Ati fundamental 1 Version 4

A nurse is caring for a client who has a terminal illness. The client asks several questions about the nurse's religious beliefs related to death and dying. Which of the following actions should the nurse take?

A) Change the topic because the client is trying to divert attention from the illness to the nurse.

B) Encourage the client to express his thoughts about death and dying?

C) Tell the client that religious beliefs are a personal matter.

D) Offer to contact the client's minister or the facility's chaplain. B

A nurse should recognize the client's need to talk about impending death, and encourage the client to discuss his thoughts on the subject. This is therapeutic technique of reflecting. Depending on the situation, the nurse can also share some thoughts on this topic. Self-disclosure is a communication skill that can help open lines of communication when appropriate. If the nurse does not want to share personal

beliefs, the communication skills of offering self and listening to the client's thoughts are appropriate.
A nurse is preparing to provide tracheostomy care for a client. Which of the following actions should the nurse take first?

A) Open all sterile supplies and solutions.

B) Stabilize the tracheostomy tube.

C) Don sterile gloves.

D) Perform hand hygiene. D

According to evidence-based practice, the nurse should first perform hand hygiene before touching the client or performing any skills, such as tracheostomy care. This is vital because contamination of the nurse's hands is a primary source of infection.

A nurse is measuring vital signs for a client and notices an irregularity in the pulse. Which of the following actions should the nurse take?

A) Measure the pulse using a Doppler ultrasound stethoscope.

B) Check the client's pedal pulses.

C) Count the apical pulse rate for a full minute and describe the rhythm in the chart.

D) Take the pulse at each peripheral site and count the rate for 30 seconds. C

If the peripheral pulse is irregular, the nurse should auscultate the apical pulse for 1 minute to obtain an accurate rate. The nurse should document irregularity in the client's medical record.
A nurse on a med-surg unit is caring for a client. Which of the following actions should the nurse take first when using the nursing process?

A) Identify goals for client care.

B) Obtain client information

C) Document nursing care needs

D) Evaluate the effectiveness of care B

The nursing process is based on scientific process. The first step in the scientific process is the collection of data. Therefore, the first step is assessing and obtaining information about the client.
A nurse is receiving a client from the PACU (post-anesthetic care unit) who is postoperative following abdominal surgery. Which of the following actions should the nurse take to transfer the client from stretcher to the bed?

A) Lock the wheels on the bed and stretcher

B) Instruct the client to raise his arms above his head

C) Elevate the stretch 2.5 cm (1 inch) above the height of the bed

D) Log roll the client
A

Locking the wheels prevents the client from falling to the floor by not allowing the cart of bed to move apart or away from the client.
A nurse is admitting a client who has decreased circulation in his left leg. Which of the following actions should the nurse take first?

A) Evaluate pedal pulses

B) Obtain medical history

C) Measure vital signs

D) Assess for leg pain A

For a client who has decreased circulation in the leg, evaluating pedal pulses is critical in order to determine adequate blood supply to the foot. The nurse should apply the safety and risk reduction priority-setting framework. This framework assigns priority to the factor posing the greatest safety risk to the client. When there are several risks to client safety, the one posing the greatest threat is the highest priority. The nurse should use Maslow's Hierarchy of Needs, the ABC priority-setting framework, or nursing knowledge to identify which risk poses the greatest threat to the client.
A nurse is caring for a client who is postoperative and has paralytic ileum. Which of the following abdominal assessments should the nurse expect?

A) Frequent bowel sounds with flatus

B) Absent bowel sounds with distention

C) Hyperactive bowel sounds with diarrhea