

1 . The nurse has been asked to review an agency's emergency response plan as a member of the Emergency Operations Committee. Which components should the nurse identify for inclusion in the agency's emergency plan? Select all that apply.

- A. Need to call 911 to activate an emergency response
- B. A plan for internal and external communication
- C. Documentation of available external resources
- D. The agency plan for performing practice drills
- E. List of expendable resources that may be needed
- F. Methods to be used for educating agency personnel

ANSWER: B, C, D, E, F

- A. An activation response defines where, how, and when the response is initiated. Calling 911 would not be an appropriate activation.
- B. Communication to and from the prehospital arena and to all parties involved is needed for a rapid and orderly response to a disaster.
- C. Local, state, and federal resources should be identified as well as how to activate these resources.
- D. Practice drills with community participation allow for troubleshooting problems before an event happens and give persons an opportunity to practice their roles.
- E. Expendable resources such as food, water, and supplies must be available and sources for these identified.
- F. Educating personnel allows for improved readiness and additional input for refining the process.

2. The hospital is overloaded with victims from a tornado that leveled a nearby community of 75,000 people, and the hospital is short-staffed. Which actions might be necessary in this situation? Select all that apply.

- A. Nurses performing duties outside of the nurses' area of expertise
- B. Family members providing nonskilled interventions for their loved ones
- C. Giving care to persons with extensive injuries and little chance of survival first
- D. Setting up a hospital ward in a community shelter
- E. Asking if anyone can interpret for clients that only speak a foreign language

ANSWER: A, B, D, E

- A. Due to staff shortages, nurses may be asked to take on responsibilities normally held by HCPs or advanced practice nurses.

- B. When insufficient health care personnel are available, family members may take on non- skilled responsibilities.
- C. Victims with extensive injuries and unlikely to survive should be triaged and treated last. Nursing care in a disaster focuses on essential care from the perspective of what is best for all persons.
- D. In a disaster, care may need to be provided outside of the hospital setting.
- E. Although client confidentiality is important, a medical emergency may require the services of laypersons to interpret for non—English— speaking clients.

3. The hospital's disaster response plan is initiated to prepare for receiving victims from a bridge collapse. To increase bed capacity, which clients on a maternal-infant unit should the nurse identify as appropriate for discharge? Select all that apply.

- A. The 1-day-old healthy full-term infant with a strong suck; mother is healthy
- B. The 2-day—old infant with a total serum bilirubin of 16 mg/dL; mother is healthy
- C. The multipara woman who delivered 20 hours ago and has an intact perineum
- D. The woman who had a cesarean section; just put on IV antibiotics for an infection
- E. The infant born 28 hours ago who was at 34 weeks of gestation; mother is fatigued

ANSWER: A, B, C

- A. The 1-day-old healthy infant and the infant's mother can be discharged because they are both healthy.
- B. Although the 2-day-old infant has an elevated serum bilirubin, a home phototherapy blanket can be prescribed. Phototherapy is prescribed when the total serum bilirubin level rises to 15 mg/dL at 25 to 28 hours of age.
- C. The multipara woman is stable; a mother can be discharged even if the infant needs to remain hospitalized.
- D. The woman on antibiotics should remain hospitalized because the antibiotic's effectiveness is unknown.
- E. An infant born before 34 weeks of gestation is preterm. Preterm infants can have respiratory or other health problems and should remain hospitalized.

4. The community nurse is teaching disaster preparedness to community members. Which statement is most appropriate?

- A. "Yearly, discard and replace the disaster kit's supply of bottled water."
- B. "Keep on hand a 3-day supply of water, 1 gallon per person per day."
- C. "Animals will be able to fend for themselves for a few days in a disaster."
- D. "Include a 1-day supply of food for each person in the disaster kit."

ANSWER: B

- A. Bottled water that is stored for use in an emergency should be replaced before it expires or, if self-prepared, every 6 months.
- B. The amount of water to keep on hand is calculated according to family size (1 gallon per person per day) for a 3-day supply of water.
- C. A disaster kit should contain water, food, and other necessary items for household pets.
- D. The disaster kit should contain a 3-day (not 1-day) supply of food that will not spoil.

5. An explosion occurred at a nearby factory. The ED charge nurse receives a call from EMS personnel that 35 clients will arrive by ambulance within 10 minutes. These clients were triaged at the scene as red and yellow according to the NATO mass casualty categories; others will be arriving, and the unit is short-staffed. Which action should the nurse initiate first?

- A. Activate the hospital's emergency response plan.
- B. Contact the emergency department nursing director.
- C. Notify other emergency nurses of the need for extra help.
- D. Call a nearby hospital to determine if 15 clients could be rerouted.

ANSWER: A

- A. Every health care facility is required by the Joint Commission to have a plan in place for emergency preparedness. The activation response defines where, how, and when the response should be initiated.
- B. The nursing director would be notified as part of the emergency response plan.
- C. The nurse receiving the call should be getting ready to receive the victims and would not call for extra staff. The agency's emergency response plan would identify the person who would make calls to obtain additional staff.
- D. The agency's emergency response plan would identify the person who would make decisions about rerouting clients. The nurse should be getting ready to receive the victims.

6. A passenger train derailed with more than 500 casualties. The nurse is receiving clients who were triaged according to the NATO triage system. Place the clients in the order in which the clients should be treated.

- A. Client with an upper arm fracture and minor burn tagged as green
- B. Client who has wounds involving multiple anatomical sites tagged as black
- C. Client who has an incomplete leg amputation tagged as red

D. Client who has an eye injury, broken jaw, and facial wounds tagged as yellow

ANSWER: C, D, A, B

C. Client who has an incomplete leg amputation tagged as red. Red is priority according to the NATO triage system.

D. Client who has an eye injury, broken jaw, and facial wounds tagged as yellow. Yellow follows red in priority according to the NATO triage system.

A. Client with an upper arm fracture and minor burn tagged as green. Green is after red and yellow in priority according to the NATO triage system.

B. Client who has wounds involving multiple anatomical sites tagged as black. The client tagged black according to the NATO triage system has the least chance of survival.

7. Two military personnel are hospitalized after exposure more than 2 hours ago to liquid sulfur mustard during a terrorist attack. Which assessment finding should the nurse associate with the exposure to liquid sulfur mustard?

- A. Small vesicles on the skin
- B. Hyper stimulation of nerves
- C. Profuse bleeding from orifices
- D. Frothy sputum production

ANSWER: A

- A. Liquid sulfur mustard is a vesicant that causes blistering 2 to 18 hours after exposure.
- B. Nerve agents, such as sarin or soman, or organophosphates used by terrorists or found in pesticides cause nerve hyperstimulation similar to with cholinergic crisis.
- C. Strychnine used in poisons can cause profuse bleeding from orifices.
- D. Pulmonary agents such as phosgene and chlorine destroy the pulmonary membrane and can cause pulmonary edema with frothy sputum production.

8. The ED charge nurse is informed that an unknown number of clients were exposed to a nerve agent during a terrorist attack. Which medication should the nurse prepare to have readily available in sufficient quantities to treat the clients?

- A. Atropine sulfate
- B. Labetalol
- C. Dopamine
- D. Phentolamine

ANSWER: A

- A. Atropine sulfate increases the HR and dries secretions, symptoms caused by the nerve agent.
- B. Labetalol (Trandate) is a beta-adrenergic blocking agent that will decrease the HR.
- C. Dopamine (Intropin) is a vasopressor used to treat cardiac output and increase the BP.
- D. Phentolamine (Regitine) is an alpha-adrenergic receptor blocker that will produce hypotension. It is given subcutaneously to treat dopamine extravasation.

9. Hospital personnel are eating outdoors when a nearby train carrying anhydrous ammonia derails- Which direction by the emergency nurse experienced with biochemical contamination is most appropriate to reduce exposure?

- A. "Stand up and quickly move away from the chemical cloud to avoid exposure."
- B. "Crawl away from the chemical cloud, holding your breath as much as possible."
- C. "Lie down under the tables to stay under the chemical cloud until help arrives."
- D. "Sit and only take small breaths until the cloud dissipates; it is relatively harmless."

ANSWER: A

- A. Standing prevents heavy exposure because the chemical will sink to the floor or ground.
- B. Crawling increases exposure to the chemical.
- C. Lying increases exposure to the chemical.
- D. Sitting will cause some exposure, but telling people that the chemical is relatively harmless is untrue.

10. Clients from an alleged inhalation anthrax exposure are being admitted to an ED. Which actions should the nurse plan in treating the clients? Select all that apply.

- A. Don level D personal protective equipment (PPE).
- B. Prepare to administer ciprofloxacin orally.
- C. Prepare to give postexposure prophylaxis (PEP).
- D. Assess for dyspnea, fever, cough, or chest pain.
- E. Prepare clients to receive an abdominal x-ray.

ANSWER: B, C, D

- A. Level D is basically the work uniform and is typically used to care for someone infected with anthrax. However, level A PPE is worn in suspected inhalation anthrax exposure because maximum respiratory, skin, eye, and mucous membrane protection is required.
- B. Ciprofloxacin (Cipro) is the treatment of choice for inhalation anthrax exposure. Antibiotics prevent systemic involvement.
- C. PEP includes the administration of doxycycline or any quinolone (e.g., ciprofloxacin, levofloxacin) antibiotics to prevent inhalational anthrax. PEP should be continued for 60 days.
- D. Signs of inhalation anthrax are more severe than skin contact or ingestion. Initial signs include dyspnea, fever, cough, chest pain, weakness, and syncope. Within 1 to 3 days severe respiratory distress, hypotension, and shock can ensue.
- E. With inhalation anthrax exposure a CXR, not an abdominal x-ray, would be prescribed. It can reveal widened mediastinum or hemorrhagic mediastinitis that occurs with anthrax exposure.

11 . Clients who were exposed to a white phosphorus chemical spill are arriving by ambulance. Which intervention should the ED nurse plan to implement first?

- A. Triage clients before transport to designated areas.
- B. Put on personal protective equipment (PPE).
- C. Flush the clients' skin and clothing with water.
- D. Brush the chemical off of the clients' skin-

ANSWER: B

- A. The clients need to be decontaminated before being triaged and separated to maintain safety of the hospital environment.
- B. The nurse should first don PPE because white phosphorus can burn the skin.
- C. Because of the potential for an explosion or for deepening the burn, all evidence of white phosphorus should be brushed off of the clients' skin before any flushing occurs.
- D. All evidence of white phosphorus should be brushed off of the clients' skin to prevent an explosion or deepening of the burn, but first the nurse should don PPE.

12. Five families of clients injured in an apartment fire have arrived at an ED to inquire about the health status of their family members. Which is the nurse's best action?

- A. Take the families to the triage area so they can be with their loved ones.
- B. Ask the families to wait in the waiting area until information is available.

- C. Have families taken to a designated room that is staffed by a social worker or clergy.
- D. Direct families to a lounge where a receptionist will keep families informed.

ANSWER: C

- A. To protect the privacy of other clients and to prevent congestion or interference with treatment measures, families should not be in the triage or treatment areas.
- B. Support systems would be unavailable in a waiting area or in a lounge.
- C. Families should be in a designated area where social workers, counselors, therapists, or clergy members are available for support. Family should be provided with information and updates as soon as possible.
- D. Family members may be feeling intense anxiety, shock, or grief. A receptionist would not have the expertise to handle these emotions.

13. The triage nurse in an ED is caring for injured clients of a mass casualty disaster. Which client should the nurse establish as the priority client?

- A. The unresponsive client with a penetrating head injury.
- B. The partially responsive client with a sucking chest wound.
- C. The client with a maxilla fracture and facial wounds without airway compromise.
- D. The client with third-degree burns over 65% of the body surface area.

ANSWER: B

- A. The unresponsive client with a penetrating head injury has a limited potential for survival, even with definitive care, and would be categorized as a priority 4 level (black).
- B. A sucking chest wound is a life-threatening but survivable emergency. The client would be triaged as priority 1 (red) according to the NATO triage system.
- C. The client with the facial wounds would be classified as priority 2 (yellow) because injuries are significant and require medical care but can wait hours without threat to life.
- D. The severely burned client has a limited potential for survival, even with definitive care, and would be categorized as a priority 4 level (black).

14. An emergency trauma center receives a call to expect to receive the infant illustrated. Which precautions should the nurse plan when preparing for the infant's care? Select all that apply.



- A. Place the infant in a negative-air—pressure isolation room
- B. Wear a surgical mask when in contact with the infant's lesions
- C. Wear an N95 (I-IEPA) particulate mask when in contact with the infant
- D. Wear gloves and a gown when entering the room to assess the infant
- E. Notify the Centers for Disease Control of possible bioterrorism
- F. Decontaminate the infant because of suspected smallpox exposure

ANSWER: A. C. D

- A. The lesions are characteristic of smallpox, which is highly contagious. Smallpox is airborne and transmitted by both large and small respiratory droplets and by contact with skin lesions or secretions. Airborne, contact, and standard precautions should be used. A negative-air-pressure isolation room is necessary to prevent transmission of smallpox to others.
- B. An N95 particulate mask, not a surgical mask, is required to prevent airborne and droplet transmission of smallpox.
- C. Respiratory protection with an N95 particulate mask is needed to protect against airborne droplet nuclei smaller than 5 microns.
- D. Smallpox is transmitted by contact with skin lesions or secretions. Contact precautions include wearing a gown and gloves when in contact with the infant or environmental surfaces that could be contaminated.

- E. Although the CDC should be notified by the agency, there is no indication that this is an act of bioterrorism. The nurse caring for the infant would not notify the CDC. In most agencies, a nursing supervisor or other designated person would be notifying the CDC.
- F. Environmental surfaces should be decontaminated utilizing low- to intermediate-level chemical germicides or EPA-registered detergent disinfectants. The infant is not decontaminated.

15. The nurse is triaging four clients who enter the ED at the same time. Which client should be assigned as the highest priority?

- A. The 16-year-old with a severe sunburn injury that is blistering
- B. The 55-year-old client experiencing dyspnea, diaphoresis, and chest pain
- C. The 40-year-old client with a leg laceration that appears to need stitches
- D. The 19-year-old who has headaches, diplopia, and fever of 102.8°F (39.3°C)

ANSWER: B

- A. The client with a blistering sunburn is a level 3 priority according to the five-level Emergency Severity Index (ESI).
- B. Among the clients identified, the client with chest pain is priority. According to the five-level ESI, clients with chest pain, multiple trauma (unless responsive), child with fever and lethargy, and disruptive psychiatric clients are classified as threatened and are level 2 priority.
- C. The client with a leg laceration is a level 3 priority according to the ESI.
- D. The client with neurological symptoms is a level 3 priority according to the ESI.

16. The school nurse is planning an intervention program for children who lost their homes due to a tornado and are now residing in temporary housing. Which group should be the nurse's initial focus?

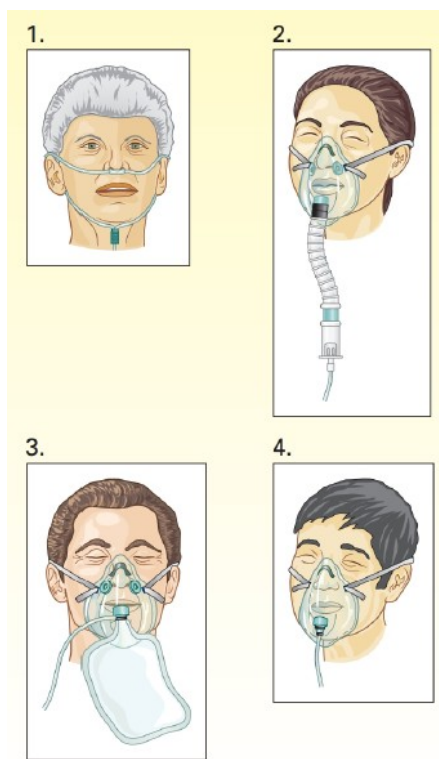
- A. Older age female children of higher socioeconomic status
- B. Older age male children of higher socioeconomic status
- C. Younger age female children of lower socioeconomic status
- D. Younger age male children of lower socioeconomic status

ANSWER: C

- A. Older age female children of higher socioeconomic status are not the highest risk group for mental health distress after a natural disaster.
- B. Older age male children of higher socioeconomic status are not the highest risk group for mental health distress after a natural disaster.

- C. Clients who are female, younger age, and lower socioeconomic status are more likely to experience symptoms of mental health distress after a natural disaster, and they should be the nurse's initial focus for an intervention program.
- D. Younger age male children of lower socioeconomic status are not the highest risk group for mental health distress after a natural disaster.

17. The client is in respiratory distress following exposure to an unknown substance, and requires oxygen- Which oxygen delivery device should the nurse plan to select to deliver an FIO₂ of 100%?



ANSWER: C

- A. A nasal cannula will only deliver an FIO₂ of 44% with oxygen flow rates at 6 L.
- B. The venturi mask will only deliver an FIO₂ of 24%—50%.
- C. The nonrebreather mask can deliver an FIO₂ of 100% with oxygen flow rates at 15 L. The oxygen reservoir bag contains only oxygen, and a valve keeps exhaled air from entering the reservoir bag. The bag must be inflated during oxygen delivery.
- D. The simple mask delivers FIO₂ of 40% to 60% at an oxygen flow rate of 5 to 10 L.

18. The nurse is supervising a basic life support class. Which action by the class participants would indicate the need for further instruction?

- A. Performing chest compressions at a depth of 1.5 inches on the adult client
- B. Implementing use of the head—tilt, chin-lift maneuver to open the airway
- C. Applying defibrillator pads to the client's bare chest upon AED arrival
- D. Using a bag-valve-mask device to administer ventilations to the client

ANSWER: A

- A. The recommended depth of chest compressions for the adult client is 2 inches.
- B. The head-tilt, chin-lift maneuver is an acceptable technique for opening the client's airway when no cervical spine injury is suspected.
- C. It is advised to attach AED pads to the client's bare chest as soon as the AED arrives to the scene.
- D. A bag-valve-mask device is one method for ventilating the client.

19. During resuscitation efforts of a trauma victim, the spouse tells the nurse that her husband has terminal cancer, has completed an advance I-ICD, and does not want CPR. What should be the nurse's next action?

- A. Contact medical records to see if the client's HCD is on file.
- B. In honor of the client's wishes, stop the resuscitation team's actions-
- C. Document the spouse's statement in the client's medical record.
- D. Inform the health-care provider in charge of the resuscitation team.

ANSWER: D

- A. Depending on the situation and status of the client, the HCP may want to review the HCD, but this is not the next action because it delays a decision.
- B. Even if the client requests no CPR, an IICP's order is required to carry out the request.
- C. The spouse's statements should be documented, but this is not the next action.
- D. The HCP must prescribe whether to withhold or terminate CPR even if it is specified in the client's HCD.

20. The client's spouse is allowed to be present during resuscitation efforts. Which statement made by the nurse is most appropriate?

- A. "Hold your loved one's hand; sometimes a recovering person will remember that touch."

- B. "I will show you where you can stand near your husband; another staff will be with you."
- C. "The resuscitation team needs to work quickly, so stay out of the way and do not interfere."
- D. "If resuscitation fails, the HCP will ask you if you want resuscitation efforts terminated."

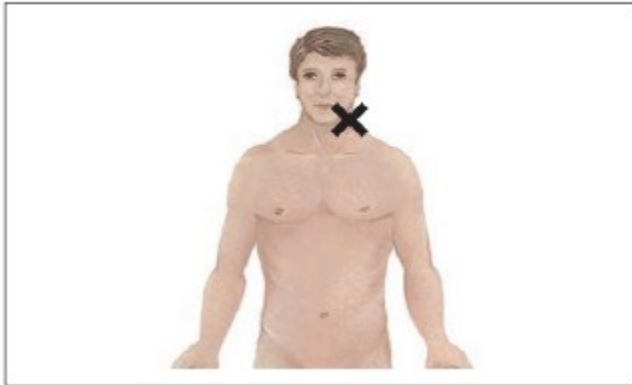
ANSWER: B

- A. Touching the client is unsafe. If a shock is delivered and another person is touching the client or bed, that person will also receive a shock.
- B. Family members allowed to be present during resuscitation should have a support person with them who is able to answer their questions and explain expected outcomes of treatment and procedures.
- C. Telling the wife to stay out of the way and not interfere is insensitive.
- D. While the HCP may ask the wife regarding terminating resuscitation should efforts fail, it is insensitive to present a preconceived idea of failure.

21 . Two nurses are performing CPR on an adult. The nurse performing chest compressions is on the right side of the client, and the nurse performing rescue breathing is on the left. The nurse performing rescue breathing checks the client's pulse to determine if the nurse's compressions are perfusing. Place an X at the location where the nurse should check the client's pulse.



ANSWER:



The person performing rescue breathing is on the left; thus the client's left carotid pulse should be checked.

22. Members of a resuscitation team arrive at the client's bedside with a defibrillator. The nurse and an NA are performing CPR. What should be the nurse's next action?

- A. Stop CPR while the resuscitation team applies the conduction pads and analyzes the rhythm.
- B. Complete a full minute of CPR, then apply the conduction pads and analyze the rhythm.
- C. Continue with CPR while the conduction pads are being applied and the rhythm analyzed-
- D. Continue with rescue breathing until the resuscitation team is ready to analyze the rhythm.

ANSWER: D

- A. CPR should continue, not be stopped; defibrillator pads are placed on the chest, or one on the chest and one on the back.
- B. Continuing with CPR for a full minute can delay defibrillation. Every minute that defibrillation is delayed worsens the prognosis.
- C. The rhythm cannot be accurately analyzed while CPR is being performed.
- D. Rescue breathing should continue until the resuscitation team applies the conduction pads and the team is ready to analyze the rhythm. The client should not be touched while the rhythm is being analyzed.

23. The nurse applies AED pads to the client's chest, and a shock is advised. What should be the nurse's next action?

- A. Push the AED button to deliver a shock.
- B. Clear everyone from touching the client.
- C. Place the client into the shock position.
- D. Nothing; the AED will deliver a shock.

ANSWER: B

- A. The nurse must push the button to deliver a shock but only after verifying that no one is touching the client.
- B. To deliver a shock, the nurse must first be sure that everyone is clear of the client.
- C. A shock position (modified Trendelenburg) is not used for defibrillation.
- D. The AED does not automatically deliver a shock.

24. When placing defibrillator pads on the client, the nurse observes that the client possibly has an implanted pacemaker on the left upper chest. Which statement demonstrates that the nurse knows where to correctly place the defibrillator pad?

- A. "One of the defibrillator pads should be placed directly over the pacemaker."
- B. "The defibrillator pads should be placed at least 8 cm away from the pacemaker."
- C. "The pads should not be used because defibrillation may damage the pacemaker."
- D. "One defibrillator pad should be placed on the upper back, the other a little lower."

ANSWER: B

- A. The defibrillator pads should not be placed over any implanted device such as an internal pace- maker or defibrillator if possible to prevent damage to the implanted device.
- B. It is recommended that the defibrillator pads be placed at least 8 cm away from any implanted device when possible to prevent damage to the implanted device.
- C. The pads can be used on clients with implanted pacemakers, but these cannot be directly over the implanted device site.
- D. Placing both defibrillator pads on the back will prevent the correct flow of current to shock the client effectively. The pads may be placed one anterior and one posterior.

25. While jogging, the nurse finds an adult lying on the ground. The nurse uses both tactile and verbal stimulation to determine that the client is unresponsive. What action should the nurse perform next?

- A. immediately dial 911 to activate emergency medical services-
- B. Check the carotid pulse to determine whether it is absent.
- C. Rapidly open the airway using the head-tilt, chin-lift maneuver-
- D. Promptly start chest compressions at a rate of 100 per minute.

ANSWER: B

- A. Activating the emergency response system is crucial to this client's care, but according to the adult chain of survival, activation comes second after recognition.
- B. Part of recognition of cardiac arrest is to establish if the client is unresponsive and to determine whether or not a pulse is present. Since the given scenario only describes ascertaining unresponsiveness, it would be most appropriate to check for a pulse next.
- C. The nurse should not attempt to open the airway without first assessing the respiratory status.
- D. Until recognition is complete it would be inappropriate for the nurse to begin chest compressions.

26. The nurse is teaching rescue breathing to the daughter of an adult client. Which statement indicates that the client understands how to perform rescue breathing?

- A. "I should provide one breath every 5 to 6 seconds."
- B. "I should provide one breath every 3 seconds."
- C. "I should provide at least 20 breaths per minute."
- D. "I should provide a breath every few minutes."

ANSWER: A

- A. Rescue breaths for adult clients should be administered at a rate of 1 breath every 5 to 6 seconds to provide optimal ventilation.
- B. Administering a breath every 3 seconds provides a rate of 20 breaths per minute. This is faster than recommended by the American Heart Association (AHA) for rescue breathing.
- C. A rate of 20 breaths per minute is faster than recommended by the AHA for rescue breathing.
- D. A rate of one breath every few minutes would be far too slow to provide adequate ventilation.

27. The nurse finds an unresponsive, pulseless client lying in a puddle of water in a shower. The resuscitation team would like to attach the AED to the client immediately. What intervention should the nurse implement first?

- A. Assist with defibrillator pad placement quickly to facilitate early defibrillation.
- B. Assist the team to move the client from the puddle of water before defibrillation.

- C. Dry the chest off and place the defibrillator pads on the client's anterior chest-
- D. Ensure that the team is performing adequate compressions during defibrillation.

ANSWER: B

- A. The defibrillator pads should be placed quickly; however, if the client is in a puddle of water, rescuers may be injured if a shock is delivered.
- B. For the safety of the rescuers, it is recommended that the client be moved from the puddle of water before defibrillation.
- C. The client's chest will need to be dry for the defibrillator pads to stick, but the priority is to move the client from the puddle first.
- D. No one should ever be touching the client when the defibrillator's shock is being delivered.

28. The home health nurse finds an adult client unresponsive and considers cardiopulmonary arrest. Which actions should the nurse perform? Select all that apply.

- A. Assess the client's pulse for at least 15 seconds-
- B. Quickly activate emergency medical services.
- C. Provide 100 chest compressions over a minute.
- D. Auscultate the client's heart and lung sounds-
- E. Use the fist to quickly hit the client's chest.

ANSWER: B, C

- A. According to the American Heart Association (AHA), pulse checks should take no longer than 10 seconds, not 15 seconds. If a pulse is not definitely detected within 10 seconds, chest compressions should begin.
- B. Early activation of EMS by calling 911 will provide additional help and activate advanced care.
- C. Providing chest compressions of at least 100 per minute is an appropriate goal for the client in cardiopulmonary arrest in order to optimize circulation.
- D. Auscultation of heart and lung sounds is not a recommended action for the client in cardiopulmonary arrest because it will delay CPR.
- E. Performing a chest blow may be indicated in a witnessed arrest when an AED is unavailable; this arrest was not witnessed.

29. The nurse is providing post resuscitation care to the client. The client's HR is 80 bpm, and the RR is 14 breaths per minute and regular. Which action should the nurse perform next?

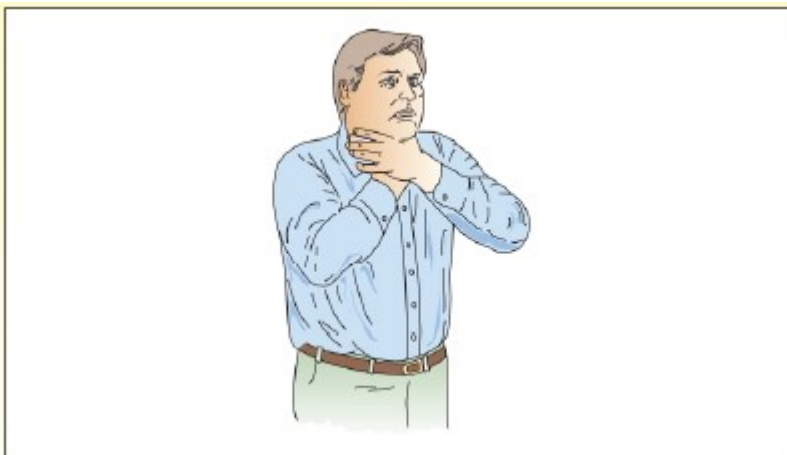
- A. Resume with bag-valve-mask ventilations at a rate of one breath every six seconds.

- B. Continue the chest compressions at a depth of two inches and rate of 100 per minute-
- C. Monitor the client closely until advanced life support personnel arrive at the scene.
- D. Press the “analyze” button on the AED to decide if defibrillation is needed at this time.

ANSWER: C

- A. Bag-valve-mask ventilation is needed when the client’s respirations are inadequate. A respiratory rate of 14 is normal.
- B. Chest compressions are needed when the client’s HR is insufficient. The client’s HR is normal at 80 bpm.
- C. Advanced life support personnel are needed to provide care for any client who was just resuscitated following cardiac arrest because the client may arrest again. When the client’s HR and respiratory effort are adequate, the nurse should frequently monitor these until the advanced life support team arrives.
- D. There is no need to reanalyze the client’s heart rhythm; the client has a normal heart rate and respiratory rate.

30. The nurse enters the client’s room and notes the client in the position illustrated. Which action should be taken by the nurse?



- A. Immediately yell for help.
- B. Ask the client if he is okay.
- C. Ask the client if he is choking.
- D. Call for the acute response team.

ANSWER: C

- A. The nurse should first determine if the client is choking before calling for help.
- B. Asking the client if he is okay will elicit a yes or no response if the client were choking, but then the nurse would still need to determine the client's problem.
- C. Hands crossed at the neck is the universal sign for choking. The nurse's first action is to ask the client if he is choking and, if so, to perform the Heimlich maneuver.
- D. The client is still responsive; there may not be a need for the ART if the object can be expelled by the Heimlich maneuver.

31. The nurse is performing abdominal thrusts on a conscious, choking client. Place the nurse's actions in the sequence in which they should be performed.

- A. Place both arms around the person's waist.
- B. Place the thumb side of the fist against the person's abdomen above the navel and below the xiphoid process-
- C. Press upward with firm, quick thrusts 6 to 10 times until the obstruction is cleared.
- D. Stand behind the person who is choking.
- E. Grasp the fist with the other hand.

ANSWER: D, A, B, E, C

- D. Stand behind the person who is choking.
- A. Place both arms around the person's waist.
- B. Place the thumb side of the fist against the person's abdomen above the navel and below the xiphoid process.
- E. Grasp the fist with other hand.
- C. Press upward with firm, quick thrusts 6 to 10 times until the obstruction is cleared.

32. The adult client reports to the nurse that he feels like he is choking. The client is coughing loudly, and his skin is acyanotic. What action should the nurse take next?

- A. Monitor the client closely for any deterioration.
- B. Implement immediate use of the Heimlich maneuver.
- C. Assist the client to the floor and begin rescue breathing.
- D. Perform chest thrusts over the lower half of the sternum.

ANSWER: A

- A. If the client can verbally communicate to the nurse and cough loudly, and if the skin is not cyanotic, then the airway is not occluded. This client should be closely observed by the nurse for signs of deterioration, but no other intervention is required at this time.
- B. The Heimlich maneuver is used for the client whose airway is obstructed by a foreign object.
- C. Rescue breathing is applicable only for the client with a pulse who is not breathing.
- D. Chest thrusts over the lower half of the sternum are appropriate for clients who are unresponsive, obese, or gravid.

33. The nurse sees the coworker assisting the obviously pregnant client who appears to be choking. The coworker's fist and hand placement is appropriate. Which description best describes the coworker's hand placement?

- A. At the level of the sternum
- B. At the level of the umbilicus
- C. Between the umbilicus and the sternum
- D. At the level of the sternal notch

ANSWER: A

- A. The woman who is in later stages of pregnancy may require adjustment of hand placement for Heimlich maneuver, with the rescuer's fist and hand placed over the sternum for chest thrusts.
- B. Chest thrusts for choking are not performed at the level of the umbilicus because it could damage the fetus.
- C. The usual site for chest thrusts for the choking client is between the umbilicus and the xiphoid; however, this client has a gravid abdomen. The rescuer's fist and hand should be displaced upward over the sternum.
- D. The sternal notch is not a recommended site for chest thrusts because it can be damaged.

34. During transport for an emergency surgery, the client experiences a cardiac arrest and dies. The client's family witnesses the arrest and is present when the client is pronounced dead. Which action by the nurse best demonstrates compassionate care?

- A. Explaining the actions of the code team in trying to save the life of their loved one
- B. Accompanying the family to a waiting room where they can contact other relatives

- C. Closing doors to allow the family to be alone with their loved one to say good-bye
- D. Asking questions to determine if there was some underlying cause for the arrest

ANSWER: C

- A. Explaining the actions of the code team depersonalizes the client and puts the focus on the code team's actions.
- B. Accompanying the family to a waiting room demonstrates respect for the family but is not the best response.
- C. Allowing family time alone with the deceased demonstrates compassionate care by treating the client with respect and dignity and recognizing that the client is part of a family unit.
- D. Asking questions to determine an underlying cause may induce family guilt about possibly missing the client's symptoms or information in the client's history.

35. The nurse is to administer epinephrine 1 mg to the client during a cardiac arrest. Epinephrine injection 1 : 10,000 is supplied in a syringe for administration. The 10 -mL syringe states 0.1 mg/mL. How many milliliters should the nurse administer?

_____ mL (Record your answer as a whole number.)

ANSWER: 10

Use a proportion formula and multiply the outside values, then the inside values and solve for X:

0.1 mg : 1 mL :: 1 mg : X mL; $0.1X = 1$;

$X = 1 \div 0.1$; $X = 10$.

Using desired over have formula:

$$\frac{X \text{ mL}}{1 \text{ mg}} = \frac{1 \text{ mL}}{0.1 \text{ mg}}$$

Cross multiply to obtain $0.1X = 1$; $X = 1 \div 0.1$;

$X = 10$.

36. The nurse is caring for the 4-year-old with respiratory distress. The child has pale, cool skin, is hypotensive, and has an HR of 54 bpm and decreasing despite respiratory support. Which intervention should the nurse implement?

- A. Begin chest compressions.
- B. Administer IV atropine.
- C. Perform defibrillation.
- D. Initiate external pacing.

ANSWER: A

- A. For pediatric clients with bradycardia and signs of inadequate perfusion despite appropriate ventilatory support, chest compressions should be started immediately.
- B. Atropine will increase the HR but not necessarily the child's cardiac output. With signs of inadequate perfusion, the child needs more cardiac output in the form of chest compressions-
- C. Defibrillation is inappropriate at this time. Delibrillation is suitable only for pulseless ventricular dysrhythmias, such as ventricular fibrillation and pulseless ventricular tachycardia.
- D. External pacing is not indicated at this time. The treatment of choice for the pediatric client who is being properly ventilated yet has bradycardia and signs of inadequate perfusion is chest compressions.

37. The resuscitation team has been performing CPR on the child for 15 minutes. The mother, who is present during the resuscitation, asks when CPR would be stopped. What is the most appropriate response by the nurse?

- A. "The physician will consider the amount of time passed before CPR is started and multiple factors before making a decision to stop CPR."
- B. "Every effort will be made to save your child. Sometimes CPR is performed for a long time, and a child is revived."
- C. "The physician will likely ask you about your feelings before making the decision to terminate CPR."
- D. "You seem concerned- Are you worried that CPR will be stopped too soon or that it will be performed too long?"

ANSWER: A

- A. The decision to terminate resuscitative efforts rests with the resuscitation team physician and is based on many factors, such as the amount of time passed before starting CPR and defibrillation, comorbid disease, prearrest

state, and initial arrest rhythm. This response directly answers the mother's question.

- B. Although the nurse is attempting to be reassuring, telling the mother that CPR is sometimes performed for a long time does not answer the mother's question.
- C. The physician may ask the parents' feelings about terminating CPR, but depending on the parents' emotional reaction to the situation, this may not happen.
- D. Using a therapeutic communication technique of reflection does not answer the mother's question.

38. The cardiac monitor of the 6-year-old shows ventricular fibrillation. Which interventions should the two responding nurses implement? Select all that apply.

- A. Auscultate the child's apical pulse for 10 seconds.
- B. Activate the facility emergency response system.
- C. Provide at least 100 chest compressions per minute.
- D. Prepare to cardiovert the child as soon as possible.
- E. Prepare to defibrillate the child as soon as possible.

ANSWER: B, C, E

- A. A pulse check should not take longer than 10 seconds. The carotid artery is the recommended pulse check site for the adult or child, not the apical pulse.
- B. Activating the emergency response system early is recommended in order to gain access to additional help and to activate advanced care.
- C. It is recommended that at least 100 chest compressions be provided per minute for the child in cardiopulmonary arrest.
- D. Cardioversion is not recommended for ventricular fibrillation because there is no QRS complex for synchronization.
- E. The child is in ventricular fibrillation; early defibrillation is indicated.

39. The nurse is performing CPR on the 5-year-old in asystolic cardiac arrest. A second rescuer arrives. The client remains pulseless and apneic. What intervention should the team provide next?

- A. Perform rescue breathing, giving one breath every 5 seconds.
- B. Change to 10 cycles of 15 compressions to 2 ventilations.
- C. Continue chest compressions at a depth of at least 1 inch.
- D. Defibrillate as soon as possible at 1 joule per kilogram.

ANSWER: B

- A. Although the correct rate of rescue breathing for the pediatric client is one breath every 3 to 5 seconds, rescue breathing is not an appropriate intervention for the client in cardiac arrest.
- B. Once a second rescuer arrives to the scene of a pediatric cardiac arrest, the compression! ventilation ratio changes from 30 compressions and 2 ventilations to 15 compressions and 2 ventilations.
- C. Chest compressions for the pediatric client over 1 year of age should be delivered at a depth of 2 inches, not 1 inch. Proper depth is important for providing suitable cardiac output-
- D. Defibrillation is not indicated in asystole, only ventricular fibrillation and pulseless ventricular tachycardia. For the pediatric client, 2 joules per kilogram is given for the initial shock and 4 joules per kilogram for subsequent shocks.

40. The nurse is performing CPR on a neonate. Which action indicates that the nurse needs further instruction on performing CPR on a neonate?

- A. Compresses the chest with two thumbs while the fingers encircle the chest.
- B. Delivers chest compressions on the lower third of the neonate's sternum.
- C. Completes a total of 100 compressions and 30 breaths over each minute.
- D. Raises the thumbs an inch from the chest between chest compressions.

ANSWER: D

- A. Compressions can be performed with two thumbs or with two fingers while a second hand supports the neonate's back.
- B. Compressions are performed on the lower third of the sternum to a depth of approximately one-third of the anterior-posterior diameter of the chest, or about 1½ inches.
- C. The compressions rate is 100 compressions and 30 breaths per minute to achieve approximately 130 events per minute.
- D. The thumbs should remain on the chest between chest compressions to maintain the correct position.

41 . Resuscitation efforts have been provided for two minutes for the 4-month-old in cardiac arrest, and CPR is now paused. The cardiac monitor shows sinus tachycardia. What intervention should the nurse implement next?

- A. Check the brachial pulse.
- B. Ready the defibrillator.
- C. Check for breathing.
- D. Prepare for transport.

ANSWER: A

- A. Pauses between two-minute rounds of CPR should be limited to less than 10 seconds. During this time the team should perform a pulse check and rhythm check. This will direct the team on how best to proceed with resuscitative care.
- B. Defibrillation is not indicated for sinus tachycardia. It is only necessary when the client is experiencing ventricular fibrillation or pulseless ventricular tachycardia.
- C. The pulse should be checked before observing for spontaneous breathing. The monitor could be displaying a rhythm in the absence of a pulse.
- D. The presence of a rhythm on the cardiac monitor does not necessarily indicate that a pulse has returned and that the infant is stable enough for transport to a higher level of care.

42. The nurse is attempting to relieve a foreign body air- way obstruction from an infant. The infant suddenly becomes unresponsive. Which action should the nurse perform next?

- A. Begin delivering back blows-
- B. Go and locate an AED.
- C. Begin chest compressions.
- D. Deliver rescue breathing.

ANSWER: C

- A. Back blows in the infant client with a foreign body airway obstruction are used only while the infant remains responsive.
- B. Leaving the infant to retrieve an AED could cause the infant harm.
- C. Initiation of chest compressions and CPR is recommended for all clients with foreign body airway obstruction who become unresponsive.
- D. Rescue breaths will not be effective in cases where the airway is occluded by a foreign body.

43. The nurse is one of many team members who respond to an infant in cardiopulmonary arrest. The nurse is directed to begin chest compressions while another maintains the infant's airway. What action should the nurse perform next?

- A. Begin compressions with the two-thumbs- encircling-chest technique-
- B. Begin compressions using the heel of one hand over the infant's sternum.
- C. Begin compressions after another person obtains intraosseous (IO) access.
- D. Begin compressions using the two-hand technique over the sternal wall.

ANSWER: A

- A. When two rescuers are available, the two- thumbs-encircling—chest technique is recommended for chest compressions on an infant.

- B. Chest compressions using a one-hand technique is appropriate for smaller children, not infants. With one hand on an infant, the rescuer would deliver compressions too deeply and too forcefully, or compress too large an area, causing harm.
- C. Chest compressions are priority in a cardiac arrest situation and should be performed prior to obtaining intraosseous (IO) or IV access.
- D. Chest compressions using a two-hand technique are appropriate for adults and larger children, not infants. The rescuer would deliver compressions too deeply and too forcefully, or compress too large an area on the infant, causing harm.

44. The nurse is providing basic life support teaching to the parent of the 2-year-old. Which statement made by the parent would indicate the need for further instruction?

- A. "Injury prevention in children over one year of age may avoid many cases of cardiac arrest."
- B. "Cardiopulmonary resuscitation compressions should be provided at a rate of 100 per minute."
- C. "Rescue breathing for children should be delivered at a rate of one breath every 5—6 seconds."
- D. "If a child is choking and the airway is blocked, the child won't be able to speak or cough."

ANSWER: C

- A. By preventing injury in children over 1 year of age, most cases of cardiac arrest in this population may also be avoided.
- B. The recommended rate of compressions for all clients regardless of age is 100 compressions per minute.
- C. The rate of delivered rescue breaths for the pediatric client should be one breath every 3 to 5 seconds. Breaths given at a rate of every 5 to 6 seconds would be appropriate for the adult client but too slow for the child.
- D. The inability to speak, cough, or cry is one of the hallmark indications of choking.

45. CPR is in progress when the client's wife and teenage son arrive. The nurse intercepts them and tries to move them away from the room, but the wife states, "He needs us there to pray for him!" The son keeps walking and attempts to enter. Which action is most appropriate?

- A. Call for a member of the clergy to be with the wife and son outside of the client's room-

- B. Explain that they will be taken into the room by a designated person who will stay with them.
- C. Touch the wife and son to console and detain them and explain what is taking place.
- D. Page for security to be available in case the client's wife and son become uncontrollable-

ANSWER: B

- A. While being outside the room with a member of the clergy is an option, the room door would be closed to protect the client's privacy.
- B. The 2010 CPR guidelines recommend allowing family presence during CPR with a designated person (clergy, social worker, or nurse) with them in the room.
- C. Detaining the wife and son is likely to be met with resistance.
- D. It is premature to page for security. Explaining that they would be accompanied in the room with a staff member may be sufficient to calm the family members.