# ATI Comprehensive Predictor 2019 A Study Review Questions with Correct Answers and Rationales Latest Update 2023.

A nurse is caring for a client who states, "My boss accused me of stealing yesterday. I was so angry I went to the gym and worked out." The nurse should recognize the client is demonstrating which of the following defense mechanisms? - **Correct Answer:** Sublimation

**Rationale**: The client is exhibiting behaviors consistent with sublimation, which is displayed when a client substitutes socially unacceptable behavior for acceptable behavior.

A nurse is caring for a client who has generalized anxiety disorder and is to begin taking alprazolam. Which of the following actions should the nurse take? - **Correct Answer:** Initiate fall precautions for the client

**Rationale**: The nurse should initiate fall precautions for a client who has a new prescription for alprazolam because common adverse effects

associated with this medication are orthostatic hypotension, dizziness, confusion, and lethargy.

A nurse on a med surg unit is caring for a client prior to a surgical procedure. Which of the following findings should indicate to the nurse that the client has the ability to sign the informed consent? - **Correct Answer:** The client is able to accurately describe the upcoming procedure

**Rationale**: The ability of the client to accurately describe the upcoming procedure indicates that the provider adequately informed the client and that the client is able to sign the informed consent

Assistive personnel (AP) and a nurse are turning a client onto the right side. Which of the following actions by the AP requires the nurse to intervene? - **Correct Answer:** Places a pillow under the client's right arm.

**Rationale**: The AP should place a pillow under the client's left arm to prevent internal rotation of the left shoulder.

A nurse is providing dietary teaching to the parents of a 6-month-old infant. Which of the following instructions should the nurse include? - **Correct Answer:** Introduce new foods one at a time over 5 to 7 days.

A nurse is caring for a client who has MRSA in an abdominal wound. Which of the following precautions should the nurse implement? - **Correct Answer:** Contact

**Rationale**: The nurse should implement contact precautions for a client who has an infection spread by direct contact, such as MRSA.

A nurse is caring for a client who is 4 hr postpartum and has a boggy uterus with heavy lochia. Which of the following actions should the nurse take first - **Correct Answer:** Massage the uterus to expel clots

**Rationale**: Using the EBP approach to client care, the nurse should identify that the priority action is massaging the client's uterus. Uterine massage will expel clots and increase uterine firmness, resulting in decreased bleeding.

A nurse is providing discharge teaching to a new parent about car seat safety. Which of the following statements should the nurse include in

the teaching? - **Correct Answer:** "Secure the retainer clip at the level of your baby's armpits"

A nurse is providing discharge teaching to a client who has colorectal cancer and a new colostomy. The client states, "I'm worried about being discharged because I live alone, and my insurance doesn't cover ostomy supplies. "Which of the following actions should the nurse take? (SATA) - **Correct Answer:** -Refer the client to a community based social workers
-Initiate a consult with a home health care provider
-Give the client information about local support groups

**Rationale**:
-A social worker is necessary to help a client with self-care, as well as assist in locating agencies who can help the client face challenges with self-care and paying for necessary ostomy supplies
-A home health nurse can assist the client in learning to care for the colostomy as well as provide medication management and emotional support
-A client who has cancer and a new colostomy can get help with coping from a support group and possibly receive assistance obtaining supplies from local agencies

A nurse manager is reviewing unit records and discovers that client falls occur most frequently during the hours of 0530 and 0730. Which of the following actions should the nurse take when conducting a root cause analysis? - **Correct Answer:** Investigate environmental factors that might be contributing to client injury during these hours.

**Rationale**: When conducting a root cause analysis, the nurse should look at the factors that could possibly lead to the clients' falls. This can include environmental factors that might be causing the problem.

A nurse is caring for a client who has terminal illness and requests lifesaving measures if a cardiac arrest occurs. Which of the following statements should the nurse make? - **Correct Answer:** "I will provide you with information about medical treatment to include in your living will"

**Rationale**: The nurses' responsibility is to provide the client with information about specific instructions for addressing medical treatment in a living will. The nurse should assist the client while they are able to make decisions for themself by providing information about what end-of-life preferences to document.

A nurse is assessing a client who has delirium. Which of the following manifestations should the nurse expect? - **Correct Answer:** Rapid speech

**Rationale**: Clients who have delirium exhibit rapid, inappropriate, incoherent, and rambling speech patterns

A night shift nurse is giving a change of shift report to the day shift nurse on a client who is ready for discharge. Which of the following information is the priority for the nurse to communicate to the oncoming nurse? - **Correct Answer:** The client needs assistance when transferring from the bed to a wheelchair.

**Rationale**: The greatest risk to this client is injury due to a fall. Therefore, the priority information for the nurse to communicate is that the client requires assistance during transfers.

A nurse is assessing a client during the immediate postpartum period. Which of the following findings requires immediate intervention by the nurse? - **Correct Answer:** Boggy uterus

**Rationale**: When using urgent vs. nonurgent approach to client care, the nurse should determine that the priority finding is a boggy uterus, which can indicate uterine hemorrhage. The nurse should immediately intervene to stimulate uterine contractions and prevent blood loss. If the uterus becomes relaxed during the postpartum period, the client will rapidly lose blood because no permanent thrombi have formed at the placenta.

A nurse in an emergency department is preparing to discharge a client who has experienced intimate partner violence. Which of the following actions should the nurse take first? - **Correct Answer:** Develop a safety plan with the client

**Rationale**: The greatest risk to this client is injury from violence. Therefore, the first action the nurse should take is to develop a safety plan with the client.

A client is receiving lorazepam IV for panic attacks and develops a respiratory rate of 6/min and a blood pressure of 90/44 mm Hg. Which of the following medications should the nurse anticipate administering. - **Correct Answer:** Flumazenil

**Rationale**: The nurse should anticipate administering flumazenil, a competitive benzodiazepine receptor antagonist, to reverse the sedative effects of lorazepam. In addition, the nurse should continue to support the client's respirations with a bag valve mask.

A home health nurse is planning care for an older adult client who has impaired vision. Which of the following interventions should the nurse include in the plant of care to prevent injury in the home? - **Correct Answer:** Mark the edges of the stairs for contrast

**Rationale**: Marking the edges of stairs with paint or colored tape for contrast can help older adult clients who have impaired vision prevent injury by decreasing the risk of falls.

A nurse manager is planning to make changes to the current scheduling system on the unit. To facilitate the staff's acceptance of this change, which of the following actions should the nurse manager take first? - **Correct Answer:** Provide information about scheduling issues to the staff.

**Rationale**: The first stage of the change process is the unfreezing stage, when the nurse should inform the staff about the current staffing

issues. This can increase their understanding of why changes are necessary.

A nurse is teaching a group of guardians about child safety measures. Which of the following statements by guardian indicates an understanding of the teaching? - **Correct Answer:** "I should have my child avoid sun exposure between 10 am and 2 pm"

**Rationale**: To prevent sunburns, guardians should apply sunscreen, dress their child in protective clothing, and avoid sun exposure between 1000 and 1400.

An RN is planning care for a group of clients and is working with a licensed practical nurse (LPN) and an assistive personnel (AP). Which of the following tasks should the RN delegate to the LPN? - **Correct Answer:** Insertion of a nasogastric tube

**Rationale**: The nurse should delegate the insertion of a nasogastric tube to the LPN because this task is within the LPN's scope of practice.

A nurse is assessing a newborn who is 2 hr old. Which of the following findings should the nurse report to the provider? - **Correct Answer:** Axillary temperature 36.2 C (97.2 F)

**Rationale**: The expected reference range for the axillary temperature of newborn is between 36.5 C to 37.5 C (97.7 F to 99.5 F). An axillary temperature of 36.2 C (97.2 F) or below in a newborn who is 2 hr old indicates cold stress and should be reported to the provider.

A nurse is caring for a newborn whose parent asks why the baby is receiving vitamin K. The nurse should explain to the parent that the newborn should receive vitamin K to prevent which of the following? - **Correct Answer:** Bleeding

The nurse should explain to the parent that newborns are deficient in vitamin K and should receive it following birth because this deficiency can lead to bleeding.

A nurse is caring for a client who requires physical therapy following discharge. Which of the following actions should the nurse take? - **Correct Answer:** Involve the client in selection of a physical therapy provider/

**Rationale**: The nurse should involve the client in the referral process, including selection of the physical therapist and the location.

A nurse in an emergency department is assessing a client who reports taking MDMA. Which of the following should the nurse expect? - **Correct Answer:** Diaphoresis

**Rationale**: Diaphoresis is an expected finding of MDMA use. Additionally, the client might experience increased tactile sensitivity, lowered inhibition, chills, muscle cramping, teeth clenching, and mild hallucinogenic effects.

A nurse is caring for a client who vomits on a reusable BP cuff. Which of the following actions should the nurse take? - **Correct Answer:** Place the BP cuff in a labeled bag to send it for decontamination.

**Rationale**: The nurse should place the BP cuff in a labeled bag before removing it from the client's room and sending it to the proper facility location for decontamination.

A nurse is reviewing the medical record of a client who has schizophrenia and is to start taking clozapine. Which of the following findings should the nurse identify as a contraindication for the client to receive clozapine? - **Correct Answer:** WBC count 2,800/mm3

**Rationale**: Clozapine can cause agranulocytosis, which can be life-threatening. Therefore, a WBC count of less than 3,000/mm3 is a contraindication for the client to receive clozapine. The nurse should withhold the medication and notify the provider of the client's WBC count.

A nurse is providing teaching to an adolescent following insertion of a tunneled central venous catheter without a pressure sensitive valve. Which of the following information should the nurse include in the teaching? - **Correct Answer:** "You should keep the catheter clamped when not in use"

**Rationale**: The adolescent should keep the catheter clamped to prevent blood backflow. Not all tunneled catheters have a pressure-sensitive valve that prevents blood reflux.

A nurse is conducting visual acuity testing when using the Snellen letter chart for a school age child who has eyeglasses. Which of the following instructions should the nurse give to the child? - **Correct Answer:** "You should keep both eyes open during the testing"

**Rationale**: The nurse should instruct the child to keep both eyes open during visual acuity testing.

When caring for a child, a nurse plans to use non-pharmacological interventions to enhance the effectiveness of pain medication. Which of the following strategies incorporates visualization techniques to help decrease the child's discomfort? - **Correct Answer:** Blowing bubbles with liquid soap to "blow the hurt away"

**Rationale**: Having the child blow bubbles is a visualization technique that can help to decrease the child's discomfort. The child can visualize the pain as the bubble that they blow away from themself and into the air.

A nurse is preparing to administer heparin 5,000 units SQ. Available is heparin injection 10,000 units/mL. How many mL should the nurse administer per dose? - **Correct Answer:** 0.5 mL

5,000 units/ 10,000 units = 0.5 mL

A charge nurse is observing a newly licensed nurse performing a physical assessment on a client. Which of the following actions by the nurse indicates that the charge nurse should intervene? - **Correct Answer:** The newly licensed nurse writes detailed notes while performing the head-to-toe assessment.

**Rationale**: The newly licensed nurse should record brief notes during the assessment to avoid delays and write more detailed notes after completing the assessment.

A nurse is assessing a client who has schizophrenia. The nurse should identify the following alteration in speech as which of the following? (Audio) - **Correct Answer:** Clang association

**Rationale**: Clang association is an alteration in speech in which the client uses words based on their sound, rather than their meaning. Clients who have neurological disorders can also have this alteration in speech.

A nurse is assessing a school age-child who has cystic fibrosis. Which of the following findings is the priority for the nurse to report to the provider? - **Correct Answer:** Hemoptysis 275 mL/24 hr

**Rationale**: Hemoptysis greater than 250 mL/24 hr indicates that this child is at greatest risk for hemorrhage. Therefore, this is the priority finding for the nurse to report.
Fever

A nurse is caring for a client who ha bipolar disorder. The nurse observes that the client is becoming increasingly restless. The client is pacing the unit and speaking rapidly, frequently using profanities and sexual references. Which of the following actions should the nurse take first? - **Correct Answer:** Move the client to a quiet place away from others.

**Rationale**: The client's behavior indicates the greatest risk is injury to others. Therefore, the first action the nurse should take is to prevent harm to other clients by moving the client to a quiet place away from others.

A nurse is providing colostomy care for a client using a two-piece pouching system. Which of the following actions should the nurse take? - **Correct Answer:** Place the skin barrier over the stoma and hold it for 30 seconds.

**Rationale**: The nurse should activate the adhesive in the skin barrier by holding it in place over the stoma for 30 seconds.

A nurse is teaching the parent of a school-age about administering ear drops. Which of the following response by the parent indicates an understanding of the teaching? - **Correct Answer:** "I should pull the top of the ear upward and back while instilling the medication."

**Rationale**: The nurse should instruct the parent to pull the pinna upward and back in children older than 3 years of age to straighten the ear canal and allow the medication to reach the entire canal. For children younger than 3 years of age, the parent should gently pull the pinna downward and back.

A nurse is assessing a client who is 2 hr postoperative following a cardiac catheterization. Which of the following information should the nurse report to the provider? - **Correct Answer:** Neurologic status

**Rationale**: This client is experiencing slurred speech and extremity weakness, which are indications of a stroke, a potential complication of cardiac catheterization. The nurse should report these findings to the provider.

A nurse is caring for a client who is receiving total parenteral nutrition (TPN) solution by continuous IV infusion at 60 mL/hr. The nurse discovers the infusion pump has stopped working. Which of the following actions should the nurse take while waiting for a new infusion pump? - **Correct Answer:** Provide dextrose 10% in water solution using manual drip tubing at 60 mL/hr.

**Rationale**: The nurse should use an infusion pump when administering TPN solution to ensure accurate dosage and should taper the infusion rate before discontinuing the solution to prevent hypoglycemia. If the nurse is unable to continue the TPN infusion by infusion pump, the nurse should use manual drip tubing to infuse dextrose 10% in water at the same rate as the TPN solution.

A nurse is caring for a client who has an STI that must be reported to the state health department. Which of the following actions should the

nurse take? - **Correct Answer:** Explain to the client why this information will be shared.

**Rationale**: It is the responsibility of the nurse to advocate for the client, provide confidential information, and explain legal requirements. Reporting communicable disease occurrences helps with identifying outbreaks and overall disease trends.

A nurse is caring for a group of clients. For which of the following events should the nurse complete an incident report? - **Correct Answer:** A client's IV pump delivers an inadequate dose of medication.

**Rationale**: The nurse should complete an incident report to record occurrences which resulted in a medication error, such as a failure of the IV pump, as part of the quality improvement process. Other situations requiring an incident report include significant complaints about care quality and visitor or client injury.

A nurse is caring for a client who has hypertension and is taking captopril. Which of the following tasks should the nurse delegate to an assistive personnel (AP)? - **Correct Answer:** Obtain the client's blood pressure before the nurse administers medication.

**Rationale**: The nurse can delegate obtaining blood pressure before and after medication administration because this task is within the range of function for an AP.

A nurse is assessing a client who is receiving a blood transfusion. Which of the following findings should indicate to the nurse that the client is having a hemolytic transfusion reaction? - **Correct Answer:** Low back pain

**Rationale**: The nurse should expect low back pain in a client who is having a hemolytic transfusion reaction.

A nurse is caring for a toddler who has infectious gastroenteritis. Which of the following actions should the nurse take? - **Correct Answer:** Initiate oral rehydration therapy for the toddler.

**Rationale**: Infectious gastroenteritis can lead to dehydration. The nurse should treat the toddler with oral rehydration therapy to replace fluids lost by diarrhea. Soft or pureed foods can be given along with the oral rehydration therapy. After adequate rehydration has occurred, a regular diet can be resumed.

A nurse is administering medications to a client who has percutaneous gastrostomy tube for enteral feedings. Which of the following actions should the nurse take to prevent clogging of. the tube? - **Correct Answer:** Flush the client's gastrostomy tube with 30 mL of water before administering the medication.

**Rationale**: The nurse should flush the gastrotomy tube with at least 30 mL of water before and after medication administration to clear the tube of any residuals and to ensure patency.

A nurse is teaching home wound care to the family of a child who has a large wound. Which of the following interventions should the nurse recommend? - **Correct Answer:** Double-bag soiled dressings in plastic bags for disposal.

**Rationale**: The client should double-bag soiled dressings in plastic bags to prevent the spread of micro-organisms to other household members.

A nurse is teaching the parents of a toddler about snacks. Which of the following foods should the nurse recommend? - **Correct Answer:** Diced steamed carrots