ATI ENGAGE ADULT MEDICAL SURGICAL RN: ALTERATION IN HEALTHCARE- RN ALTERATION IN CARDIOVASCULAR FUNCTION AND PERFUSION ASSESSMENT

RN Alterations in Cardiovascular Function and Perfusion Assessment

CLOSE

Question: 1 of 30 CORRECT

Time Elapsed: 00:02:01

FLAG

A nurse is caring for a client who has pericarditis.

Exhibit 1 | Exhibit 2 | Exhibit 3 | Exhibit 4

Nurses' Notes

0900:
Client resting quietly in bed. The client ambulates to the bathroom with a steady gait. Client reports hiccups this morning. The client denies having chest pressure or lightheadedness. Lung sounds clear. Heart sounds regular. Bowel sounds normoactive in all quadrants. Reports mild chest pain with a 2 on a pain scale of 0 to 10. Reports recent history of weight loss.

1200:
Client reports body chills and dizziness. Client states "I am having trouble swallowing my water and I keep hiccupping." Reports chest pain 5 on pain scale of 0 to 10. Client rubbing chest. Heart sounds with pericardial friction rub noted.

Based on the assessment findings, which of the following lab tests should the nurse anticipate will have abnormal results?
Select all that apply.

- [ ] Serum sodium
- [x] Erythrocyte sedimentation rate (ESR)
- [x] C-reactive protein (CRP)
- [ ] Hemoglobin
- [ ] Blood urea nitrogen (BUN)
- [x] White blood cell count (WBC)

CORRECT My Answer

When recognizing cues, the nurse should identify that the findings of low-grade fever with body chills, reports of dizziness, hiccups, pericardial friction rub, chest pain, and difficulty swallowing indicate worsening of pericarditis. The nurse should expect laboratory results from the white blood cell count (WBC), erythrocyte sedimentation rate (ESR), and C-reactive protein (CRP) to be elevated from inflammatory processes consistent with pericarditis.

CONTINUE

Question: 2 of 30

PARTIALLY CORRECT

Time Elapsed: 00:04:21

FLAG

A nurse is caring for a client who is experiencing heart palpitations.

Exhibit 1 | Exhibit 2

Nurses' Notes

2000:
The client was admitted for cardiac monitoring. The client reports occasional heart palpitations. Skin warm and dry. ECG reveals sinus tachycardia with heart rate 106/min. Heart sounds regular. Lung sounds clear to auscultation. Bowel sounds normoactive in all quadrants.

2345:
The client reports sudden onset of shortness of breath, respiratory rate 26/min, diaphoresis, chest pressure, and feeling lightheaded. ECG reveals SVT with a heart rate of 180/min. Oxygen saturation 86%.

Which of the following interventions should the nurse include in the plan of care for this client?
Select all that apply.

- [ ] Ambulate the client 20 feet.
- [ ] Encourage the client to exhale with their mouth and nose closed.
- [x] Ask the client to cough forcefully.
- [x] Encourage the client to swallow through a straw.
- [x] Have the client bear down as if for a bowel movement.

PARTIALLY CORRECT My Answer

When generating solutions, the nurse should identify that the client is experiencing symptomatic supraventricular tachycardia (SVT) and that immediate vasovagal maneuvers are required to attempt convert the heart rhythm and stabilize the client. These may include vagal maneuvers such as forceful coughing, gagging, or valsalva maneuvers such as bearing down like having a bowel movement.

Question: 3 of 30

CORRECT

Time Elapsed: 00:05:31

FLAG

A nurse is caring for a client who has dilated cardiomyopathy.

Exhibit 1 | Exhibit 2 | Exhibit 3 | Exhibit 4 | Exhibit 5

Nurses' Notes

1635:
Awake, alert, oriented x 3. Skin warm and dry. Client's morning weight is 58 kg (127.8 lb). Lung sounds clear to auscultation. Oxygen saturation is 95% on room air. Telemetry reveals normal sinus rhythm, rate 86/min. Lower extremities with 2+ pitting edema. Reports shortness of breath with ambulation.

1920:
Awake, alert, oriented x 3. Skin warm and dry. Lung sounds with crackles bilaterally throughout. Oxygen saturation is 88% on room air. Oxygen @ 8 L/min applied as prescribed. Telemetry reveals sinus tachycardia, rate 125/min. Lower extremities with 3+ pitting edema. Reports increasing shortness of breath with ambulation and activities. Noted urine output for previous 24 hours 575 mL.

Which of the following interventions should the nurse implement with this client?
Select all that apply.

- [ ] Administer intravenous infusion of nitroglycerine.
- [x] Increase oxygen to 4 L/min via nasal cannula.
- [ ] Obtain consent for a pericardiocentesis.
- [x] Administer furosemide 80 mg intravenous venous push.
- [ ] Administer oral valsartan 120 mg.
- [x] Prepare client for insertion of left ventricular assistive device.

CORRECT My Answer

When recognizing cues, the nurse should identify that the client is experiencing worsening of dilated cardiomyopathy manifestations including increased shortness of breath, decreased oxygen saturation with oxygen therapy, lower extremity edema, and decreased urine output. These manifestations indicate a decreased cardiac output and increased fluid volume overload. The nurse should recognize that the client will require treatment options that can improve long-term survival and heart functionality including administration of furosemide 80 mg intravenous push, left ventricular assistive device, and increasing oxygen to 4L/min for oxygen saturation less than 95%.

Question: 4 of 30

CORRECT

Time Elapsed: 00:06:28

FLAG

A nurse is teaching a group of clients about risk factors for developing coronary artery disease (CAD). Which of the following should the nurse include in the teaching? (Select all that apply.)

- [x] High levels of stress
- [x] Diabetes mellitus
- [x] Family history of CAD
- [ ] Valvular heart disease
- [x] Hypertension
- [x] Hyperlipidemia

CORRECT My Answer

High levels of stress is correct. Stress, diabetes mellitus, family history of CAD, hypertension, and hyperlipidemia are risk factors for the development of coronary artery disease.
Diabetes mellitus is correct. Stress, diabetes mellitus, family history of CAD, hypertension, and hyperlipidemia are risk factors for the development of coronary artery disease.
Family history of CAD is correct. Stress, diabetes mellitus, family history of CAD, hypertension, and hyperlipidemia are risk factors for the development of coronary artery disease.
Valvular heart disease is incorrect. Valvular heart disease is not a risk factor for coronary artery disease. However, coronary artery disease is one of many risk factors for valvular disease.
Hypertension is correct. Stress, diabetes mellitus, family history of CAD, hypertension, and hyperlipidemia are risk factors for the development of coronary artery disease.
Hyperlipidemia is correct. Stress, diabetes mellitus, family history of CAD, hypertension, and hyperlipidemia are risk factors for the development of coronary artery disease.

Question: 5 of 30

Time Elapsed: 00:06:53

FLAG

A nurse is teaching a client about reducing risk factors for coronary artery disease (CAD). Which of the following client statements indicates to the nurse understanding of the teaching?

- "I will follow a moderate exercise regimen."
- "I will only smoke cigars."
- "Coronary artery disease is an unavoidable part of aging."
- "I will drink whole milk with my meals."

Question: 6 of 30

Time Elapsed: 00:07:21

FLAG

A nurse is teaching a group of clients about modifiable risk factors for developing valvular dysfunction. Which of the following risk factors should the nurse include in the teaching?

- Elevated homocysteine levels
- Increased stress levels
- Hypertension
- Chronic pulmonary disease

PREVIOUS

CONTINUE

Question: 7 of 30

Time Elapsed: 00:08:23

FLAG

A nurse is assessing a client who has atrial fibrillation. Which of the following client statements by the client should indicate to the nurse that this condition is affecting the client's ability to perform activities of daily living (ADLs)?

- "I feel pressure in my chest when I climb stairs."
- "I feel so nauseated when I turn my head too quickly."
- "My heart rate increases but stays regular when I run on the track."
- "I go to the grocery store at least once a week."

Question: 8 of 30

Time Elapsed: 00:08:56

FLAG

A nurse is caring for a client who has coronary artery disease that has progressed to an ST elevation myocardial infarction (STEMI). Which of the following procedures should the nurse anticipate for this client?

- (●) Heart catheterization and percutaneous intervention
- ( ) Balloon valvuloplasty
- ( ) Administration of pentoxifylline
- ( ) Heparin bolus followed by a continuous infusion

PREVIOUS

CONTINUE

Question: 9 of 30

Time Elapsed: 00:09:16

FLAG

A nurse is assisting in caring for a client who has chronic venous disease, and the client asks why their legs have been swelling and feel so heavy at times. Which of the following statements should the nurse include?

- "The arteries are narrowed due to plaque and blood flow is decreased and spasms occur."
- "Blood flow is altered due to excessive stretching of the ventricles, impairing the heart to contract, and causing decreased blood flow."
- "The veins are damaged as a result of the compression stockings you have been wearing."
- "Damaged or occluded veins cause blood to pool in the legs instead of returning to the heart."

Question: 10 of 30

Time Elapsed: 00:09:30

FLAG

A nurse is teaching a group of clients about chronic health conditions that increase the risk for developing premature ventricular contractions (PVCs). Which of the following should the nurse include in the teaching?

- Recent illness that caused vomiting and diarrhea.
- Myocardial infarction that required stent placement.
- Diabetes mellitus type 2 that requires daily insulin injections.
- Peripheral vascular disease with diminished capillary refill.