ATI MATERNAL NEWBORN PROCTORED EXAM

1. The nurse is preparing a patient for surgery. Which goal is a **priority** for assessing the patient before surgery?

a. Plan for care after the procedure.

b. Establish a patient's baseline of normal function.

c. Educate the patient and family about the procedure.

d. Gather appropriate equipment for the patient's needs.

ANS: B

The goal of the preoperative assessment is to identify a patient's normal preoperative function and the presence of any risks to recognize, prevent, and minimize possible postoperative complications. Gathering appropriate equipment, planning care, and educating the patient and family are all important interventions that must be provided for the surgical patient; they are part of the nursing process but are not the priority reason/goal for completing an assessment of the surgical patient.

2. The nurse is completing a medication history for the surgical patient in preadmission testing. Which medication should the nurse instruct the patient to hold (discontinue) in preparation for surgery according to protocol?

a. Warfarin

b. Vitamin C

c. Prednisone

d. Acetaminophen

ANS: A

Medications such as warfarin or aspirin alter normal clotting factors and thus increase the risk of hemorrhaging. Discontinue at least 48 hours before

surgery. Acetaminophen is a pain reliever that has no special implications for surgery. Vitamin C actually assists in wound healing and has no special implications for surgery. Prednisone is a corticosteroid, and dosages are often temporarily increased rather than held.

3. The nurse is prescreening a surgical patient in the preadmission testing unit. The medication history indicates that the patient is currently taking an anticoagulant. Which action should the nurse take when consulting with the health care provider?

a. Ask for a radiological examination of the chest.

b. Ask for an international normalized ratio (INR).

c. Ask for a blood urea nitrogen (BUN).

d. Ask for a serum sodium (Na).

ANS: B

INR, PT (prothrombin time), APTT (activated partial thromboplastin time), and platelet counts reveal the clotting ability of the blood. Anticoagulants can be utilized for different conditions, but its action is to increase the time it takes for the blood to clot. This action can put the surgical patient at risk for bleeding tendencies.

Typically, if at all possible, this medication is held several days before a surgical procedure to decrease this risk. Chest x-ray, BUN, and Na are diagnostic screening tools for surgery but are not specific to anticoagulants.

4. The nurse is encouraging the postoperative patient to utilize diaphragmatic breathing. Which **priority** goal is the nurse trying to achieve?

a. Manage pain

b. Prevent atelectasis

c. Reduce healing time

d. Decrease thrombus formation

ANS: B

After surgery, patients may have reduced lung volume and may require greater effort to cough and deep breathe; inadequate lung expansion can lead

to atelectasis and pneumonia. Purposely utilizing diaphragmatic breathing can decrease this risk. During general anesthesia, the lungs are not fully inflated during surgery and the cough reflex is suppressed, so mucus collects within airway passages. Diaphragmatic breathing does not manage pain; in some cases, if splinting and pain medications are not given, it can cause pain. Diaphragmatic breathing does not reduce healing time or decrease thrombus formation. Better, more effective interventions are available for these situations.

5. The nurse is caring for a postoperative patient on the medical-surgical floor. Which activity will the nurse encourage to prevent venous stasis and the formation of thrombus?

a. Diaphragmatic breathing

b. Incentive spirometry

c. Leg exercises

d. Coughing

ANS: C

After general anesthesia, circulation slows, and when the rate of blood slows, a greater tendency for clot formation is noted. Immobilization results in decreased muscular contractions in the lower extremities; these promote venous stasis. Coughing, diaphragmatic breathing, and incentive spirometry are utilized to decrease atelectasis and pneumonia.

6. The nurse is caring for a preoperative patient. The nurse teaches the principles and demonstrates leg exercises for the patient. The patient is unable to perform leg exercises correctly. What is the nurse's best **next** step?

a. Encourage the patient to practice at a later date.

b. Assess for the presence of anxiety, pain, or fatigue.

c. Ask the patient why exercises are not being done.

d. Evaluate the educational methods used to educate the patient.

ANS: B

If the patient is unable to perform leg exercises, the nurse should look for circumstances that may be impacting the patient’s ability to learn. In this case, the patient can be anticipating the upcoming surgery and may be experiencing anxiety. The patient may also be in pain or may be fatigued; both of these can affect the ability to learn. Evaluation of educational methods may be needed, but in this case, principles and demonstrations are being utilized. Asking anyone “why” can cause defensiveness and may not help in attaining the answer. The nurse is aware that the patient is unable to do the exercises. Moving forward without ascertaining that learning has occurred will not help the patient in meeting goals.