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STUDENT WORKBOOK

CAT

TEST TACTICS: CAT DECISION-MAKING SKILLS

ITEM 1 OF 6

Nurses' Notes | Assessment | Vital Signs

The nurse in an emergency department is caring for a 43-year-old male client.

0830: Client arrived at the emergency department via a friend's private car following a motor vehicle collision that occurred 15 minutes prior to arrival. Client appears anxious. He reports that he was the driver of the vehicle and was involved in a head-on collision with airbag deployment. He was traveling 45 mph (72 kph) and states he was alone in the car at the time of the accident. He denies any loss of consciousness but does not remember if he hit his head during the impact. The client reports severe left-sided chest pain that is described as sharp with shortness of breath. He states, "The left side of my chest has been hurting where the airbag hit me. I also started to feel short of breath after the accident, and it seems to be getting worse." He is tachypneic with an oxygen saturation of 92% on room air; breathing appears slightly labored with clear lung sounds on the right side and absent lung sounds on the left side. He has a 4 cm x 4 cm superficial abrasion to the left chest wall with no bleeding noted.

ITEM 1 OF 6

Nurses' Notes | Assessment | Vital Signs

The nurse in an emergency department is caring for a 43-year-old male client.

Body System	Assessment Findings
Neurologic	Alert and oriented x 3; appears restless; pupils are 3 mm, equal, round, and reactive to light; Glasgow Coma Scale score of 15
Respiratory	Dyspnea; tachypnea; lung sounds clear on the right, absent on the left; tracheal deviation to the right side
Cardiovascular	Jugular venous distention present; S1, S2 present; no carotid bruits; bilateral radial pulses 3+; capillary refill <3 seconds
Gastrointestinal	Bowel sounds normoactive x 4; abdomen soft and nontender
Skin	No rashes; skin is warm and dry, no erythematous areas; abrasion to left chest wall with no bleeding noted
Extremities	No edema, cyanosis, or clubbing
Musculoskeletal	5/5 strength; normal range of motion; no swollen or erythematous joints

NOTES:

ITEM 1 OF 6

Nurses' Notes | Assessment | Vital Signs

The nurse in an emergency department is caring for a 43-year-old male client.

0830	
T	98.6 F (37.0 C)
P	132
RR	26
BP	102/84
Pulse oximetry reading	92% on room air
Pain level	10/10

ITEM 1 OF 6

Drag the top 3 client findings that require immediate follow-up to the box on the right.

Client Findings

1. Dyspnea
2. Vital signs
3. Abrasion to chest wall
4. Lung sounds
5. Glasgow Coma Scale score

Top 3 Findings

NOTES:

ITEM 2 OF 6

Complete the following sentence by choosing from the list of options:

The nurse should recognize that this client is most likely experiencing a [ ]

Select...
1. cardiac tamponade
2. traumatic brain injury
3. tension pneumothorax

ITEM 3 OF 6

Select the top 2 complications the client is at risk for developing.

1. Sepsis
2. Seizures
3. Respiratory arrest
4. Obstructive shock
5. Hypovolemic shock

NOTES:

ITEM 4 OF 6

Laboratory Results

The nurse in an emergency department is caring for a 43-year-old male client.

Laboratory Test and Reference Range	0830
Hemoglobin Male: 14-18 g/dL (140-180 g/L) Female: 12-16 g/dL (120-160 g/L)	16.0 g/dL (160 g/L)
Hematocrit Male: 42-52% (0.42-0.52) Female: 37-47% (0.37-0.47)	46% (0.46)

ITEM 4 OF 6

The emergency nurse reviews the client's Laboratory Results from 0830.

For each potential nursing intervention, click to specify whether the intervention is indicated, nonessential, or not indicated for the care of the client at this time.

Potential Interventions	Indicated	Nonessential	Not Indicated
1. Administer oxygen			
2. Insert an indwelling urinary catheter			
3. Perform wound care on the abrasion			
4. Prepare the client for chest tube insertion			
5. Prepare the client for a blood transfusion			

NOTES:

ITEM 4 OF 6

Nurses' Notes

The nurse in an emergency department is caring for a 43-year-old male client.

0840: Client lying supine on stretcher with friend at bedside. He suddenly reports worsening shortness of breath. Client has absent lung sounds to the left side with tracheal deviation to the right. His breathing appears labored. Cyanosis present to the mouth and lips.

ITEM 4 OF 6

Vital Signs

The nurse in an emergency department is caring for a 43-year-old male client.

	0830	0840
T	98.6 F (37.0 C)	98.6 F (37.0 C)
P	132	148
RR	26	32
BP	102/84	88/62
Pulse oximetry reading	92% on room air	86% on room air
Pain level	10/10	10/10

NOTES:

ITEM 5 OF 6

The nurse reviews the updated Vital Signs and Nurses' Notes at 0840.

Which **3 actions** should the nurse take at this time?

1. Insert a peripheral IV
2. Administer pain medication
3. Apply supplemental oxygen
4. Notify the healthcare provider
5. Administer an albuterol breathing treatment
6. Raise the head of the stretcher to a semi-Fowler's position

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ITEM 6 OF 6

Nurses' Notes

The nurse in an emergency department is caring for a 43-year-old male client.

0900: Assisted the healthcare provider with bedside chest tube insertion. Chest tube now in place to -20 cm H_2O wall suction via a chest drainage unit; continuous bubbling noted in water seal chamber. Trachea noted to be midline. Lung sounds diminished on the left.

NOTES:

ITEM 6 OF 6

Vital Signs

The nurse in an emergency department is caring for a 43-year-old male client.

	0830	0840	0900
T	98.6 F (37.0 C)	98.6 F (37.0 C)	98.6 F (37.0 C)
P	132	148	112
RR	26	32	23
BP	102/84	88/62	106/70
Pulse oximetry reading	92% on room air	86% on room air	94% on non-rebreather mask
Pain level	10/10	10/10	10/10

ITEM 6 OF 6

The client was admitted to the intensive care unit (ICU) following chest tube insertion. The ICU nurse records a Nurses' Note and updated Vital Signs at 0900.

Which admission assessment findings indicate **improvement** in the client's condition? Select all that apply.

1.Trachea is midline
2.Pain level of 10/10
3.Respiratory rate of 23
4.Blood pressure of 106/70
5.Diminished lung sounds on the left side
6.Continuous bubbling in the chest tube water seal chamber

NOTES:

ITEM 1 OF 1

Nurses' Notes

The nurse is caring for a 24-year-old female diagnosed with borderline personality disorder.

1500: Client was admitted today to the inpatient psychiatric unit following engagement in self-harm via cutting that required stitches and reporting suicidal ideation with a plan to overdose. The client works as an administrative assistant but states she may lose her job soon as she often experiences conflict with her co-workers due to difficulty controlling her emotions at work. The client is flamboyantly dressed and hyperverbal. She quickly starts crying and states that today's events occurred because her therapist would not return her calls, saying, "She is leaving me like everyone else; I hate her!" The client describes herself as a perfectionist and states she often spends hours arranging her apartment until it feels just right. She denies having any romantic partners at the time stating, "I'm not interested in romantic relationships."

ITEM 1 OF 1

The nurse is caring for a 24-year-old female diagnosed with borderline personality disorder.

Click to highlight below the **4 findings** that are most consistent with a diagnosis of borderline personality disorder.

1500: Client was admitted today to the inpatient psychiatric unit following engagement in self-harm via cutting that required stitches and reporting suicidal ideation with a plan to overdose. The client works as an administrative assistant but states she may lose her job soon as she often experiences conflict with her co-workers due to difficulty controlling her emotions at work. The client is flamboyantly dressed and hyperverbal. She quickly starts crying and states that today's events occurred because her therapist would not return her calls, saying, "She is leaving me like everyone else; I hate her!" The client describes herself as a perfectionist and states she often spends hours arranging her apartment until it feels just right. She denies having any romantic partners at the time stating, "I'm not interested in romantic relationships.

NOTES:

ITEM 1 OF 6

Health History | Diagnostic Results | Vital Signs

The nurse cares for a 26-year-old laboring client.

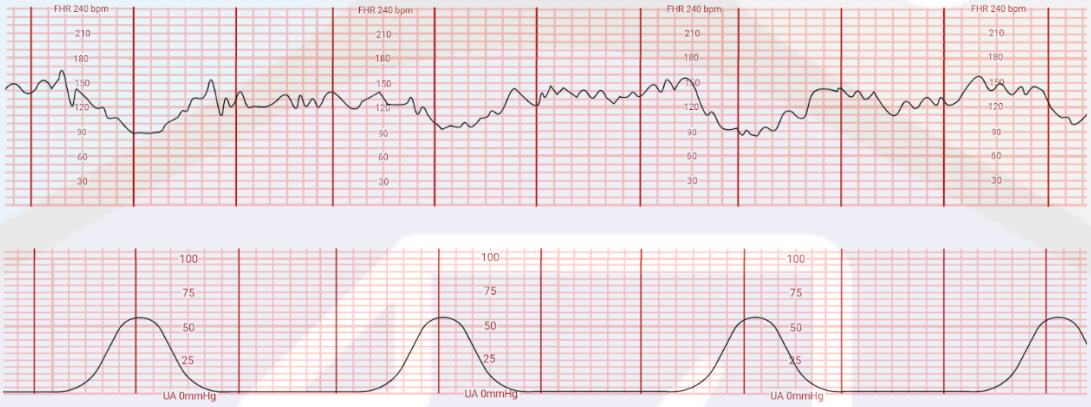
Client is a G2P1 who has an epidural in place and has been pushing for 3 hours. Fetal station 0; positioned right occiput anterior (ROA). Fetal weight is estimated to be 8 lb 9 oz (4,050 g). Client has polyhydramnios and diabetes mellitus type 1. She reports tingling in her hands over the last month. Indwelling urinary catheter removed before pushing started.

ITEM 1 OF 6

Health History | Diagnostic Results | Vital Signs

The nurse cares for a 26-year-old laboring client.

1045 Fetal Heart Rate and Contraction Monitor



NOTES:

ITEM 1 OF 6

Health History | Diagnostic Results | Vital Signs

The nurse cares for a 26-year-old laboring client.

1045	
T	100.1 F (37.8 C)
P	80
RR	18
BP	105/72
Pulse oximetry reading	98% on room air

ITEM 1 OF 6

Which of the following findings requires **immediate** follow-up?

1. Temperature
2. Time pushing
3. Tingling in hands
4. Fetal monitoring strip

NOTES:

REMEMBER

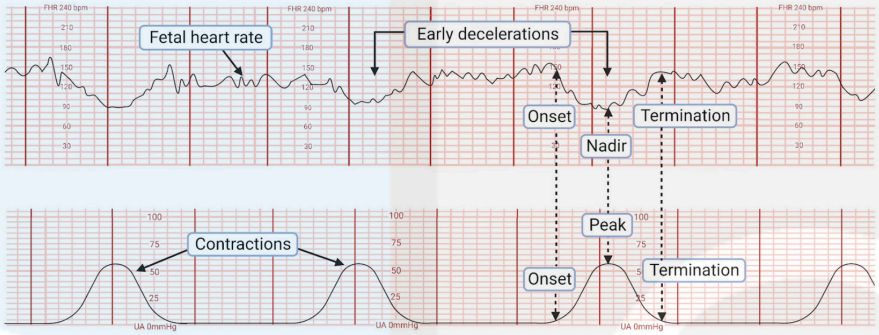
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Etapa	Definición	Características
Primera Etapa	Inicio de contracciones uterinas regulares hasta la dilatación cervical completa (10 cm)	- Etapa más larga Fase latente: dilatación cervical de 0 a 5 cm, borramiento cervical, algo de descenso fetal Fase activa: dilatación cervical rápida de 6 a 10 cm, aumento del descenso fetal
Segunda Etapa	Dilatación cervical completa hasta el nacimiento del recién nacido	- Descenso pasivo del feto causado por contracciones uterinas Rotación fetal a la posición anterior Empuje activo con ganas de pujar Tiempos de empuje esperados: Multiparas: 20 minutos Nulíparas: 50 minutos
Tercera Etapa	Nacimiento del recién nacido hasta la entrega de la placenta	- La separación placentaria causa un chorro visible de sangre
Cuarta Etapa	Entrega de la placenta hasta la estabilización/recuperación (es decir, >2 horas después del nacimiento)	- Cambios de líquidos Pérdida de sangre vaginal Contracciones uterinas Descenso del fondo uterino hacia el estado pre-embarazo

REMEMBER

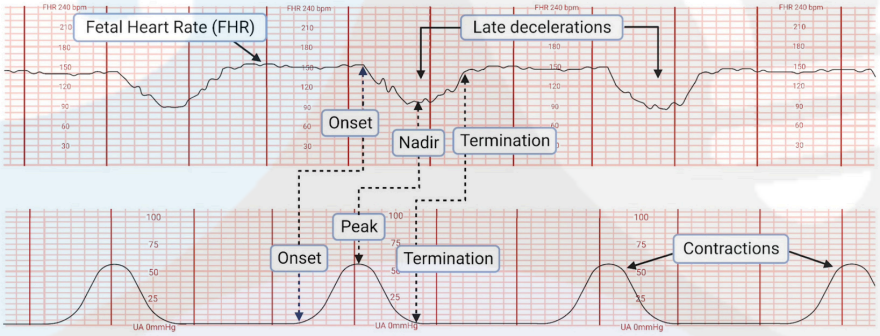
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Early Decelerations



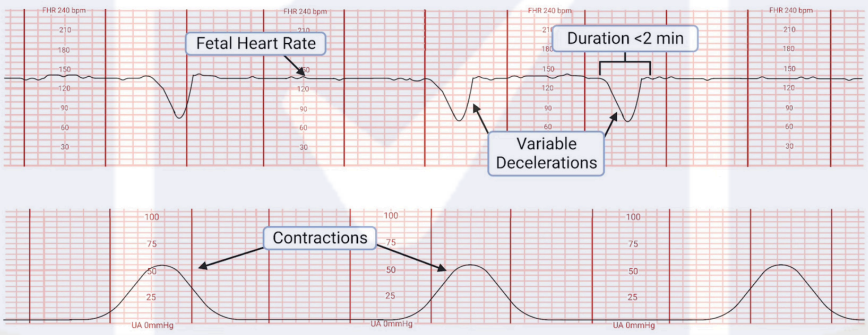
Early decelerations: Gradual decrease in FHR lasting ≥30 sec where the onset, nadir, and termination of the deceleration occur at the **same time** as the onset, peak, and termination of the contraction

Late Decelerations



Late Decelerations: Gradual decrease in FHR (onset to nadir >30 sec) where the onset, nadir, and termination of the deceleration occur **after** the onset, peak, and termination of the contraction

Variable Decelerations



Variable Decelerations: Abrupt fetal heart rate deceleration (≥15 bpm) lasting ≥15 sec that rapidly returns to baseline in <2 min and occurs independent of or during a contraction

ITEM 2 OF 6

Which of the following client findings **increases** the **risk** for prolonged labor? Select all that apply.

1. Polyhydramnios
2. Occiput anterior
3. Contraction pattern
4. Estimated fetal weight
5. Number of pregnancies
6. Macrosomia

ITEM 3 OF 6

Nurses' Notes

The nurse cares for a 26-year-old laboring client.

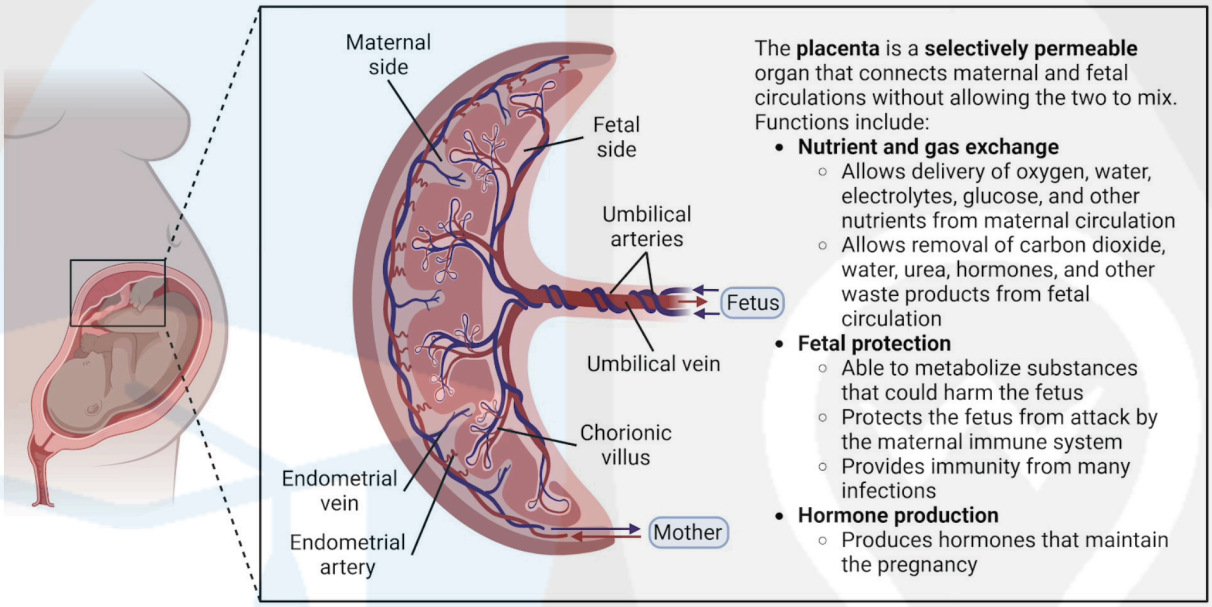
1100: The fetal head crowns and then retracts between each push. Client screams during each push and reports 6/10 burning perineal pain. Contractions are 2 minutes apart. Fetal heart rate decelerates to the 90s during pushing and returns to baseline after pushing.

NOTES:

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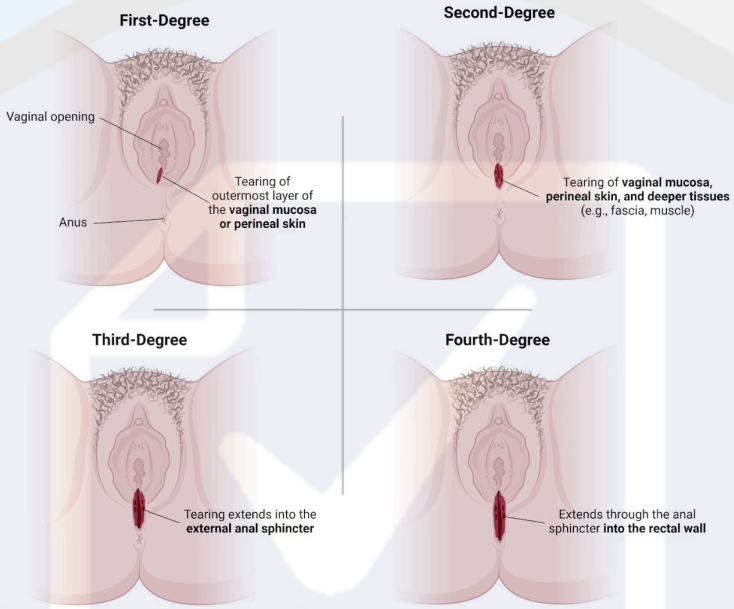
Placenta



The **placenta** is a **selectively permeable** organ that connects maternal and fetal circulations without allowing the two to mix. Functions include:

- **Nutrient and gas exchange**
  - Allows delivery of oxygen, water, electrolytes, glucose, and other nutrients from maternal circulation
  - Allows removal of carbon dioxide, water, urea, hormones, and other waste products from fetal circulation
- **Fetal protection**
  - Able to metabolize substances that could harm the fetus
  - Protects the fetus from attack by the maternal immune system
  - Provides immunity from many infections
- **Hormone production**
  - Produces hormones that maintain the pregnancy

Perineal Lacerations



ITEM 3 OF 6

Complete the following sentence by choosing from the list of options:

The nurse should **first address** the client's [ ]

followed by the [ ]

Word Choices

1. pain rating
2. full bladder
3. fetal heart rate
4. pushing technique

ITEM 4 OF 6

Nurses' Notes

The nurse cares for a 26-year-old laboring client.

1115: Bladder emptied via intermittent catheterization. Client performing effective pushes with focused breathing efforts. The fetal head delivered 30 seconds ago, and the health care provider has been attempting to deliver the shoulders without success.

NOTES:

The nurse reviews the Nurses' Notes from 1115.

For each potential nursing intervention, click to specify if each intervention is indicated or not indicated at this time.

Potential Nursing Interventions	Indicated	Not Indicated
1. Apply fundal pressure.		
2. Hyperflex the client's legs.		
3. Request order for oxytocin.		
4. Lower the head of the bed.		
5. Obtain a vacuum extractor.		
6. Notify the neonatal intensive care unit team.		

ITEM 4 OF 6

Nurses' Notes

The nurse cares for a 26-year-old laboring client.

1130: Newborn delivered vaginally at 1115 and is on the radiant warmer being evaluated by the neonatal intensive care unit team. Moro reflex absent unilaterally, and facial paralysis present on the right side. Small, firm swelling noted on right side of skull that does not cross suture lines. Scleral hemorrhages to bilateral eyes. Newborn rooting and putting fingers in the mouth.

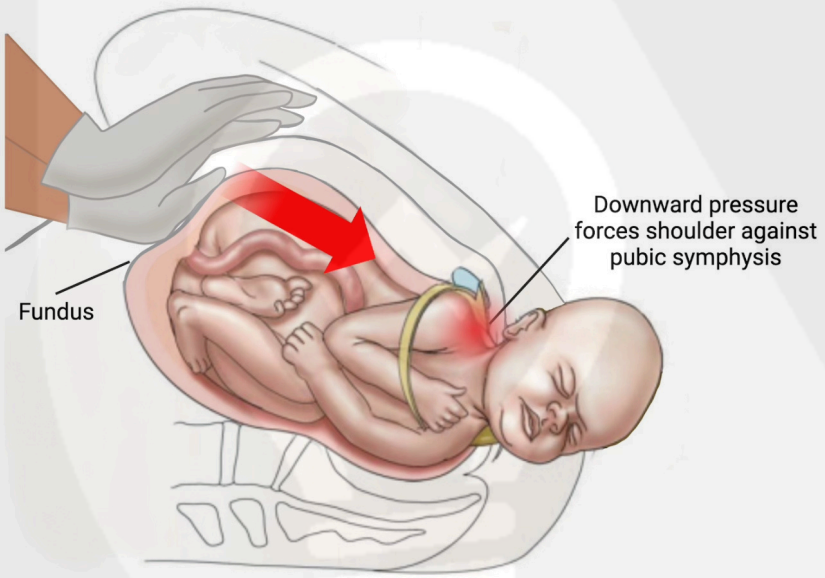
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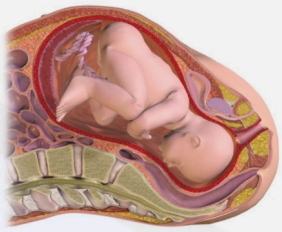
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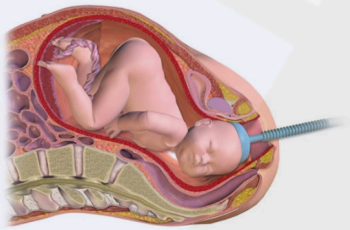
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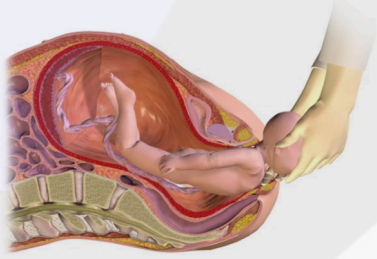
NOTES:

Fundal Pressure









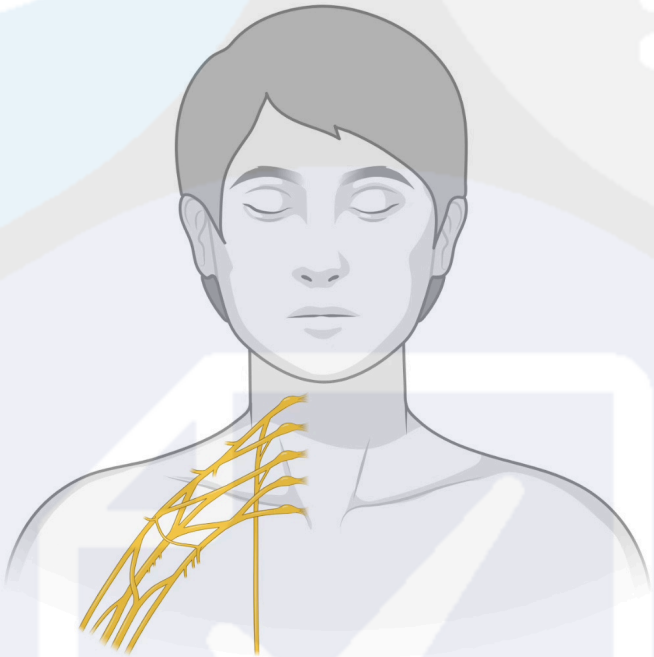
NOTES:

The nurse reviews the Nurses' Note from 1130.

For each potential nursing intervention, click to specify if each intervention is anticipated or not anticipated at this time.

Potential Nursing Interventions	Anticipated	Not Anticipated
1. Consult an ophthalmologist.		
2. Assess bilirubin levels frequently.		
3. Prepare the newborn for a chest x-ray.		
4. Prepare the newborn for a head CT scan.		
5. Perform head measurements every 2 hours.		

Brachial Plexus



NOTES:

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NOTES:

Moro Reflex



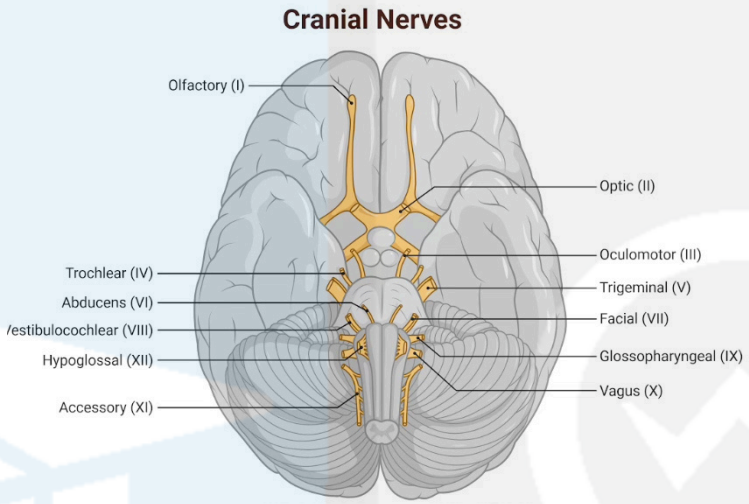
NOTES:

To elicit: Tilt the supported newborn back to 30 degrees or clap loudly while the newborn is supine

Expected response: Extends arm and legs with slight tremor, fingers fan out

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Cranial Nerve Functions		
Cranial Nerve	**Basic Function**	**Mnemonic**
I - Olfactory	Smell	On
II - Optic	Vision	Old
III - Oculomotor	Pupil dilation, eye movements	Olympus's
IV - Trochlear	Eye movements	Towering
V - Trigeminal	Jaw clenching/chewing, facial sensation	Top
VI - Abducens	Eye movements	A
VII - Facial	Facial movements, taste	Finn
VIII - Acoustic (vestibulocochlear)	Hearing, balance	And
IX - Glossopharyngeal	Swallowing, gag reflex, taste, speech	German
X - Vagus	Swallowing, speech, parasympathetic control of gastrointestinal tract and heart rate	Viewed
XI - Spinal accessory	Turning head, shrugging shoulders	Some
XII - Hypoglossal	Tongue movement	Hops

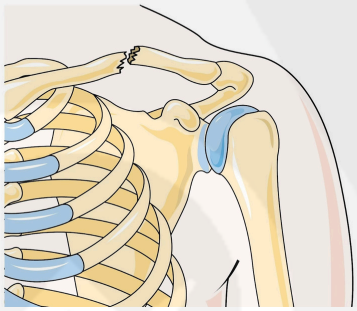
ITEM 6 OF 6

Diagnostic Results

The nurse cares for a 26-year-old laboring client.

1200: Chest X-ray results show right clavicle is fractured.

Clavicle fracture



ITEM 6 OF 6

The nurse reviews the Diagnostic Results from 1200.

The nurse has provided teaching to the client on expectations following a delivery complicated by shoulder dystocia and birth injuries. Which of the following statements by the client would indicate a correct **understanding** of the teaching? **Select all that apply.**

1. "My baby may struggle to breastfeed for several weeks."
2. "I should let the nurse know if my baby develops a high-pitched cry."
3. "My baby's clavicle will heal in a few weeks without requiring surgery."
4. "I should try not to pick the baby up too much to prevent making the injury worse."
5. "I will keep my baby's affected arm swaddled against the chest to prevent further injury."

NOTES:

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