Nursing
ABPANC-CPAN
American Board of Perianesthesia Nursing Certification: Certified Post Anesthesia Nurse

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Question: 1

A perianesthesia nurse is caring for a patient who has just undergone surgery and is still sedated. The patient's spouse requests detailed postoperative updates. What is the nurse's best course of action in this situation?

A. Confirm the spouse's legal authority before sharing any information
B. Provide general recovery information to avoid delay
C. Inform the spouse immediately to promote transparency
D. Ask the physician to provide the update instead

Answer: A

Explanation:
The best course of action is to confirm the spouse's legal authority before sharing any detailed health information. This protects the patient's right to confidentiality and aligns with HIPAA and professional standards. Even spouses do not automatically have access to protected health information unless the patient has given explicit consent or documentation indicates authorized disclosure.
Providing general recovery information may seem harmless, but could unintentionally breach patient confidentiality. Without proper authorization, even vague medical updates can constitute a violation of privacy laws and hospital policy.
Informing the spouse immediately to promote transparency prioritizes perceived openness over legal compliance. While transparency is important, it must be balanced with legal and ethical obligations to the patient's privacy, especially when the patient cannot participate.
Asking the physician to provide the update does not eliminate the nurse's responsibility to verify appropriate disclosure. The nurse is still ethically and legally obligated to ensure that protected information is shared only with authorized individuals, regardless of who delivers the message.

Question: 2

A patient is ready to be transferred from the PACU to the medical-surgical unit. The perianesthesia nurse must ensure what condition is met before initiating transfer?

A. Anesthesia has completed the operative note
B. Postoperative diet has been resumed
C. The receiving unit confirms readiness
D. Family is present to accompany the patient

Answer: C

Explanation:

The receiving unit confirming readiness is essential before the transfer can proceed. Safe patient handoff requires both teams to be available and prepared to accept and monitor the patient. This ensures continuity of care and prevents unsafe delays or gaps in monitoring.
Family presence is supportive but not a required condition for transfer. While it may help ease the patient's transition, it does not impact clinical readiness or safety in transfer.
Postoperative diet resumption is not a prerequisite for PACU discharge to the surgical unit. Many patients remain NPO until further assessment or surgeon orders, and diet advancement typically occurs on the floor.
Completion of the anesthesia operative note is part of the documentation but is not required to initiate patient transfer if all clinical criteria are met. Nursing handoff and patient safety take priority during the physical transition between units.

Question: 3

A patient in the PACU reports taking saw palmetto for BPH. Which post-op complication should the nurse closely monitor?

A. Hallucinations
B. Hypertension
C. Hypoglycemia
D. Hematuria

Answer: D

Explanation:
Hematuria is the post-op complication the nurse should most closely monitor in a patient taking saw palmetto. Saw palmetto has mild anticoagulant and antiplatelet properties, which may increase the risk of bleeding during or after surgery. This can manifest as hematuria, especially in procedures involving the genitourinary tract.
Hypertension is not commonly associated with saw palmetto use; it is not a primary concern linked to this supplement.
Hallucinations are not a known side effect of saw palmetto and are more likely associated with other medications, metabolic disturbances, or anesthesia-related factors.
Hypoglycemia is not a recognized risk with saw palmetto; this condition is more typically associated with insulin, sulfonylureas, or supplements like ginseng.

Question: 4

When educating a patient about the postoperative use of an incentive spirometer, which instruction should the nurse provide?

A. "Inhale deeply through the device and then cough forcefully."
B. "Hold the device at eye level and inhale slowly to raise the indicator."
C. "Exhale solely into the device to completely clear your lungs."
D. "Use the device at least once daily to prevent lung complications."

Answer: B

Explanation:
The correct technique for using an incentive spirometer is to instruct the patient to hold the device at eye level and inhale slowly. This practice encourages lung expansion, prevents atelectasis, and improves oxygenation after surgery. Eye-level positioning allows patients to monitor progress and maintain proper form.
Instructing the patient to inhale and then cough forcefully may be part of pulmonary hygiene, but it is not the primary instruction for using the spirometer. The spirometer's purpose is focused on slow inhalation to expand the lungs, not the act of coughing itself.
Exhaling into the device is incorrect and reflects a misunderstanding of its function. Incentive spirometers are designed to promote deep inhalation, not exhalation.
Using the device only once daily is inadequate. Patients are typically instructed to use it frequently, up to multiple times per hour, to effectively prevent postoperative pulmonary complications.

Question: 5

Following emergence from general anesthesia, a patient becomes agitated and hypertensive. The anesthesiologist suspects inadequate reversal of a benzodiazepine. Which reversal agent should the nurse anticipate administering?

A. Physostigmine
B. Dantrolene
C. Naloxone
D. Flumazenil

Answer: D

Explanation:
Flumazenil is the correct reversal agent for benzodiazepines. It acts as a competitive antagonist at the GABA receptor, reversing the sedative, anxiolytic, and amnestic effects of drugs like midazolam and diazepam. It is appropriate in cases of suspected benzodiazepine-induced agitation or oversedation.
Naloxone is an opioid antagonist and is used for reversing the effects of opioid drugs such as fentanyl or morphine. It does not reverse benzodiazepine effects and would not address the suspected cause of the patient's symptoms.
Dantrolene is used to treat malignant hyperthermia, not benzodiazepine overdose. It works by reducing calcium release in muscle tissue and has no role in managing sedation or agitation due to benzodiazepines.
Physostigmine is used to reverse central anticholinergic toxicity and is not indicated for benzodiazepine reversal. It may cause seizures or bradycardia and is not the appropriate antidote in this clinical scenario.

Question: 6

A diabetic patient with poorly controlled blood glucose undergoes a laparoscopic procedure. Postoperatively, the wound appears erythematous with delayed healing. What is the most likely physiologic reason for impaired healing in this patient?

A. Suppressed histamine release from mast cells
B. Increased insulin receptor sensitivity in tissues
C. Decreased collagen breakdown and angiogenesis
D. Reduced leukocyte chemotaxis due to hyperglycemia

Answer: D

Explanation:
Reduced leukocyte chemotaxis due to hyperglycemia is the most likely reason for impaired wound healing in this diabetic patient. Hyperglycemia interferes with multiple aspects of the immune response, particularly by impairing neutrophil function and chemotaxis, which delays bacterial clearance and prolongs inflammation. These are key contributors to delayed wound healing and increased risk of infection.
Suppressed histamine release is not a major factor in delayed wound healing and is not primarily influenced by hyperglycemia.
Increased insulin receptor sensitivity is not characteristic of poorly controlled diabetes; insulin resistance can be present, further impairing metabolic and healing processes.
Decreased collagen breakdown would theoretically promote healing; impaired healing in diabetes is more often due to reduced collagen synthesis and impaired angiogenesis, not the reverse.

Question: 7

A perianesthesia nurse must monitor for signs of anesthetic overdose. Which sign would warrant immediate escalation?

A. Light snoring and relaxed jaw
B. Absence of light reflex in dilated pupils
C. Shallow, but regular respirations
D. Bradycardia with an O2 saturation of 95%

Answer: B

Explanation:
The absence of light reflex in dilated pupils is a key indicator of Stage IV anesthesia and warrants immediate escalation. This finding reflects brainstem depression and is often accompanied by respiratory and cardiovascular compromise, requiring prompt intervention to prevent cardiopulmonary arrest.
Shallow but regular respirations may occur in light to moderate anesthesia and are not, by themselves, indicative of overdose. As long as oxygenation is adequate and other vital signs are stable, this pattern can be monitored with supportive care.

Light snoring and a relaxed jaw are common in patients under moderate sedation or recovering from general anesthesia. These signs suggest partial airway obstruction but do not signify overdose unless accompanied by hypoventilation or hypoxia.
Bradycardia with an O2 saturation of 95% should be monitored, but if the patient remains perfused and oxygenated, it does not immediately suggest an anesthetic overdose. Escalation would depend on trending and associated symptoms.

Question: 8

A 4 year old emerges from anesthesia with stridor, indrawing, and an SpO2 of 86% despite 4 L/min nasal cannula oxygen. Which immediate nursing action is most appropriate?

A. Increase the cannula flow to 10 L/min and recheck in 30 seconds
B. Elevate the head of the bed and obtain an arterial blood gas sample
C. Prepare racemic epinephrine for nebulization while paging respiratory therapy
D. Apply a tightly sealed bag mask device and deliver two slow rescue breaths

Answer: D

Explanation:
Applying a tightly-sealed bag-mask device and delivering rescue breaths is the most appropriate immediate response. The presence of stridor, indrawing, and persistent hypoxemia despite supplemental oxygen indicates upper airway obstruction and inadequate ventilation. Manual ventilation ensures airway patency and effective oxygen delivery while definitive management is initiated.
Increasing the cannula flow to 10 L/min may provide a modest improvement in oxygen delivery but does not resolve the underlying airway compromise. With clear signs of obstruction and respiratory distress, waiting 30 seconds may allow further deterioration.
Preparing racemic epinephrine and alerting respiratory therapy is appropriate as a secondary step, but it takes time. It does not immediately provide the oxygenation or ventilation support urgently needed in a hypoxic child with upper airway compromise.
Elevating the head of the bed and obtaining an ABG may be useful for ongoing assessment, but it is not an emergent intervention. The priority is airway management and oxygenation, which must take precedence before diagnostic testing.

Question: 9

A patient with poorly controlled hypertension experiences acute agitation and a systolic pressure of 210 mmHg in the first hour post-op. Which complication related to the pre-existing condition is the immediate concern?

A. Intracranial hemorrhage
B. Acute renal failure
C. Hypoglycemia
D. Surgical site bleeding

Answer: A

Explanation:
Intracranial hemorrhage is the most immediate concern in a patient with poorly controlled hypertension and a sudden surge in systolic blood pressure to 210 mmHg. Excessively high blood pressure increases the risk of cerebral vessel rupture, especially in the postoperative period when autoregulation may be impaired. Agitation could be an early neurologic sign of increased intracranial pressure or bleeding.
Acute renal failure is a possible long-term consequence of uncontrolled hypertension, but it does not typically present acutely with agitation. Although renal perfusion is influenced by blood pressure, neurologic symptoms are not a hallmark of early renal dysfunction.
Hypoglycemia can cause agitation, but it is not directly related to hypertension. Additionally, there is no mention of glucose-lowering therapies or risk factors for hypoglycemia in this patient. It would not be the immediate priority unless the clinical picture strongly suggested it.
Surgical site bleeding is a general concern in hypertensive patients due to elevated vascular pressures, but it typically presents with external signs such as excessive drainage or hematoma, not agitation. The neurologic change paired with hypertensive crisis points more urgently toward intracranial involvement.

Question: 10

A 62-year-old patient in Phase I recovery develops a heart rate of 38 bpm and a blood pressure of 82/50 mmHg unresponsive to oxygen and fluid bolus. According to the ACLS adult bradycardia algorithm, which action should the perianesthesia nurse take first?

A. Prepare for emergent transvenous pacing
B. Initiate transcutaneous pacing
C. Administer 1 mg atropine IV push
D. Begin a dopamine infusion at 5 mcg/kg/min

Answer: C

Explanation:
Administering 1 mg atropine IV push is the first-line intervention for symptomatic bradycardia per the ACLS algorithm. In a patient with hypotension and a heart rate of 38 bpm unresponsive to oxygen and fluids, atropine helps block parasympathetic influence on the heart, thereby increasing heart rate and improving perfusion. It is the initial pharmacologic agent recommended in this situation.
Initiating transcutaneous pacing is indicated if atropine is ineffective or if the patient is in high-degree AV block or unstable. While pacing is part of the algorithm, it is not the first step unless atropine is contraindicated or fails to produce improvement.
Beginning a dopamine infusion is appropriate for bradycardia that does not respond to atropine or pacing, particularly when pacing is not immediately available. However, it is a second-line pharmacologic strategy after atropine fails or is unavailable.
Preparing for emergent transvenous pacing is considered in refractory cases but is not an immediate bedside intervention. This requires specialized equipment and personnel and is not prioritized above atropine or transcutaneous pacing in initial management.

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