ATI PHARMACOLOGY PROCTORED 2019 B NGN COMPLETE EXAM ALL 70 QUESTIONS AND CORRECT ANSWERS WITH RATIONALES.

- A nurse is caring for a pt who is receiving Haloperidol. The nurse should identify which of the following findings as an adverse effect of the med?

  -Akathisia = CORRECT ANSWER
  An adverse effect associated with haloperidol is the development of extrapyramidal manifestations such as dystonia, pseudoparkinsonism, and akathisia.

  -Paresthesia
  Haloperidol, an antipsychotic neuroleptic medication, can cause CNS adverse effects such as seizures, confusion, and neuroleptic syndrome. However, paresthesia is not an adverse effect of haloperidol.

  -Excess tear production
  Haloperidol has anticholinergic properties that can cause sensory adverse effects such as increased intraocular pressure, blurred vision, and dry eyes.

  -Anxiety
  Haloperidol can be prescribed to treat severe agitation as well as psychotic manifestations.
- A nurse is providing teaching to a pt who is to start taking Sumatriptan. Which of the following adverse effects should the nurse instruct the pt to monitor for and report to the provider?

  -Chest pressure= CORRECT ANSWER
  Sumatriptan is an antimigraine agent which can cause coronary vasospasms, resulting in angina. The client should report chest pressure or heavy arms to the provider.

  -White patches on the tongue
  White patches on the tongue can indicate a fungal infection, which is not an adverse effect of sumatriptan.

  -Bruising
  Ecchymosis can indicate thrombocytopenia, which is not an adverse effect of sumatriptan.

  -Insomnia
  Sumatriptan can cause drowsiness and sedation as an adverse effect of the medication.

- A nurse is teaching a pt who is starting to take Amitriptyline. Which of the following findings should the nurse include in the teaching as an adverse effect of the med?

  -Diarrhea
  Constipation is an adverse effect of amitriptyline.

  -Cough
  Developing a cough is not an adverse effect of amitriptyline.

  -Urinary retention = CORRECT ANSWER
  The nurse should instruct the client that amitriptyline causes the anticholinergic effect of urinary retention.

  -Increased libido
  A decrease in libido is an adverse effect of amitriptyline.
- A nurse is assessing a pt who is taking Tamoxifen to treat breast cancer. Which of the following findings is the priority for the nurse to report to the provider?

  -Hot flashes
  The client is at risk for hot flashes as an adverse effect of tamoxifen; however, another finding is the priority to report to the provider. The nurse should encourage the client to avoid caffeine and spicy foods to prevent hot flashes.

  -Gastrointestinal irritation
  The client is at risk for gastrointestinal irritation (GI) as an adverse effect of tamoxifen; however, another finding is the priority to report to the provider. The nurse should administer the medication with food or fluids to reduce GI irritation.

  -Vaginal dryness
  The client is at risk for vaginal dryness as an adverse effect of tamoxifen; however, another finding is the priority to report to the provider. The nurse should encourage the client to use vaginal moisturizers if dryness occurs.

-Leg tenderness = CORRECT ANSWER
The greatest risk to this client is the development of a thromboembolism, which is an adverse effect of tamoxifen. The nurse should also monitor the client for other manifestations of a thromboembolism, including leg tenderness, redness, swelling, and shortness of breath.

- A nurse is teaching a pt who is taking Allopurinol for the treatment of gout. Which of the following info should the nurse include in the teaching?

-Plan to increase the dosage each week by 200 mg increments.
The nurse should instruct the client to increase the dosage each week by 50 to 100 mg until they experience relief or reach a maximum of 800 mg daily.

-Prolonged use of the medication can cause glaucoma.

The nurse should instruct the client that the prolonged use of allopurinol can cause cataracts; therefore, the client should have periodic ophthalmic checkups.

-Drink 2 L of water daily. = CORRECT ANSWER
The nurse should instruct the client to drink at least 2 L of water each day to prevent renal stone formation and kidney injury, because allopurinol is eliminated through the kidneys.

-A fine red rash is transient and can be treated with antihistamines.
The nurse should instruct the client to report a rash to the provider immediately as this can be an indication of hypersensitivity syndrome, a life-threatening toxicity. Treatment for allopurinol toxicity can require hemodialysis or the administration of glucocorticoid medications

- A nurse is caring for a pt who has diabetes mellitus and is taking Glyburide. The pt reports feeling confused and anxious. Which of the following actions should the nurse take first?

-Perform a capillary blood glucose test. = CORRECT ANSWER
The greatest risk to this client is injury from hypoglycemia. Therefore, the nurse should perform a capillary blood glucose test to determine the client's blood glucose status. Manifestations of hypoglycemia include weakness, anxiety, confusion, sweating, and seizures.

-Provide the client with a protein-rich snack.
The nurse should provide the client with a protein-rich snack after determining the client's blood glucose value and providing a carbohydrate first. However, there is another action that the nurse should take first.

-Give the client 120 mL (4 oz) of orange juice.
The nurse should give the client 10 to 15 g of carbohydrates, such as 4 oz of orange juice, to treat hypoglycemia. However, there is another action that the nurse should take first.

-Schedule an early meal tray.
The nurse should schedule an early meal tray to maintain the client's blood glucose level following the initial interventions for hypoglycemia. However, there is another action the nurse should take first.

- A nurse is administering Cefotetan via intermittent IV bolus to a pt who suddenly develops dyspnea and widespread hives. Which of the following actions should the nurse take first?

-Administer epinephrine 0.5 mL via IV bolus.
The nurse should administer epinephrine, which is a beta-adrenergic agonist that can stimulate the heart, cause vasoconstriction of blood vessels in the skin and mucous membranes, and cause bronchodilation in the lungs. However, there is another action the nurse should take first.

-Discontinue the medication IV infusion. = CORRECT ANSWER
The greatest risk to the client is respiratory arrest from anaphylaxis. Therefore, the first action the nurse should take is to discontinue the medication IV infusion to prevent the client from receiving more medication. However, the nurse should not remove the IV catheter. Instead, the nurse should change the tubing and administer 0.9% sodium chloride by continuous IV infusion.

-Elevate the client's legs above the level of the heart.
The nurse should elevate the client's legs and feet to a level above the client's heart to facilitate blood flow to the vital organs. However, there is another action the nurse should take first.

-Collect a blood specimen for ABGs.
The nurse should collect a blood specimen for ABGs levels to evaluate the client's respiratory status. However, there is another action the nurse should take first.

• A nurse is preparing to administer 0.9% Sodium Chloride 1000mL IV over 8hr to a pt. The drop factor of the manual IV tubing is 15gtt/mL. The nurse should set the manual IV infusion to deliver how many gtt/min? (round to nearest whole #, do not use trailing zero)

The nurse should set the manual IV infusion to deliver 0.9% sodium chloride IV at **31 gtt/min. = CORRECT ANSWER**

• A nurse is teaching about a new prescription for Ciprofloxan to a pt who has a UTI. The nurse should identify which of the following statements as an indication that the pt understands the teaching?

-"I will take this medication with an antacid to prevent gastrointestinal upset."
The client should avoid taking ciprofloxacin with an antacid containing aluminum, magnesium, or calcium because this can decrease the effectiveness of the medication. The nurse should instruct the client to take antacids 2 hr before or 6 hr after the ciprofloxacin.

-"I will stop taking this medication when I no longer have pain upon urination."
The client should take the full course of ciprofloxacin to prevent reoccurring colonization of bacteria.

-"I will report any signs of tendon pain or swelling." = CORRECT ANSWER
Ciprofloxacin, a fluoroquinolone, is associated with a risk of tendon rupture. This risk is increased in older adult clients, so the client should notify the provider at the onset of tendon pain or swelling.

-"I will take this medication with milk."
The client should take ciprofloxacin with water and increase fluids to 2 to 3 L daily to avoid the development of crystals in the kidneys. Milk products will decrease the absorption of the medication.

• A nurse is preparing to teach a pt who is to start a new prescription for extended release Verapamil. Which of the following instructions should the nurse plan to include?

-Take the medication on an empty stomach.
The nurse should instruct the client to take extended release verapamil with food to minimize gastric distress.

-Avoid crowds.
Avoiding crowds is not necessary for the client who is taking verapamil because it does not cause an immunosuppression disorder.

-Discontinue the medication if palpitations occur.
The nurse should instruct the client that verapamil can cause palpitations, which should be reported to the provider. The client should never discontinue the medication abruptly because the client might experience chest pain.

-Change positions slowly. = CORRECT ANSWER
The nurse should instruct the client to change positions gradually to prevent orthostatic hypotension and syncope.

-A nurse is caring for a pt who is refusing to take their scheduled morning Furosemide. Which of the following statements should the nurse make?

-"By not taking your furosemide, you might retain fluid and develop swelling." = CORRECT ANSWER
The nurse should respect the client's right to refuse the medication and inform the client of the risks of not taking the medication, notify the provider, and document the refusal. Furosemide is a loop diuretic given to reduce edema.

-"You can double your dose of furosemide this evening if that would be better for you."
The nurse should respect the client's right to refuse the medication and identify that the client should not double the medication dose if missed.

-"If you do not take your furosemide, we might get in trouble."
The nurse should respect the client's right to refuse the medication and inform the client of the risks of not taking the medication, notify the provider, and document the refusal. This response uses nontherapeutic communication because the nurse is threatening the client.

-"I'll go ahead and mix the furosemide into your breakfast cereal."
The nurse should respect the client's right to refuse the medication and inform the client of the risks of not taking the medication, notify the provider, and document the refusal. This response is dismissing the client's right to refuse a medication.

-A nurse is providing teaching to a pt who has a prescription for Trimethoprim/Sulfamethoxazole. Which of the following instructions should the nurse include in the teaching?

-Take the medication with food.
The nurse should instruct the client to take the medication on an empty stomach either 1 hr before or 2 hr after meals.

-Expect a fine, red rash as a transient effect.
The nurse should instruct the client to notify the provider if a rash develops, because this can be an indication of Stevens-Johnson syndrome. However, the client should not expect to have a fine, red rash as a transient effect.

-Drink 8 to 10 glasses of water daily. = CORRECT ANSWER
The nurse should instruct the client to increase water intake to 1,920 to 2,400 mL (65 to 81 oz) a day to decrease the chance of kidney damage from crystallization.

-Store the medication in the refrigerator.
The nurse should inform the client to store trimethoprim/sulfamethoxazole in a light-resistant container at room temperature.

- A nurse in a clinic is caring for a pt who is taking Aspirin for treatment of arthritis. The nurse should identify which of the following findings as an indication that the pt is beginning to exhibit salicylism?

-Gastric distress
Gastric distress is a possible adverse effect of aspirin therapy, but it is not an indication of salicylism. Gastric distress can be minimized by taking aspirin with food or an enteric form of the medication.

-Oliguria
Kidney impairment is an adverse effect associated with aspirin use. Manifestations include reduced urinary output, weight gain, and elevated BUN and creatinine levels. However, oliguria is not an indication of salicylism.

-Excessive bruising
Excessive bruising is a possible adverse effect of aspirin therapy, caused by the antiplatelet effects of the medication. However, excessive bruising is not an indication of salicylism.

-Tinnitus = CORRECT ANSWER
Tinnitus is a manifestation of aspirin toxicity, also called salicylism. Other manifestations include sweating, headache, and dizziness.

- A nurse is caring for a pt who has heart failure and a prescription for Enalapril. The nurse should monitor the pt for which of the following findings as an adverse effect of the med?

-Bradycardia
Enalapril is an ACE inhibitor that has several cardiovascular adverse effects including hypotension, tachycardia, and dysrhythmias.

-Hyperkalemia = CORRECT ANSWER
Enalapril improves cardiac functioning in clients who have heart failure and can cause hyperkalemia due to potassium retention by the kidneys.

-Loss of smell
Enalapril can cause several sensory adverse effects such as a loss of taste. However, it does not cause a loss of smell.

-Hypoglycemia
Enalapril does not cause hypoglycemia.

- A circulating nurse is planning care for a pt who is scheduled for surgery and has a latex allergy. Which of the following actions should the nurse include in the plan of care?

-Schedule the client for the last surgery of the day.
The nurse should schedule the client for the first surgery of the day to minimize the client's exposure to latex, including latex dust.

-Place monitoring cords and tubes in a stockinet. = CORRECT ANSWER
The nurse should place monitoring devices in a stockinet to prevent direct contact with the client's skin.

-Choose rubber injection ports for fluid administration.
The nurse should ensure that latex-free products are used in the care of this client. Rubber injection ports contain latex, which puts the client at risk for a severe allergic reaction.

-Ensure phenytoin IV is readily available.
The nurse should ensure that epinephrine is readily available in the operating room in case of an anaphylactic reaction caused by an accidental exposure to latex.

- A nurse is precepting a newly licensed nurse who is caring for 4 pts. The nurse should complete an incident report for which of the following actions by the newly licensed nurse?

-Administers isosorbide mononitrate to a client who has BP 82/60 mm Hg = CORRECT ANSWER
Isosorbide mononitrate is a nitrate used for clients with angina. Taking isosorbide mononitrate leads to vasodilation, which can result in hypotension. The nurse should withhold the medication and notify the provider if the client's systolic blood pressure is below the expected reference range of 120/80.

-Administers digoxin to a client who has a heart rate of 92/min
Digoxin is a cardiac glycoside used for clients who have heart failure because it strengthens the contractility of the heart, increasing cardiac output. A slowing of the heart rate is an effect of digoxin, so it should be withheld if the client's heart rate is less than 60/min.

-Administers regular insulin to a client who has a blood glucose of 250 mg/dL
Insulin is a hormone that promotes the uptake of glucose into the cells, thereby decreasing circulating glucose. A blood glucose value of 250 mg/dL is above the expected reference range, so the nurse should administer regular insulin.

-Administers heparin to a client who has an aPTT of 70 seconds
Heparin is an anticoagulant that decreases the coagulability of the blood and is used for clients who have thrombus. Dosing of heparin is dependent upon achieving a therapeutic aPTT level. An aPTT of 70 seconds is within the expected reference range when administering heparin.

- A nurse is caring for a pt who has sickle cell anemia and is taking Hydroxyurea. Which of the following findings should the nurse report to the provider? (Select all that apply)

-Hemoglobin 7.0 g/dL = correct
A hemoglobin level of 7.0 g/dL indicates hydroxyurea toxicity. This hemoglobin level is below the expected reference range of 14 to 19 g/dL for a male client and 12 to 16 g/dL for a female client. Therefore, the nurse should report this finding to the provider.

-Platelets 75,000/mm3 = correct
A platelet level of 75,000/mm3 indicates hydroxyurea toxicity. This platelet level is below the expected reference range of 150,00 to 400,000/mm3. Therefore, the nurse should report this finding to the provider.

-Potassium 5.2 mEq/L = correct
A potassium level of 5.2 mEq/L indicates tumor lysis syndrome. This potassium level is above the expected reference range of 3.5 to 5 mEq/L. Therefore, the nurse should report this finding to the provider.

-Creatinine 1 mg/dL
A creatinine level of 1 mg/dL is within the expected reference range of 0.5 mg/dL to 1.2 mg/dL.

-RBC 4.7 million/mm3
An RBC count of 4.7 million/mm3 is within the expected reference range of 4.7 to 6.1 million/mm3 for a male client and 4.2 to 5.4 million/mm3 for a female client.

- A nurse is caring for a pt who has a magnesium level of 3.1mEq/L. The nurse should expect to administer which of the following meds?

-Magnesium gluconate
A magnesium level of 3.1 mEq/L is above the expected reference range of 1.3 to 2.1 mEq/L. Magnesium gluconate is administered to treat hypomagnesemia.

-Cinacalcet
Cinacalcet is administered to treat hypercalcemia.

-Calcium gluconate = CORRECT ANSWER
The nurse should expect to administer IV calcium gluconate to the client and prepare to provide ventilatory support. This client is at risk for respiratory depression and cardiac dysrhythmias because a magnesium level of 3.1 mEq/L is above the expected reference range of 1.3 to 2.1 mEq/L.

-Regular insulin
Regular insulin is administered to treat hyperkalemia.