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Question: 1458

An intubated ICU patient at high risk for stress ulcer (coagulopathy, high-dose steroids) requires prophylaxis. Which agent is first-line per current guidelines?

- A. Pantoprazole 40 mg IV daily
- B. Famotidine 20 mg IV BID
- C. Sucralfate 1 g QID
- D. No prophylaxis needed

Answer: A

Explanation: Proton pump inhibitors like pantoprazole are preferred for stress ulcer prophylaxis in high-risk critically ill patients (mechanical ventilation >48h, coagulopathy) due to superior acid suppression over H2RAs. Discontinue when risk resolves to avoid C. diff and pneumonia.

Question: 1459

A post-evacuation review identifies gaps in patient tracking. What integrated procedure improves future disaster movement and protection?

- A. Use digital tags or wristbands with barcodes
- B. Verbal handoffs only between teams
- C. Centralized command without patient-specific documentation
- D. Rely on paper triage tags discarded after initial sorting

Answer: A

Explanation: Robust tracking systems with unique identifiers ensure continuity of care, accurate resource allocation, and accountability during complex patient movement in mass casualty events.

Question: 1460

A 55-year-old post-cardiac arrest patient has BNP 850 pg/mL, troponin T 0.8 ng/mL, and hemoglobin 9.1 g/dL with stable vital signs on vasopressors. Echocardiogram shows reduced ejection fraction. What clinical action should be anticipated next based on these cardiac markers and CBC?

- A. Initiate beta-blocker therapy for rate control
- B. Immediate diuresis with furosemide to reduce preload
- C. Fluid challenge with 500 mL crystalloid despite elevated BNP
- D. Transfuse packed red blood cells to hemoglobin >10 g/dL

Answer: D

Explanation: The elevated BNP and troponin indicate heart failure with possible myocardial injury post-arrest, where anemia (Hb 9.1 g/dL) can worsen myocardial oxygen supply-demand mismatch. In this context, cautious transfusion to improve hemoglobin optimizes oxygen delivery to the myocardium, particularly with reduced EF and vasopressor dependence. Diuresis risks hypotension, and fluid challenge is contraindicated with high BNP; beta-blockers may not be priority without tachyarrhythmia. This integrates lab data for anticipatory hemodynamic optimization in critical care.

Question: 1461

The water seal chamber shows absent tidaling and no output in a patient with known pleural effusion. The tubing has visible fluid loops. What is the primary troubleshooting step?

- A. Elevate the drainage unit above chest level temporarily
- B. Add more sterile water to the suction control chamber
- C. Milk the tubing vigorously toward the collection chamber
- D. Straighten all tubing, and ensure unit is below chest level

Answer: D

Explanation: Dependent loops create a water trap impeding drainage and tidaling. Proper positioning below chest level with straight tubing restores gravity-assisted function and accurate monitoring. Milking is controversial and not first-line.

Question: 1462

Hospital policy review emphasizes hand hygiene compliance. In the context of sepsis prevention, which measure has the greatest impact on reducing healthcare-associated infections?

- A. Alcohol-based hand rub or soap-and-water handwashing
- B. Use of antimicrobial soap exclusively
- C. Scheduled environmental cleaning once per shift
- D. Glove use without prior hand hygiene

Answer: A

Explanation: Consistent hand hygiene remains the single most effective intervention for preventing transmission of pathogens and reducing HAIs, including those leading to sepsis in vulnerable ICU patients.

Question: 1463

A patient with impending respiratory failure from laryngeal edema is on noninvasive support and still has marked work of breathing. You plan to initiate heliox. Which choice best reflects why heliox may help?

- A. Heliox provides nitric oxide–mediated pulmonary vasodilation for V/Q mismatch
- B. Heliox primarily increases alveolar oxygen diffusion, eliminating the need for FiO_2
- C. Helium directly increases hemoglobin saturation and corrects hypoxemia
- D. Helium reduces gas density, lowering resistance and improving flow in narrowed airways

Answer: D

Explanation: Heliox benefits come from reduced density, which lowers resistance and can improve flow dynamics in upper airway obstruction. It does not increase hemoglobin saturation directly, does not provide nitric oxide effects, and does not replace oxygenation requirements. Heliox does not “eliminate the need for FiO_2 ” because oxygen must still be provided; the fraction of oxygen in the mixture is chosen based on needed oxygenation.

Question: 1464

A 66-year-old postoperative patient was paralyzed with rocuronium and will be reversed. Quantitative neuromuscular monitoring shows TOF ratio 0.55 (T1 present). The patient weighs 110 kg. There is no renal failure requiring dialysis, but he has moderate hepatic impairment. Which reversal approach is most appropriate?

- A. Administer neostigmine to reverse fully when TOF ratio is >0.90
- B. Give naloxone to reverse neuromuscular blockade
- C. Administer flumazenil to reverse rocuronium-induced block
- D. Administer sugammadex at a dose appropriate to the degree of block suggested by TOF ratio

Answer: D

Explanation: Sugammadex selectively encapsulates steroidal non-depolarizing agents like rocuronium and vecuronium, enabling rapid reversal. The TOF ratio provides guidance for reversal strategy; at TOF ratios suggesting incomplete recovery, sugammadex dosing depends on the depth of block. Neostigmine is less reliable and requires that some spontaneous recovery is occurring; it is also associated with cholinergic side effects and can precipitate residual block if used at inappropriate depths. Flumazenil and naloxone reverse benzodiazepines and opioids respectively, not neuromuscular blockade.

Question: 1465

During evacuation from a hospital due to flooding, you must move patients using a single stairwell route. You have 6 wheelchairs with brakes and 2 power-assisted gurneys. Patient A: unstable pelvic fracture, SBP 90 after fluids. Patient B: intubated, FiO₂ 0.7, PEEP 10. Patient C: chronic COPD, SpO₂ 88% on room air. Patient D: sedated but stable after intubation. Which ordering best integrates physiologic risk and movement feasibility?

- A. $C \rightarrow A \rightarrow B \rightarrow D$ because mobility determines survival more than physiology
- B. $A \rightarrow C \rightarrow D \rightarrow B$ because pelvic fracture and room air hypoxemia are more dangerous than high ventilator settings
- C. $B \rightarrow D \rightarrow A \rightarrow C$ because ventilatory failure risk and airway security dominate
- D. $D \rightarrow B \rightarrow C \rightarrow A$ because stable sedation should always precede unstable patients

Answer: C

Explanation: High FiO₂/PEEP intubated patients are at greater risk of rapid desaturation if ventilation support is disrupted during stair movement. Next are intubated but less extreme ventilator settings, then patients with hemodynamic instability who need securement to reduce bleeding/sequelae during transport. Chronic hypoxemia can often tolerate delay with supplemental oxygen while higher-acuity movement proceeds.

Question: 1466

A 39-year-old with severe traumatic brain injury is being considered for organ donation after circulatory determination. The patient does not meet brain death criteria. Which statement best describes the ethical and operational approach to donation in this scenario?

- A. Withdrawal of life support can occur based on the patient's goals and medical indication
- B. Donation is ethically acceptable only if the patient consents after withdrawal begins
- C. Donation after circulatory determination requires that brain death be established
- D. Life support must be withdrawn solely to enable organ retrieval

Answer: A

Explanation:

Donation after circulatory determination is ethically distinct from intentionally causing death for organ procurement. The withdrawal decision should be based on appropriate goals-of-care and medical appropriateness, independent of the potential for donation. If donation occurs, it must follow established legal and institutional protocols, including timing, consent processes, and determination criteria. It is not required that brain death be present, and ethically the plan should not depend on consent being obtained only after withdrawal begins.

Question: 1467

A 48-year-old man with fever and hypotension after dental surgery develops urticaria, bronchospasm, and swelling of the lips. He is tachycardic at 140, BP 70/40, RR 30, SpO₂ 82% despite high-flow oxygen. Lactate is 6 mmol/L. After the first dose of intramuscular epinephrine, BP rises to 88/52 but respiratory symptoms persist. What is the most appropriate next step in shock management?

- A. Initiate beta-blocker infusion to blunt tachycardia from catecholamine excess
- B. Administer additional epinephrine promptly and escalate to continuous IV epinephrine while securing the airway as needed
- C. Stop resuscitation and wait for lactate to normalize before giving vasopressors
- D. Give only IV fluids without epinephrine because lactate is high

Answer: B

Explanation: Anaphylactic shock requires immediate epinephrine as first-line therapy, with repeat dosing and escalation to continuous IV infusion if not promptly responding. Persistent bronchospasm and hypotension after initial IM epinephrine indicates ongoing systemic mediator effects and inadequate initial hemodynamic

response. Waiting for lactate normalization risks ongoing shock; fluids alone can be helpful but are not a substitute for epinephrine in anaphylaxis. Beta-blockade can worsen hypotension and block epinephrine's cardiac effects. Early airway and breathing support should be undertaken alongside hemodynamic resuscitation.

Question: 1468

During mechanical ventilation, a patient's endotracheal tube cuff develops a slow, continuous air leak due to a faulty pilot balloon spring valve. What is the safest temporary bedside management step to preserve cuff inflation until definitive evaluation?

- A. Inflate 30 mL of air into the balloon and fold the line over using a rubber band
- B. Replace the endotracheal tube immediately without checking pilot valve integrity
- C. Cut the pilot balloon off completely and insert a blunt 18-gauge needle into the remaining catheter
- D. Apply a stopcock or hemostat clamp to the pilot balloon tubing after inflating to appropriate pressure

Answer: D

Explanation: If a pilot valve fails and leaks air, inserting a three-way stopcock or placing a smooth-jawed hemostat clamp onto the pilot tubing after inflating the cuff to target pressure (20 to 30 cmH₂O) safely seals the air volume in the cuff. This maintains the airway seal and prevents microaspiration without subjecting the patient to an immediate high-risk reintubation.

Question: 1469

A 66-year-old male with severe emphysema ventilated on Pressure Support 12 cmH₂O and PEEP 5 cmH₂O exhibits active contraction of abdominal muscles during exhalation. The clinician attempts an expiratory hold maneuver to measure total PEEP, but the ventilator displays an inaccurate, fluctuating reading. What is the technical cause of this measurement failure?

- A. Expiratory hold maneuvers require continuous positive airway pressure mask interface.
- B. Expiratory hold maneuvers require passive exhalation without patient muscular effort.
- C. Expiratory hold maneuvers can only be performed in pressure control.
- D. Expiratory hold maneuvers require high inspiratory peak flow rate delivery.

Answer: B

Explanation: Accurate measurement of total PEEP (and auto-PEEP) via an end-expiratory pause maneuver requires complete patient relaxation and passive exhalation. Active contraction of expiratory muscles (such as the rectus abdominis) increases intrathoracic pressure artificially, generating falsely elevated circuit pressure readings that do not reflect true alveolar auto-PEEP. Transient sedation or timing the hold during passive conditions is required for valid static pressure equilibration.

Question: 1470

A 62-year-old man with multiple rib fractures is intubated and ventilated. He is tachycardic and hypertensive with high ventilatory demand. After starting fentanyl infusion, he develops increasing airway pressures and is now noted to have miosis and rising CO₂ on ABG despite unchanged ventilator settings. Which analgesic strategy best addresses both pain control and avoids worsening hypercapnia while continuing sedation?

- A. Switch from fentanyl to intermittent morphine boluses to reduce respiratory depression
- B. Stop analgesia completely and rely on benzodiazepine-only sedation
- C. Confirm appropriate ventilator support and titrate opioids carefully
- D. Treat respiratory depression by giving naloxone while stopping analgesia

Answer: C

Explanation: Opioids can depress ventilatory drive, especially at higher doses or with co-administered sedatives, leading to hypercapnia and increased work of breathing. The clinical approach is to ensure adequate ventilatory mechanics and settings are addressed, then titrate opioid dosing to achieve comfort without excessive respiratory depression. Adjunct non-opioid analgesia (depending on the clinical context) can reduce opioid requirements. Naloxone would reverse analgesia and may precipitate acute withdrawal or agitation in patients with opioid dependence; it is typically reserved for life-threatening respiratory depression or specific urgent reversal scenarios. Morphine is not inherently “less” respiratory depressant than fentanyl in general ICU practice, and benzodiazepine-only sedation does not provide analgesia, risking stress responses and ventilator dyssynchrony.

Question: 1471

A patient with abdominal compartment syndrome has Pes 25 cmH₂O at end-expiration. PEEP is set at 18 cmH₂O. Calculate end-expiratory PL and recommend adjustment.

- A. Use direct Paw method only
- B. PL = -7 cmH₂O; decrease PEEP
- C. PL normal; no change
- D. PL = 7 cmH₂O; increase PEEP to target positive PL

Answer: D

Explanation: $PL = PEEP - P_{es} = 18 - 25 = -7$ cmH₂O (negative, risking derecruitment). Higher PEEP is often needed in high chest wall pressure states to achieve positive end-expiratory PL.

Question: 1472

A 58-year-old mechanically ventilated patient is declared brain dead and cleared for multi-organ donation. Laboratory testing reveals a blood glucose level of 310 mg/dL. What is the recommended glycemic control target and management strategy in organ donor care?

- A. Administer oral metformin via nasogastric tube targeting a blood glucose level under 100 mg/dL.
- B. Allow blood glucose to remain between 300 and 400 mg/dL to ensure adequate carbohydrate availability.
- C. Initiate continuous intravenous insulin infusion targeting a blood glucose level between 110 and 180 mg/dL.
- D. Perform urgent hemodialysis to clear excess circulating glucose and prevent osmotic diuresis.

Answer: C

Explanation:

Hyperglycemia is extremely common in brain-dead organ donors due to stress response, loss of endogenous insulin regulation, and administration of corticosteroids or dextrose-containing fluids. Uncontrolled hyperglycemia causes osmotic diuresis, electrolyte disturbances, and cellular damage to donor organs (particularly the

pancreas, kidneys, and liver). Current donor management guidelines recommend maintaining blood glucose between 110 and 180 mg/dL (or 100-150 mg/dL in some protocols) using a continuous intravenous insulin infusion and frequent glucose monitoring.

Question: 1473

A patient with acute hypoxemic respiratory failure due to severe ARDS is receiving mechanical ventilation. The team decides to initiate aerosolized prostacyclin (epoprostenol) to improve arterial oxygenation. Which physiological mechanism explains how inhaled epoprostenol improves $\text{PaO}_2/\text{FiO}_2$ ratio without causing systemic arterial hypotension?

- A. Systemic absorption leads to generalized arterial vasodilation, increasing cardiac output and tissue oxygen delivery.
- B. It increases systemic vascular resistance while selectively dilating the coronary arteries.
- C. Aerosolized epoprostenol diffuses into non-ventilated atelectatic alveoli, inducing localized hypoxic pulmonary vasoconstriction.
- D. Selective pulmonary vasodilation occurs exclusively in ventilated lung segments, decreasing intrapulmonary shunt.

Answer: D

Explanation: Inhaled pulmonary vasodilators (such as epoprostenol, iloprost, and nitric oxide) are distributed specifically to well-ventilated lung units via airflow. Once deposited in these ventilated alveoli, the drug diffuses directly into adjacent pulmonary vascular beds, causing localized vasodilation. Blood flow is thereby redirected away from unventilated/poorly ventilated regions toward well-ventilated regions, significantly reducing intrapulmonary ventilation-perfusion (V/Q) mismatch and right-to-left shunting. Because the drug is rapidly inactivated upon entering the

systemic circulation (or bound to hemoglobin in the case of iNO), systemic vascular resistance is unaffected, avoiding systemic hypotension.

Question: 1474

A patient in cardiogenic shock with low cardiac output requires support. Which vasoactive agent primarily increases contractility with minimal vasoconstriction at moderate doses?

- A. Phenylephrine
- B. Norepinephrine
- C. Dobutamine
- D. Vasopressin

Answer: C

Explanation: Dobutamine is a beta-1 predominant inotrope that increases myocardial contractility and cardiac output with mild vasodilation (beta-2), ideal for low-output states without severe hypotension. Norepinephrine is primarily vasopressor (alpha), phenylephrine pure alpha, and vasopressin non-catecholamine vasoconstrictor.

Question: 1475

A tornado causes mass casualties. Your evacuation bus has room for 6 patients. You must choose which patients to move immediately from a crowded holding area.

Criteria: severe hypothermia (Temp 32°C) and unstable bleeding; one patient with GCS 8 and SBP 60; one patient walking but with RR 10 and SpO2 98%. Two patients have stable airway but increasing agitation. Which best movement/protection decision maximizes expected survival?

- A. Move the two agitated patients first because agitation is usually reversible
- B. Move only the hypothermic patient because temperature restoration is the only survival factor
- C. Move the walking patient with RR 10 because low RR indicates safer physiology
- D. Move patients most at risk of death without immediate intervention—those with profound shock/low GCS

Answer: D

Explanation: When transportation capacity is limited, triage prioritizes those with imminent risk of death without prompt care. Profound shock (SBP 60) and low GCS suggest a life-threatening physiologic state needing immediate stabilization. Actively unstable bleeding and severe hypothermia can lead to rapid deterioration, so securing airway/bleeding control and providing whatever transport stabilization is feasible supports survival. Walking with RR 10 and high SpO₂ suggests lower immediate risk relative to shock and bleeding.

Question: 1476

An intubated patient with end-stage chronic obstructive pulmonary disease (COPD) has failed multiple spontaneous breathing trials due to rapid shallow breathing and diaphragmatic fatigue. Current laboratory values indicate: serum potassium 4.0 mEq/L, serum sodium 139 mEq/L, serum magnesium 2.0 mg/dL, ionized calcium 1.20 mmol/L, and serum phosphate 1.1 mg/dL (reference range: 2.5–4.5 mg/dL). Which intervention is most directly targeted at resolving the weaning failure?

- A. Perform rapid shallow breathing index measurement immediately without intervention.
- B. Increase positive end-expiratory pressure to reduce diaphragm workload.
- C. Transition patient to high-frequency oscillatory ventilation for lung recruitment.

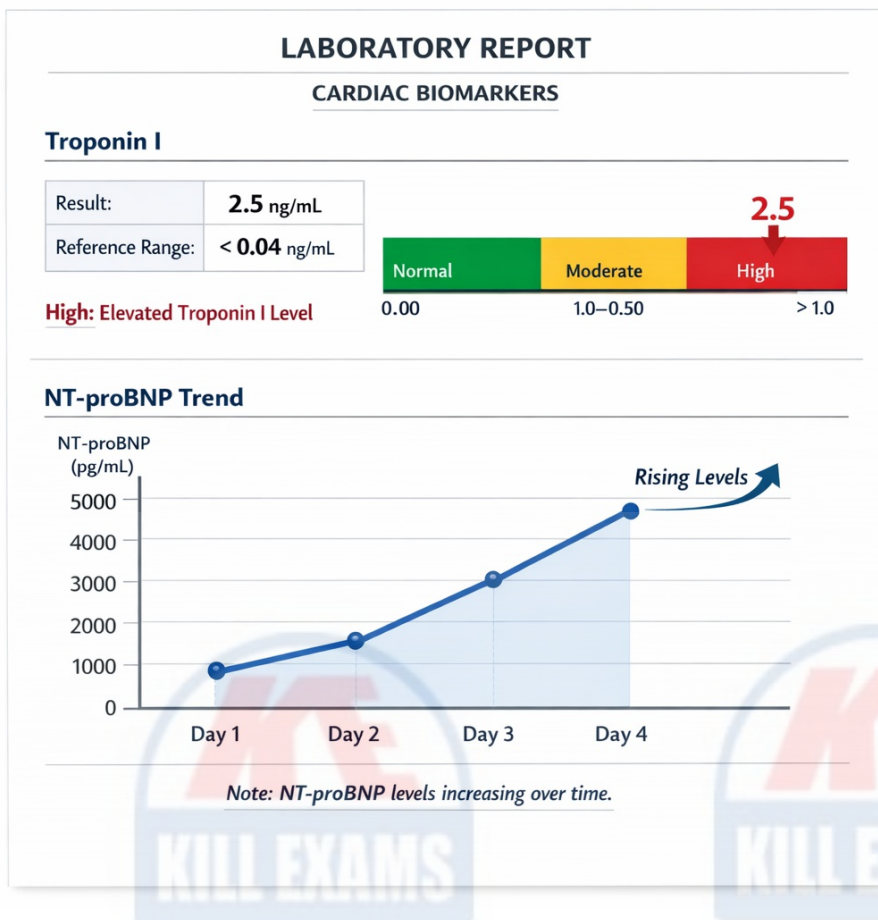
D. Administer intravenous sodium phosphate or potassium phosphate repletion.

Answer: D

Explanation: Severe hypophosphatemia (<1.5 mg/dL) depletes intracellular adenosine triphosphate (ATP) and 2,3-diphosphoglycerate (2,3-DPG), directly causing respiratory muscle weakness, impaired diaphragmatic contractility, and failure to wean from mechanical ventilation. Restoring serum phosphate via intravenous repletion restores ATP generation and diaphragmatic contractile force, enabling successful spontaneous breathing trials and extubation.

Question: 1477

A 72-year-old patient with a history of congestive heart failure is receiving mechanical ventilation. Arterial blood gas results show a pH of 7.28, P_aCO_2 of 55 mmHg, and HCO_3^- of 24 mEq/L. You review the patient's most recent cardiac biomarker panel:



Which of the following interventions is most appropriate to address the underlying cause of the patient's respiratory acidosis?

- A. Increase the mechanical ventilation rate
- B. Initiate a bicarbonate infusion
- C. Administer intravenous diuretics
- D. Start a beta-blocker infusion

Answer: C

Explanation: The patient is in acute respiratory acidosis, likely secondary to pulmonary edema from congestive heart failure, as evidenced by the elevated NT-proBNP and Troponin I. The primary goal is to resolve the pulmonary edema to improve gas exchange. Intravenous diuretics are the standard of care to reduce preload and pulmonary congestion. Increasing the ventilation rate might address the CO₂, but it does not treat the underlying cardiac failure. Bicarbonate infusion is not indicated for respiratory acidosis, and beta-blockers are generally contraindicated in the acute phase of decompensated heart failure.

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