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Test Bank for High Acuity Nursing 6th Edition by Wagner and Pierce

Chapter 15: Alterations in Cardiac Output

Question 1

Type: MCSA

A patient, admitted with the diagnosis of stroke, has left hemiparesis involving the face, arm, and leg. The nurse explains that this stroke most likely involves which artery?

1. Right vertebral
2. Left posterior communicating
3. Left middle cerebral
4. Right middle cerebral

Correct Answer: 4

Rationale 1: The right vertebral area is not the most common site of damage causing a stroke.

Rationale 2: The posterior communicating arteries are part of the circle of Willis, but are not the most common areas involved in stroke.

Rationale 3: The middle cerebral arteries supply blood to the lateral surfaces of the frontal, temporal, and parietal lobes. These arteries are often involved in stroke. The motor fibers cross so the left side of the brain controls the right side of the body.

Rationale 4: The middle cerebral arteries supply blood to the lateral surfaces of the frontal, temporal, and parietal lobes. These arteries are often involved in stroke. The motor fibers cross so the right side of the brain controls the left side of the body.

Global Rationale:

Cognitive Level: Analyzing

Client Need: Physiological Integrity
Client Need Sub: Physiological Adaptation

Nursing/Integrated Concepts: Nursing Process: Assessment

Learning Outcome: 15-1

Question 2

Type: MCSA

A patient recovering from a frontal craniotomy is positioned with the head of the bed elevated 45 degrees at all times. What rationale would the nurse provide for this position?

1. The brain will compress the cerebral veins less in this position.
2. The ventricles of the brain will drain better in this position.
3. This position allows for less pain for the patient.
4. The cerebral spinal veins are valveless and drain by gravity.

Correct Answer: 4

Rationale 1: This statement is not physiologically correct.

Rationale 2: This statement is not physiologically correct.

Rationale 3: There is no reason that pain would be reduced in this position.

Rationale 4: The cerebral spinal veins drain best via gravity, an important characteristic to remember when caring for patients with the risk for increased intracranial pressure as would be present in intracranial surgeries.

Global Rationale:

Cognitive Level: Applying

Client Need: Physiological Integrity

Client Need Sub: Physiological Adaptation

Nursing/Integrated Concepts: Nursing Process: Implementation
Learning Outcome: 15-1

Question 3

Type: MCSA

The nurse is providing care for a patient who sustained a severe head injury. The nurse would intervene to prevent which occurrence that increases cerebral blood flow?

1. Oversedation
2. Hypothermia
3. Fever
4. Paralysis

Correct Answer: 3

Rationale 1: Sedation will decrease cerebral blood flow.

Rationale 2: Hypothermia will decrease cerebral blood flow.

Rationale 3: Fever increases the body's metabolic rate and will increase cerebral blood flow.

Rationale 4: Paralysis, often initiated chemically, will decrease cerebral blood flow.

Global Rationale:

Cognitive Level: Applying

Client Need: Physiological Integrity

Client Need Sub: Physiological Adaptation

Nursing/Integrated Concepts: Nursing Process: Planning

Learning Outcome: 15-1

Question 4

Type: MCSA

The nurse is providing care for a patient who is at risk for developing an increase in intracranial pressure due to swelling of the brain. The nurse is aware that this increased brain size must be accompanied by which other change if intracranial pressure is to remain stable?

1. There will be an increase in the blood flow to the brain.
2. There is a decrease in the blood–brain barrier.
3. There must be a decrease in another of the intracranial compartments.
4. There will be an increase in the production of cerebrospinal fluid.

Correct Answer: 3

Rationale 1: Blood flow to the brain would decrease as more space is taken up by the brain.

Rationale 2: The blood–brain barrier does not increase or decrease in response to changes in the brain.

Rationale 3: The contents of the intracranial vault include the brain, cerebral blood volume, and cerebrospinal fluid. The Monro–Kellie hypothesis states that as the content of one of the intracranial compartments increases, it is at the expense of the other two. The correct answer is that if there is an increase in the volume of brain tissue, there will need to be a decrease in another of the intracranial compartments.

Rationale 4: An increased amount of cerebrospinal fluid would increase the pressure in the intracranial vault.

Global Rationale:

Cognitive Level: Analyzing

Client Need: Physiological Integrity

Client Need Sub: Physiological Adaptation

Nursing/Integrated Concepts: Nursing Process: Assessment

Learning Outcome: 15-2

Question 5

Type: MCSA

A nurse is monitoring the intracranial pressure of a patient with a closed-head injury. Which pressure would the nurse evaluate as requiring no additional intervention?

1. 12 mm Hg
2. 22 mm Hg
3. 25 mm Hg
4. 30 mm Hg

Correct Answer: 1

Rationale 1: The normal intracranial pressure ranges from 0 to 15 mm Hg.

Rationale 2: This pressure exceeds normal.

Rationale 3: This pressure exceeds normal.

Rationale 4: This pressure exceeds normal.

Global Rationale:

Cognitive Level: Applying

Client Need: Physiological Integrity

Client Need Sub: Physiological Adaptation

Nursing/Integrated Concepts: Nursing Process: Assessment

Learning Outcome: 15-2

Question 6

Type: MCSA

A nurse is providing care for a patient with increased intracranial pressure and is monitoring cerebral perfusion pressure. The nurse compares measurements to which critical normal value?

1. 50 mm Hg
2. 70 mm Hg
3. 120 mm Hg
4. 30 mm Hg

Correct Answer: 2

Rationale 1: The CPP critical value is higher than 50 mm Hg.

Rationale 2: In order to ensure adequate cerebral oxygenation, the cerebral perfusion pressure must be maintained at greater than 70 mm Hg.

Rationale 3: CPP of 120 mm Hg is high and will result in a loss of autoregulation. This is not the critical value to which the nurse compares actual measurements.

Rationale 4: A CPP of 30 mm Hg is low and will result in loss of autoregulation. This is not the critical value to which the nurse compares actual measurements.

Global Rationale:

Cognitive Level: Applying

Client Need: Physiological Integrity

Client Need Sub: Physiological Adaptation

Nursing/Integrated Concepts: Nursing Process: Assessment

Learning Outcome: 15-2

Question 7

Type: MCSA

A patient with a head injury has a mean arterial pressure of 70 mm Hg and an intracranial pressure of 20 mm Hg. Which cerebral perfusion pressure would the nurse document for this patient?

1. 50 mm Hg
2. 90 mm Hg
3. 70/40 mm Hg
4. 40/70 mm Hg

Correct Answer: 1

Rationale 1: The cerebral perfusion pressure is calculated as the mean arterial pressure minus the intracranial pressure. In this patient the cerebral perfusion pressure would be inadequate and intervention is needed.

Rationale 2: This calculation is incorrect for the values given.

Rationale 3: This calculation is incorrect for the values given.

Rationale 4: This calculation is incorrect for the values given.

Global Rationale:

Cognitive Level: Analyzing

Client Need: Physiological Integrity

Client Need Sub: Physiological Adaptation

Nursing/Integrated Concepts: Nursing Process: Assessment

Learning Outcome: 15-3

Question 8

Type: MCSA

A nurse is monitoring a patient who sustained a head injury. The nurse recognizes which finding as the earliest sign of change in neurologic status?

1. The patient cannot remember where he is.
2. The patient's pupil size is increased.
3. The patient's blood pressure has increased.
4. The patient exhibits decorticate posturing when stimulated.

Correct Answer: 1

Rationale 1: The level of consciousness is the most important indicator of neurological function in the high-acuity patient.

Rationale 2: Pupillary changes do occur with neurological damage but are not the earliest signs.

Rationale 3: Changes in vital sign can indicate neurological damage, but are not the earliest signs.

Rationale 4: Posturing is an important finding associated with neurologic damage, but is not the earliest sign.

Global Rationale:

Cognitive Level: Analyzing

Client Need: Physiological Integrity

Client Need Sub: Physiological Adaptation

Nursing/Integrated Concepts: Nursing Process: Assessment

Learning Outcome: 15-3

Question 9

Type: MCSA

A nurse is monitoring a patient's Glasgow Coma Scale (GSC). At which point would the nurse document that the patient is comatose?

1. 11
2. 15

- 3. 7
- 4. 9

Correct Answer: 3

Rationale 1: A score of 11 indicates some impairment, but does not indicate coma.

Rationale 2: A GCS of 15 is normal.

Rationale 3: A score of 7 or less indicates a significant alteration in the level of consciousness and the development of coma.

Rationale 4: A GCS score of 9 indicates significant neurological changes, but does not indicate coma.

Global Rationale:

Cognitive Level: Applying

Client Need: Physiological Integrity

Client Need Sub: Physiological Adaptation

Nursing/Integrated Concepts: Nursing Process: Assessment

Learning Outcome: 15-3

Question 10

Type: MCMA

The nurse, assessing a patient with a Glasgow Coma Score 4, finds the patient's pupils to be pinpoint and nonreactive to light. The nurse takes into consideration that this finding can be due to which situations?

Note: Credit will be given only if all correct choices and no incorrect choices are selected.

Standard Text: Select all that apply.

1. The patient was given atropine sulfate for bradycardia.
2. The patient has increased blood glucose.
3. The patient may have taken an opioid drug overdose.
4. The patient has sustained compression of the oculomotor nerve.
5. The patient has sustained damage to the pons.

Correct Answer: 3,5

Rationale 1: Recent administration of atropine sulfate leads to dilated pupils.

Rationale 2: Metabolic disorders cause small but reactive pupils.

Rationale 3: Opioid drug overdose will result in pinpoint, nonreactive pupils.

Rationale 4: Compression of the oculomotor nerve causes a unilateral fixed and dilated pupil.

Rationale 5: Damages to the pons will result in fixed and pinpoint pupils.

Global Rationale:

Cognitive Level: Analyzing

Client Need: Physiological Integrity

Client Need Sub: Physiological Adaptation

Nursing/Integrated Concepts: Nursing Process: Assessment

Learning Outcome: 15-4

Question 11

Type: MCMA

A nurse is assisting with a patient's oculoccephalic and oculovestibular reflex assessment. How should the nurse prepare for this testing?

Note: Credit will be given only if all correct choices and no incorrect choices are selected.

Standard Text: Select all that apply.

1. Prepare for oculocephalic testing to be done after oculovestibular testing.
2. Ensure that cervical spine injury has been ruled out.
3. Obtain cold water and a syringe
4. Be certain there is no perforation of the tympanic membrane in the side being tested.
5. Tell the patient he will be asked to report any feeling of numbness or vertigo.

Correct Answer: 2,3,4

Rationale 1: Patients with an absent oculocephalic reflex may have a normal oculovestibular reflex, so testing for oculovestibular reflex should follow oculocephalic reflex.

Rationale 2: Oculocephalic testing requires moving the patient's head from side-to-side, so it should not be performed until the cervical spine is cleared of injury.

Rationale 3: Oculovestibular reflex testing includes injecting cold water into the patient's ear.

Rationale 4: Since oculovestibular testing includes placing water in the ear, it is contraindicated if there is a perforation or tear in the tympanic membrane.

Rationale 5: Oculovestibular and oculocephalic testing is done on patients with suspected brain stem depression. The patients are not conscious.

Global Rationale:

Cognitive Level: Applying

Client Need: Physiological Integrity

Client Need Sub: Physiological Adaptation

Nursing/Integrated Concepts: Nursing Process: Planning

Learning Outcome: 15-4

Question 12

Type: MCSA

A patient with a head injury is being monitored with an intraventricular catheter. The nurse would design interventions based upon which priority nursing diagnosis (NDX)?

1. Risk for Injury
2. Decreased Intracranial Adaptive Capacity
3. Altered Comfort, Acute Pain
4. Risk for Infection

Correct Answer: 4

Rationale 1: This patient is at risk for injury, but this is not the priority NDX.

Rationale 2: This patient likely has at risk for decreased intracranial adaptive capacity but this is not the priority NDX.

Rationale 3: This patient may have altered comfort due to injury, procedures, or positioning, but this is not the priority NDX.

Rationale 4: The placement of an intraventricular catheter to monitor intracranial pressure places the patient at risk for infection. The nurse must practice meticulous infection control measures while caring for these patients.

Global Rationale:

Cognitive Level: Analyzing

Client Need: Physiological Integrity

Client Need Sub: Physiological Adaptation

Nursing/Integrated Concepts: Nursing Process: Diagnosis

Learning Outcome: 15-4

Question 13

Type: MCSA

A patient with an intraventricular catheter for the assessment of increased intracranial pressure is demonstrating A waves. The nurse would assess for which other findings?

Note: Credit will be given only if all correct choices and no incorrect choices are selected.

1. Decreasing level of consciousness
2. Pupillary changes
3. Posturing
4. Variations in blood pressure
5. Changes in the wave associated with respiration

Correct Answer: 1,2,3

Rationale 1: A waves are clinically significant and typically occur when ICP is elevated. A decreasing level of consciousness may occur with this elevation.

Rationale 2: A waves are clinically significant and typically occur when ICP is elevated. Pupillary changes may occur with this elevation.

Rationale 3: A waves are clinically significant and typically occur when ICP is elevated. Posturing may occur with this elevation.

Rationale 4: C waves occur with variations in blood

pressure. **Rationale 5:** C waves vary according to

respiration. **Global Rationale:**

Cognitive Level: Analyzing

Client Need: Physiological Integrity

Client Need Sub: Physiological Adaptation

Nursing/Integrated Concepts: Nursing Process: Assessment

Learning Outcome: 15-4

Question 14

Type: MCMA

A patient who sustained a traumatic brain injury is being sent for a CT scan. Which nursing statements would help the patient's spouse understand the rationale for a CT scan rather than an MRI?

Note: Credit will be given only if all correct choices and no incorrect choices are selected.

Standard Text: Select all that apply.

1. "CT scans are easier for patients with head injuries because movement is allowed."
2. "We can get results from a CT scan quicker than from an MRI."
3. "MRIs are more costly so the least expensive test is always done first."
4. "CT scans are noninvasive."
5. "CT scans show more detail than an MRI."

Correct Answer: 4

Rationale 1: CT scans do not necessarily provide more patient movement while the test is being conducted.

Rationale 2: The CT scan is the test of choice with head injury patients because MRIs take longer.

Rationale 3: MRIs are typically more expensive, but the nurse should not use this as a rationale for the choice when talking with the family.

Rationale 4: CT scans are noninvasive.

Rationale 5: MRIs show more tissue detail than do CT scans.

Global Rationale:

Cognitive Level: Analyzing

Client Need: Physiological Integrity

Client Need Sub: Physiological Adaptation

Nursing/Integrated Concepts: Nursing Process: Implementation

Learning Outcome: 15-4

Question 15

Type: MCSA

The family of a comatose patient asks the nurse if there is any way to know if their loved one will ever “wake up.” The nurse should consider which test when formulating a response to this concern?

1. Evoked potentials
2. CT scan
3. Electroencephalogram
4. Lumbar puncture

Correct Answer: 1

Rationale 1: Evoked potentials are recordings of cerebral electrical impulses generated in response to visual, auditory, or somatosensory stimuli. They are used to assist in the evaluation of the location and extent of brain dysfunction after head injury. Evoked potentials may be useful in predicting coma outcome.

Rationale 2: A CT scan can help diagnose structural changes, but does not help predict outcome of a coma.

Rationale 3: Electroencephalography allows recording of the electrical activity of the brain using electrodes attached to the scalp but is not used to help predict the outcome of a coma.

Rationale 4: Lumbar puncture can help determine cause of coma but does not help predict outcome of coma.

Global Rationale:

Cognitive Level: Applying

Client Need: Physiological Integrity

Client Need Sub: Physiological Adaptation

Nursing/Integrated Concepts: Nursing Process: Planning

Learning Outcome: 15-3

Question 16

Type: MCSA

A patient was the unrestrained driver of a car that was struck head on by another vehicle. During initial assessment the nurse observes another nurse using supraorbital pressure to assess for response. What nursing intervention is indicated?

1. Hold the patient's head still so that the test will be valid.
2. Stop the procedure.
3. Ask the nurse to repeat the procedure on the other orbit.
4. Document the response as 1+, 2+, 3+, or 4+.

Correct Answer: 2

Rationale 1: The nurse should not attempt to hold the patient's head still.

Rationale 2: Since this patient is at high risk for facial fractures, supraorbital pressure should not be used.

Rationale 3: The procedure should not be repeated.

Rationale 4: The nurse should intervene in a different manner. **Global Rationale:**

Cognitive Level: Analyzing

Client Need: Physiological Integrity

Client Need Sub: Physiological Adaptation

Nursing/Integrated Concepts: Nursing Process: Implementation

Learning Outcome: 15-3

Question 17

Type: MCMA

A nurse is preparing to conduct a neurological assessment on a patient who is not suspected for having neurological impairment. Which tests should the nurse perform?

Note: Credit will be given only if all correct choices and no incorrect choices are selected.

Standard Text: Select all that apply.

1. Observation for level of consciousness
2. Checking pupillary response to light
3. Ability to count by serial 7s
4. Assessing the blood pressure
5. Visual acuity

Correct Answer: 1,2,3,4

Rationale 1: Simple testing for level of consciousness includes observing the patient for response to auditory or tactile stimuli.

Rationale 2: Simple penlight testing for pupillary response to light is a part of the abbreviated neuro check.

Rationale 3: Ability to count by serial 7s is not part of the abbreviated neuro check.

Rationale 4: Vital sign assessment is part of the abbreviated neuro check.

Rationale 5: Visual acuity is not a part of the abbreviated neuro check.

Global Rationale:

Cognitive Level: Applying

Client Need: Physiological Integrity

Client Need Sub: Physiological Adaptation

Nursing/Integrated Concepts: Nursing Process: Assessment

Learning Outcome: 15-3

Question 18

Type: MCSA

Following a stroke a patient is diagnosed with expressive aphasia. What nursing intervention is indicated?

1. Speak slowly and face the patient directly when speaking.
2. Speak at a slightly louder volume.
3. Watch the patient carefully for behavioral clues.
4. Decrease environmental stimuli before attempting to communicate with the patient.

Correct Answer: 3

Rationale 1: The patient with expressive aphasia can understand speech, so this action is not necessary.

Rationale 2: The patient with expressive aphasia can understand speech, so it is not necessary to speak at a louder volume.

Rationale 3: The patient with expressive aphasia cannot write or use language. The nurse should observe for behavioral clues to the patient's needs.

Rationale 4: The patient with expressive aphasia can understand speech, so decreasing environmental stimuli is not necessary for the purpose of communication.

Global Rationale:

Cognitive Level: Applying

Client Need: Physiological Integrity

Client Need Sub: Physiological Adaptation

Nursing/Integrated Concepts: Nursing Process: Planning

Learning Outcome: 15-3

Question 19

Type: MCSA

A nurse is starting an intravenous line in a patient being treated for a head injury. Suddenly the patient extends his legs and demonstrates extreme plantar flexion. What action should be taken by the nurse?

1. Document the presence of decorticate posturing.
2. Immediately stop the attempt at intravenous insertion and obtain a blood pressure reading.
3. Assess the position of the patient's arms.
4. Administer intravenous sedation as quickly as possible after access is obtained.

Correct Answer: 3

Rationale 1: It is not possible to assess decorticate posturing from this scenario.

Rationale 2: It is important to gain IV access for this patient. Posturing to noxious stimuli indicates brain damage. Blood pressure is not pertinent at this time.

Rationale 3: The nurse should assess the position of the patient's arms to determine if decorticate or decerebrate posturing is present.

Rationale 4: Administering sedation is not indicated at this time as assessment is continuing.

Global Rationale:

Cognitive Level: Analyzing

Client Need: Physiological Integrity

Client Need Sub: Physiological Adaptation

Nursing/Integrated Concepts: Nursing Process: Assessment

Learning Outcome: 15-3

Question 20

Type: MCMA

A nurse is assisting with a patient's oculocephalic and oculovestibular reflex assessment. How should the nurse prepare for this testing?

Note: Credit will be given only if all correct choices and no incorrect choices are selected.

Standard Text: Select all that apply.

1. Prepare for oculocephalic testing to be done after oculovestibular testing.

2. Ensure that cervical spine injury has been ruled out.
3. Obtain cold water and a syringe
4. Be certain there is no perforation of the tympanic membrane in the side being tested.
5. Tell the patient he will be asked to report any feeling of numbness or vertigo.

Correct Answer: 2,3,4

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Rationale 3: Oculovestibular reflex testing includes injecting cold water into the patient's ear.

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Rationale 5: Oculovestibular and oculoccephalic testing is done on patients with suspected brain stem depression. The patients are not conscious.

Global Rationale: