IA MED CERTIFIED FLIGHT REGISTERED NURSE (CFRN) PRACTICE TEST (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.

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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!

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Questions

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1. **In a scenario involving a rapid sequence intubation with hemodynamic instability, which adjustment would most likely reduce the risk of further instability?**

   A. Reduce the dose of the paralytic agent

   B. Increase the dose of the induction agent

   C. administer a large fluid bolus before induction

   D. administer push-dose vasopressor after induction

2. **If a patient on a ventilator desaturates to 82% with all connections secure and suctioning ineffective, which change should be attempted first?**

   A. Increase FiO2

   B. Increase PEEP

   C. Decrease tidal volume

   D. Increase respiratory rate

3. **Which ventilator setting should NOT be employed on a patient who is Auto-PEEPing?**

   A. PEEP

   B. APRV

   C. Volume assist control

   D. CMV

4. **Which radiographic sign is NOT associated with epiglottitis?**

   A. Thumbprint sign

   B. Steeple sign

   C. Kernig's sign

   D. Cullen's sign

5. **In a pregnant patient with IV drug use presenting with fever and murmur, which surgical intervention is most likely indicated?**

   A. Cardiac valve replacement

   B. Infected pericardial sac drainage

   C. Hand compartment decompression

   D. Pulmonary artery debridement

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6. Which option best represents the correct order of events in managing an umbilical cord prolapse?

A. Manual relief of cord compression followed by knee-to-chest position

B. Administer terbutaline then knee-to-chest

C. Place in McRobert's position first, then elevate the cord

D. Immediate cesarean without manual relief

7. Initial management of HHNK focuses on what primary step?

A. Aggressive IV fluid resuscitation with isotonic saline

B. Immediate insulin therapy without fluids

C. Dialysis

D. Oral hypoglycemics

8. Night vision goggles will cause which perceptual effect?

A. A lack of depth perception

B. 3D effect of distant objects

C. Blinding light if suddenly entering a well-lit environment

D. A shimmering beach on the horizon

9. Beck's triad is most closely associated with which condition?

A. Cardiac tamponade

B. Pulmonary embolism

C. Myocardial infarction

D. Aortic dissection

10. In obstetric emergencies, which cord-related condition presents with the cord descending into the birth canal ahead of the presenting part?

A. Prolapsed cord

B. Nuchal cord

C. Shoulder dystocia

D. Cephalad presentation

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Answers

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

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Explanations

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1. In a scenario involving a rapid sequence intubation with hemodynamic instability, which adjustment would most likely reduce the risk of further instability?

A. Reduce the dose of the paralytic agent

B. Increase the dose of the induction agent

C. administer a large fluid bolus before induction

D. administer push-dose vasopressor after induction

Minimizing the cardiovascular perturbations that can occur during airway management is essential when the patient is hemodynamically unstable. In rapid sequence intubation, the combination of induction and paralysis can cause a drop in blood pressure and other instability. Using a smaller dose of the paralytic agent helps limit the depth and abruptness of neuromuscular blockade, which in turn reduces the likelihood of sudden hemodynamic swings associated with a large or rapid paralytic effect. This approach aims to achieve quick, safe intubation while avoiding additional cardiovascular stress. Increasing the induction dose would more likely worsen hypotension in an unstable patient. Administering a large fluid bolus before induction risks fluid overload and pulmonary edema. Relying on a vasopressor after induction addresses BP after instability has occurred but does not prevent the instability during the induction–paralysis sequence.

2. If a patient on a ventilator desaturates to 82% with all connections secure and suctioning ineffective, which change should be attempted first?

A. Increase FiO2

B. Increase PEEP

C. Decrease tidal volume

D. Increase respiratory rate

Raising the fraction of inspired oxygen is the quickest way to improve oxygenation when a ventilated patient desaturates. If the airway and circuits are secure and suctioning hasn't helped, the problem is the amount of oxygen reaching the lungs. Increasing FiO2 directly raises the oxygen available for diffusion into the blood, which can rapidly lift the SpO2 from desaturated levels toward normal. Other adjustments affect ventilation and CO2 removal more than oxygenation. Increasing tidal volume can alter pressures and risk lung injury if not careful, and increasing the respiratory rate mainly changes CO2 clearance rather than the immediate oxygen content. PEEP helps recruit collapsed alveoli and improve oxygenation, but it's typically considered after confirming FiO2 isn't at an adequate level or when there's persistent hypoxemia despite adequate FiO2. So, the first step is to increase FiO2 to address the low oxygenation directly.

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3. Which ventilator setting should NOT be employed on a patient who is Auto-PEEPing?

A. PEEP

B. APRV

C. Volume assist control

D. CMV

Auto-PEEP (intrinsic PEEP) comes from air trapping when exhalation isn't complete before the next breath starts. The main goal in this situation is to give the lungs enough time to exhale and to avoid increasing the time air stays in the lungs or raising the overall pressure. Delivering a fixed tidal volume with a set inspiratory time (volume-targeted assist-control) tends to push air in with a relatively rigid cycle, which can shorten the available expiratory time or raise mean airway pressure. That combination makes it easier for air to remain trapped and increases end-expiratory lung volume, worsening auto-PEEP. So, this mode is not appropriate for a patient with auto-PEEP. Other approaches aim to prolong expiratory time and reduce air trapping: using PEEP cautiously to aid triggering elsewhere in the ventilator strategy, employing modes like APRV that allow long expiratory phases, or choosing CMV with adjustable expiratory timing to optimize exhalation.

4. Which radiographic sign is NOT associated with epiglottitis?

A. Thumbprint sign

B. Steeple sign

C. Kernig's sign

D. Cullen's sign

In pediatric airway imaging, epiglottitis and croup show different radiographic patterns. Epiglottitis typically presents with the thumbprint sign on a lateral neck view, caused by a swollen, enlarged epiglottis. The steeple sign, seen as subglottic narrowing on an anteroposterior neck radiograph, is characteristic of croup, not epiglottitis. Cullen's sign and Kernig's sign are not radiographic airway findings at all (Cullen's sign is abdominal ecchymosis; Kernig's sign is a meningeal irritation sign). Therefore, the radiographic sign not associated with epiglottitis is the steeple sign, since it points to croup rather than epiglottitis.

5. In a pregnant patient with IV drug use presenting with fever and murmur, which surgical intervention is most likely indicated?

A. Cardiac valve replacement

B. Infected pericardial sac drainage

C. Hand compartment decompression

D. Pulmonary artery debridement

Infective endocarditis from IV drug use commonly attacks a heart valve, and fever with a new or changing murmur points to valve involvement with destruction and potential hemodynamic compromise. When the infection has progressed to the point of significant valvular damage, causing severe regurgitation or heart failure, or when the infection persists despite antibiotics, surgical replacement of the affected valve becomes the definitive treatment. In a pregnant patient, controlling the infection and preserving maternal cardiac function is critical for both mother and fetus, so replacing the diseased valve is the intervention most likely indicated to restore proper valve function and hemodynamics. The other options don't fit this scenario. Draining the infected pericardial sac targets purulent pericarditis rather than valvular endocarditis. Decompressing a limb compartment is for compartment syndrome, not a cardiac infection. Debridement of the pulmonary artery is not a standard primary treatment for infective endocarditis and would not address the valve destruction driving the clinical picture.

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6. Which option best represents the correct order of events in managing an umbilical cord prolapse?

A. Manual relief of cord compression followed by knee-to-chest position

B. Administer terbutaline then knee-to-chest

C. Place in McRobert's position first, then elevate the cord

D. Immediate cesarean without manual relief

In cord prolapse, the priority is to relieve the cord from compression to protect fetal oxygenation. Start by gently lifting the presenting part off the cord with a sterile gloved hand to relieve the pressure. Once the cord is no longer compressed, place the patient in a position that uses gravity to reduce ongoing pressure—most commonly knee-to-chest or Trendelenburg—to move the uterus away from the cord and improve blood flow to the fetus. This sequence—manual relief first, then repositioning—is essential because you must stop the compression before relying on positioning to sustain relief and perfusion. Call for help and prepare for emergent delivery, since the situation may progress to urgent cesarean if the fetus remains distressed or labor cannot proceed quickly. A tocolytic like terbutaline is not the primary action here because relaxing the uterus does not promptly fix the prolapse and can worsen the situation. The McRobert's maneuver is used for shoulder dystocia, not cord prolapse. Delivering by cesarean without attempting to relieve the cord first would waste critical time and leave the fetus at continued risk.

7. Initial management of HHNK focuses on what primary step?

A. Aggressive IV fluid resuscitation with isotonic saline

B. Immediate insulin therapy without fluids

C. Dialysis

D. Oral hypoglycemics

In HHNK, the top priority is restoring circulating volume because severe dehydration from osmotic diuresis is life-threatening. Starting aggressive intravenous fluid resuscitation with isotonic saline rehydrates the patient, improves renal perfusion, and helps dilute the hyperosmolar state. This initial step also lays the groundwork for effective glucose reduction and electrolyte stabilization. Insulin therapy is essential, but it is started after fluids have begun correcting the volume status. Administering insulin too early, without adequate fluids, can precipitate dangerous shifts in fluids and potassium, and may worsen blood pressure and perfusion. Dialysis isn't the first move; it's reserved for specific situations such as refractory hyperglycemia with renal failure or severe electrolyte disturbances that don't respond to fluids and insulin. Oral hypoglycemics aren't appropriate in the acute HHNK situation because they don't act quickly enough to correct the profound dehydration and hyperglycemia.

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8. Night vision goggles will cause which perceptual effect?

A. A lack of depth perception

B. 3D effect of distant objects

C. Blinding light if suddenly entering a well-lit environment

D. A shimmering beach on the horizon

Night vision goggles limit depth perception because they provide a flat, two dimensional image with a fixed focal plane. The brain normally judges distance using a combination of binocular disparity, motion parallax, and the eyes' accommodation and vergence cues. NVGs distort or reduce these cues, especially since the image is produced and presented at a fixed focus and the two-eye input is not aligned with real-world depth changes. As a result, you can see shapes and movement clearly, but judging how far away objects are becomes unreliable. This is why you'll often be advised to rely on slow, deliberate movements and external reference points rather than guessing distance from the image alone. Briefly, if you ever notice a washout from bright light or other phenomena, those are separate considerations related to device brightness control or environmental factors, not the core perceptual change NVGs introduce.

9. Beck's triad is most closely associated with which condition?

A. Cardiac tamponade

B. Pulmonary embolism

C. Myocardial infarction

D. Aortic dissection

Beck's triad points to cardiac tamponade, caused by fluid around the heart compressing it and impairing filling. The triad consists of low blood pressure, distended neck veins, and muffled heart sounds. This happens because the increased pericardial pressure limits diastolic filling, so venous return backs up (JVD) while the heart can't pump effectively, leading to hypotension and only faint heart sounds transmitted through the fluid-filled sac. In this scenario, tamponade is the best match because the full triad is classic for it. Other conditions can have overlapping signs, but they don't typically present with the complete triad; for example, pulmonary embolism may cause hypotension, MI presents with chest pain and ECG changes, and aortic dissection with sudden severe pain and possible pulse abnormalities, but not the characteristic combination of hypotension, JVD, and muffled heart sounds.

10. In obstetric emergencies, which cord-related condition presents with the cord descending into the birth canal ahead of the presenting part?

A. Prolapsed cord

B. Nuchal cord

C. Shoulder dystocia

D. Cephalad presentation

Prolapsed umbilical cord occurs when the umbilical cord slides down into the birth canal ahead of the presenting part. This creates a critical situation because the cord can be compressed as the baby descends, cutting off blood flow and oxygen to the fetus. The hallmark sign is feeling or seeing the cord ahead of the presenting part during a vaginal exam or in the vagina. Think of it as the cord preemptively entering the birth canal, whereas other scenarios involve the cord in a different relation: a nuchal cord is the cord around the baby's neck; shoulder dystocia is when a shoulder gets stuck after the head is delivered; cephalad presentation means the head presents first, which is not a cord problem. Management focuses on relieving cord compression immediately and expediting delivery: gently reduce pressure on the cord by elevating the presenting part with a gloved hand, position the patient to maximize blood flow (often knee-chest or Trendelenburg), keep the cord moist, provide oxygen and IV fluids, and summon help for rapid delivery by the safest route given the fetal status.

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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:

https://iamedcfrn.examzify.com

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

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