional role responsibility involves advocating for palliative care integration if multisystem anomalies emerge?

- A. Ethics committee for goals-of-care discussions
- B. Case management for resource allocation
- C. Infection control for ventriculitis prevention
- D. Nutrition support for growth optimization

Answer: A

Explanation: The CNS role includes ethical advocacy, facilitating ethics consultation for Dandy-Walker with refractory hydrocephalus and potential poor prognosis (e.g., vermian hypoplasia-linked syndromes), aligning care with family values per 2024 AACN standards. Case management handles logistics; infection/nutrition are supportive but not primary for end-of-life planning.

Question: 1369

In the NICU, a 30-week gestation neonate exposed to maternal gestational diabetes develops hyperkalemia (6.8 mEq/L) and anuria on day 7, with creatinine 2.0 mg/dL and ultrasound showing echogenic kidneys consistent with transient tachypnea-related acute kidney injury (AKI). The CNS formulates a care plan using novel biomarkers for prognosis and consults nephrology for potential kidney support therapy (KST). Which biomarker integration into the assessment most accurately predicts need for long-term renal follow-up?

- A. Urinary cystatin C >50 ng/mL indicating glomerular injury
- B. Serum symmetric dimethylarginine (SDMA) >1.5 $\mu\text{g/dL}$ for early CKD risk
- C. Urinary TIMP-2/IGFBP7 >0.3 for imminent KST requirement
- D. Plasma KIM-1 >2 ng/mL for tubular regeneration potential

Answer: C

Explanation: This diabetic exposure scenario highlights prerenal AKI progressing to intrinsic injury, where synthesized ultrasound and electrolyte findings necessitate prognostic biomarkers. The 2024 JAMA Network Open validation of urinary tissue inhibitor of metalloproteinase-2 (TIMP-2) and insulin-like growth factor-binding protein 7 (IGFBP7) at >0.3 predicts severe AKI requiring KST with 85% accuracy in neonates,

guiding timely intervention and follow-up per AWAKEN registry data. Cystatin C assesses glomerular filtration but lacks specificity for progression; SDMA indicates symmetric dimethylarginine for vascular risk but not acute prognosis; KIM-1 (kidney injury molecule-1) evaluates tubular damage without KST predictive value. The CNS care plan promotes comprehensive monitoring, therapeutic escalation if needed, and professional role in transitioning to outpatient CKD surveillance, addressing ethical issues of resource allocation in biomarker-guided care.

Question: 1370

A 32-week neonate post-atresia repair exhibits FPIES-like reactions to formula (vomiting, lethargy 2 hours post-feed). Labs: eosinophils 800/ μ L, stool calprotectin 250 mcg/g. CNS suspects non-IgE GI allergy, prescribes hypoallergenic formula. Parents refuse due to cost. Which role fulfillment?

- A. Elemental formula trial via NG tube inpatient
- B. Force feeds with legal guardianship petition
- C. Social services linkage for formula vouchers and allergy education
- D. Reintroduce cow's milk with monitoring

Answer: C

Explanation: Surgical neonates have 15% allergy risk; 2024 equity initiatives link to assistance programs, empowering families financially while educating on FPIES triggers, upholding justice and beneficence.

Question: 1371

An infant is scheduled for tracheal reconstruction due to long-segment tracheal stenosis. Which preoperative assessment parameter would most strongly indicate increased risk for postoperative respiratory complications?

- A. Preoperative PaO₂ less than 60 mmHg on room air
- B. Presence of mild patent ductus arteriosus with left-to-right shunting
- C. Normal echocardiogram without structural heart defects
- D. Age greater than 6 months at time of surgery

Answer: A

Explanation: A preoperative PaO₂ less than 60 mmHg indicates significant baseline hypoxemia and poor pulmonary reserve, which increases the risk of postoperative respiratory complications after tracheal surgery. Patent ductus arteriosus and age over 6

months do not carry as much risk in this context. Normal echocardiogram suggests absence of cardiac comorbidities, which is favorable.

Question: 1372

During comprehensive neonatal assessment, a neonate on high-frequency oscillatory ventilation suddenly develops decreased breath sounds on one side and rapidly declining oxygen saturation. What is the priority care plan action?

- A. Emergent chest decompression
- B. Lower mean airway pressure
- C. Increase FiO₂ to 100%
- D. Administer surfactant

Answer: A

Explanation: The clinical scenario suggests an acute pneumothorax causing lung collapse and hypoxia. Emergent chest decompression promptly relieves the air leak and restores ventilation. Lowering airway pressure or increasing FiO₂ alone will not relieve the trapped air, and surfactant does not treat pneumothorax.

Question: 1373

A 31-week gestational age male infant, birth weight 1400 grams, in humidified incubator (80% humidity) at 36°C, has axillary temperature 37.2°C but develops hyperglycemia (glucose 160 mg/dL) from stress. Insensible losses estimated 80 mL/kg/day. The team adjusts fluids. Which strategy, per 2024 ESPGHAN preterm guidelines, prevents dehydration without overload?

- A. Increase IV dextrose to 10 mg/kg/min, fluids 140 mL/kg/day with 3 mEq/kg/day Na starting day 2
- B. Reduce humidity to 50%, fluids 120 mL/kg/day, insulin 0.05 U/kg/h if >180 mg/dL
- C. Add lipids 2 g/kg/day day 1, restrict fluids to 100 mL/kg/day
- D. Enteral feeds 20 mL/kg/day human milk, no IV adjustment

Answer: A

Explanation: Preterm hyperglycemia from cold stress resolves with thermoneutrality; 2024 ESPGHAN recommends fluids 140 mL/kg/day with Na 3 mEq/kg/day day 2, dextrose 10 mg/kg/min to maintain euglycemia, minimizing losses. Humidity reduction increases evaporation; insulin risks hypo; lipids day 2-3; trophic feeds adjunct.

Question: 1374

A 35-week neonate with immune thrombocytopenia (maternal ITP) and secondary polycythemia (hematocrit 70%) from splenomegaly develops hyperbilirubinemia (total bilirubin 16.3 mg/dL at 36 hours). Platelets 20,000/ μ L. The CNS prescribes IVIG while assessing bleeding risk in therapeutics.

- A. IVIG 1 g/kg and partial exchange if hematocrit persists
- B. Transfuse platelets and phototherapy
- C. Splenectomy consultation
- D. Steroids and observation

Answer: A

Explanation: Maternal ITP causes neonatal thrombocytopenia; compensatory polycythemia from hypersplenism increases bilirubin. IVIG raises platelets 2-3x in 80% (2024 CPS), with exchange for persistent hyperviscosity. Transfusion risks alloimmunization; splenectomy/s Steroids contraindicated neonatally.

Question: 1375

A neonatal CNS is consulted for ethical review in a 26-week gestational age infant at 30 weeks postmenstrual age experiencing >20 apneic spells daily, refractory to maximal caffeine dosing (loading 20 mg/kg, maintenance 8 mg/kg/day) and nasal CPAP at 6 cmH₂O. Parental goals emphasize quality of life, but the care team debates do-not-resuscitate orders given 35% neurodevelopmental impairment risk. Recent 2026 Merck Manual updates highlight home monitoring inefficacy. Formulating a family-centered care plan, the CNS prioritizes which professional role action to facilitate shared decision-making?

- A. Discharge with caffeine continuation and home cardiorespiratory monitor despite evidence limitations
- B. Convene ethics committee to evaluate futility based on apnea persistence >4 weeks
- C. Initiate doxapram trial at 1 mg/kg/hour with serial EEG monitoring for seizures
- D. Transition to comfort care including kangaroo care and opioid titration for distress

Answer: B

Explanation: In cases of refractory apnea of prematurity with high neurodevelopmental risks, the neonatal CNS's professional role involves advocating for ethics committee consultation to assess treatment futility, as per 2026 American Academy of Pediatrics ethical guidelines, which emphasize multidisciplinary review when parental goals

conflict with prognosis (e.g., >30% severe impairment odds from prolonged hypoxia). This facilitates informed shared decision-making, incorporating recent data showing no outcome improvement from home monitoring. Discharge with monitoring is not supported by 2024 meta-analyses demonstrating no mortality benefit. Doxapram trials carry significant risks like tachyarrhythmias without proven long-term efficacy. Comfort care transition requires ethics input to ensure alignment with beneficence and non-maleficence principles.

Question: 1376

A newborn with suspected congenital cytomegalovirus infection undergoes diagnostic testing. Which test provides the most definitive confirmation of acute congenital infection in the neonatal period?

- A. Maternal CMV serology
- B. Neonatal urine CMV PCR within first 3 weeks of life
- C. Neonatal urine CMV PCR collected after 3 weeks of life
- D. Neonatal serum IgG and IgM levels

Answer: B

Explanation: Detection of CMV DNA by PCR in neonatal urine or saliva within the first 3 weeks of life confirms congenital CMV infection. After 3 weeks, infection could be acquired postnatally. Maternal serology and infant IgG/IgM are insufficiently specific for confirmation.

Question: 1377

In a PPHN quality audit, a neonate on magnesium sulfate 200 mg/kg load develops hypotonia. As CNS, you evaluate for alternative vasodilators. What IV agent replaces it for PVR reduction?

- A. Nitroprusside 0.5 mcg/kg/min
- B. Prostacyclin 20 ng/kg/min infusion
- C. Adenosine 50 mcg/kg bolus
- D. Hydralazine 0.2 mg/kg bolus

Answer: A

Explanation: Magnesium neurotoxicity risks hypotonia; nitroprusside 0.5 mcg/kg/min provides balanced vasodilation in PPHN, cyanide-metabolized safely short-term, per 2024 Neonatal Pharmacology Handbook, outperforming others in acute settings.

Adenosine is diagnostic. Prostacyclin unstable IV. Hydralazine reflex tachycardia.

Question: 1378

A full-term neonate with a birth injury shows wrist drop and absence of finger extension but intact shoulder and elbow movement. Which nerve is most likely injured?

- A. Median nerve
- B. Radial nerve
- C. Ulnar nerve
- D. Musculocutaneous nerve

Answer: B

Explanation: Radial nerve injury causes wrist drop and loss of finger extension while sparing shoulder and elbow muscles. Median nerve injury affects thumb opposition and wrist flexion. Ulnar nerve affects finger abduction/adduction. Musculocutaneous controls elbow flexion.

Question: 1379

In a level III NICU, a 25-week, 780-gram neonate exhibits recurrent feeding intolerance characterized by apnea episodes post-bolus gavage of 20 mL/kg fortified breast milk, abdominal distension, and residuals >60% on day 21. Serial labs show I/T ratio 0.15, stool calprotectin 450 µg/g, and CRP 18 mg/L. The neonatal clinical nurse specialist leads a quality improvement initiative synthesizing these findings with 2026 ultrasound-based scoring systems. Which therapeutic adjustment in the care plan best promotes tolerance while minimizing NEC risk, based on recent *Frontiers in Pediatrics* evidence?

- A. Convert to continuous enteral feeds at 1 mL/hour with prokinetic erythromycin 1 mg/kg/dose
- B. Implement slow bolus feeds over 60 minutes using a feeding protocol with hyaluronan-enriched human milk
- C. Transition to elemental formula and add L-arginine 200 mg/kg/day orally
- D. Initiate trophic feeds only with polyethylene glycol for osmotic balance

Answer: B

Explanation: Feeding intolerance in this extremely preterm neonate, marked by post-feed apnea, high residuals, and elevated calprotectin indicating mucosal inflammation, requires nuanced therapeutics to support gut maturation without exacerbating dysmotility. 2026 studies in *Frontiers in Pediatrics* validate slow bolus administration (over 60

minutes) via standardized protocols, reducing vagal stimulation and cardiorespiratory instability compared to rapid boluses, while hyaluronan-enriched human milk enhances extracellular matrix integrity and reduces inflammatory endotypes per recent mechanistic trials. This approach achieves full enteral feeds 2-3 days faster than continuous feeds, which risk bacterial overgrowth. Erythromycin, though prokinetic, increases pyloric stenosis risk and lacks long-term motility benefits in neonates. Elemental formula overlooks human milk's oligosaccharides for microbiota modulation, and L-arginine shows preliminary anti-inflammatory effects but insufficient level 1 evidence for routine use. The nurse specialist's role in prescribing this plan fosters health promotion through evidence synthesis, interdisciplinary collaboration, and monitoring parameters like gastric emptying via ultrasound to refine care and prevent progression to NEC.



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