Nursing

ABPANC-CAPA

American Board of Perianesthesia Nursing Certification: Certified Ambulatory Perianesthesia Nurse

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Question: 1

A patient is transferring from the Phase I to the Phase II recovery area following outpatient surgery. Which piece of information is most important for the perianesthesia nurse to communicate to the receiving nurse during hand-off?
Length of time the patient was NPO prior to surgery
Amount of IV fluids infused intraoperatively
Any changes in the patient's status postoperatively
Family concerns about transportation home

Answer: C

Explanation:
Reporting any changes in the patient's status postoperatively is critical for a safe and effective hand-off. Communicating alterations from baseline, new complications, or unexpected findings ensures the receiving nurse can anticipate needs and risks, potentially improving outcomes during the transition between phases.
The amount of IV fluids infused intraoperatively, while relevant, can usually be confirmed in the chart and is not as essential as direct, real-time patient status changes that could impact immediate care.
The length of time the patient was NPO before surgery has less immediate relevance during hand-off compared to dynamic, postoperative changes.
Family concerns about transportation home are important for discharge planning, but ensuring clinical hand-off of the patient's status takes precedence at the point of transition.

Question: 2

A pregnant woman in her third trimester requires an emergent surgery. What is a key anesthesia consideration in this scenario?

A. Positioning the patient prone to improve comfort during surgery
B. Decreasing the amount and depth of anesthesia to avoid overdosing the fetus
C. Monitoring closely for signs of supine hypotensive syndrome
D. Administering magnesium sulfate during the surgery to avoid uterine contractions

Answer: C

Explanation:
Monitoring closely for signs of supine hypotensive syndrome is essential. In pregnant patients, the enlarged uterus can compress the inferior vena cava, reducing venous return and causing hypotension when supine.
Decreasing the amount and depth of anesthesia to avoid overdosing the fetus is overly cautious and unnecessary. The focus should be on appropriate dosing and monitoring.
Positioning the patient prone is inappropriate and generally not viable during pregnancy. It could cause additional discomfort and complications.

Administering magnesium sulfate during the surgery to avoid uterine contractions is not standard. Magnesium sulfate is used to treat preterm labor or preeclampsia, not routinely for surgery.

Question: 3

A postoperative patient receiving opioid analgesia reports sudden chest pain and shortness of breath. Vital signs include HR 110, BP 110/64, RR 24, and SpO2 90% on 2L O2. What pathophysiological process should the nurse suspect?

A. Pulmonary embolism
B. Cerebral edema
C. Opioid overdose
D. Acute myocardial infarction

Answer: A

Explanation:
Pulmonary embolism should be suspected when a postoperative patient suddenly develops chest pain, tachycardia, dyspnea, and hypoxemia despite supplemental oxygen. The clinical picture is characteristic of a thromboembolic event due to immobility and recent surgery, which increase venous thromboembolism risk.
An opioid overdose would generally be characterized by respiratory depression and a decreased level of consciousness rather than increased respiratory rate and hypoxemia with chest pain in an alert patient.
Acute myocardial infarction can cause chest pain, but it is less commonly associated with sudden onset shortness of breath and hypoxemia as the primary features in the immediate postsurgical period; risk factors are not clearly indicated here.
Cerebral edema would more likely present with neurological changes like headache, altered consciousness, or focal deficits rather than isolated chest pain and shortness of breath.

Question: 4

A patient with schizophrenia needs outpatient surgery. What anesthesia-related consideration is most important for this patient?

A. Keeping the patient isolated to prevent sensory overload
B. Increasing the patient's psychiatric medication dosage before surgery
C. Using minimal sedation to improve patient awareness
D. Involving mental health professionals in care planning

Answer: D

Explanation:
Involving mental health professionals ensures comprehensive care addressing both physical and psychiatric needs, fostering continuity and tailored care.
Increasing the patient's psychiatric medication dosage before surgery should be guided by a mental health provider rather than as a routine preoperative adjustment.

Using minimal sedation improves awareness but may not address anxiety or procedural cooperation, which are also important. Minimizing sedation could also lead to an increased risk of an exacerbation of the underlying psychological condition.
Keeping the patient isolated prevents beneficial interactions and can increase anxiety. Ensuring supportive environments helps alleviate distress.

Question: 5

An elderly patient with a history of recurrent falls is scheduled for an outpatient procedure. What individualized preoperative intervention is most appropriate?

A. Advise the patient to limit clutter on their floor at home
B. Advise the patient to take small steps and look at their feet while walking
C. Assess for history of motion sickness
D. Perform a preoperative Braden scale to assess fall risk

Answer: A

Explanation:
Advising the patient to limit clutter on their floor at home is the most appropriate individualized preoperative intervention. This addresses one of the most modifiable risks for falls in the home environment and offers a practical strategy to reduce post-discharge fall risk, which is especially important after a procedure when the patient may be less steady.
Performing a preoperative Braden scale to assess fall risk is not appropriate because the Braden scale is primarily designed to evaluate the risk of pressure ulcers, not falls. Other assessments, such as the Morse Fall Scale, are more suitable, but in this context, home safety education is more directly relevant.
Assessing for a history of motion sickness is not specific to fall prevention and, while relevant to anesthesia planning, does not address the particular risk of falls after discharge.
Advising the patient to take small steps and look at their feet while walking may not address the root cause of home falls and could potentially increase the risk of tripping, as looking down can reduce awareness of obstacles at eye level.

Question: 6

A patient with a seizure disorder has been NPO for 6 hours pre-procedure and is now postanesthesi
a. What is the nurse's best priority to minimize the risk of a seizure?
A. Resume any prescribed oral anticonvulsant medications.
B. Provide IV lorazepam every 30 minutes until discharge
C. Ensure the patient is not exposed to any external stimuli
D. Encourage immediate ambulation

Answer: A

Explanation:

The best priority is to resume any prescribed oral anticonvulsant medications. Patients with seizure disorders are at increased risk for breakthrough seizures if their medication regimen is interrupted, so timely resumption decreases the risk of complications.
Providing IV lorazepam every 30 minutes until discharge is inappropriate unless the patient is actively seizing or there are clear indications for such frequent dosing, as this could lead to oversedation and other complications.
Ensuring the patient is not exposed to external stimuli may help limit triggers, but it does not address the underlying pathophysiology of potential medication lapse.
Encouraging immediate ambulation post-procedure is not related to seizure prevention and could actually precipitate a fall or injury if the patient is unsteady or at risk of a seizure.

Question: 7

A patient undergoing an awake craniotomy is anxious about the procedure. What nursing intervention is most helpful in alleviating anxiety?

A. Providing detailed procedural explanations
B. Teaching relaxation techniques
C. Explaining that no pain will be felt while awake
D. Administering prescribed sedatives

Answer: B

Explanation:
Teaching relaxation techniques is highly effective in managing anxiety, especially in awake procedures. Skills such as deep breathing and visualization can help patients maintain calmness and reduce anxiety during stressful experiences.
Administering prescribed sedatives might help with anxiety control, but awake craniotomies require the patient to be alert and responsive, making sedatives less preferable as a focused intervention.
Explaining that no pain will be felt while awake can be reassuring, but it may not fully address the patient's anxiety and may not be correct in some situations. Techniques for active coping are better at enhancing patient autonomy over emotional states.
Providing detailed procedural explanations is informative but may not directly help with anxiety mitigation. Overloading with information can sometimes increase anxiety compared to equipping patients with trustworthy self-regulation techniques.

Question: 8

A 30-year-old outpatient develops urticaria, angioedema, and hypotension following IV contrast exposure during a preoperative scan. Which primary pathophysiological effect is involved?

A. Decreased sympathetic control over vascular tone
B. Ischemia-induced acute renal failure
C. Acute suppression of cortisol production
D. Mast cell degranulation leading to systemic vasodilation

Answer: D

Explanation:
Mast cell degranulation leading to systemic vasodilation is correct because these symptoms indicate an anaphylactic reaction, in which allergen exposure causes mast cells to release histamine and other mediators, resulting in vasodilation, increased capillary permeability, and symptoms like urticaria, angioedema, and hypotension.
Ischemia-induced acute renal failure typically presents with decreased urine output and elevated creatinine rather than the acute allergic symptoms seen here.
Acute suppression of cortisol production is unrelated to the acute onset of allergic symptoms and does not explain the urticaria, angioedema, and hypotension.
Decreased sympathetic control over vascular tone might result in hypotension, but it does not account for the acute allergic signs and is not the pathophysiology behind anaphylaxis. This pathology instead describes neurogenic shock.

Question: 9

A PACU patient has a blood pressure of 82/54 mmHg. Which additional assessment most helps determine the significance of this finding?

A. Pupil size
B. Urinary color
C. Abdominal girth
D. Mental status

Answer: D

Explanation:
Assessing mental status is key in determining the clinical significance of hypotension. Mental status changes can indicate decreased cerebral perfusion, suggesting the patient is experiencing significant effects from low blood pressure.
Pupil size is less likely to reflect the immediate hemodynamic impact of hypotension and is generally used to assess neurological status rather than circulatory compromise.
Urinary color can be useful for monitoring renal function and hydration, but it is not most helpful for assessing the effects of a current episode of hypotension.
Abdominal girth is only a concern in this context if internal bleeding is suspected. Typically, the immediate concern is how well vital organs, especially the brain, are being perfused. Thus, mental status is the priority assessment.

Question: 10

A patient in the PACU develops persistent bradycardia and is found to be taking valerian root at home. What is the nurse's priority intervention?

A. Discharge the patient as planned
B. Encourage the patient not to take valerian root in the future

C. Notify the anesthesia provider and monitor cardiovascular status
D. Administer atropine immediately

Answer: C

Explanation:
The priority for a patient who is bradycardic and has a history of valerian root use is to notify the anesthesia provider and carefully monitor cardiovascular status. Valerian root can cause central nervous system depression and interact with anesthetic agents, increasing risks related to heart rate and stability.
Administering atropine should only be done if bradycardia is symptomatic or hemodynamically unstable and with provider direction; it isn't an automatic initial response without further assessment.
Discharging the patient as planned is inappropriate since the patient's bradycardia may be related to complex pharmacological effects and requires additional medical evaluation.
Encouraging the patient not to take valerian root in the future is a useful educational point for discharge, but it does not address the immediate clinical need of monitoring and response for ongoing bradycardia.

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