ATI RN LEADERSHIP PROCTORED EXAM 2023 VERSION 123 LATEST UPDATE COMPLETE QNS &ANS

A nurse answers a call light and finds a client anxious, short of breath, reporting chest pain, and having a blood pressure of 88/52 mm Hg on the cardiac monitor. What action by the nurse takes priority?
- Assess the client's lung sounds.
- Notify the Rapid Response Team.
- Provide reassurance to the client.
- Take a full set of vital signs.
- b

This client has manifestations of a pulmonary embolism, and the most critical action is to notify the Rapid Response Team for speedy diagnosis and treatment. The other actions are appropriate also but are not the priority.

A client is admitted with a pulmonary embolism (PE). The client is young, healthy, and active and has no known risk factors for PE. What action by the nurse is most appropriate?
- Encourage the client to walk 5 minutes each hour.
- Refer the client to smoking cessation classes.
- Teach the client about factor V Leiden testing.
- Tell the client that sometimes no cause for disease is found.c

Factor V Leiden is an inherited thrombophilia that can lead to abnormal clotting events, including PE. A client with no known risk factors for this disorder should be referred for testing. Encouraging the client to walk is healthy, but is not related to the development of a PE in this case, nor is smoking. Although there are cases of disease where no cause is ever found, this assumption is premature.

A client has a pulmonary embolism and is started on oxygen. The student nurse asks why the client's oxygen saturation has not significantly improved. What response by the nurse is best?
- "Breathing so rapidly interferes with oxygenation."
- "Maybe the client has respiratory distress syndrome."
- "The blood clot interferes with perfusion in the lungs."
- "The client needs immediate intubation and mechanical ventilation."c

A large blood clot in the lungs will significantly impair gas exchange and oxygenation. Unless the clot is dissolved, this process will continue unabated. Hyperventilation can interfere with oxygenation by shallow breathing, but there is no evidence that the client is hyperventilating, and this is also not the most precise physiologic answer. Respiratory distress syndrome can occur, but this is not as likely. The client may need to be mechanically ventilated, but without concrete data on FiO2 and SaO2, the nurse cannot makethat judgment.

A client is on intravenous heparin to treat a pulmonary embolism. The client's most recent partial thromboplastin time (PTT) was 25 seconds. What order should the nurse anticipate?
- Decrease the heparin rate.
- Increase the heparin rate.
- No change to the heparin rate.
- Stop heparin; start warfarin (Coumadin).b

For clients on heparin, a PTT of 1.5 to 2.5 times the normal value is needed to demonstrate the heparin is working. A normal PTT is25 to 35 seconds, so this client's PTT value is too low. The heparin rate needs to be increased. Warfarin is not indicated in this situation.

A client is hospitalized with a second episode of pulmonary embolism (PE). Recent genetic testing reveals the client has an alteration in the gene CYP2C19. What action by the nurse is best?
- Instruct the client to eliminate all vitamin K from the diet.
- Prepare preoperative teaching for an inferior vena cava (IVC) filter.
- Refer the client to a chronic illness support group.
- Teach the client to use a soft-bristled toothbrush.b

Often clients are discharged from the hospital on warfarin (Coumadin) after a PE. However, clients with a variation in the CYP2C19gene do not metabolize warfarin well and have higher blood levels and more side effects. This client is a poor candidate for warfarin therapy, and the prescriber will most likely order an IVC filter device to be implanted. The nurse should prepare to do preoperative teaching on this procedure. It would be impossible to eliminate all vitamin K from the diet. A chronic illness support group may be needed, but this is not the best intervention as it is not as specific to the client as the IVC filter. A soft-bristled toothbrush is a safetymeasure for clients on anticoagulation therapy.

A nurse is caring for four clients on intravenous heparin therapy. Which laboratory value possibly indicates that a serious side effecthas occurred?
- Hemoglobin: 14.2 g/dL
- Platelet count: 82,000/L
- Red blood cell count: 4.8/mm3
- White blood cell count: 8.7/mm3b

This platelet count is low and could indicate heparin-induced thrombocytopenia. The other values are normal for either gender. A client appears dyspneic, but the oxygen saturation is 97%. What action by the nurse is best?
- Assess for other manifestations of hypoxia.

- Change the sensor on the pulse oximeter.
- Obtain a new oximeter from central supply.
- Tell the client to take slow, deep

breaths.a

Pulse oximetry is not always the most accurate assessment tool for hypoxia as many factors can interfere, producing normal or

near-normal readings in the setting of hypoxia. The nurse should conduct a more thorough assessment. The other actions are not appropriate for a hypoxic client.

A nurse is assisting the health care provider who is intubating a client. The provider has been attempting to intubate for 40 seconds. What action by the nurse takes priority?

- Ensure the client has adequate sedation.
- Find another provider to intubate.
- Interrupt the procedure to give oxygen.
- Monitor the client's oxygen

saturation.c

Each intubation attempt should not exceed 30 seconds (15 is preferable) as it causes hypoxia. The nurse should interrupt the intubation attempt and give the client oxygen. The nurse should also have adequate sedation during the procedure and monitor the client's oxygen saturation, but these do not take priority. Finding another provider is not appropriate at this time.

An intubated client's oxygen saturation has dropped to 88%. What action by the nurse takes priority?

- Determine if the tube is kinked.
- Ensure all connections are patent.
- Listen to the client's lung sounds.
- Suction the endotracheal

tube.c

When an intubated client shows signs of hypoxia, check for DOPE: displaced tube (most common cause), obstruction (often by secretions), pneumothorax, and equipment problems. The nurse listens for equal, bilateral breath sounds first to determine if the endotracheal tube is still correctly placed. If this assessment is normal, the nurse would follow the mnemonic and assess the patency of the tube and connections and perform suction.

A client is on a ventilator and is sedated. What care may the nurse delegate to the unlicensed assistive personnel (UAP)?

- Assess the client for sedation needs.
- Get family permission for restraints.
- Provide frequent oral care per protocol.
- Use nonverbal pain assessment

tools.c

The client on mechanical ventilation needs frequent oral care, which can be delegated to the UAP. The other actions fall within the scope of practice of the nurse.

A nurse is caring for a client on mechanical ventilation. When double-checking the ventilator settings with the respiratory therapist, what should the nurse ensure as a priority?

- The client is able to initiate spontaneous breaths.
- The inspired oxygen has adequate humidification.
- The upper peak airway pressure limit alarm is off.
- The upper peak airway pressure limit alarm is

on.d

The upper peak airway pressure limit alarm will sound when the airway pressure reaches a preset maximum. This is critical to prevent damage to the lungs. Alarms should never be turned off. Initiating spontaneous breathing is important for some modes of ventilation but not others. Adequate humidification is important but does not take priority over preventing injury.

A nurse is caring for a client on mechanical ventilation and finds the client agitated and thrashing about. What action by the nurse is most appropriate?

- Assess the cause of the agitation.
- Reassure the client that he or she is safe.
- Restrain the client's hands.
- Sedate the client

immediately.a

The nurse needs to determine the cause of the agitation.

A nurse is preparing to admit a client on mechanical ventilation from the emergency department. What action by the nurse takes priority?

- Assessing that the ventilator settings are correct
- Ensuring there is a bag-valve-mask in the room
- Obtaining personal protective equipment
- Planning to suction the client upon arrival to the

roomb

Having a bag-valve-mask device is critical in case the client needs manual breathing. The respiratory therapist is usually primarily responsible for setting up the ventilator, although the nurse should know and check the settings. Personal protective equipment isimportant, but ensuring client safety takes priority. The client may or may not need suctioning on arrival.

A client is on mechanical ventilation and the client's spouse wonders why ranitidine (Zantac) is needed since the client "only has lung problems." What response by the nurse is best?

- "It will increase the motility of the gastrointestinal tract."
- "It will keep the gastrointestinal tract functioning normally."

- "It will prepare the gastrointestinal tract for enteral feedings."
- "It will prevent ulcers from the stress of mechanical ventilation."d

Stress ulcers occur in many clients who are receiving mechanical ventilation, and often prophylactic medications are used to prevent them. Frequently used medications include antacids, histamine blockers, and proton pump inhibitors. Zantac is a histamine blocking agent.

A client has been brought to the emergency department with a life-threatening chest injury. What action by the nurse takes priority?

- Apply oxygen at 100%.
- Assess the respiratory rate.
- Ensure a patent airway.
- Start two large-bore IV lines.c

The priority for any chest trauma client is airway, breathing, circulation. The nurse first ensures the client has a patent airway. Assessing respiratory rate and applying oxygen are next, followed by inserting IVs.

A client is being discharged soon on warfarin (Coumadin). What menu selection for dinner indicates the client needs more education regarding this medication?

- Hamburger and French fries
- Large chef's salad and muffin
- No selection; spouse brings pizza
- Tuna salad sandwich and chipsb

Warfarin works by inhibiting the synthesis of vitamin K-dependent clotting factors. Foods high in vitamin K thus interfere with its action and need to be eaten in moderate, consistent amounts. The chef's salad most likely has too many leafy green vegetables, which contain high amounts of vitamin K. The other selections, while not particularly healthy, will not interfere with the medication's mechanism of action.

A nurse is teaching a client about warfarin (Coumadin). What assessment finding by the nurse indicates a possible barrier to self- management?

- Poor visual acuity
- Strict vegetarian
- Refusal to stop smoking
- Wants weight loss surgeryb

Warfarin works by inhibiting the synthesis of vitamin K-dependent clotting factors. Foods high in vitamin K thus interfere with its action and need to be eaten in moderate, consistent amounts. A vegetarian may have trouble maintaining this diet. The nurseshould explore this possibility with the client. The other options are not related.

A student nurse is preparing to administer enoxaparin (Lovenox) to a client. What action by the student requires immediate intervention by the supervising nurse?

- Assessing the client's platelet count
- Choosing an 18-gauge, 2-inch needle
- Not aspirating prior to injection
- Swabbing the injection site with alcoholb

Enoxaparin is given subcutaneously, so the 18-gauge, 2-inch needle is too big. The other actions are appropriateA client in the emergency department has several broken ribs. What care measure will best promote comfort?

- Allowing the client to choose the position in bed
- Humidifying the supplemental oxygen
- Offering frequent, small drinks of water
- Providing warmed blanketsa

Allow the client with respiratory problems to assume a position of comfort if it does not interfere with care. Often the client will choose a more upright position, which also improves oxygenation. The other options are less effective comfort measures.

A client has been diagnosed with a very large pulmonary embolism (PE) and has a dropping blood pressure. What medication should the nurse anticipate the client will need as the priority?

- Alteplase (Activase)
- Enoxaparin (Lovenox)
- Unfractionated heparin
- Warfarin sodium (Coumadin)a

Activase is a "clot-busting" agent indicated in large PEs in the setting of hemodynamic instability. The nurse knows this drug is the priority, although heparin may be started initially. Enoxaparin and warfarin are not indicated in this setting.

A client is brought to the emergency department after sustaining injuries in a severe car crash. The client's chest wall does not appear to be moving normally with respirations, oxygen saturation is 82%, and the client is cyanotic. What action by the nurse is the priority?

- Administer oxygen and reassess.
- Auscultate the client's lung sounds.
- Facilitate a portable chest x-ray.

- Prepare to assist with
intubation.d

This client has manifestations of flail chest and, with the other signs, needs to be intubated and mechanically ventilated immediately. The nurse does not have time to administer oxygen and wait to reassess, or to listen to lung sounds. A chest x-ray will be taken after the client is intubated.

A student nurse asks for an explanation of "refractory hypoxemia." What answer by the nurse instructor is best?

- "It is chronic hypoxemia that accompanies restrictive airway disease."
- "It is hypoxemia from lung damage due to mechanical ventilation."
- "It is hypoxemia that continues even after the client is weaned from oxygen."
- "It is hypoxemia that persists even with 100% oxygen
administration."d

Refractory hypoxemia is hypoxemia that persists even with the administration of 100% oxygen. It is a cardinal sign of acute respiratory distress syndrome. It does not accompany restrictive airway disease and is not caused by the use of mechanical ventilation or by being weaned from oxygen.

A nurse is caring for a client on the medical stepdown unit. The following data are related to this client:

Subjective Information Laboratory Analysis Physical Assessment
Shortness of breath for 20
minutesFeels frightened
"Can't catch my breath" pH:
7.12PaCO2: 28 mm Hg
PaO2: 58 mm Hg
SaO2: 88% Pulse: 120
beats/minRespiratory rate: 34
breaths/min Blood pressure
158/92 mm Hg Lungs have
crackles

What action by the nurse is most appropriate?

- Call respiratory therapy for a breathing treatment.
- Facilitate a STAT pulmonary angiography.
- Prepare for immediate endotracheal intubation.
- Prepare to administer intravenous
anticoagulants.b

This client has manifestations of pulmonary embolism (PE); however, many conditions can cause the client's presentation. The gold standard for diagnosing a PE is pulmonary angiography. The nurse should facilitate this test as soon as possible. The client does not have wheezing, so a respiratory treatment is not needed. The client is not unstable enough to need intubation and mechanical ventilation. IV anticoagulants are not given without a diagnosis of PE.

The nurse assesses a client with asthma and finds wheezing throughout the lung fields and decreased pulse oxygen saturation. In addition, the nurse notes suprasternal retraction on inhalation. What is the nurse's best action?

- Perform peak expiratory flow readings.
- Assess for a midline trachea.
- Administer oxygen and a rescue inhaler.
- Call a code.
- C

Suprasternal retraction caused by inhalation usually indicates that the client is using accessory muscles and is having difficulty moving air into the respiratory passages because of airway narrowing. Wheezing indicates a narrowed airway; a decreased pulse oxygen saturation also supports this finding. The asthma is not responding to the medication, and intervention is needed. Administration of a rescue inhaler is indicated, probably along with administration of oxygen. The nurse would not do a peak flow reading at this time, nor would a code be called. Midline trachea is a normal and expected finding.

A client has a mediastinal chest tube. Which symptoms require the nurse's immediate intervention? (Select all that apply.)

- Production of pink sputum
- Tracheal deviation
- Oxygen saturation greater than 95%
- Sudden onset of shortness of breath
- Drainage greater than 70 mL/hr
- Pain at insertion site
- Disconnection at Y site
- B, D, E, G

Immediate intervention is warranted if the client has tracheal deviation because this could indicate a tension pneumothorax; sudden shortness of breath because this could indicate dislodgment of the tube, occlusion of the tube, or pneumothorax; or drainage greater than 70 mL/hr because this could indicate hemorrhage. Disconnection at the Y site could result in air entering the tubing. Productionof pink sputum, oxygen saturation less than 95%, and pain at the insertion site are not signs/symptoms that would require immediate intervention.

A nurse assesses a client who has a chest tube. For which manifestations should the nurse immediately intervene? (Select all that apply.)

a.Production of pink
sputumb.Tracheal
deviation

c.Sudden onset of shortness of
breathd.Pain at insertion site
e.Drainage of 75 mL/hr
ANS: B, C
Tracheal deviation and sudden onset of shortness of breath are manifestations of a tension pneumothorax. The nurse must intervene immediately for this emergency situation. Pink sputum is associated with pulmonary edema and is not a complication of a chest tube. Pain at the insertion site and drainage of 75 mL/hr are normal findings with a chest tube.
A nurse is caring for five clients. For which clients would the nurse assess a high risk for developing a pulmonary embolism (PE)? (Select all that apply.)
- Client who had a reaction to contrast dye yesterday
- Client with a new spinal cord injury on a rotating bed
- Middle-aged man with an exacerbation of asthma
- Older client who is 1-day post hip replacement surgery
- Young obese client with a fractured femur
- b, d, e

Conditions that place clients at higher risk of developing PE include prolonged immobility, central venous catheters, surgery, obesity, advancing age, conditions that increase blood clotting, history of thromboembolism, smoking, pregnancy, estrogen therapy, heart failure, stroke, cancer (particularly lung or prostate), and trauma. A contrast dye reaction and asthma pose no risk for PE.
When working with women who are taking hormonal birth control, what health promotion measures should the nurse teach to prevent possible pulmonary embolism (PE)? (Select all that apply.)
- Avoid drinking alcohol.
- Eat more omega-3 fatty acids.
- Exercise on a regular basis.
- Maintain a healthy weight.
- Stop smoking cigarettes.
- c, d, e

Health promotion measures for clients to prevent thromboembolic events such as PE include maintaining a healthy weight, exercising on a regular basis, and not smoking. Avoiding alcohol and eating more foods containing omega-3 fatty acids are heart- healthy actions but do not relate to the prevention of PE.
A client with a new pulmonary embolism (PE) is anxious. What nursing actions are most appropriate? (Select all that apply.)
- Acknowledge the frightening nature of the illness.
- Delegate a back rub to the unlicensed assistive personnel (UAP).
- Give simple explanations of what is happening.
- Request a prescription for antianxiety medication.
- Stay with the client and speak in a quiet, calm voice.
- a, b, c, e

Clients with PEs are often anxious. The nurse can acknowledge the client's fears, delegate comfort measures, give simple explanations the client will understand, and stay with the client. Using a calm, quiet voice is also reassuring. Sedatives and antianxiety medications are not used routinely because they can contribute to hypoxia. If the client's anxiety is interfering with diagnostic testing or treatment, they can be used, but there is no evidence that this is the case.
The nurse caring for mechanically ventilated clients uses best practices to prevent ventilator-associated pneumonia. What actions are included in this practice? (Select all that apply.)
- Adherence to proper hand hygiene
- Administering anti-ulcer medication
- Elevating the head of the bed
- Providing oral care per protocol
- Suctioning the client on a regular schedule
- a, b, c, d

The "ventilator bundle" is a group of care measures to prevent ventilator-associated pneumonia. Actions in the bundle include using proper hand hygiene, giving anti-ulcer medications, elevating the head of the bed, providing frequent oral care per policy, preventing aspiration, and providing pulmonary hygiene measures. Suctioning is done as needed.
A nurse is caring for a client who is on mechanical ventilation. What actions will promote comfort in this client? (Select all that apply.)
- Allow visitors at the client's bedside.
- Ensure the client can communicate if awake.
- Keep the television tuned to a favorite channel.
- Provide back and hand massages when turning.
- Turn the client every 2 hours or more.
- a, b, d, e

There are many basic care measures that can be employed for the client who is on a ventilator. Allowing visitation, providing a means of communication, massaging the client's skin, and routinely turning and repositioning the client are some of them. Keeping the TV on will interfere with sleep and rest.
The nurse caring for mechanically ventilated clients knows that older adults are at higher risk for weaning failure. What age-related changes contribute to this? (Select all that apply.)
- Chest wall stiffness
- Decreased muscle strength
- Inability to cooperate
- Less lung elasticity