VERSION 2

ATI MED-SURG PROCTORED EXAM PRACTICE QUESTIONS WITH ANSWERS (73 Q/A)

1. A nurse is collecting data from a client who has emphysema. Which of the following findings should the nurse expect? (Select all that apply.)

1) Dyspnea

2) Barrel chest

3) Clubbing of the fingers

4) Shallow respirations

INCORRECT

5) Bradycardia

Answer Rationale:

Dyspnea is correct. Dyspnea is experienced by clients who have emphysema due to inadequate oxygen exchange in the lungs.

Barrel chest is correct. The lungs of clients who have emphysema lose their elasticity, and the diaphragm becomes permanently flattened by overdistention of the lungs. The muscles of the rib cage also become rigid, and the ribs flare outward. This produces the barrel chest typical of emphysema clients.

Clubbing of the fingers is correct. Air is trapped in the lungs due to their lack of elasticity, which decreases oxygenation. Clubbing results from these chronic low blood-oxygen levels.

Shallow respirations is correct. Clients who have emphysema lose lung elasticity; consequently, respirations become increasingly shallow and more rapid.

Bradycardia is incorrect. The heart rate will increase as the heart tries to compensate for less oxygen being delivered to the tissues.

2. A nurse is caring for a client who has Cushing's syndrome. Which of the following clinical manifestations should the nurse expect to observe? (Select all that apply.)

1) Buffalo hump

2) Purple striations

3) Moon face

INCORRECT
4) Tremors

INCORRECT
5) Obese extremities

Answer Rationale:
Buffalo hump is correct. Cushing's syndrome is a disease caused by an increased production of cortisol or by excessive use of corticosteroids. Buffalo hump, a collection of fat between the shoulders, is a common manifestation of Cushing's syndrome.**Purple striations is correct.** Purple striations on the skin of the abdomen, thighs, and breasts are a common manifestation of Cushing's syndrome. This is due to the collection of body fat in these areas.**Moon face is correct.** Moon face is a common manifestation of Cushing's syndrome. Clients who have this manifestation present with a round, red, full face.**Tremors is incorrect.** Tremors are not a common finding of Cushing's syndrome.**Obese extremities is incorrect.** Clients who have Cushing's syndrome have truncal obesity, a protuberant abdomen, with thin extremities, which is due to an alteration in protein metabolism.

3. A nurse is assisting with the care of a client immediately following a lumbar puncture. Which of the following actions should the nurse take? (Select all that apply.)

1) Encourage fluid intake.

2) Monitor the puncture site for hematoma.

INCORRECT
3) Insert a urinary catheter.

INCORRECT
4) Elevate the client’s head of bed.

INCORRECT
5) Apply a cervical collar to the client.

Answer Rationale:

Encourage fluid intake is correct. The nurse should encourage fluids, unless contraindicated, to replace the cerebrospinal fluid that was removed during the procedure and reduce the risk for a headache.

Monitor the puncture site for a hematoma is correct. The nurse should monitor and report a hematoma at the insertion site because this can indicate bleeding.

Insert a urinary catheter is incorrect. There is no indication for a urinary catheter insertion.

Elevate the client's head of bed is incorrect. The client should remain flat in bed for 1 hr or more to reduce the risk for a headache.

Apply a cervical collar to the client is incorrect. There is no indication for a cervical collar for this client.

4. A nurse is reinforcing pre-operative teaching for a client who is scheduled for surgery and is to take hydroxyzine preoperatively. Which of the following effects of the medication should the nurse include in the teaching? (Select all that apply.)

1) Decreasing anxiety

2) Controlling emesis

INCORRECT

3) Relaxing skeletal muscles

INCORRECT

4) Preventing surgical site infections

5) Reducing the amount of narcotics needed for pain relief

Answer Rationale:

Decreasing anxiety is correct. The nurse should include that hydroxyzine is an effective antianxiety agent and is used to decrease anxiety in surgical clients as well as in persons with moderate anxiety.

Controlling emesis is correct. The nurse should include that hydroxyzine is an effective antiemetic and is used to control nausea and vomiting in pre- and postoperative clients.

Relaxing skeletal muscles is incorrect. The nurse should recognize benzodiazepines, such as diazepam (Valium), are used to produce skeletal muscle relaxation.

Preventing surgical site infections is incorrect. The nurse should instruct the client that antibiotics administered prior to surgery are used to diminish the risk of surgical site infections; hydroxyzine, an antiemetic, does not have any effect on bacteria.

Reducing the amount of narcotics needed for pain relief is correct. Hydroxyzine increases the

effects of narcotic pain medications. The nurse should instruct the client that when it is used for surgical clients, narcotic requirements may be significantly reduced.

5. A nurse is reinforcing teaching with a client who has type 2 diabetes mellitus. The nurse determines that teaching has been effective when the client identifies which of the following manifestations of hypoglycemia? (Select all that apply.)

INCORRECT

1) Polyuria

2) Blurry vision

3) Tachycardia

INCORRECT

4) Polydipsia

5) Sweating

Answer Rationale:

Polyuria is incorrect. Hyperglycemia causes polyuria.

Blurry vision is correct. Manifestations of hypoglycemia include blurry vision, tremors, anxiety, irritability, headache, and hypotension.

Tachycardia is correct. Manifestations of hypoglycemia include tachycardia, tremors, anxiety, irritability, headache, and hypotension.

Polydipsia is incorrect. Hyperglycemia causes polydipsia.

Sweating is correct. Manifestations of hypoglycemia include sweating, tremors, anxiety, irritability, headache, and hypotension.

6. A nurse is collecting data from a client who has an exacerbation of gout. Which of the following findings should the nurse expect? (Select all that apply.)

1) Edema

2) Erythema

3) Tophi

4) Tight skin

INCORRECT

5) Symmetrical joint pain

Answer Rationale:

Edema is correct. Swelling over the affected joints is a classic manifestation of gout.

Erythema is correct. Redness over the affected joints is a classic manifestation of gout.

Tophi is correct. Tophi are a classic manifestation of gout. They are nodules that form in subcutaneous tissue due to the accumulation of urate crystals.

Tight skin is correct. Tight skin over the affected joints is a classic manifestation of gout.

Symmetrical joint pain is incorrect. Symmetrical joint pain is a manifestation of rheumatoid arthritis, not gout.

7. A nurse is assisting in the plan of care for a client who had surgery for a bowel obstruction. The client has a nasogastric tube in place. Which of the following actions should the nurse include in the client's plan of care? (Select all that apply.)

1) Perform leg exercises every 2 hr.

2) Encourage hourly use of an incentive spirometer while awake.

3) Document the color, consistency, and amount of nasogastric drainage.

INCORRECT

4) Irrigate the nasogastric tube every 4 to 8 hr.

INCORRECT

5) Maintain bed rest for 48 hr following surgery.

Answer Rationale:

Perform leg exercises every 2 hr is correct. Postoperative clients should frequently perform leg exercises, independently or with assistance, to prevent skin breakdown.**Encourage hourly use of an incentive spirometer while awake is correct.** Postoperative clients should be encouraged to use the incentive spirometer ten times each hour while awake to prevent atelectasis.**Document the color, consistency, and amount of nasogastric drainage is correct.** Documenting the color, consistency, and amount of nasogastric drainage is appropriate to include in the client's plan of care.**Irrigate the nasogastric tube every 4 to 8 hr is incorrect.** Following abdominal surgery, the NG tube should not be moved or irrigated unless prescribed by the provider.**Maintain bed rest for 48 hr following surgery is incorrect.** Maintaining bed rest following surgery should not be included in the plan of care. Early ambulation prevents distention and improves intestinal mobility.

8. A nurse is assisting with discharge teaching for a client who is postoperative following a laryngectomy. Which of the following instructions should the nurse include in the teaching? (Select all that apply.)

1) To aid in swallowing food, tip the chin before swallowing.

INCORRECT

2) Avoid using liquid supplements.

INCORRECT

3) Include warm foods in your diet because they are easier to swallow.

4) Swallow twice after each bite.

INCORRECT

5) Take a sip of water with each bite of food.

Answer Rationale:

To aid in swallowing food, tip the chin before swallowing is correct. This action decreases the risk of aspiration.

Avoid using liquid supplements is incorrect. Following a laryngectomy, the client is at risk for malnutrition. Liquid supplements provide needed protein and calories.

Include warm foods in your diet because they are easier to swallow is incorrect. The client should include cold foods in her diet because they are easier to swallow.

Swallow twice after each bite is correct. Swallowing once when initially propelling food down the esophagus and a second time (dry swallowing) to fully clear the esophagus of food will decrease the risk of aspirating food left in the esophagus.

Take a sip of water with each bite of food is incorrect. This action places the client at risk for aspiration.

9. A nurse is assisting with discharge teaching for a client who is postoperative from a mastectomy including the removal of axillary lymph nodes. Which of the following instructions should the nurse include? (Select all that apply.)

INCORRECT

1) Use talcum powder instead of deodorant on the affected side for the first two weeks after surgery.

2) Perform range-of-motion exercises of the affected arm.

INCORRECT

3) Avoid lifting arm above shoulder level on the affected side.

INCORRECT

4) Wait 72 hr before consuming a regular diet.

5) Elevated the affected arm on a pillow when resting in bed.

Answer Rationale:

Use talcum powder instead of deodorant on the affected side for the first two weeks after surgery is incorrect. The client should avoid the use of talcum powder and deodorant until the incision is healed.

Perform range-of-motion exercises of the affected arm is correct. The client should perform range-of-motion exercises on the affected arm to improve circulation and reduce the risk of lymphedema.

Avoid lifting arm above shoulder level on the affected side is incorrect. The client should face

a wall with the arms slightly bent and “walk” both arms up the wall as high as possible.

Wait 72 hr before consuming a regular diet is incorrect. The client can eat a regular diet 24 hr after surgery.

Elevated the affected arm on a pillow when resting in bed is correct. The client should elevate the affected arm to increase circulation and reduce the risk of lymphedema.

10. A client who is postoperative returns to the unit in skeletal traction. When collecting data from the client, the nurse should expect which of the following findings? (Select all that apply.)

1) Redness at the pin sites

2) Warmth at the pin sites

INCORRECT

3) Movement of the pins at the insertion sites

INCORRECT

4) No drainage from the pin sites

INCORRECT

5) Tenting of the skin around the pin sites

Answer Rationale:

Redness at the pin sites is correct. The nurse should expect the client to have redness at the pin sites, as it is a manifestation of the expected reaction after insertion.

Warmth at the pin sites is correct. The nurse should expect the client to have warmth at the pin sites, as it is a manifestation of the expected reaction after insertion.

Movement of the pins at the insertion sites is incorrect. The nurse should report movement of the pins to the surgeon immediately, as it is a manifestation of infection.

No drainage from the pin sites is incorrect. Up to 72 hr after surgery, serosanguineous drainage from the pin sites can be heavy; therefore, it is important to clean the pin sites daily.

Tenting of the skin around the pin sites is incorrect. The nurse should report tenting to the surgeon immediately, as it is a manifestation of infection.

11. A nurse is reinforcing teaching about dietary recommendations for a client who has a hiatal hernia. Which of the following client statements indicate understanding of the teaching? (Select all that apply.)

INCORRECT

1) "I will lie down for one half hour after meals."

2) "I will consume less caffeine and spicy foods."

3) "I will sleep with the head of my bed elevated."

4) "I will try not to gain weight."

INCORRECT

5) "I will drink less fluid."

Answer Rationale:

"I will lie down for one half hour after meals." is incorrect. A client who has a hiatal hernia should remain upright for at least 1 hr after meals and preferably for several hours.

"I will consume less caffeine and spicy foods." is correct. These foods and beverages can worsen the symptoms of a hiatal hernia.

"I will sleep with the head of my bed elevated." is correct. The client should raise the head of the bed on blocks to avoid lying flat when sleeping.

"I will try not to gain weight." is correct. Obesity raises intra-abdominal pressure and makes the hernia worse.

"I will drink less fluid." is incorrect. Clients should consume adequate and appropriate amounts of fluid, whether or not they have a hiatal hernia.

12. A nurse is collecting data from a client who has an acute myocardial infarction (MI). Which of the following clinical manifestations should the nurse expect to find? (Select all that apply.)

INCORRECT

1) Orthopnea

INCORRECT

2) Headache

3) Nausea

4) Tachycardia

5) Diaphoresis

Answer Rationale:

Orthopnea is incorrect. Orthopnea is a manifestation of heart failure, which can develop from a myocardial infarction, but it is not a common manifestation of acute MI.

Headache is incorrect. Chest pain and sometimes jaw and shoulder pain, not headache, are classic manifestations of acute MI.

Nausea is correct. Nausea and vomiting are classic manifestations of acute MI.

Tachycardia is correct. Tachycardia and dysrhythmias are classic manifestations of acute MI.

Diaphoresis is correct. Profuse sweating and anxiety are classic manifestations of acute MI.

13.A nurse is reinforcing nutrition teaching for a client who has chronic kidney disease about limiting foods high in potassium. Which of the following foods should the nurse instruct the client to avoid? (Select all that apply).

1) Orange juice

INCORRECT
2) Watermelon

3) Bananas

INCORRECT
4) Corn flakes cereal

INCORRECT
5) White rice

Answer Rationale:
Orange juice is correct. Orange juice is high in potassium; 240 mL (8 oz) contains 496 mg of potassium

Watermelon is incorrect. Watermelon is low in potassium; 152 g (1 cup) of diced watermelon contains 170 mg of potassium.

Bananas is correct. Bananas are high in potassium; one medium banana contains 422 mg of potassium.

Corn flakes cereal is incorrect. Corn flakes cereal is low in potassium; 34 g (1 cup) of corn flakes cereal contains 60 mg of potassium.

White rice is incorrect. White rice is low in potassium; 158 g (1 cup) of cooked white rice contains 55 mg of potassium.

14.A nurse is reinforcing nutrition teaching to a client who has chronic kidney disease about limiting foods high in phosphorus. Which of the following foods should the nurse instruct the client to avoid? (Select all that apply).

1) Milk

2) Sunflower seeds

INCORRECT
3) Orange juice

INCORRECT
4) Frozen kale

5) Poultry

Answer Rationale:

Milk is correct. All animal products, including dairy, are a source of phosphorus and should be avoided by a client who is on a phosphorus restricted diet.

Sunflower seeds is correct. Sunflower seeds are a food source high in phosphorus and should be avoided by a client who is on a phosphorus restricted diet.

Orange juice is incorrect. Orange juice is not a food source high in phosphorus and is safe for clients on a phosphorus restricted diet.

Frozen kale is incorrect. Frozen kale is not a food source high in phosphorus and is safe for clients on a phosphorus restricted diet.

Poultry is correct. All animal products, including poultry, are a source of phosphorus and should be avoided by a client who is on a phosphorus restricted diet.

15.A nurse is assisting in the plan of care for a client who is scheduled to have a renal biopsy. Which of the following actions should the nurse include in the plan? (Select all that apply).

1) Collect a urine specimen prior to the procedure.

2) Obtain an informed consent prior to the procedure.

INCORRECT

3) Administer diphenhydramine prior to the procedure.

INCORRECT

4) Maintain a clear liquid diet 4 hr prior to the procedure.

5) Complete coagulation studies prior to the procedure.

Answer Rationale:

Collect a urine specimen prior to the procedure is correct. A urine specimen is needed prior to the procedure to allow for postprocedure comparison.

Obtain an informed consent is correct. Because the procedure is invasive it requires written, informed consent.

Administer diphenhydramine prior to the procedure is incorrect. Benadryl is sometimes used prior to a procedure that uses dye, but not for a renal biopsy.

Maintain a clear liquid diet 4 hr prior to the procedure is incorrect. NPO for 6 to 8 hr prior to the procedure is usually required.

Complete coagulation studies prior to the procedure is correct. Coagulation studies are obtained prior to the procedure to evaluate the risk for bleeding from the biopsy site.

16. A nurse is caring for a client following a renal biopsy. Which of the following actions should the nurse take? (Select all that apply).

1) Monitor for hematuria.

2) Check for flank pain.

INCORRECT

3) Observe for extravasation of tissue surrounding the biopsy site.

INCORRECT

4) Encourage ambulation.

INCORRECT

5) Administer aspirin PRN for pain.

Answer Rationale:

Monitor for hematuria is correct. The nurse should monitor the client for bleeding, such as hematuria, tachycardia, hypotension, or bleeding at the biopsy site.

Check for flank pain is correct. Flank pain is a manifestation of internal bleeding from the renal biopsy.

Observe for extravasation of tissue surrounding the biopsy site is incorrect. Extravasation is associated with the infiltration of dye or medication around an IV site and is not a risk following a renal biopsy.

Encourage ambulation is incorrect. The client should be on strict bedrest following a renal biopsy.

Administer aspirin PRN for pain is incorrect. Aspirin is contraindicated for a client who is postoperative renal biopsy due to the increased risk for bleeding.

17.A nurse is reinforcing preoperative teaching to a client who is to undergo a radical prostatectomy. Which of the following statements should the nurse include in the teaching? (Select all that apply).

1) "You may feel the need to urinate even though a catheter is in place."

2) "Performing Kegel exercises following the surgery will help you to manage incontinence."

INCORRECT

3) "There is very little postoperative pain with this procedure."

INCORRECT

4) "You will be on a low-fiber diet following the surgery."

5) "You should expect your urine to be blood-tinged for a few days following the surgery."

Answer Rationale:

"You may feel the need to urinate even though a catheter is in place." is correct. Pressure from the taping of the catheter to the thigh or abdomen may cause the sensation of the need to void.

"Performing Kegel exercises following the surgery will help you to manage incontinence." is correct. Urinary incontinence is a common complication following a radical prostatectomy. Kegel exercises can reduce the severity of the incontinence.

"There is very little postoperative pain with this procedure." is incorrect. Along with incisional pain, the client may also experience pain from bladder spasms. Clients are often provided a patient-controlled analgesia pump for the first 24 hr postoperative period.

"You will be on a low-fiber diet following the surgery." is incorrect. Straining with defecation can lead to postoperative bleeding. A high-fiber diet and a stool softener are often prescribed.

"You should expect your urine to be blood-tinged for a few days following the surgery." is correct. The flow of bladder irrigation is maintained to keep the urine a reddish pink, which should clear to a pink tinge within 48 hr following surgery. Urine which turns bright red indicates bleeding and should be reported immediately.

18. A nurse is reinforcing teaching about possible treatments with a client who has psoriasis. Which of the following treatment options should the nurse include in the teaching? (Select all that apply.)

1) Tar preparations

2) Corticosteroids

3) Ultraviolet light therapy

INCORRECT

4) Laser therapy

INCORRECT

5) Topical antibiotics

Answer Rationale:

Tar preparations is correct. Tar preparations help to impede the proliferation of skin cells and are effective to remove scales as well as increase remission.

Corticosteroids is correct. Corticosteroids help reduce the inflammation and pruritus associated with psoriasis.

Ultraviolet light therapy is correct. Ultraviolet light therapy is effective in the treatment of psoriasis by decreasing the growth rate of epidermal cells.

Laser therapy is incorrect. Laser therapy is appropriate for the removal of skin lesions rather than for the treatment of psoriasis.

Topical antibiotics is incorrect. Antibiotics are not appropriate for the treatment of psoriasis, as it is not a bacterial condition.

19. A nurse is assisting in planning an educational session regarding risk factors for skin cancer to a group of clients. Which of the following information should the nurse plan to include in the session? (Select all that apply.)

INCORRECT

1) Being dark-skinned

INCORRECT

2) Age under 40 years

3) Overexposure to ultraviolet light

4) Chronic skin irritations

5) Genetic predisposition

Answer Rationale:

Being dark-skinned is incorrect. Light-skinned individuals are at greater risk for developing skin cancer.

Age under 40 years is incorrect. Individuals between the ages of 30 and 60 are at the greatest risk for developing nonmelanoma skin cancers.

Overexposure to ultraviolet light is correct. Overexposure to ultraviolet light is a risk factor for developing skin cancer. Rays from the sun are known to be carcinogenic and can result in malignant changes.

Chronic skin lesions is correct. Chronic skin lesions are a risk factor for developing skin cancer. Clients are taught to monitor for a change in these chronic lesions as a precursor to a malignancy.

Genetic predisposition is correct. Genetic predisposition is a risk factor for developing skin cancer, particularly malignant melanoma.

20.A nurse is reinforcing teaching with a client who has questions concerning the various treatment options for his new diagnosis of basal cell carcinoma (BCC). Which of the following treatments should she include in the teaching? (Select all that apply).

1) Cryosurgery

2) Electrodessication

3) Radiation therapy

INCORRECT

4) Photochemotherapy

5) Mohs surgery

Answer Rationale:
Cryosurgery is correct. Cryosurgery freezes the cancerous tissue and is used in the treatment of BCC.

Electrodessication is correct. Electrodessication uses electrical energy to destroy and remove cancerous tissue and is used in the treatment of BCC.

Radiation therapy is correct. Radiation therapy can be used in the treatment of BCC depending on client age and the location of the tumor.

Photochemotherapy is incorrect. Photochemotherapy is used in the treatment of psoriasis rather than BCC.

Mohs surgery is correct. Mohs micrographic surgery is used in the treatment of BCC as the most accurate method of removing the tumor while preserving healthy tissue.

21. A nurse is collecting data for a client who has giant cell arteritis. Which of the following findings should the nurse expect? (Select all that apply.)

1) Chest pain

2) Loss of vision

INCORRECT
3) Weight gain

4) Dyspnea

5) Headache

Answer Rationale:
Chest pain is correct. Chest pain is a finding associated with giant cell arteritis because of the inflammation of the coronary arteries that can occur. **Loss of vision is correct.** Loss of vision is a finding associated with giant cell arteritis because of the inflammation that can occur with the vessels of the eyes. **Weight gain is incorrect.** Weight loss can occur because of the inflammatory process and metabolic process. **Dyspnea is correct.** Dyspnea is a finding associated with giant cell arteritis that may occur with inflammation of the pulmonary arteries.**Headache is correct.** Headache is a finding associated with giant cell arteritis that may occur with inflammation of the cranial arteries.

22. A nurse is collecting data from a client who has a herniated intervertebral cervical disc. Which of the following findings should the nurse expect? (Select all that apply.)

1) Tingling in the arms

INCORRECT
2) Low back pain

3) Shoulder pain

INCORRECT

4) Hip pain

5) Neck stiffness

Answer Rationale:

Tingling in the arms is correct. Numbness and tingling in the upper extremities are common findings of a herniated cervical intervertebral disc.**Low back pain is incorrect.** Low back pain with muscle spasms is a common finding of a herniated lumbar intervertebral disc.**Shoulder pain is correct.** Shoulder pain, particularly on the top of the shoulders, is a common finding of a herniated cervical intervertebral disc.**Hip pain is incorrect.** Hip pain is a common finding of a herniated lumbar intervertebral disc. **Neck stiffness is correct.** Stiffness and pain in the neck are common findings of a herniated cervical intervertebral disc.

23. A nurse is collecting data from a client who has Paget's disease. Which of the following findings should the nurse expect? (Select all that apply.)

1) Cranial enlargement

2) Skeletal pain

3) Waddling gait

INCORRECT

4) Cold extremities

INCORRECT

5) Muscle weakness

Answer Rationale:

Cranial enlargement is correct. When the skull is involved, Paget's disease causes thickening and enlargement of the skull bones and enlargement of the cranium.**Skeletal pain is correct.** Paget's disease causes pain and tenderness over the affected bones.**Waddling gait is correct.** When the legs are involved, Paget's disease causes bowing of the legs and a waddling gait.**Cold extremities is incorrect.** Paget's disease causes warmth over the affected bones.**Muscle weakness is incorrect.** The nurse should expect muscle weakness for a client who has osteomalacia.

24. An occupational health nurse is instructing workers at an industrial facility about emergency procedures to follow in the event of a traumatic amputation. Which of the following guidelines should the nurse include about preserving the amputated part for possible surgical reattachment? (Select all that apply.)

1) Wrap the part in sterile gauze.

INCORRECT

2) Place the severed end of the part directly into crushed ice.

3) Put the severed part in a plastic bag.

INCORRECT

4) Scrub the severed part with antibacterial solution.

5) Prevent the severed part from coming in contact with water.

Answer Rationale:

Wrap the part in sterile gauze is correct. The person at the scene should wrap the severed part in sterile gauze or a clean cloth, and soak it with saline solution, if available.**Place the severed end of the part directly into crushed ice is incorrect.** The person at the scene should not allow direct contact between the part and ice.**Put the severed part in a plastic bag is correct.** The person at the scene should place the severed part in a sealed, waterproof plastic bag and then put the bag in ice water.**Scrub the severed part with antibacterial solution is incorrect.** The person on the scene should only rinse the amputated part if needed to remove visible debris.**Prevent the severed part from coming in contact with water.** The person at the scene should not allow the severed part to become wet but should keep it dry.

25. A nurse in a provider's office is reinforcing teaching with a client about the risk factors for osteoarthritis. Which of the following information should the nurse include? (Select all that apply.)

INCORRECT

1) Bacterial infections

INCORRECT

2) Use of diuretic medications

3) Aging

4) Obesity

5) Heredity

Answer Rationale:

Bacteria is incorrect. Bacterial infections can lead to infectious arthritis or rheumatoid arthritis, but it is not a risk factor for osteoarthritis.

Diuretics is incorrect. Diuretic therapy is a possible risk factor for gout, but not for osteoarthritis.

Aging is correct. Aging is a risk factor for osteoarthritis, as the joints bear the load of the body's weight over time.

Obesity is correct. Obesity is a risk factor for osteoarthritis, as it increases the load of the body's weight over time.

Heredity is correct. There is a genetic component to the development of osteoarthritis.

26. A nurse in a provider's office is reinforcing teaching with a female client about risk factors for osteoporosis. Which of the following factors should the nurse include in the teaching? (Select all that apply.)

1) Sedentary lifestyle

INCORRECT

2) Obesity

3) Aging

4) Excessive caffeine

INCORRECT

5) Hormone therapy

Answer Rationale:

Sedentary lifestyle is correct. Immobility depletes bone.

Obesity is incorrect. Women who are obese have a greater capacity for storing estrogen to help maintain acceptable levels of calcium.

Aging is correct. Women lose bone due to estrogen depletion after menopause.

Caffeine intake is correct. Excessive caffeine intake causes calcium loss in the urine.

Hormone therapy is incorrect. Estrogen protects women from developing osteoporosis.

27. A nurse is instructing coworkers about how to minimize lower back pain and avoid repeated episodes of back pain. Which of the following strategies should the nurse include? (Select all that apply.)

1) Avoid prolonged sitting.

INCORRECT

2) Apply cold packs frequently.

3) Do partial sit-ups with the knees bent.

INCORRECT

4) Sleep on a soft mattress.

5) Ask for help when moving clients.

Answer Rationale:

Avoid prolonged sitting is correct. Staying in any one position for too long, even lying down, can worsen back pain. Changing positions frequently is essential.

Apply cold packs frequently is incorrect. For back pain, the nurse should recommend heat, but for no longer than 30 min at a time to prevent rebound effects.

Do partial sit-ups with the knees bent is correct. Exercises that strengthen back muscles and help prevent pain include partial sit-ups with the knees bent, knee-chest exercises, and pelvic tilts.

Sleep on a soft mattress is incorrect. The recommendation is to sleep on a firm mattress for good back support.

Ask for help when moving clients is correct. The nurse should remind coworkers to use good body mechanics when handling clients and never to attempt lifting or moving clients by themselves.

28. A nurse is caring for a client who has an acute respiratory illness. For which of the following manifestations of an airway obstruction should the nurse monitor? (Select all that apply.)

1) Inspiratory stridor

2) Cyanosis

INCORRECT

3) Muscle tremors

4) Retractions

INCORRECT

5) Nausea

Answer Rationale:

Inspiratory stridor is correct. The client who has an obstruction of the airway may exhibit inspiratory stridor as the inspired air is partially blocked.**Nausea is incorrect.** Gastrointestinal upset may occur in response to antibiotic therapy used to treat the respiratory infection. However, it is not an indication of impending airway obstruction.**Retractions is correct.** Substernal, suprasternal, and intercostal retractions as well as flaring nares are indications of an impended or obstructed airway.**Muscle tremors is incorrect.** Muscle tremors may occur in a client who has an electrolyte imbalance. However, they are not an indication of an airway obstruction.**Cyanosis is correct.** The client who has an airway obstruction may become cyanotic due to a lack of oxygen transfer to the cells. Other manifestations include coughing and labored respirations.

29. A nurse is reinforcing teaching with the parent of a school-age client who has asthma about the use of a peak flow meter. Which of the following statements about the yellow zone should the nurse include in the teaching? (Select all that apply.)

1) The child should increase his routine medications.

2) The child is having an exacerbation of the asthma.

INCORRECT

3) The child is blowing too hard into the meter.

INCORRECT

4) The child needs to go to the hospital.

INCORRECT

5) The child can participate in strenuous physical activity.

Answer Rationale:

The child should increase his routine medications is correct. A peak flow reading in the yellow zone indicates a decrease in airflow. The child should increase the prescribed routine medications and recheck the peak flow rate several minutes after using a relief medication.**The child is having an exacerbation of the asthma is correct.** A peak flow reading in the yellow zone signals that usual airflow has decreased, indicating an exacerbation of the asthma.**The child is blowing too hard into the meter is incorrect.** A reading in the yellow zone is an indication that the child's breathing is less than baseline measures. In order to use a peak flow meter, the child should blow into the device as hard and quickly as possible.**The child needs to go to the hospital is incorrect.** A child whose peak flow is in the yellow zone should increase his prescribed medication and recheck the peak flow rate. A child with a red zone reading needs to go to the hospital if he is still in the red zone after taking his medications.**The child can participate in strenuous physical activity.** A child whose peak flow rate is in the green zone can perform his usual activities. A child whose rate is in the yellow zone can perform some activities. However, he will be limited in the amount of physical exertion he can expend because this may aggravate his shortness of breath and further exacerbate the asthma symptoms.

30. A nurse is giving a presentation to a community group about preventing atherosclerosis. Which of the following should the nurse include as a modifiable risk factor for this disorder? (Select all that apply.)

INCORRECT

1) Genetic predisposition

2) Hypercholesterolemia

3) Hypertension

4) Obesity

5) Smoking

Answer Rationale:

Genetic predisposition is incorrect. Although it is a risk factor for heart disease, clients cannot change their genetic predisposition; therefore it is not a modifiable risk factor.

Hypercholesterolemia is correct. Cholesterol levels outside the healthful range increase clients' risk for heart disease, and they can change these levels.

Hypertension is correct. Although it may not always be possible to eliminate hypertension, clients can change their blood pressure levels and thus reduce their risk for cardiovascular disease.

Obesity is correct. Clients who are overweight or obese can reduce their risk for heart disease by losing weight.

Smoking is correct. Clients who smoke can reduce their risk for heart disease by quitting smoking.

31. A nurse is reinforcing teaching with a class about preventing deep-vein thrombosis. The nurse should include in the teaching that which of the following is a risk factor for this disorder? (Select all that apply.)

1) Dehydration

2) Oral contraceptive use

INCORRECT
3) Hypertension

INCORRECT
4) High calcium intake

5) Immobility

Answer Rationale:
Dehydration is correct. Dehydration increases the blood's viscosity, thus increasing the risk for clot formation.**Oral contraceptive use is correct.** Thromboembolic events are an adverse effect of oral contraceptives.**Hypertension is incorrect.** Hypertension does not increase the risk for clot formation.**High calcium intake is incorrect.** High calcium intake does not increase the risk for clot formation.**Immobility is correct.** Immobility leads to stasis of blood, thus increasing the risk for clot formation.

32. A nurse is assisting with the care of a client who is postoperative following a cardiac catheterization via the femoral artery. Which of the following actions should the nurse take? (Select all that apply.)

1) Check peripheral pulses in the affected extremity.

INCORRECT
2) Place the client in high-Fowler's position.

INCORRECT
3) Measure the client's vital signs every 8 hr.

4) Keep the client's hip and leg extended.

5) Have the client remain in bed up to 6 hr.

Answer Rationale:
Check peripheral pulses in the affected extremity is correct. The nurse should check peripheral pulses, skin temperature, and color in the affected extremity.**Place the client in high-Fowler's position is incorrect.** The client should remain flat for 6 hr following the procedure.**Measure the client's vital signs every 8 hr is incorrect.** The nurse should measure the client's vital signs every 15 min for the first hr, every 30 min for 2 hr or until stable, and then every 1 hr until stable.**Keep the client's hip and leg extended is correct.** Preventing the leg and hip from flexing helps promote clot formation.**Have the client remain in bed up to 6 hr is**