ATI Skills Modules 3.0 – Safety Video Practice Test (Sample)

Study Guide

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Questions

1. What is the best way to prevent infection and conserve resources when terminating an IV piggyback medication infusion?

A. Remove the piggyback tubing after the infusion.

B. Leave both the piggyback tubing and the bag attached to the primary line Y-site port until the next scheduled dose.

C. Flush the line with sterile water after the infusion.

D. Change the primary line every 24 hours.

2. Which sign may indicate infection at the insertion site of a CVAD?

A. Patient's oral temperature gradually increases

B. Patient exhibits swelling around the site

C. Patient reports redness at the site

D. Patient feels pain during movement

3. When administering an IV piggyback medication to infuse by gravity, how can the nurse ensure that the medication will flow properly?

A. Adjust the primary fluid bag height.

B. Prime the medication line completely.

C. Hang the piggyback medication higher than the primary fluid.

D. Use a large-bore catheter for infusion.

4. It is determined that a patient who received a blood transfusion received an infection from the blood. Whom should the nurse notify of this infection?

A. The patient's physician only

B. The clinical laboratory only

C. Blood bank and infection control department

D. The nursing supervisor only

5. What is a critical intervention prior to initiating an IV piggyback medication?

A. Consult the patient's family.

B. Confirm the medication and patient identity.

C. Document the medication on the MAR.

D. Change the IV site.

6. What instruction might the nurse give to nursing assistive personnel (NAP) regarding the care of a patient with a CVAD?

A. “Let me know immediately if the patient's dressing becomes damp.”

B. “Ensure the patient’s arms are unrestricted.”

C. “Report any signs of anxiety from the patient.”

D. “Monitor the patient's blood pressure every hour.”

7. A patient received two 300-mL units of packed red blood cells, and the line was flushed with 25 mL of solution between the units. What is the total amount of fluid the nurse will document having provided to the patient?

A. 600 mL.

B. 625 mL.

C. 650 mL.

D. 700 mL.

8. What action might the nurse take to assess for dislodgement of a patient's CVAD?

A. Palpate the skin for coiling

B. Check the patient's heart rate

C. Take the patient's blood pressure

D. Ask the patient about discomfort

9. When initiating a blood transfusion, at what rate should the transfusion be started?

A. Fast as tolerated

B. Slowly for the first 15 minutes

C. Immediately at full rate

D. Only after pre-medication

10. What instruction should a nurse give to nursing assistive personnel regarding a patient with an intravenous access device?

A. Notify me when the IV bag is containing less than 50 milliliters

B. Let me know the IV bag contains less than 100 milliliters

C. It’s okay to leave the IV bag empty

D. Ensure the bag is changed at least every 24 hours

Answers

1. B
2. A
3. C
4. C
5. B
6. A
7. B
8. A
9. B
10. B

Explanations

1. What is the best way to prevent infection and conserve resources when terminating an IV piggyback medication infusion?

A. Remove the piggyback tubing after the infusion.

B. Leave both the piggyback tubing and the bag attached to the primary line Y-site port until the next scheduled dose.

C. Flush the line with sterile water after the infusion.

D. Change the primary line every 24 hours.

Leaving both the piggyback tubing and the bag attached to the primary line Y-site port until the next scheduled dose is the best approach for preventing infection and conserving resources. This method minimizes the risk of contamination by reducing the number of times the connection between the lines needs to be disturbed or manipulated. Additionally, retaining the piggyback setup allows for a quicker readiness for the next dose without requiring a new setup, which saves time and resources. By keeping the system intact, healthcare providers also maintain a sterile connection that helps prevent the introduction of pathogens. This practice helps to ensure patient safety and decreases the likelihood of complications associated with multiple line manipulations.

2. Which sign may indicate infection at the insertion site of a CVAD?

A. Patient's oral temperature gradually increases

B. Patient exhibits swelling around the site

C. Patient reports redness at the site

D. Patient feels pain during movement

A gradual increase in the patient's oral temperature is indeed a significant indicator of infection, as it may reflect a systemic response to an infectious process. When a central venous access device (CVAD) is in place, it can serve as a potential portal for bacteria to enter the bloodstream or the local tissue at the insertion site. An increase in temperature is a common physiological response when the body is fighting an infection, signaling that the immune system is activated. While each of the other signs can also indicate complications associated with a CVAD, they may not be as specific or indicative of an infection. For example, swelling around the site can result from various issues, including inflammation or irritation, which may not necessarily indicate an infection. Similarly, redness at the site may indicate irritation or local inflammation, but it is not definitive on its own without other signs. Pain during movement can suggest local issues related to the insertion site, but again, it does not specifically indicate an infection. Understanding the role of fever as a systemic indicator of infection can help in monitoring patients with CVADs effectively.

3. When administering an IV piggyback medication to infuse by gravity, how can the nurse ensure that the medication will flow properly?

A. Adjust the primary fluid bag height.

B. Prime the medication line completely.

C. Hang the piggyback medication higher than the primary fluid.

D. Use a large-bore catheter for infusion.

To ensure that the medication flows properly when administering an IV piggyback, it's important to hang the piggyback medication higher than the primary fluid. This positioning takes advantage of gravity, which allows the medication to flow downwards into the primary line. When the piggyback bag is elevated, the pressure difference enables the medication to infuse effectively into the bloodstream. Maintaining the correct height is crucial for proper flow, as it ensures that gravity can assist in moving the medication through the IV line when the primary fluid is in use. If the piggyback medication is not positioned higher, it may not flow as intended, leading to inadequate medication delivery to the patient.

4. It is determined that a patient who received a blood transfusion received an infection from the blood. Whom should the nurse notify of this infection?

A. The patient's physician only

B. The clinical laboratory only

C. Blood bank and infection control department

D. The nursing supervisor only

Notifying both the blood bank and the infection control department is essential when an infection is linked to a blood transfusion. The blood bank needs to be informed because they are responsible for managing and tracking blood products. They must be aware of any adverse events to investigate the source of the infection, assess the safety of blood products, and possibly initiate measures to prevent further occurrences. The infection control department should also be notified, as they play a critical role in monitoring and managing infections within the healthcare facility. Their involvement is necessary for implementing protocols to investigate potential outbreaks, enhance monitoring, and improve safety practices. This coordinated notification helps ensure patient safety and aligns with protocols to mitigate risks associated with blood transfusions. Other options, which involve notifying only the physician, the clinical laboratory, or the nursing supervisor, do not encompass the broader responsibility of tracking and managing transfusion-related infections adequately. Each of these departments plays a role, but the critical link to overall safety comes from ensuring both the blood bank and the infection control department are informed.

5. What is a critical intervention prior to initiating an IV piggyback medication?

A. Consult the patient's family.

B. Confirm the medication and patient identity.

C. Document the medication on the MAR.

D. Change the IV site.

Confirming the medication and patient identity is a critical intervention prior to initiating an IV piggyback medication because it ensures that the right patient is receiving the correct medication. This step is vital to prevent medication errors, which can lead to serious adverse effects. The process typically involves checking the medication label against the patient's identification bracelet, as well as verifying the order in the electronic health record or medication administration record. This confirmation reduces the risk of administering the wrong medication or delivering it to the wrong patient, both of which can have significant health consequences. Additionally, this verification process aligns with the principles of patient safety and the "Five Rights" of medication administration, which advocate for giving the right medication, at the right dose, to the right patient, via the right route, and at the right time. Other options may involve elements of patient interaction or documentation; however, they do not hold the same level of immediate importance in the context of safe medication administration as confirming that the medication and patient data are accurate, which directly impacts patient safety during the IV medication process.

6. What instruction might the nurse give to nursing assistive personnel (NAP) regarding the care of a patient with a CVAD?

A. "Let me know immediately if the patient's dressing becomes damp."

B. "Ensure the patient's arms are unrestricted."

C. "Report any signs of anxiety from the patient."

D. "Monitor the patient's blood pressure every hour."

The instruction to notify the nurse immediately if the patient's dressing becomes damp is crucial because a damp dressing can indicate several issues, including potential leaks or infections at the site of the Central Venous Access Device (CVAD). Keeping the dressing dry and intact is essential for preventing contamination and ensuring the CVAD functions properly. Prompt reporting allows for timely intervention, which can help prevent further complications for the patient. Prioritizing the integrity of the dressing is fundamental in CVAD care, as it serves as a barrier to infection. This instruction emphasizes the importance of vigilance in monitoring the insertion site for any signs of compromise, thereby supporting safe and effective patient care.

7. A patient received two 300-mL units of packed red blood cells, and the line was flushed with 25 mL of solution between the units. What is the total amount of fluid the nurse will document having provided to the patient?

A. 600 mL.

B. 625 mL.

C. 650 mL.

D. 700 mL.

To determine the total amount of fluid provided to the patient, it's essential to sum the volumes of the packed red blood cells along with the volume of the solution used to flush the line between administrations. In this case, the patient received two units of packed red blood cells, each with a volume of 300 mL. When you calculate that, you get: 300 mL (first unit) + 300 mL (second unit) = 600 mL from the packed red blood cells. Additionally, the line was flushed with 25 mL of solution between the units. This volume must also be added to the total: 600 mL (from the blood cells) + 25 mL (flush solution) = 625 mL total. Thus, the total amount of fluid documented would be 625 mL, which corresponds to the correct answer. This method of calculation ensures that all administered fluids are accounted for, crucial for proper patient documentation and care management.

8. What action might the nurse take to assess for dislodgement of a patient's CVAD?

A. Palpate the skin for coiling

B. Check the patient's heart rate

C. Take the patient's blood pressure

D. Ask the patient about discomfort

To assess for dislodgement of a patient's Central Venous Access Device (CVAD), palpating the skin for coiling is a key action because it helps to determine if the catheter has moved from its original position. Palpation allows the nurse to feel for any unusual kinks, loops, or shifts in the catheter that may indicate that it has become dislodged or is not properly positioned in the vein. This physical examination is crucial because dislodgement can lead to complications such as improper drug administration, decreased effectiveness of the treatment, or potential injury to the vein. When the catheter is properly positioned, it should remain straight and firm against the skin. Conversely, if palpation reveals coiling or abnormal positioning, it suggests that the catheter may not be in the correct location. Other actions, while important for overall patient assessment, do not directly indicate catheter position or dislodgement. Checking the heart rate and taking blood pressure can provide information on the patient's overall hemodynamic status but does not specifically address the state of the CVAD. Asking the patient about discomfort may offer subjective information but is not as direct or reliable in assessing for dislodgement compared to a physical assessment like palpation.

9. When initiating a blood transfusion, at what rate should the transfusion be started?

A. Fast as tolerated

B. Slowly for the first 15 minutes

C. Immediately at full rate

D. Only after pre-medication

Starting a blood transfusion slowly for the first 15 minutes is important because it allows healthcare providers to monitor the patient for any adverse reactions or side effects. This initial slow infusion rate helps ensure that if a reaction occurs, it can be detected early and appropriate interventions can be taken. During this time, vital signs should be closely monitored, as this is a critical period when reactions, such as fever, chills, or allergic responses, may manifest. Once the patient has been assessed and, if no adverse reactions are observed, the rate can typically be increased. This approach emphasizes patient safety and the importance of vigilance during the initiation of such a procedure.

10. What instruction should a nurse give to nursing assistive personnel regarding a patient with an intravenous access device?

A. Notify me when the IV bag is containing less than 50 milliliters

B. Let me know the IV bag contains less than 100 milliliters

C. It’s okay to leave the IV bag empty

D. Ensure the bag is changed at least every 24 hours

The appropriate instruction for nursing assistive personnel regarding a patient with an intravenous access device centers around monitoring the IV bag's volume. In this context, notifying the nurse when the IV bag contains less than 100 milliliters is critical because it allows for timely intervention to prevent interruptions in medication delivery or fluid administration. An IV bag that is nearing its end of volume indicates the necessity for a replacement soon to maintain the continuity of care and avoid potential complications, such as air entering the IV line or the patient not receiving the necessary fluids or medications. Monitoring a threshold of 100 milliliters is practical, as it provides adequate time for the nurse to prepare a new bag and ensures that patient's needs are met without delays. This facilitates proper management of intravenous therapy by ensuring that there is always enough fluid or medication available to the patient.