

# ATI Swift River Test Practice Exam (Sample)

## Study Guide



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**SAMPLE**

## **Questions**

- 1. What should be the nursing approach when a patient is concerned about STDs and possible pregnancy?**
  - A. Provide emotional support**
  - B. Discuss support groups**
  - C. Educate about STDs and pregnancy**
  - D. Review lab tests**
- 2. After inserting a chest tube, which action is crucial to ensure its proper function?**
  - A. Maintain chest tube connections**
  - B. Encourage deep breathing exercises**
  - C. Observe patient for pain**
  - D. Document the procedure**
- 3. What is critical for documentation after patient care?**
  - A. It should be done before patient care**
  - B. It should be as comprehensive as possible**
  - C. It must be performed after patient care**
  - D. It should include personal opinions**
- 4. In treating ventricular tachycardia, what outcome signifies a successful cardioversion?**
  - A. The patient is responsive with stable vitals**
  - B. Patient exhibits normal ECG rhythm**
  - C. The patient's heart rate is elevated**
  - D. Patient does not require intubation**
- 5. Why is a full assessment performed following a change in a patient's condition?**
  - A. To evaluate the latest nursing interventions**
  - B. To identify the cause of the change**
  - C. To reassure the patient**
  - D. To document changes for the medical record**

- 6. What is the priority nursing action once a chest tube has been inserted and the patient is stabilized?**
- A. Assess vital signs**
  - B. Auscultate lung fields**
  - C. Inspect the insertion site**
  - D. Document patient care**
- 7. If a nurse observes another nurse being disrespectful to a patient, what is the best action to take?**
- A. Notify lead nurse**
  - B. Offer assistance to the patient**
  - C. Remain with the patient**
  - D. Document the incident**
- 8. What should be done after assessing a patient who has experienced trauma and expresses a need to shower?**
- A. Provide emotional support immediately**
  - B. Offer to assist with the shower**
  - C. Educate the patient on common feelings**
  - D. Document the request**
- 9. During the dressing change, which step should follow the removal of the old dressing?**
- A. Wash hands and put on sterile gloves**
  - B. Assess the wound condition**
  - C. Clean the wound with saline**
  - D. Document previous dressing change**
- 10. What is the first step to understand a patient's psychological condition after a traumatic event?**
- A. Full assessment**
  - B. Provide emotional support**
  - C. Documentation**
  - D. Use therapeutic communication/Active listening**

## **Answers**

SAMPLE

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

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## **Explanations**

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**1. What should be the nursing approach when a patient is concerned about STDs and possible pregnancy?**

- A. Provide emotional support**
- B. Discuss support groups**
- C. Educate about STDs and pregnancy**
- D. Review lab tests**

The most appropriate nursing approach when a patient has concerns about sexually transmitted diseases (STDs) and possible pregnancy is to educate them about these topics. Providing education empowers the patient by giving them the information needed to understand their risk factors, modes of transmission, prevention methods, and potential outcomes related to STDs and pregnancy. This knowledge can alleviate fears, help them make informed decisions about their health, and encourage them to seek testing or treatment if necessary. In addition to education, addressing the patient's questions and concerns about STDs and pregnancy can promote a supportive environment where they feel valued and understood. While providing emotional support is important for overall care, the key focus should be on delivering specific, factual information that addresses their immediate worries. Discussing support groups and reviewing lab tests can be beneficial, but these approaches are secondary and follow the essential step of education on the conditions they are concerned about.

**2. After inserting a chest tube, which action is crucial to ensure its proper function?**

- A. Maintain chest tube connections**
- B. Encourage deep breathing exercises**
- C. Observe patient for pain**
- D. Document the procedure**

Maintaining chest tube connections is crucial to ensure the proper function of the chest tube because any disconnection can lead to air leakage or a loss of negative pressure within the pleural space. This can compromise the effectiveness of the drainage system, potentially leading to re-accumulation of pleural fluid or air, and can increase the risk of complications such as pneumothorax. Ensuring that all connections are secure prevents accidental removal or dislodgment during patient movement or care, which is vital for effective treatment and recovery. While encouraging deep breathing exercises, observing for pain, and documenting the procedure are all important aspects of patient care following the insertion of a chest tube, they do not directly impact the mechanical functioning of the chest tube itself. Encouraging deep breathing exercises is aimed at preventing atelectasis and maintaining lung expansion, which is important for recovery, but it does not inherently ensure that the drainage system is functioning correctly. Similarly, observing the patient for pain helps in managing discomfort but does not influence the integrity of the chest tube connections. Documentation is essential for legal and medical records, but it also does not contribute to the operational aspect of the chest tube system.

### 3. What is critical for documentation after patient care?

- A. It should be done before patient care
- B. It should be as comprehensive as possible
- C. It must be performed after patient care**
- D. It should include personal opinions

The necessity of performing documentation after patient care revolves around the principle of capturing accurate and relevant information while it is fresh and directly relates to the care provided. Documenting after patient care ensures that the details reflect the patient's condition, the interventions performed, and the observations made during the encounter. This practice supports continuity of care and helps in the coordination of treatment among different healthcare providers, as all information is recorded as it pertains directly to the care that was rendered. Moreover, timely documentation is crucial for legal, ethical, and professional standards in healthcare. It not only serves as a record for the healthcare team but also protects the interests of both the patient and the provider should any disputes arise concerning the care provided. In contrast, performing documentation before patient care would lack context and not accurately represent the patient's current status or the care given. Being comprehensive is important but follows the necessity of a timely record to be meaningful. Similarly, including personal opinions in medical documentation can lead to biases and misinterpretations, detracting from the factual reporting that is essential in healthcare records.

### 4. In treating ventricular tachycardia, what outcome signifies a successful cardioversion?

- A. The patient is responsive with stable vitals**
- B. Patient exhibits normal ECG rhythm
- C. The patient's heart rate is elevated
- D. Patient does not require intubation

A successful cardioversion in the context of treating ventricular tachycardia is indicated by the patient being responsive with stable vital signs. This outcome is crucial because it reflects not only the immediate effectiveness of the procedure but also the patient's overall clinical stability. When a patient is responsive and their vital signs are stable, it suggests that the heart has returned to a manageable rhythm and that the patient is hemodynamically stable. While exhibiting a normal ECG rhythm is certainly an important aspect of recovery following cardioversion, it is the patient's responsiveness and stability that indicates they are effectively tolerating the rhythm change and that the cardioversion has resulted in a successful clinical improvement. An elevated heart rate commonly seen during tachycardia does not signify a successful treatment outcome, while the lack of need for intubation is also a positive indicator, it primarily pertains to respiratory management rather than the direct effectiveness of the cardioversion itself.

**5. Why is a full assessment performed following a change in a patient's condition?**

- A. To evaluate the latest nursing interventions**
- B. To identify the cause of the change**
- C. To reassure the patient**
- D. To document changes for the medical record**

Performing a full assessment after a change in a patient's condition is essential primarily to identify the cause of that change. This process allows healthcare professionals to gather comprehensive information about the patient's current state, which can help to determine the underlying factors contributing to the change in condition. Understanding the root cause is crucial for developing an effective care plan and implementing appropriate interventions to address the patient's needs. Clinicians need to assess various parameters, including vital signs, physical examination findings, and any relevant medical history or recent treatments, to piece together a comprehensive picture. Identifying the cause can lead to timely interventions that may prevent further deterioration and promote recovery. This thorough evaluation also aids in anticipating how a patient's condition may evolve, allowing for proactive management. While evaluating nursing interventions, reassuring the patient, and documenting changes are important steps in patient care, they are secondary to first identifying the cause of a condition change. Without understanding the cause, the effectiveness of interventions and overall patient safety may be compromised.

**6. What is the priority nursing action once a chest tube has been inserted and the patient is stabilized?**

- A. Assess vital signs**
- B. Auscultate lung fields**
- C. Inspect the insertion site**
- D. Document patient care**

The priority nursing action after a chest tube has been inserted and the patient is stabilized is to assess vital signs. This action is essential because vital signs provide critical information about the patient's physiological status and can indicate how well they are tolerating the chest tube and whether any complications, such as pneumothorax or infection, may be developing. Monitoring vital signs helps in identifying any changes that may require immediate intervention or indicate the effectiveness of the chest tube in improving respiratory function. While auscultating lung fields, inspecting the insertion site, and documenting patient care are all important steps in the nursing process, they can follow the initial assessment of vital signs. Auscultation will provide information on breath sounds and whether the tube is functioning properly, inspecting the insertion site ensures proper healing and that there are no signs of infection or complications, and documentation is critical for legal and continuity of care reasons. However, the immediate priority after insertion is monitoring the vital signs to ensure the patient remains stable.

**7. If a nurse observes another nurse being disrespectful to a patient, what is the best action to take?**

- A. Notify lead nurse**
- B. Offer assistance to the patient**
- C. Remain with the patient**
- D. Document the incident**

The best action in this scenario is to notify the lead nurse. This step is crucial because it ensures that the incident of disrespect is addressed at an institutional level, allowing for appropriate action to be taken. By informing a supervisor or lead nurse, you are invoking the proper channels within the healthcare facility to handle such behaviors, ensuring that the nurse in question can receive guidance or corrective action. This approach also serves to protect the patient and uphold the standards of care and professionalism that must be maintained in a healthcare setting. It prioritizes the patient's dignity and rights and simultaneously holds healthcare providers accountable for their actions, promoting a culture of respect within the healthcare environment. The other actions, while they may seem appropriate in some contexts, do not address the need for institutional oversight or corrective measures. Offering assistance to the patient may provide temporary comfort, but it does not resolve the underlying issue of the disrespectful behavior, nor does it ensure it won't happen again. Remaining with the patient could provide emotional support but similarly fails to address the misconduct being exhibited. Documenting the incident is important, but it should follow notifying the appropriate personnel for timely action and intervention.

**8. What should be done after assessing a patient who has experienced trauma and expresses a need to shower?**

- A. Provide emotional support immediately**
- B. Offer to assist with the shower**
- C. Educate the patient on common feelings**
- D. Document the request**

The most appropriate action following the assessment of a trauma patient who expresses a desire to shower is to educate the patient on common feelings that may arise after experiencing trauma. This is essential because trauma can elicit a range of emotional responses, including anxiety, fear, and confusion. Providing education helps the patient understand that these feelings are normal reactions to their experiences, which can be reassuring and facilitate their emotional processing. Offering emotional support immediately may seem beneficial, but without understanding the specific context of the patient's feelings and needs, it may not address the patient's primary concern - which is their desire to shower. Likewise, while assisting with the shower can demonstrate care, it should be done with the patient's consent and full understanding of their emotional state related to trauma. Documenting the request is a necessary part of patient care; however, doing so does not directly address the patient's immediate emotional and psychological needs in the aftermath of a traumatic event. Prioritizing education about common feelings enables the patient to feel more in control and supported as they navigate their emotional response.

**9. During the dressing change, which step should follow the removal of the old dressing?**

- A. Wash hands and put on sterile gloves**
- B. Assess the wound condition**
- C. Clean the wound with saline**
- D. Document previous dressing change**

The appropriate step that should follow the removal of the old dressing is to wash hands and put on sterile gloves. This is crucial for maintaining aseptic technique. After removing the old dressing, healthcare providers need to ensure that their hands are clean to prevent any contamination of the wound. Using sterile gloves is essential to protect both the wound from pathogens and the caregiver from exposure to potential infections. By adhering to this practice, you ensure that the surrounding environment remains sterile, particularly before any further assessments or cleaning of the wound. This foundational step in infection control is vital in wound management and is a key practice in nursing and medical protocols. While it may also be necessary to assess the wound condition, cleaning the wound, or documenting previous actions as part of the dressing change process, these steps must come after the proper infection control measures have been established by hand hygiene and the use of sterile gloves. Maintaining a clean and safe environment for the wound management process is the priority at this stage.

**10. What is the first step to understand a patient's psychological condition after a traumatic event?**

- A. Full assessment**
- B. Provide emotional support**
- C. Documentation**
- D. Use therapeutic communication/Active listening**

Using therapeutic communication and active listening is essential as the first step in understanding a patient's psychological condition after a traumatic event. This approach creates a safe environment where the patient feels comfortable sharing their experiences and emotions. By actively engaging with the patient, healthcare providers can gather valuable information about the patient's state of mind, coping mechanisms, and specific reactions to the trauma. Therapeutic communication involves not just listening to what the patient says, but also being attuned to non-verbal cues and emotional expressions, which can provide deeper insights into their psychological condition. Active listening shows the patient that their feelings are valid and important, encouraging them to open up more about their trauma. This engagement fosters trust, which is crucial when addressing psychological issues stemming from trauma. Without this foundational step, any assessment, documentation, or provision of emotional support may be less effective, as these actions rely on a strong understanding of the patient's emotional and psychological state. Active listening and therapeutic communication set the stage for further evaluation and intervention tailored to the patient's individual needs.