ATI FUNDAMENTALS PROCTORED CUMULATIVE FINAL EXAM COMPLETE QNS & ANS FINAL LATEST 2023

- The nurse is preparing a 4 year old for surgery. Which technique is most appropriate?
- a.allow the child to handle safe medical equipment
  b.limit the teaching to one 1 hour session
  c.explain to the child that she will be put to sleep for the procedure
  d.use an anatomically correct doll to explain the procedure

- The nurse is admitting a patient with a methicillin-resistant Staphylococcus aureus (MRSA)infection isolated in his stage III pressure ulcer. The nurse places the patient on:
  a.contact precautions.
  b.airborne precautions.
  c.droplet precautions.
  d.protective environment.

- The nurse is caring for a school-aged child who has injured the right leg after a bicycleaccident.
  Which signs and symptoms will the nurse assess for to determine if the child is experiencinga localized inflammatory response?
  - Malaise, anorexia, enlarged lymph nodes, and increased white blood cells
  - Chest pain, shortness of breath, and nausea and vomiting
  - Dizziness and disorientation to time, date, and place
  - Edema, redness, tenderness, and loss of function

- A diabetic patient presents to the clinic for a dressing change. The wound is located on theright foot and has purulent yellow drainage. Which action will the nurse take to prevent thespread of infection?
  - Position the patient comfortably on the stretcher.
  - Explain the procedure for dressing change to the patient.
  - Review the medication list that the patient brought from home.
  - Don gloves and other appropriate personal protective equipment.

- The nurse is caring for a patient in labor and delivery. When near completing an assessmentof the patient's cervix, the electronic infusion device being used on the intravenous (IV) infusion alarms. Which sequence of actions is mostappropriate for the nurse to take?
  - Complete the assessment, remove gloves, and silence the alarm.

- Discontinue the assessment, silence the alarm, and assess the intravenous site.
- Complete the assessment, remove gloves, wash hands, and assess the intravenousinfusion.
- Discontinue the assessment, remove gloves, use hand gel, and assess the intravenousinfusion.

- The nurse is dressed and is preparing to care for a patient in the perioperative area. Thenurse has
  scrubbed hands and has donned a sterile gown and gloves. Which action will indicate a break in sterile technique?
  - Touching clean protective eyewear
  - Standing with hands above waist area
  - Accepting sterile supplies from the surgeon
  - Staying with the sterile table once it is open

- The nurse is caring for a patient with an incision. Which actions will best indicate anunderstanding of medical and surgical asepsis for a sterile dressing change?
  - Donning clean goggles, gown, and gloves to dress the wound
  - Donning sterile gown and gloves to remove the wound dressing
  - Utilizing clean gloves to remove the dressing and sterile supplies for the newdressing
  - Utilizing clean gloves to remove the dressing and clean supplies for the new dressing

- The nurse is caring for a patient who has just delivered a neonate. The nurse is checking thepatient for excessive vaginal drainage. Which precaution will the nurse use?
  - Contact
  - Droplet
  - Standard
  - Protective environment

- The nurse is performing hand hygiene before assisting a health care provider with insertion of achest tube. While washing hands, the nurse touches the sink. Which action will the nurse take next?
  - Inform the health care provider and recruit another nurse to assist.
  - Rinse and dry hands, and begin assisting the health care provider.
  - Extend the handwashing procedure to 5 minutes.
  - Repeat handwashing using antiseptic soap.

- The nurse is caring for a patient on contact precautions. Which action will be most appropriateto
  prevent the spread of disease?
  - Place the patient in a room with negative airflow.
  - Wear a gown, gloves, face mask, and goggles for interactions with the patient.
  - Transport the patient safely and quickly when going to the radiology department.

- Use a dedicated blood pressure cuff that stays in the room and is used for that patientonly.

- The nurse is caring for a patient who has cultured positive for Clostridium difficile. Whichaction
  will the nurse take next?
  - Instruct assistive personnel to use soap and water rather than sanitizer.
  - Wear an N95 respirator when entering the patient room.
  - Place the patient on droplet precautions.
  - Teach the patient cough etiquette.

- The nurse is caring for a patient who has a bloodborne pathogen. The nurse splashes bloodabove
  the glove to intact skin while discontinuing an intravenous (IV) infusion. Which step(s) will thenurse
  take next?

  - Obtain an alcohol swab, remove the blood with an alcohol swab, and continue care.
  - Immediately wash the site with soap and running water, and seek guidance from themanager.
  - Do nothing; accidentally getting splashed with blood happens frequently and is partof the job.
  - Delay washing of the site until the nurse is finished providing care to the patient.

- The nurse has received a report from the emergency department that a patient with tuberculosiswill be coming to the unit. Which items will the nurse need to care for this patient? (Select all that
  apply.)
  - Private room
  - Negative-pressure airflow in room
  - Surgical mask, gown, gloves, eyewear
  - N95 respirator, gown, gloves, eyewear
  - Communication signs for droplet precautions
  - Communication signs for airborne precautions

- When providing hygiene for an older-adult patient, the nurse closely assesses the skin. What isthe
- rationale for the nurse's action?
  - Outer skin layer becomes more resilient.
  - Less frequent bathing may be required.
  - Skin becomes less subject to bruising.
  - Sweat glands become more active.

- The patient has been brought to the emergency department following a motor vehicle accident.The patient is unresponsive. The driver's license states that glasses are needed to operate a motor

vehicle, but no glasses were brought in with the patient. Which action should the nurse take next?

- Stand to the side of the patient's eye and observe the cornea.
- Conclude that the glasses were lost during the accident.
- Notify the ambulance personnel for missing glasses.
- Ask the patient where the glasses are.

- The nurse is caring for a patient who is immobile. The nurse frequently checks the patient forimpaired skin integrity. What is the rationale for the nurse's action?
  - Inadequate blood flow leads to decreased tissue ischemia.
  - Patients with limited caloric intake develop thicker skin.
  - Pressure reduces circulation to affected tissue.
  - Verbalization of skin care needs is decreased

- The nurse is caring for a patient who has diabetes mellitus and circulatory insufficiency, withperipheral neuropathy and urinary incontinence. On which areas does the nurse focus care?
  - Decreased pain sensation and increased risk of skin impairment
  - Decreased caloric intake and accelerated wound healing
  - High risk for skin infection and low saliva pH level
  - High risk for impaired venous return and dementia

- The nurse is caring for a patient who has undergone surgery for a broken leg and has a cast inplace. What should the nurse do to prevent skin impairment?
  - Assess surfaces exposed to the edges of the cast for pressure areas.
  - Keep the patient's blood pressure low to prevent overperfusion of tissue.
  - Do not allow turning in bed because that may lead to redislocation of the leg.
  - Restrict the patient's dietary intake to reduce the number of times on the bedpan.

- The nurse is providing oral care to an unconscious patient and notes that the patient has extremely bad breath. Which term will the nurse use when reporting to the oncoming shift?
  - Cheilitis
  - Halitosis
  - Glossitis
  - Dental caries

- The patient is being treated for cancer with weekly radiation therapy to the head andchemotherapy treatments. Which assessment is the priority?
  - Feet
  - Nail beds
  - Perineum
  - Oral cavity

- The nurse is caring for an older-adult patient with Alzheimer's disease who is ambulatory but requires total assistance with activities of daily living (ADLs). The nurse notices that the patientis
  edentulous. Which area should the nurse assess?
  - Assess oral cavity.
  - Assess room for drafts.
  - Assess ankles for edema.
  - Assess for reduced sensations.

- A nurse is providing perineal care to a female patient. Which washing technique will the nurseuse?
  - Back to front
  - In a circular motion
  - From pubic area to rectum
  - Upward from rectum to pubic area

- The patient is reporting an inability to clear nasal passages. Which action will the nurse take?
  - Use gentle suction to prevent tissue damage.
  - Instruct patient to blow nose forcefully to clear the passage.
  - Place a dry washcloth under the nose to absorb secretions.
  - Insert a cotton-tipped applicator to the back of the nose.

- A nurse is performing an admission assessment on a middle-age patient. A normal changeseen in this age group
  includes which of the following? (Select all that
  apply.)
  a.A progressive decrease in skin turgor
  b.Decreased visual acuity
  c.Decreased ability to solve practical
  problems
  d.Decreased strength of abdominal
  muscles
  e.Loss of accommodation
- A nurse is teaching young adults about health risks. Which statement from a young adultindicates

a correct understanding of the teaching?

- "It's probably safe for me to start smoking. At my age, there's not enough time for cancer to develop."
- "My mother had appendicitis so this increases my chance for developing appendicitis."
- c. "Controlling the amount of stress in my life may decrease the risk of illness."

d. "I don't do drugs. I do drink coffee, but caffeine is not a drug."

- A nurse is choosing an appropriate topic for a young-adult health fair. Which topic should thenurse include?

- Retirement
- Menopause

- Climacteric factors
- Unplanned pregnancies

- During a routine physical assessment, the nurse obtaining a health history notes that a 50-year-old

female patient reports pain and redness in the right breast. Which action is best for the nurse to takein response to this finding?

- Assess the patient as thoroughly as possible.
- Explain to the patient that breast tenderness is normal at her age.
- Tell the patient that redness is not a cause for concern and is quite common.
- Inform her that redness is the precursor to normal unilateral breast enlargement

- A young-adult patient is brought to the hospital by police after crashing the car in a high-speedchase when trying to avoid arrest for spousal abuse. Which action should the nurse take?

- Question the patient about drug use.
- Offer the patient a cup of coffee to calm nerves.
- Discretely assess the patient for sexually transmitted infections.
- Deal with the issue at hand, not asking about previous illnesses

- A nurse is assessing the cognitive changes in a preschooler. Which standard will the nurse use todetermine normal?

- The ability to think abstractly and deal effectively with hypothetical problems
- The ability to think in a logical manner about the here and now
- The ability to assume the view of another

person

- d. The ability to classify objects by size or color

- The nurse is observing a 2-year-old hospitalized patient in the playroom. Which activity will thenurse most likely observe?

- Seeking out same sex children to play with
- Participating as the leader of a small group

activity

- c. Sitting beside another child while playing with blocks

d. Separating building blocks into groups by size and color

- Which action should the nurse take when teaching a 5-year-old patient about a scheduledsurgery?

- Do not discuss the procedure with the child to decrease anxiety.
- Let the child know the surgery will be at 9:00 AM in the morning.
- Insist that the parents wait outside the room to ensure privacy of the

child.

- d. Allow the child to touch and hold medical equipment such as thermometers.

- While receiving a shift report on a patient, the nurse is informed that the patient has urinaryincontinence. Upon assessment, which finding will the nurse expect?

- An indwelling Foley catheter
- Reddened irritated skin on buttocks

- Tiny blood clots in the patient's urine
- Foul-smelling discharge indicative of infection

- Which clinical manifestation will the nurse expect to observe in a patient with excessive whiteblood cells present in the urine?

- Reduced urine specific gravity
- Increased blood pressure
- Abnormal blood sugar
- d. Fever with chills

- The nurse will anticipate inserting a Coudé catheter for which patient?

- An 8-year-old male undergoing anesthesia for a tonsillectomy
- A 24-year-old female who is going into labor
- c. A 56-year-old male with an enlarged prostate

d. An 86-year-old female admitted for a urinary tract infection

- A nurse is evaluating a nursing assistive personnel's (NAP) care for a patient with an indwellingcatheter. Which action by the NAP will cause the nurse to intervene?

- Emptying the drainage bag when half full
- Kinking the catheter tubing to obtain a urine specimen
- Placing the drainage bag on the side rail of the patient's bed
- Securing the catheter tubing to the patient's thigh

- Which nursing actions will the nurse implement when collecting a urine specimen from apatient?

(Select all that apply.)

- Growing urine cultures for up to 12 hours
- Labeling all specimens with date, time, and initials
- Allowing the patient adequate time and privacy to void
- Wearing gown, gloves, and mask for all specimen handling
- e. Transporting specimens to the laboratory in a timely manner

f. Collecting the specimen from the drainage bag of an indwelling catheter

- The nurse is obtaining a 24-hour urine specimen collection from the patient. Which actionsshould the nurse take? (Select all that apply.)

- Keeping the urine collection container on ice when indicated
- Withholding all patient medications for the day
- Irrigating the sample as needed with sterile solution
- Testing the urine sample with a reagent strip by dipping it in the urine
- Asking the patient to void and discarding that urine to start the collection

- The nurse is planning care for a group of patients. Which task will the nurse assign to thenursing assistive personnel?

- Measuring capillary blood glucose level
- Measuring nasoenteric tube for insertion

- Measuring pH in gastrointestinal aspirate
- Measuring the patient's risk for aspiration

- In teaching mothers-to-be about infant nutrition, which instruction should the nurse provide?

- Supplement breast milk with corn syrup.
- Give cow's milk during the first year of life.
- Add honey to infant formulas for increased energy.
- Provide breast milk or formula for the first 4 to 6 months.

- The patient is admitted with facial trauma, including a broken nose, and has a history ofesophageal reflux and of aspiration pneumonia. With which tube will the nurse most likely administer the feeding?

a. Nasogastric tube
b. Jejunostomy tube
c. Nasointestinal tube
d. Percutaneous endoscopic gastrostomy (PEG) tube

- The nurse is preparing to insert a nasogastric tube in a patient who is semiconscious. Todetermine the length of the tube needed to be inserted, how should the nurse measure the tube?

- From the tip of the nose to the earlobe
- From the tip of the earlobe to the xiphoid process
- From the tip of the earlobe to the nose to the xiphoid process
- d. From the tip of the nose to the earlobe to the xiphoid process

- A small-bore feeding tube is placed. Which technique will the nurse use to best verify tubeplacement?

- X-ray
- pH testing
- Auscultation
- Aspiration of contents

- The patient has just started on enteral feedings, and the patient is reporting abdominal cramping.Which action will the nurse take next?

- Slow the rate of tube feeding.
- Instill cold formula to "numb" the stomach.
- Change the tube feeding to a high-fat formula.
- Consult with the health care provider about prokinetic medication

- The nurse is providing home care for a patient diagnosed with acquired immunodeficiencysyndrome (AIDS). Which dietary intervention will the nurse add to the care plan?

- Provide small, frequent nutrient-dense meals for maximizing kilocalories.
- Prepare hot meals because they are more easily tolerated by the patient.
- Avoid salty foods and limit liquids to preserve electrolytes.
- Encourage intake of fatty foods to increase caloric intake.

- The nurse is preparing to lift a patient. Which action will the nurse take first?

• Position a drawsheet under the patient.
• Assess weight and determine assistance needs.
• Delegate the task to a nursing assistive personnel.
• Attempt to manually lift the patient alone before asking for assistance.

- The nurse is caring for an older-adult patient who has been diagnosed with a stroke. Whichintervention will the nurse add to the care plan?

• Encourage the patient to perform as many self-care activities as possible.
• Provide a complete bed bath to promote patient comfort.
• Coordinate with occupational therapy for gait training.

• Place the patient on bed rest to prevent fatigue.

- The patient is being admitted to the neurological unit with a diagnosis of stroke. When will thenurse begin discharge planning?

• At the time of admission
• The day before the patient is to be discharged
• When outpatient therapy will no longer be needed
• As soon as the patient's discharge destination is known

- The nurse is caring for a patient with impaired physical mobility. Which potential complicationswill the nurse monitor for in this patient? (Select all that apply.)

• Footdrop
• Somnolence
• Hypostatic pneumonia
• d. Impaired skin integrity
e. Increased socialization

- A nurse is teaching a health promotion class about isotonic exercises. Which types of exerciseswill the nurse give as examples? (Not exact question, but very similar)

• Swimming, jogging, and bicycling
• Tightening or tensing of muscles without moving body parts
• Quadriceps set exercises and contraction of the gluteal muscles
• Push-ups, hip lifting, pushing feet against a footboard on the bed

- A nurse is teaching a community group of school-aged parents about safety. Which safety itemis most important for the nurse to include in the teaching session?

• Proper fit of a bicycle helmet
• Proper fit of soccer shin guards
• Proper fit of swimming goggles
• Proper fit of baseball sliding shorts

- The nurse is caring for a patient who suddenly becomes confused and tries to remove anintravenous (IV) infusion. Which priority action will the nurse take?

• Assess the patient.

- Gather restraint supplies.
- Try alternatives to restraint.
- Call the health care provider for a restraint order.

- The nurse is monitoring for the four categories of risk that have been identified in the health careenvironment. Which examples will alert the nurse that these safety risks are occurring? (Not exact question, but very similar)

- Tile floors, cold food, scratchy linen, and noisy alarms
- Dirty floors, hallways blocked, medication room locked, and alarms set
- Carpeted floors, ice machine empty, unlocked supply cabinet, and call light in reach

d.Wet floors unmarked, patient pinching fingers in door, failure to use lift for patient, and alarms notfunction properly

A patient is admitted and is placed on fall precautions. The nurse teaches the patient and familyabout fall precautions. Which action will the nurse take? (Not exact question, but very similar)

- Check on the patient once a shift.
- Encourage visitors in the early evening.
- Place all four side rails in the "up" position.

- Keep the patient on fall risk until discharge.

- The patient is confused, is trying to get out of bed, and is pulling at the intravenous infusiontubing. Which nursing diagnosis will the nurse add to the care plan?

- Impaired home maintenance
- Deficient knowledge
- Risk for poisoning
- d. Risk for injury

- A confused patient is restless and continues to try to remove the oxygen cannula and urinarycatheter. What is the priority nursing diagnosis and intervention to implement for this patient?

- Risk for injury: Check on patient every 15 minutes.
- Risk for suffocation: Place "Oxygen in Use" sign on door.
- Disturbed body image: Encourage patient to express concerns about body.
- Deficient knowledge: Explain the purpose of oxygen therapy and the urinary catheter.

- The nurse is caring for a patient in restraints. Which essential information will the nursedocument in the patient's medical record to provide safe care? (Select all that apply.)

- One family member has gone to lunch.
- Patient is placed in bilateral wrist restraints at 0815.
- Bilateral radial pulses present, 2+, hands warm to touch
- Straps with quick-release buckle attached to bed side rails
- Attempts to distract the patient with television are unsuccessful.
- Released from restraints, active range-of-motion exercises completed