1. MISSING

2. A nurse is caring for a client who is scheduled to have his alanine aminotransferase (ALT) level checked. The client asks the nurse to explain the laboratory test. Which of the following is an appropriate response by the nurse?

a. "This test will indicate if you are at risk for developing blood clots
b. "This test will determine if your heart is performing properly"
c. "This test will provide information about the function of your liver"
d. "This test is used to check how your kidneys are working"

Rationale: Leadership 7.0. ALT and AST measure you liver function. Creatinine and BUN measure your kidney function.

3. A nurse is caring for a client who has a prescription for morphine 5mg IM accidentally administers the whole 10 mg from the single-dose vial. Which of the following actions should the nurse take **first**?

a. Notify the client's provider.
b. Report the incident to the pharmacy.
c. Complete an incident report.
d. Measure the client's respiratory rate.

Rationale: Morphine can cause respiratory depression if given too much. Also you should ALWAYS ASSESS the patient first when a med error is performed to make sure med error doesn't put the client's health in risk.

4. A nurse is preparing to administer diphenhydramine 20 mg orally to a 6-year-old child who has difficulty swallowing pills. Available is diphenhydramine 12.5 mg/5 mL oral syrup. Which of the following images shows the correct # of mL the nurse should administer? (Round the answer to the nearest whole number.)

Click on the syringe that has 8 mL of med.

20 mg x (5mL/12.5mg) = 8 mL

5. A nurse is caring for a 6-year-old child who has a new prescription for cefoxitin 80 mg/kg/day administered intravenously every 6 hour. The child weighs 20 kg. How much cefoxitin should the nurse administer with each **dose**? (Round the answer to the nearest whole number. Use a leading zero if it applies. Do not use a trailing zero.)

- So it says each dose for the final answer, but we are given 80 mg/kg/**day.**
- 80 x 20 = 1600 / 4 (dose is given every 6 hours a day) = 400 mg

6. A nurse is preparing to administer IV fluids to a client. The nurse notes sparks when plugging in the IV pump. Which of the following actions should the nurse take first?

a. Label the pump with a defective equipment sticker.
b. Unplug the pump.
c. Obtain a replacement pump.
d. Notified the biomedical department to fix the pump.

Rationale: Prioritization question. YOU WILL FIRST UNPLUG the IV pump to avoid causing a fire.

7. A nurse is caring for a client who has a surgical wound. Which of the following laboratory values places the client at risk for poor wound healing? Ch

a. ***Serum albumin 3 g/dL***
b. Total lymphocyte count 2400 mm3
c. HCT 42%
d. HGB 16g/dL

Rationale: Albumin in low. Normal range is 3.5 to 5.5 g/dL. Low albumin places the client at risk for poor wound healing. The other lab values are within normal limits.

8. A nurse is preparing to check a client's blood pressure. Which of the following actions should the nurse take? **Chapter 27 Vitals signs page 244**

a. Apply the cuff above the clients antecubital fossa.

b. Use a cuff with a width that is about 60% of the client's arm circumference.- width of the cuff should be 40 % of arm circumference
c. How the clients sit with his arm resting above the level of his heart.- MUST BE AT HEART LEVEL
d. Release the pressure on the client's arm 5 to 6 mm per second.- pressure release should not be more than 2 to 3 mm hg per second

Rationale: ATI FUNDA says 40% of the arm circumference pg. 139. Release the pressure no faster than 2 to 3 mm Hg per second. Apply the BP cuff 2.5 cm (1 in) above the antecubital space with the brachial artery in line with the marking on the cuff.
Apply the BP cuff 2.5 cm (1 in) above the antecubital space with the brachial artery in line with the marking on the cuff.

9. A nurse is preparing to perform nasal tracheal suctioning for a client. Which of the following is an appropriate action for the nurse to take? **Chapter 53 Airway management page 563**

a. Hold the suction catheter with the clean non-dominant hand.
b. Apply suctioning for 20 to 30 seconds.- 10 -15 seconds is the maximum.
c. Place the catheter in a location that is clean and dry for later use new line.- NEVER EVER REUSE THE SUCTION CATHETER . you throw it away after being used.
d. ***Use surgical asepsis when performing the procedure.***

Rationale: ATI FUNDA. PG. 316 Use surgical asepsis for all types of suctioning. No longer than 10-15 seconds to avoid hypoxemia

10. A nurse is documenting client care. Which of the following abbreviations should the nurse use?ati book was not thorough so i had to go on different sites for charts - not confident with this, please double check.

a. "SS" for sliding scale
b. "BRP" for bathroom privileges
c. "OJ" for orange juice- do not
d. "SQ" for subcutaneous- do not

11. MISSING

12. A nurse is collecting A blood pressure reading from a client who is sitting in a chair period the nurse determines that the clients BP is 158/96 mmhg. which of the following actions should the nurse take?

a. Ensure that the width of the BP cuff is 50% of the client's upper arm circumference. It says 40%
b. Reposition the client Supine and recheck her BP. BP. → ORTHOSTATIC HYPOTENSION
c. Recheck the clients BP and her other arm for comparison.
d. Request that another nurse check the the clients BP in 30 minutes. → 15 minutes

13. A nurse is caring for a client who has left lower atelectasis. in which of the following positions should the nurse place the client for postural drainage? **Chapter 53 Airway Management page 562**

a. Supine and low-Fowler's position
b. ***Right lateral in Trendelenburg position***
c. Side lying with the right side of the chest elevated
d. Prone with pillows under the extremities

14. A nurse is receiving the prescription for a client who is experiencing **dysphagia following a stroke.** Which of the following prescriptions should the nurse clarify?

a. Dietitian consult
b. Speech therapy referral
c. Oral suction at the bedside
d. Clear liquids

Rationale: ATI MS. Pg. 83 food levels for dysphagia include pureed, mechanically altered, advanced/mechanically soft, and regular. Liquids must be THICK.. Clear liquids can cause aspiration

15. A nurse is administering a large volume enema to a client. Identify the sequence of steps the nurse should follow after preparation and lubricating the enema set.(**ati funds video enema)**

1. Administer the enema solution.**(2)**
2. Remove the enema tube from the clients rectum.**(4)**

3. Wrap the end of the enema tube with a disposable tissue.**(5)**
4. Insert the enema tube into the client's rectum.(**1)**
5. Clamp the enema tube.**(3)**

16. A nurse is inserting an NG tube for a client who requires gastric decompression. Which of the following actions should the nurse take to **verify proper placement of the tube?**

a. Place the end of the NG tube in water to observe for bubbling.
b. Auscultate 2.5 cm (1 in) above the umbilicus while injecting 15 mL of sterile water. AIR NOT WATER OR BY ASPIRATING GASTRIC FOR PH.
c. Assess the client's gag reflex.
d. Measure the pH of the gastric aspirate.

17. A nurse is teaching a group of newly licensed nurses about the Braden Scale. Which of the following responses by the newly licensed nurse indicates an understanding of the teaching?

a. "The client's age is part of the measurement." - rationale is same as b.
b. "The scale measures six elements." - The six elements are 1. Sensory Perception, 2. Moisture, 4. activity, 5. mobility ,6. nutrition , 7. friction and shear.
c. "The higher the score, the higher the pressure ulcer risk."- the higher the score the better chance the patient has of NOT getting an ulcer . score of 12 or less is high risk. Anything above 18 is healthy.
d. "Each element has a range from 1 to 5 points."- each elements is scored from 1-4 actually .

18. A nurse is caring from a client who has a tracheostomy. Which of the following actions should the nurse take?

a. Clean the skin around the stoma with normal saline.
b. Secure the tracheostomy ties with one finger to fit snugly underneath. → 2 snug fingers widths under neck strap
c. Soak the outer cannula in warm tap water. STERILE NS
d. Use a cotton tip applicator to clean the inside in the **inner** cannula. <to clean OUTER cannula surfaces, cllity-approved solution>ean the inside with the faci

Rationale: according to POTTER, funda pg. 866 using NS-saturated cotton-tipped sterile swabs and 4x4 gauze, clean exposed outer cannula surfaces and soma under faceplate, extending 5-10cm (2-4in) in all directions from stoma.

19. A nurse is documenting in a client's medical record . Which of the following entries should the nurse record?

a. "Incision without redness or drainage."
b. "Drink adequate amounts of fluid with meals." WHATS THE AMOUNT
c. "Oral temperature slightly elevated at 0800." WHATS THE TEMP
d. "Administered pain medication."

<Any action & change to the client's condition should be recorded>

20. A staff nurse is teaching a newly hired nurse about alternatives to the use of restraints on clients who are confused. Which of the following instructions should the nurse include?

a. "Use full-length side rails on the client's bed."
b. "Check on the client frequently while he is in the restroom."
c. "En**courage physical activity throughout the day to expand energy."(only one makes sense couldn't find in ati book)**
d. "Remove clocks from the client's room."

21. A nurse in an emergency department is assessing a clients who reports RIGHT lower quadrant pain, nausea and vomiting for the past 48 hr. Which of the following actions should the nurse take first .

a. Auscultate bowel sounds. ADPIE first but i will research more into this
b. Administer an antiemetic.
c. Offer a pain med.
d. Palpate the abdomen.

Possible appendicitis "nausea/vomiting" with RLQ pain.
(IAPP) INSPECTION. AUSCULTATE. PERCUSS. PALPATE- FOR BOWEL

22. A nurse is assessing a client's extraocular eye movements. Which of the following should the nurse take ?

a. **Instruct the clients to follow a finger through the six cardinal fields of gaze.** (Cardinal fields of gaze test for cranial nerves 3, 4, and 6 which are for eye movement)
b. Hold a finger 46 cm (18 in) in front of the clients eyes.
c. Ask the clients to cover her right eye during assessment of her left eye.
d. Position the clients 6.1 m (20 feet) away from the Snellen chart. (This is for cranial nerve 2)

23. A nurse is providing a teaching to a client who had a new medication prescription . Which of the following manifestations of a **mild allergic reaction** should the nurse include

a. Urticaria
b. Ptosis
c. Nausea
d. Hematuria

24. A provider prescribes cold application for a client who reports ankle joint stiffness. Which of the following assessments findings should the nurse identify as a **contraindication** to the application of cold?

a. **Cap refill 4 seconds** -ITS CONTRAINDICATED TO USE APPLICATION OF COLD
b. 7.5 cm (3 in) diameter bruise on the ankle IT HELPS ON BRUISE
c. Warts on the affected ankle
d. 2+ pitting edema -HELPS REDUCE INFLAMMATION (EDEMA)

25. A nurse is caring for a client who has TB. Which of the following precautions should the nurse plan to implement when working with the client? Chapter 11 fundamentals 9.0 infection control **page 52**

a. Airborne - measle , varicella, pulmonary or laryngeal tuberculosis
b. Droplet-streptococcal pharyngitis or pneumonia, Haemophilus influenzae type B, scarlet fever, rubella, pertussis, mumps, mycoplasma pneumonia, meningococcal pneumonia and sepsis, pneumonic plague).
C.Protective-
d..Contact-

26. A nurse is performing a dressing change on a client and observes granulation tissue. Which of the following findings should the nurse document? Chapter 55 Pressure ulcers, wounds and wound management fundamentals pdf **page 330**

a. Stringy, white tissue- same as slough. Means that it is sepatated from the body.
b. Translucent, red tissue- red means healthy and its healing
c. Soft, yellow tissue= means presence of slough and drainage.
d. Thick, black tissue- black is necrotic = escahr is present and needs removal

27. A nurse is screening several clients at a neighborhood health fair. Which of the following assessments findings is the ***priority*** for referral for further care?

a. **Blood glucose 45 mg/dL** LOW/HYPOGLYCEMIA MAY LEAD TO SHOCK
b. Blood pressure 148/92 mm Hg STAGE 1 HYPERTENSION
c. Body mass index 28 kg/m2 OVERWEIGHT
d. Heart rate 105/min

28. A nurse is planning care for a client who has a new prescription for parenteral nutrition (PN) in 20% dextrose and fat emulsions. Which of the following is an appropriate action to include in the plan of care?

a. Obtain a random blood glucose daily.
b. Change the PN infusion bag every 48 hr. CHANGE Q24HR
c. Prepare the client for a central venous line.
d. Administer the PN and fat emulsion separately.

ATI FUNDA PG. 298 Administer separate IV line below the filter using a Y-connector or as a admixture to PN solution (3-in-1 admixture consisting dextrose, AA, and Lipids

29. A nurse is providing teaching about health promotion guidelines to a group of young adult male clients. Which of the following guidelines should the nurse include?

a. "Obtain a tetanus booster every 5 years."
b. "Obtain a herpes zoster immunization by age 50."

c. "**Have a dental examination every 6 months."(funds ati pg 201 says they need dental cause they are prone to infection)**
d. "Have a testicular examination every 2 years."

30. A home health nurse is teaching a new caregiver how to care for a client who has had a tracheostomy for 1 year. Which of the following instructions should the nurse include?
a. "**Use tracheostomy covers when going outdoors." Google**
b. "Maintain sterile technique when performing tracheostomy care."
c. "Remove the outer cannula for routine cleaning."
d. "Clean around the stoma with povidone-iodine." NS

31. A nurse in the emergency department is measuring a client's oral temperature using an electronic thermometer. Which of the following actions should the nurse take? **Chapter 27 Vital sigsn p.133**
a. Provide oral hygiene prior to measuring the client's temperature.
b. Ask the client if he has smoked within the past 30 min
c. Attach the red tip probe to the thermometer unit.
d. Place the tip of the probe along the client's buccal mucosa.- must be unde the tongue in the posterior sublingual pocket lateral to the center of the lower jaw.

32. A nurse is caring for a client who had a stroke and **requires assistance with morning ADLs**. Which of the following interprofessional team members should the nurse consult?
a. Registered dietician- helps with healthy food planning.
b. Occupational therapist chapter 2 page 7 the interprofessional team.
c. Speech-language pathologist- yes the question said stroke , but the question wants who will help him with every day ADLS. speech patho help them if they have a hard time swallowing.
d. Physical therapist- is used of the patients cannot even move his muscles.

33. MISSING

34. A nurse overhears a colleague informing a client that **he will administer her medication by injection if she refuses to swallow her pills**. The nurse should recognize that the colleague is committing which of the following torts?
a.) Defamation- you embarass someone by making fun of them.
b.) Malpractice- you did something by accident
c.) Assault- verbal threatening
d.) Battery- actually causing physical harm or trauma.

35. A nurse is caring for clients who is prescribed a **buccal** medication. Which of the following client statements indicates that the client understands how to take this medication?
a. "I will first dissolve the tablet in water."
b. "I will insert the tablet between my cheek and teeth."
c. "I will place the tablet under my tongue."- this is sublingual
d. "I will chew the tablet."- this is oral

36. A nurse is a admitting a client who is malnourished. The client states my wedding ring is loose and I'm worried I will lose it if it falls off. Which of the following is an appropriate response by the nurse?
a. "I can pin it to your hospital gown so you won't lose it."
b. "I will place it in your drawer so it won't get lost."
c. "I will hold onto it until a family member can take it home."
d. "I can put it in a locked storage unit for you."

37. A nurse is changing a client's colostomy pouch and notices peristomal skin irritation. Which of the following actions should the nurse take?
a. Change the pouch once every 24 hour.
b. Apply the pouch while the skin Barrier is still damp.(no)
c. Rub the peristomal skin dry after cleaning. (No it will irritate skin more)
d. **Ensure the pouch is 0.32 cm (1/8 in) larger than the stoma**.

rationale : ATI FUNDA PG 241

38. A nurse is preparing change of shift report after the night shift using one sbar communication tool. which of the following data should the nurse include when reporting ***background*** information?

a. "Blood pressure 160/92 mm Hg"- part of ASSESSMENT
b. "Start first dose of penicillin at 1200"-
c. "Pain rating of 5 on a scale from 0 to 10"
d. "Code status: do-not-resuscitate"

39. A nurse is caring for a client who has extracellular fluid volume deficit. Which of the following findings should the nurse expect? **Chapter 57 fluid volume imbalances page 343.**

a. Postural hypotension
b. Distended neck veins
c. Dependent edema
d. Bradycardia - would be TACHY since SNS system kicks in when detects low blood volume
TACHYCARDIA is for fluid overload.

40. A nurse is teaching a client how to self-administer daily low-dose heparin injections. Which of the following factors is most likely increase the client's motivation to learn?

a. The nurse empathy about the client having to self-inject
b. The client's belief that his needs will be met through education
c. The client seeking family approval by agreeing to a teaching plan
d. The nurse explaining the need for education to the client

41. A nurse is conducting a Weber test on a client. Which of the following is an appropriate action for the nurse to take?

a. Deliver a series of high-pitched sounds at random intervals.
b. Place an activated tuning fork in the middle of the client's forehead.
c. Hold and activated tuning fork against the client's mastoid process.
d. Whisper a series of words softly into one ear.

42. A home health nurse is teaching a client about home safety. Which of the following statements by the client indicates an understanding of the teaching? Select all that apply.

a. "I need to check my medications for expiration dates."
b. "I will use the grab bars when getting in and out of the bathtub."
c. "I need to have a fire escape plan with my family."
d. "I need to set my hot water heater to 140 degrees Fahrenheit."- no more than 120 degrees
e. "I will apply over frayed areas of electrical cords."- google frayed areas of electrical cords; it is unsafe because the cover are gone.

ATI FUNDA PG. 65

43. A nurse is caring for a client who has a prescription for a stool specimen to be sent to the laboratory to be tested for ova and parasites. Which of the **following instructions regarding specimen collection should the nurse provide to the assistive personnel**?

a. Collect at least 2 inches of formed stool.
b. Wear sterile gloves while obtaining the specimen.
c. Use a culturette for specimen collection.
d. **Record the date and time the stool was collected**.(funds ati pg423)

44. A nurse is caring for a client who has restraints to each extremity. Which of the following assessments should the nurse perform first?

a. Peripheral pulses ABCS always first
b. Comfort level
c. Elimination needs
d. Skin integrity

POTTER 391 ASSESS proper placement of restraint, skin integrity, pulses, skin temperature and color, sensation of restrained body part.

45. A nurse obtains a prescription for **wrist restraints** for a client who is trying to pull out his NG Tube. Which of the following actions should the nurse take?

a. Remove the restraints every 4 hr. Q2 INSTEAD
b. Attach the restraints securely to the side of the client's bed. BEDRAILS
c. Apply the restraints to allow as little movement as possible. UNSAFE
d. Allow room for two fingers to fit between the client's skin and the restraints.- for circulation

POTTER PG 391

46. A nurse is assisting in the use of a fracture bedpan for a client who is immobile due to a cast. Which of the following actions should the nurse take? **Page 244 and 240 chapter 44 urinary elimination**
THIS IS CONFUSING. 244 SAYS FOR CLIENTS WHO MUST REMAIN SUPINE BUT 240 SAYS THAT CLIENTS MUST HAVE Hob UP AT 30 DEGREES.
a.Place the shallow end of the fracture pan under the client's buttocks.
B Hyperextend the client's back while the fracture pan is in place.
C. Keep the bed flat while the client is on the fracture pan- head of bed must be 30 degrees . page 240

d. Encourage the client to try to defecate for 20 min while on the fracture pan.

47. A nurse is caring for a client who reports that she has insomnia. Which of the following interventions is appropriate for the nurse to recommend?

a. Exercise 1 hr before bedtime.(2 hours before)
b. Eat a light carbohydrate snack before bedtime. This was on the fundamentals practice test on ATI funds 2013
c. Drink a cup of hot cocoa before bedtime. (limit caffeine 2-4 before)
d. Take a 30 min nap daily.

48. A nurse is performing an **admission assessment** of a client. Which of the following actions should the nurse take when recording the client's medication?

a. Council the client about medication adherence.
b. Assess the client for medication reactions.
c. Compile a list of the client's current medications.
d. Evaluate the client's understanding of medications.

49. During an admission history a client tells a nurse that she is under a lot of stress. Which of the following physiological responses should the nurse expect to **increase** as a result of stress?

a. Blood glucose- common stress response. Tiamson said it
b. Intestinal peristalsis →INCREASE METABOLIC RATE
c. Peripheral blood vessels diameter- should be constricted since youll have HIGH blood pressure .
d. Urine output

Rationale p180 PDF: Alarm reaction: Body functions are heightened to respond to stressors. Hormones (epinephrine, norepinephrine, cortisone) are released, which cause elevated blood pressure and heart rate, heightened mental alertness, increased secretion of epinephrine and norepinephrine, and increased blood flow to muscles)

50. A nurse is teaching a client who has diabetes mellitus about mixing regular and NPH insulin. Which of the following statements by the client indicates an understanding of the teaching?

a. "I should roll the NPH between my hands before drawing it up."- it says ROLL so that makes sense , this would be wrong if it said SHAKE becasue that will break up the proteins.
b. "I should wait 10 minutes after mixing the insulin to inject it."- i believe it is up to 5 minutes but ima double check.
c. "I should draw up the NPH insulin before the regular insulin."- nope its clear to cloudy always so you must draw up regular beofre NPH
d. "I should inject air into the vial of regular insulin first."- nope, when doing clear to cloudy, you inject AIR into NPH first

51. A nurse is caring for a client who is grieving the loss of her partner. The client states I don't see the point of living anymore. which of the following actions should the nurse take?

a. Request the client's family provide additional support.
b. Ask the client if she plans to harm herself.- safety first
c. Tell the client that this is a normal response to grief.
d. Recommend that the client seek spiritual guidance.

52. A nurse is providing discharge teaching about safety considerations to an older adult client who lives at home. The client has heart failure and a new prescription for **hydrochlorothiazide**. Which of the following statements by the client **indicates an understanding of the teaching? Chapter 19 pharm p. 145**

a. "I will take a hot bath before going to bed."- they are old also so sensation is impaired.
b. "I will take my new medication in the evening."- this is a diueretic so this must be in the MORNING
c. "I will leave a light on in my bathroom at night."- some clients might have to take it twice per day usually last dose taken before 1400. You leave a light on in the bathroom because they might have to go urinate at night time (since nocturia is a possible side effect)
d. "I will weigh myself once weekly."- patients must weight themselves ONCE per day usually upon awakening.

53. A nurse is planning care for a client who is scheduled for an **intravenous pyelogram**. Which of the following actions is appropriate for the nurse to include?

a. Monitor the client for pain in the suprapubic region.
b. Ensure the client is free of metal objects.
c. Administer 240 mL (8 oz) of oral contrast before the procedure.
d. Assist the client with a bowel cleansing.

54. To ensure client safety a nurse manager is planning to **observe a newly licensed nurse perform a straight catheterization on a client.** In which of the following roles is a nurse manager functioning?

a. Case manager- they do not provide direct client care , over see case load of clients
b. Client care provider
c. Client educator
d. Client advocate

55. A nurse is caring for a client who has right-sided paralysis following a cerebrovascular accident. which of the following prescriptions should the nurse anticipate to prevent a plantar flexion contracture of the affected extremity? **P . 222 chapter 40 mobility and immobility**

a. Ankle-foot orthotic
b. Continuous passive motion machine- range of motion prevents ankylosis (permanent fixation of a joint).
c. Abduction splint
d. Sequential compression device

56. A nurse is planning to use non formal logical pain methods for a client who reports still having mild back pain after receiving analgesia 1 hour ago. Which of the following actions should the nurse include in the plan?

a. Apply an ice pack to the client's back for 1 hr.<<????
b. Remove distractions from the client's room.
c. Instruct the client to take deep rhythmic breaths.
d. Encourage the client to apply a heating pad for 2 hr at a time.- 2 hours seems too long

57. A nurse is caring for a client who is on bed rest following an abdominal surgery. Which of the following findings indicates the need to **increase the frequency of position changes**? Sacrum , buttock and heals are prone for ulcers. **Couldnt fund this in ati but it says NON blancking erthyema in merks manual . blanching is considered good since that means tissue perfusion**

a. Flat rash on the client's ankle
b. Non blanching red area over my clients trochanter
c. Ecchymosis on the clients left shoulder
d. Petechiae on the client's right anterior thigh

ULCER APPEARS AS A DEFINED AREA OF REDNESS THAT DOES NOT BLANCH (BECOME PALE) UNDER APPLIED PRESSURE. THEREFORE, IN NEED TO INCREASE POSITION CHANGES.

58. A nurse is assessing a client whose therapy has included bed rest for several weeks. Which of the following findings should the nurse identify as the priority? **Chapter 40 mobiltiy page 220**

a. Musculoskeletal weakness
b. Loss of appetite
c. Increased heart rate during physical activity
d. Left lower extremity tenderness- warmth and tenderness = DVT= PE if it dislodges!!!

Effects on the heart and blood: Like the muscular system, the cardiovascular system functions best when the body is in an upright position, working against gravity. After just a few days of bed rest, blood starts to pool in the legs. On standing, this can lead to dizziness and falls; Immobility also causes the heart to beat more quickly, and the volume of blood pumped is lower. The volume of blood generally in the body is lower, and there is less oxygen uptake by the body. This results in poorer aerobic fitness and fatigue sets in more easily; The blood also becomes thicker and stickier, which increases the risk of a blood clot forming, especially in the legs (deep vein thrombosis) and the lungs (pulmonary embolism).

59. A nurse is assessing a client's ability to balance. Which of the following actions is appropriate when the nurse conducts a **Romberg** test? **Page 168 chapter 31 musculoskeletal and neuro systems**

a. Ask the client to extend her arms in front of her body.
b. Ask the client to walk in a straight line heel To toe.
c. How the client stand with her feet together.- also with eyes closed. There should not be swaying
d. How the client place her hands on her hips.

60. A nurse is providing care for a client who is to undergo total laryngectomy. which of the following interventions is the nurse's priority?

a. Schedule a support session for the client.
b. Explain the techniques of esophageal speech.
c. Review the use of artificial larynx with the client.
d. Determine the client's reading ability.

ESOPHAGEAL SPEECH is based on the technique in which the patient transports a small amount of air into the esophagus.

61. MISSING

62. A nurse at an assisted living facility is preparing an in-service for residents about electrical safety. Which of the following instructions should the nurse include?

a. Avoid taping electrical cords to the floor.
b. Clean electrical equipment prior to disconnection.
c. Cover exposed wires with tape before used.
d. **Disconnect electrical equipment by grasping the plug.-** never grab the cord

63. A nurse is caring for a client who has a tracheostomy collar. As the nurse is performing tracheal suctioning, the client's heart rate and oxygen saturation decrease. which of the following actions should the nurse take?

a. Elevate the head of the bed.
b. Remove the inner cannula.
c. Irrigate the stoma.
d. Discontinued suctioning.

64. A nurse is caring for a client who has a new diagnosis of terminal cancer. Which of the following interventions is a priority?

a. Teach the client to use progressive relaxation techniques.
b. Help the client to find a local support group.
c. Discuss the client's prior coping mechanism.
d. Develop a list of goals with the client.

65. A staff nurse is teaching a newly hired nurse how to complete an informed consent document for a client. the stop should include that the nurse signature on the form confirms which of the following requirements? (Select all that apply.)

a. The client was not coerced.
b. The client does not have a mental health condition.

c. The client Signed in the nurse's presence.
d. The client speaks the same language as the nurse.
e. The client has legal authority to do so.

ATI: FUNDA PG. 17

66. A nurse is caring for a client who has a chest tube following thoracic surgery. Which of the following tasks should the nurse delegate to an assistive personnel?

a. Teach deep breathing and coughing to the client.- Teaching is always RNS job
b. Assist the client to select food choices from the menu.
c. Evaluate the client's response to pain medication. NURSING PROCESS is always RNS job
d. Monitor the characteristics of the client's chest tube drainage.- Evaluating treatment, is part of nursing process and is always RNS job.

67. A community health nurse is caring for a group of families. The nurse should identify that which of the following families is experiencing a maturational loss?

a. A family whose only child recently died due to cancer. ANTICIPATORY LOSS
b. A family whose head of household lost her job. PERCEIVED LOSS
c. A family whose house was destroyed in a fire. SITUATIONAL LOSS
d. A family whose oldest child is moving away for college

Rationale: Flashcardmachine: Maturational loss- experienced as a result of natural developmental processes. E.g. The first child may experience a loss of status when her sibling is born. Also, happens when sending children off to kindergarten or college.

68. A nurse on a medical-surgical unit is dividing care for four clients. The nurse should identify which of the following situations as an ethical dilemma? **Chapter 3 ethical resposiblities page 12**

a. A client who has a new colostomy refuses to take instructions from the ostomy therapist because she "doesn't like him."
b. A surgeon who removed the wrong kidney during a surgical procedure refuses to take responsibility for her actions. DOUBLE CHECK
c. The family of a client who has a terminal illness as the provider not to tell the client the diagnosis.
d. A client who has Crohn's disease reports that his prescription drug plan will not pay for his medications.

Rationale: ATI FUNDA pg. 11 it involves between two moral imperatives; answer will have a profound effect on the situation and the client. DEBATING B/W B OR C.

69. A nurse is caring for a client who has chronic back pain and asked about receiving **acupuncture** for relief. Which of the following findings should the nurse identify as a contraindication to receiving this treatment?

a. Obesity
b. Hypertension
c. Migraines
d. Cellulitis-->? TBC chapter 49 iv therapy chapter p. 293… fever pain and warmth at iv site .. treatment is to discontinue infusion and remove catheter and put warm compress. If it says REMOVE catheter then it must mean that we must not insert any needles in them .

Rationale: Google: You can't have acupuncture in a very swollen area e.g. Cellulitis; and it's a risk for infection

70. A nurse is auscultating a client's abdomen. The nurse hears a blowing sound over the aorta. The nurse should identify this sound as which of the following?

a. Gallop (heart)
b. Bruit
c. Thrill (feel)
d. Murmur (heart)

Rationale: Bruit- turbulent blood flow within the aorta.