Version 10

ATI MED-SURG PART B

91. A nurse is reinforcing teaching with an older adult client who has osteoporosis. Which of the following instructions should the nurse in the teaching?

a) "Place throw rugs on wooden floors at home."
b) "Supplement your diet with vitamin E."
c) "Swim laps for 20 minutes twice per week."
d) "Take calcium supplements with meals." (The nurse should instruct the client to take calcium carbonate supplements with or following meals to increase absorption and effectiveness.)

92. A nurse is reviewing the medication record of a client who is taking digoxin. Which of the following medications should the nurse identify as increasing the risk for the client to develop digoxin toxicity?

a) Potassium chloride

b) Famotidine
c) Levothyroxine
d) Furosemide (The nurse should identify that loop diuretics, such as furosemide, increase the urinary excretion of potassium, which can lead to hypokalemia. Hypokalemia increases the risk for the development of digoxin toxicity.)

93. A nurse is reinforcing teaching about insulin injections with an adult client who weighs 45.4 kg (100 lb.). Which of the following statements by the client indicates an understanding of the teaching?

a) "I should insert the needle at a 90-degree angle."
b) "I should give my shot in my belly tissue." (Clients who have low body weights can have very little subcutaneous tissue. Therefore, the nurse should instruct the client to administer the medication in the upper abdomen for proper absorption.)
c) "I will pull back on the syringe plunger to look for blood before I push the medication in."
d) "I will use the side of my hand to pull my skin to the side prior to administering the insulin."

94. A nurse is reinforcing discharge teaching for a client who had a mechanical mitral valve replacement. Which of the following statements by the client indicates an understanding of the teaching?

a) "I will notify my dentist about this procedure." (The nurse should instruct the client to notify his dentist about the mechanical mitral valve replacement before any procedures so antibiotic therapy can be initiated to reduce the risk of endocardial infection.)
b) "I will take an enteric-coated aspirin daily."
c) "I will use a firm-bristled toothbrush."
d) "I will weigh myself once a week."

95. A nurse is reviewing the medical record for an older adult client who is experiencing nausea and vomiting. Based on the client data, which of the following actions should the nurse take? (Click on the "Exhibit" button for additional client information. There are three tabs that contain separate categories of data.)

View the Exhibit

Exhibit 1	Exhibit 2	Exhibit 3
Diagnosis Results Sodium 142 mEq/ Potassium 4.2 mEq/L BUN 36 mg/dL Creatinine 1.4 mg/dL	**Nurses' Notes** 1200: Alert and oriented x3 Lungs clear to auscultation Decreased skin turgor Dry mucous	**Graphic Record** Temperature 0800: 37.7° C (99.9° F) 1200: 37.2° C (99.0° F) Pulse 0800: 96/min 1200:105/min

	membranes	Respiratory rate 0800: 18/min 1200: 20/min Blood pressure 0800; 118/62 mmHg 1200: 104/65 mm Hg

a) Encourage the client to ambulate.
b) Administer an antipyretic medication.
c) Notify the charge nurse of the client's BUN level (The client's BUN level is above the expected reference range of 10 to 20 mg/dL, which indicates dehydration and impaired renal function. The nurse should notify the charge nurse of this finding and anticipate interventions to restore the client's fluid volume.)
d) Keep the temperature in the client's room warm.

96. A nurse is providing information regarding transmission-based precautions for a client who has Clostridium difficile to an assistive personnel (AP). Which of the following instructions should the nurse include? (Select all that apply).

a) "Provide the client with disposable utensils and dishes for meals." (Clients who have C. difficile require contact precautions, which include using disposable utensils and dishes during meals to prevent exposure to contaminants by others.)
b) "Leave blood pressure equipment in the client's room." (When using contact precautions, the health care staff should dedicate equipment to single-client use to prevent transmission of the pathogen.)
c) "Clean contaminated surfaces with a bleach solution." (The health care staff should use a bleach solution to clean equipment to prevent transmission of the pathogen.)
d) "Use an alcohol-based hand sanitizer after client care."
e) "Wear a face mask when in the client's room."

97. A nurse is admitting a client who is suspected having active tuberculosis (TB). Which of the following actions should the nurse take first? (chap. 20)

a) Administer antituberculosis medication.
b) Institute airborne precautions. (The greatest risk from this client is transmitting TB to staff and other clients. Therefore, the first action the nurse should take is to implement airborne precautions.)
c) Obtain sputum cultures.
d) Auscultate breath sounds.

98. A nurse is caring for a client who is postoperative and has a Jackson-Pratt drain. Which of the following actions should the nurse take?

a) Fill the bulb reservoir with 0.9% sodium chloride.
b) Allow the Jackson-Pratt drain to hang freely.
c) Cut a slit in a gauze sponge and apply it around the tubing insertion site.

d) Compress the bulb reservoir and then close the drainage valve. (The nurse should fully compress the bulb reservoir and then replace the valve plug using aseptic technique to establish suction after emptying or activating a Jackson-Pratt drain.)

99. A nurse is reinforcing teaching with the parent of a toddler who has type I diabetes mellitus and whose prescription has been changed from regular insulin to lispro insulin. Which of the following information should the nurse include in the teaching?

a) Lispro is given once a day.
b) Lispro should be given before eating. (Lispro insulin should be given around mealtime, within 15 min before or after eating.)
c) Lispro cannot be given with other insulin.
d) Lispro does not cause hypoglycemia.

100. **A nurse is reinforcing teaching with a client who has microcytic anemia and is prescribed a daily iron supplement. The nurse tells the client to consume foods containing vitamin C when taking the supplement to enhance iron absorption. Which of the following client food choices indicates an understanding of the teaching**?

a) 1 cup cooked brown rice
b) 1 cup boiled broccoli (The nurse should determine that choosing boiled broccoli indicates an understanding of the teaching because 1 cup contains 101 mg of vitamin C per serving.)
c) 1 cup cottage cheese
d) 1 cup cooked kidney beans

101. A nurse is assisting with the development of a plan of care to manage pain for a client who has herpes zoster with lesions on the lower extremities. Which of the following interventions should the nurse include in the plan of care?

a) Keep bed linens off of the affected areas. (The nurse should keep bed linens off of the affected areas using a bed cradle, which will relieve pain caused by the linens rubbing against the lesions.)
b) Position a heat lamp over the lower extremities.
c) Apply warm, moist compresses to the affected areas.
d) Initiate droplet isolation precautions.

102. A nurse is reinforcing teaching with a client about increasing dietary fiber. The nurse should recommend which of the following foods as the best source of fiber?

a) ½ cup cooked kidney beans (The nurse should recommend kidney beans as the best source of fiber because ½ cup contains 6.5 g of fiber per serving.)
b) ½ cup raw cauliflower
c) 1 cup cucumber with peel
d) 1 cup parboiled brown rice

103. A nurse is assisting in the care of a client who has AIDS-related pneumonia. The client is receiving antibiotic therapy and albuterol nebulizer treatments daily.

Which of the following findings should indicate to the nurse that the client's therapeutic regimen is effective?

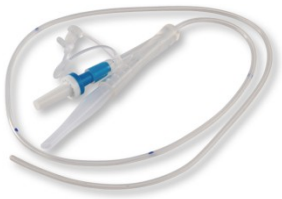
a) Adventitious lung sounds
b) Decrease in exertional dyspnea (A decrease in exertional dyspnea indicates the antibiotics are resolving the infection and the albuterol treatments are facilitating effective ventilation. Therefore, the nurse should evaluate the therapeutic regimen as effective for the client.)
c) Respiratory rate of 26/min while sitting in a chair
d) Elevation of the head of the bed is required to sleep

104. A nurse is monitoring a client who has a wrist cast and reports intense itching underneath the cast. Which of the following actions should the nurse take?

a) Blow cool air into the cast using a blow dryer on a cool setting. (Using a blow dryer on a cool setting to blow cold air into the cast is an effective way to relieve the client's itching without damaging the skin.)
b) Obtain a prescription for pregabalin.
c) Ask the provider to bivalve the cast.
d) Provide the client with a tongue blade to rub the skin under the cast.

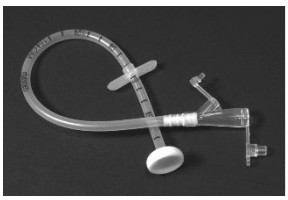
105. A nurse is preparing to insert a double-lumen gastric (Salem) sump tube for a client who has peptic disease and has developed gastrointestinal bleeding. Which of the following images indicates the tube that the nurse should select?

a.



In a double-lumen gastric (Salem) sump tube, the clear portion of the tube allows for aspiration of stomach contents. The blue portion of the tube, or the "pig tail", vents the tube to the atmosphere, which prevents the tube from becoming lodged against the wall of the stomach and protects the stomach from damage.

b.

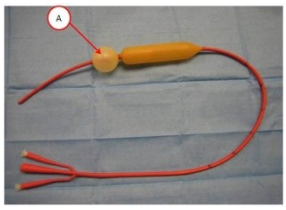


This image shows a percutaneous endoscopic gastrostomy (PEG) feeding tube. A provider inserts a PEG feeding tube surgically through the abdomen and into the stomach to allow for longer-term medication administration and tube feedings.

c.

This image shows a Levin tube. It is a single-lumen nasogastric tube which facilitates gastric decompression. Damage to the gastric mucosa can occur during aspiration of stomach contents with this tube.

d.



This image shows a Sengstaken-Blakemore tube. The provider prescribes this tube in the treatment of bleeding esophageal varices.

106. A nurse is caring for a client who has just returned to the unit following a bronchoscopy. Which of the following findings should the nurse report to the provider?

a) Absent gag reflex
b) Blood-tinged mucus
c) Diminished breath sounds (Diminished breath sounds might indicate a pneumothorax or laryngeal edema. The nurse should report this finding to the provider for further evaluation of the client.)
d) Oxygen saturation 95%

107. A nurse is caring for a client who has been taking enalapril. The nurse should monitor the client for which of the following adverse effects?

a) Bradycardia
b) Tremors
c) Cough (Enalapril is an ACE inhibitor, which can cause a dry, nonproductive cough. Therefore, the nurse should monitor the client for this adverse effect.)
d) Hyperglycemia

108. A nurse is preparing a client for a cardiac catheterization. Whicj of the following actions should the nurse take first?

a) Verify the client has given informed consent. (The greatest risk to the client in this situation is performing an unauthorized invasive procedure. Therefore, the first action the nurse should take is to verify that the client has given informed consent. If documentation of informed consent is not on the client's medical record, the nurse

should withhold medications, which can alter the client's consciousness until consent is obtained.)

b) Administer preoperative medication.
c) Mark the location of the pedal pulses.
d) Have the client void.

109. A nurse is caring for an adult client who has age-related macular degeneration. Which of the following findings should the nurse expect?

a) Seeing halos around artificial lights
b) Distorted central vision of the eyes (Macular degeneration results in a distortion and blurring of central vision. The client might completely lose central vision and view a dark spot in the center.)
c) Colored spots before the visual fields
d) Spontaneous tearing of the eyes

110. A nurse is planning care for a group of clients after receiving change-of-shift report. Which of the following clients should the nurse plan to see first?

a) A client who had a colectomy 2 days ago and has a nasogastric tube, Jackson-Pratt drain, and indwelling urinary catheter
b) A client who is dehydrated, has mental confusion, and was found getting out of bed several times during the night (When using the urgent vs. nonurgent approach to client care, the nurse determines to first see the client who has mental confusion and is getting out of bed without assistance. The client is experiencing manifestations of dehydration that can cause injury due to falls. Therefore, the nurse should see this client first.)
c) A client who had a right lower lobe lobectomy 4 days ago and has a chest tube set to continuous suction
d) A client who has pneumonia and an oral temperature of 38.7º C (101.7º F)

111. A nurse is collecting data from a client who is receiving sumatriptan. Which of the following is an outcome?

a) Reduced cough
b) Diminished headache (Sumatriptan is a vascular headache suppressant prescribed for relief of migraines or cluster headaches. Therefore, the nurse should monitor the client for a diminished headache as an expected outcome of the medication.)
c) Relaxed muscles
d) Decreased peripheral edema

112. A nurse is caring for a client who reports shortness of breath and has an oxygen saturation of 90%. Which of the following actions should the nurse take?

a) Prepare for intubation of the client.
b) Administer opioid medication.

c) Administer oxygen via nasal cannula. (The nurse should administer oxygen via nasal cannula to a client who reports shortness of breath and has an oxygen saturation below the expected reference range. The nurse should continue to monitor the client and adjust the oxygen flow rate as needed.)
d) Place the client in low-Fowler's position

113. A nurse is caring for a client who has a prescription for digoxin 0.25 mg PO daily. While taking the client's apical pulse, the nurse notes a rate of 58/min. which of the following actions should the nurse takes?

a) Give the dose as prescribed.
b) Use a different route to administer the medication.
c) Administer half of the prescribed dose.
d) Withhold the dose. (The nurse should withhold the digoxin dose for an apical pulse less than 60/min and notify the provider. Digoxin slows the heart rate, so administering the dose can cause harm to the client.)

114. A nurse is caring for a client who has neutropenia. Which of the following nursing interventions should the nurse implement?

a) Offer the client fresh fruits and vegetables.
b) Monitor the client's platelet count daily.
c) Limit visitors to healthy adults. (The nurse should limit visitors to healthy adults to minimize the client's risk of exposure to infection.)
d) Apply firm pressure to injection sites.

115. A nurse is caring for client who has an intestinal obstruction and reports a new onset of nausea. The client has an NG tube set at low intermittent suction and is receiving continuous IV infusion of 0.9% sodium chloride. Which of the following actions should the nurse take first?

a) Check for kinks in the NG tube. (The first action the nurse should take when using the nursing process is to collect data from the client. Therefore, the priority action is to check the NG tube to determine if the tube is kinked, which can interfere with the suctioning function and result in nausea.)
b) Increase the IV fluid rate.
c) Provide ice chips.
d) Administer an antiemetic.

116. A nurse in a clinic is assisting with the development of a pamphlet about STIs. Which of the following information should the nurse recommend to include in the pamphlet?

a) The number of sexual partners does not affect the risk for STIs.
b) Oral contraceptive use decreases the risk for STIs.
c) Men seek treatment for STIs later than women.

d) Women have a higher risk of contracting STIs than men. (The nurse should include that oral contraceptive use, prolonged contact with male secretions, and increased cervical permeability during hormone fluctuations increase a woman's risk of acquiring STIs.)

117. A nurse is reinforcing teaching with a client who is postoperative following a cemented total hip arthroplasty. Which of the following instructions should the nurse include in the teaching?

a) Avoid weight-bearing until healing of the hip incision is complete.
b) Cross legs intermittently several times a day.
c) Lean forward to change positions when sitting in a chair.
d) Maintain hip flexion to 90° or less when sitting. (A client who has had a cemented total hip arthroplasty should maintain hip flexion to 90° or less when sitting to prevent hip dislocation.)

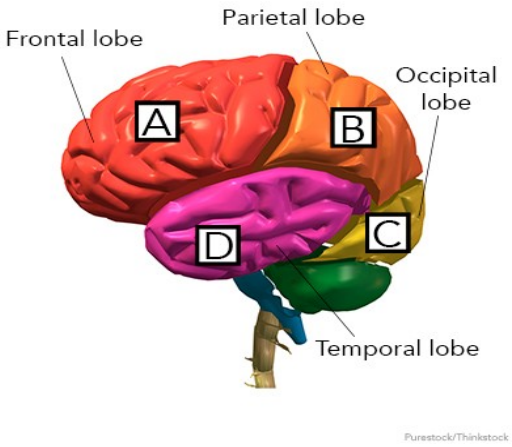
118. A nurse is caring for a client who is 24 hr postoperative following an abdominal surgery. Which of the following findings requires immediate attention from the nurse?

a) Reported pain level of 6 on a scale of 0 to 10
b) Urinary output of 110 mL in the past 4 hr
c) Temperature of 38.0º C (100.4º F)
d) Oxygen saturation of 88% (When using the airway, breathing, circulation approach to client care, the nurse determines that the finding that requires immediate attention is an oxygen saturation of 88%. This finding is below the expected reference range of 95% to 100% and requires intervention to restore oxygenation to the client's tissues.)

119. A nurse is caring for a client following a gastrectomy. Which of the following actions should the nurse take to decrease episodes of dumping syndrome?

a) Place the client in the supine position after meals. (The nurse should encourage the client to lie in the supine position for a short time following meals to decrease rapid gastric emptying.)
b) Administer pancreatic enzymes before meals.
c) Encourage the client to drink 240 mL (8 oz) of fluids with meals.
d) Offer the client three meals daily.

120. A nurse is assisting with the care of a client who has a stroke and is unable to speak. The nurse should identify that the client's injury occurred in which of the following lobes of the brain? (You will find hot spots to select in the artwork below. Select only the hot spot that corresponds to your answer.)



a) A is correct. Injury to the frontal lobe can result in alterations to motor function or voluntary movement. This involves the ability to speak and the ability to move purposefully.
b) B is incorrect. The nurse should identify that injury to the parietal lobe results in alterations to higher-level activities, such as writing, and processing sensory information, such as proprioception, pain, temperature, touch, and pressure.
c) C is incorrect. The nurse should identify that injury to the occipital lobe results in alterations in visual perception and the ability to track movement of an object. Injuries to this area can result in an inability to recognize objects, faces, or the written word.
d) D is incorrect. The nurse should identify that injury to the temporal lobe results in alterations in the ability to understand the spoken language and impaired short term memory.

121. A home health nurse is caring for a client who has COPD. The client tells the nurse that he becomes short of breath while eating despite the use of home oxygen. Which of the following instructions should the nurse include?

a) Limit protein in daily meal plan.
b) Use a bronchodilator 1 hr before meals.
c) Drink beverages at the end of meals. (Lie down for 1 hr after meals. The client should drink beverages at the end of meals, rather than during meals, to prevent shortness of breath while eating. This also prevents early satiety and promotes adequate nutrient intake during the meal)
d) Lie down for 1 hr. after meals.

122. A nurse is reinforcing teaching with a client who has chronic kidney disease about management. Which of the following statements by the client indicates an understanding of the teaching?

a) "I will add a banana to my morning cereal."
b) "I will decrease my intake of carbohydrates."
c) "I will limit my daily intake of protein." (The client should decrease his intake of protein to slow the progression of kidney failure. Therefore, the nurse should identify this statement as an understanding of the teaching.)
d) "I will season my foods with a salt substitute."

123. A nurse is caring for a client who has dementia due to Alzheimer's disease. Which of the following actions should the nurse take to reduce the client's confusion?