ATI MED-SURG 2022-2023 QUESTIONS AND CORRECT ANSWERS (VERIFIED ANSWERS)|AGRADE

A nurse is monitoring a client who has heart failure related to mitral stenosis. The client reports shortness of breath on exertion. Which of the following conditions should the nurse expect?

Increased cardiac output

INCORRECT

Cardiac output is decreased in a client who has heart failure related to mitral stenosis because the left ventricle is receiving insufficient blood volume to pump into the systemic circulation.

Increased pulmonary congestion

CORRECT My Answer

Pulmonary congestion occurs due to right-sided heart failure. Because of the defect in the mitral valve, the left atrial pressure rises, the left atrium dilates, there is an increase in pulmonary artery pressure, and hypertrophy of the right ventricle occurs. In this case, dyspnea is an indication of pulmonary congestion and right-sided heart failure.

Decreased left atria pressure

INCORRECT

As the mitral valve opening narrows, blood flow from the atria to the ventricle falls causing a back-up, and increased pressure, in the left atria.

Decreased pulmonary artery pressure

INCORRECT

Pulmonary artery pressure is increased as a result of back-up pressure from the narrowing, or stenosis, of the mitral valve that affects the flow of blood from the left atrium to the left ventricle.

A nurse is monitoring a client who had a myocardial infarction. For which of the following complications should the nurse monitor in the first 24 hr?

Infective endocarditis

INCORRECT

Infective endocarditis occurs when bacteria invades the endothelial surface of the heart. Infective endocarditis is usually seen in clients who have prosthetic heart valves or pacemakers.

Pericarditis

INCORRECT

Pericarditis can occur 10 days to 2 months following a myocardial infarction. Pericarditis is an inflammation of the pericardial sac that surrounds the heart and is usually a result of infection, connective tissue disorders, or trauma.

Ventricular dysrhythmias

CORRECT My Answer

After a myocardial infarction, the electrical conduction system of the heart can be irritable and prone to dysrhythmias. Ischemic tissue caused by the infarction can also interfere with the normal conduction patterns of the heart's electrical system.

Pulmonary emboli

INCORRECT

Pulmonary emboli occur if the client develops heart failure following a myocardial infarction. Pulmonary emboli are found more commonly with valvular disorders, atrial fibrillation, or from a deep-vein thrombosis.

A nurse is assessing a client who has pericarditis. Which of the following manifestations should the nurse expect?

Bradycardia with S-T segment depression

INCORRECT

Pericarditis is usually seen on an ECG as an ST-T spiking. This elevation represents ischemic changes caused by the inflammation around the heart. The client who has pericarditis will have tachycardia because of decreased cardiac output and oxygen perfusion.

Relief of chest pain with deep inspiration

INCORRECT

Chest pain associated with pericarditis will increase with deep inspiration due to increased pressure on the pericardial sac.

Dyspnea with hiccups

CORRECT My Answer

The client who has pericarditis will experience dyspnea, hiccups, and a nonproductive cough. These manifestations can indicate heart failure from pericardial compression due to constrictive pericarditis or cardiac tamponade.

Chest pain that increases when sitting upright

INCORRECT

Chest discomfort associated with pericarditis will decrease when the client sits upright or leans forward, as this relieves pressure in the pericardial sac.

A nurse is reviewing a client's repeat laboratory results 4 hr after administering fresh frozen plasma (FFP). Which of the following laboratory results should the nurse review?

Prothrombin time

CORRECT My Answer

The nurse should review the client's prothrombin time after the administration of FFP, which is plasma rich in clotting factors. FFP is administered to treat acute clotting disorders. The desired effect is a decrease in the prothrombin time.

WBC count

INCORRECT

The nurse should review the client's WBC count if there is a possible infection.

Platelet count

INCORRECT

The nurse should review the client's platelet count following administration of platelets.

Hematocrit

INCORRECT

The nurse should review the client's hematocrit following the administration of packed red blood cells.

A nurse is assessing a client who has right-sided heart failure. Which of the following findings should the nurse expect?

Decreased capillary refill

INCORRECT

Decreased capillary refill occurs in clients who have decreased cardiac output resulting from left-sided heart failure.

Dyspnea

INCORRECT

When the left side of the heart fails, blood return from the lungs via the pulmonary vein is slowed, causing fluid buildup in the lungs that results in shortness of breath.

Orthopnea

INCORRECT

Dizziness occurs in clients who have decreased cardiac output resulting from left-sided heart failure.

Dependent edema

CORRECT My Answer

Blood return from the venous system to the right atrium is impaired by a weakened right heart. The subsequent systemic venous backup leads to development of dependent edema.

A nurse is preparing to transfuse 250 mL of packed red blood cells (RBCs) to a client over 4 hr. Available is a blood administration set that delivers 10 gtt/mL. The nurse should set the manual blood transfusion to deliver how many gtt/min? (Round the answer to the nearest whole number. Use a leading zero if it applies. Do not use a trailing zero.)

10 gtt/min

A nurse is providing teaching about lifestyle changes to a client who had a myocardial infarction and has a new prescription for a beta blocker. Which of the following client statements indicates an understanding of the teaching?

"I should eat foods high in saturated fat."

INCORRECT

The client should consume foods low in saturated fat to decrease further atherosclerotic plaque development in her arteries.

"Before taking my medication, I will count my radial pulse rate."

CORRECT My Answer

A beta blocker will induce bradycardia. The client should take her pulse rate for 1 min before self-administration.

"I will exercise once per week for an hour at the health club."

INCORRECT

The client should exercise at least three to five times per week for a minimum of 30 min each.

"I will stop taking my medication when my blood pressure is within a normal range."

INCORRECT

The client should not discontinue the prescribed medication because adherence to a medical regimen when taking medication will help to prevent complications following a myocardial infarction.

A nurse is caring for a client who has a demand pacemaker inserted with the rate set at 72/min. Which of the following findings should the nurse expect?

Telemetry monitoring shows QRS complexes occurring at a rate of 74/min with no pacing spikes.

CORRECT My Answer

The nurse should not expect pacer spikes when the client's pulse is greater than the set rate of 72/min, because the client's intrinsic rate overrides the set rate of the pacemaker.

The client is experiencing premature ventricular complexes at 12/min.

INCORRECT

The nurse should report when the client is displaying frequent premature ventricular complexes because this is a complication that can indicate a lead wire is displaced in the ventricle.

Telemetry monitoring shows pacing spikes with no QRS complexes.

INCORRECT

The nurse should report when the client has pacer spikes without QRS complexes because this complication can indicate noncapture of the pacemaker.

The client is experiencing hiccups.

INCORRECT

The nurse should report when the client experiences hiccups because this complication can indicate a lead wire is displaced and is stimulating the diaphragm.

A nurse is caring for a client who had a myocardial infarction 5 days ago. The client has a sudden onset of shortness of breath and begins coughing frothy, pink sputum. The nurse auscultates loud, bubbly sounds on inspiration. Which of the following adventitious breath sounds should the nurse document?

Coarse crackles

CORRECT My Answer

A client who had a recent myocardial infarction is at risk for left-sided heart failure. Crackles are breath sounds caused by movement of air through airways partially or intermittently occluded with fluid and are associated with heart failure and frothy sputum. Crackling sounds are heard at the end of inspiration and are not cleared by coughing.

Wheezes

INCORRECT

The client who has wheezes will manifest a high-pitched musical squeak on inspiration or expiration through a narrow or obstructed airway.

Rhonchi

INCORRECT

The client who has rhonchi will manifest coarse, loud, low-pitched sounds during inspiration or expiration. Coughing often clears the airway and stops the sound.

Friction rub

INCORRECT

The client who has a friction rub will manifest loud, dry, rubbing or grating sounds over the lower lateral anterior chest surface during inspiration or expiration.

A nurse is caring for a client who is postoperative following vein ligation and stripping for varicose veins. Which of the following actions should the nurse take?

Position the client supine with his legs elevated when in bed.

CORRECT My Answer

The nurse should elevate the client's legs above his heart to promote venous return by gravity. During discharge teaching, the nurse should reinforce the importance of periodic positioning of the legs above the heart.

Encourage the client to ambulate for 15 min every hour while awake for the first 24 hr.

INCORRECT

The nurse should encourage the client to ambulate 5 to 10 min every hour while awake to prevent venous stasis.

Tell the client to sit with his legs dependent after ambulating.

INCORRECT

The nurse should discourage the client from sitting or standing for any duration to prevent venous stasis. Feet should be elevated above the heart to prevent venous stasis.

Instruct the client to wear knee-length socks for 2 weeks after surgery.

INCORRECT

The nurse should instruct the client to wear graduated compression stockings for up to 1 week after surgery to promote venous return.

A nurse is reviewing laboratory values for an adult client who has sickle cell anemia and a history of receiving blood transfusions. For which of the following complications should the nurse monitor?

Hypokalemia

INCORRECT

The client who has received several blood transfusions is at risk for hyperkalemia. Stored blood releases increased amounts of potassium due to red blood cell hemolysis.

Lead poisoning

INCORRECT

The client who has received numerous blood transfusions is not at risk for lead poisoning because lead is not found in blood.

Hypercalcemia

INCORRECT

The client who has received several blood transfusions is at risk for hypocalcemia. The citrate in the transfused blood bonds with calcium, causing calcium to be excreted.

Iron toxicity

CORRECT My Answer

The client who has received several blood transfusions is at risk for development of hemosiderosis, which is excess storage of iron in the body. The excessive iron can come from overuse of supplements or from receiving frequent blood transfusions, as in sickle cell anemia.

A nurse in a clinic is assessing the lower extremities and ankles of a client who has a history of peripheral arterial disease. Which of the following findings should the nurse expect?

Pitting edema

INCORRECT

The client who has venous insufficiency can display pitting edema because the valves of the veins are damaged from venous hypertension from sitting or standing in place for too long. This also can be a manifestation of congestive heart failure due to coronary artery disease.

Areas of reddish-brown pigmentation

INCORRECT

The client who has venous insufficiency can display areas of reddish-brown pigmentation because the valves of the veins are damaged from venous hypertension from sitting or standing in place for too long.

Dry, pale skin with minimal body hair

CORRECT My Answer

A client who has peripheral arterial disease can display dry, scaly, pale, or mottled skin with minimal body hair because of narrowing of the arteries in the legs and feet. This causes a decrease in blood flow to the distal extremities, which can lead to tissue damage. Common manifestations are intermittent claudication (leg pain with exercise), cold or numb feet at rest, loss of hair on the lower legs, and weakened pulses.

Sunburned appearance with desquamation

INCORRECT

Desquamation, which is the loss of bits of outer skin by peeling or shedding, is associated with sunburn, Kawasaki's disease, and various other skin lesions.

A nurse is planning care for a client who is having a percutaneous transluminal coronary angioplasty (PTCA) with stent placement. Which of the following actions should the nurse anticipate in the postprocedure plan of care?

Instruct the client on a long-term cardiac conditioning program.

INCORRECT

The nurse should provide teaching about cardiac rehabilitation prior to the client's discharge from the hospital.

Administer scheduled doses of acetaminophen.

INCORRECT

The nurse should plan to administer scheduled doses of aspirin postprocedure. This maintains the patency of the client's coronary arteries following the PTCA by preventing platelet aggregation and thrombus formation around the newly placed stent.

Check for peak laboratory markers of myocardial damage.

INCORRECT

The nurse should monitor for peak laboratory markers of myocardial damage following a myocardial infarction and reperfusion with thrombolytic therapy.

Monitor for bleeding.

CORRECT My Answer

Bleeding is a post-procedure complication of PTCA because of the administration of heparin during the procedure and the removal of the femoral (or brachial) sheath. Manual pressure or a closure device is used to obtain hemostasis to the site. The client remains on bed rest until hemostasis is assured.

A nurse is completing a medication history for a client who reports using fish oil as a dietary supplement. Which of the following substances in fish oil should the nurse recognize as a health benefit to the client?

Omega-3 fatty acids

CORRECT My Answer

Fish oil contains omega-3 fatty acids, which can help lower the risk of cardiovascular disease and stroke by decreasing triglyceride levels.

Antioxidants

INCORRECT

Antioxidants are substances that occur naturally in many fruits and vegetables, as well as in nuts, grains, and even some meat, poultry, and fish. Beta-carotene, vitamins A, C, E, and selenium are some of the most commonly known antioxidants. Studies have suggested that antioxidants can slow or even prevent the development of cancer; however, they are not found in fish oil.

Vitamins A, D, and C

INCORRECT

Vitamins A, D, and C are not substances found in fish oil.

Beta-carotene

INCORRECT

Beta-carotene is the precursor to vitamin A. Beta-carotene functions as a fat-soluble antioxidant, which can help protect the body from deleterious free-radical reactions. It is not found in fish oil.

A nurse is transfusing a unit of B-positive fresh frozen plasma to a client whose blood type is O-negative. Which of the following actions should the nurse take?

Continue to monitor for manifestations of a transfusion reaction.

INCORRECT

ABO compatibility is required for the transfusion of fresh frozen plasma. A client whose blood type is O can only receive type O plasma.

Remove the unit of plasma immediately and start an IV infusion of normal saline solution.

CORRECT My Answer

A client who receives FFP that is not compatible can experience a hemolytic transfusion reaction. The nurse should stop the transfusion and infuse 0.9% sodium chloride solution with new tubing.

Continue the transfusion and repeat the type and crossmatch.

INCORRECT

The nurse should not continue infusing plasma that is not compatible with the client. There is no indication that a repeat type and crossmatch of the client's blood is necessary.

Prepare to administer a dose of diphenhydramine IV.

INCORRECT

The nurse should administer diphenhydramine IV only if the client manifests an allergic transfusion reaction.

A nurse is completing an assessment for a client who has a history of unstable angina. Which of the following findings should the nurse expect?

Chest pain is relieved soon after resting.

INCORRECT

The client who has unstable angina will have chest pain even while resting because of insufficient blood flow to the coronary arteries and decreased oxygen supply. Chest pain at rest is a condition called variant (Prinzmetal's) angina, caused by an artery spasm.

Nitroglycerin relieves chest pain.

INCORRECT

The client who has unstable angina will have minimal, if any, relief of chest pain from nitroglycerin. This is due to the reduced blood flow in a coronary artery due to atherosclerotic plaque and thrombus formation causing partial arterial obstruction.

Physical exertion does not precipitate chest pain.

INCORRECT

The client who has unstable angina will report chest pain or discomfort with exertion, which can limit the client's activity. This is due to the reduced blood flow in a coronary artery due to atherosclerotic plaque and thrombus formation causing partial arterial obstruction.

Chest pain lasts longer than 15 min.

CORRECT My Answer

The client who has unstable angina will have chest pain lasting longer than 15 min. This is due to the reduced blood flow in a coronary artery due to atherosclerotic plaque and thrombus formation causing partial arterial obstruction, or from an artery spasm.

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A nurse is caring for a client who is in hypovolemic shock. While waiting for a unit of blood, the nurse should administer which of the following IV solutions?

0.45% sodium chloride

INCORRECT

The solution 0.45% sodium chloride is a hypotonic solution and should not be used for fluid replacement. This solution can cause lysis of red blood cells because it has fewer solutes than the cell, and osmotic pressure pulls the fluid into the few cells remaining.

Dextrose 5% in 0.9% sodium chloride

INCORRECT

The solution of dextrose 5% in 0.9% sodium chloride is a hypertonic solution and should not be used for fluid replacement. This solution will diffuse into the cells of the tissue, having no effect on circulating volume. When the fluid surrounding the cells is hypertonic or has more solutes than the cells, osmotic pressure pulls the fluid from the cells.

Dextrose 10% in water

INCORRECT

The solution of dextrose 10% in water is a hypertonic solution and should not be used for fluid replacement. This solution will diffuse into the cells of the tissue, having no effect on circulating volume. When the fluid surrounding the cells is hypertonic or has more solutes than the cells, osmotic pressure pulls the fluid from the cells.

0.9% sodium chloride

CORRECT My Answer

Solutions of 0.9% sodium chloride, as well as Lactated Ringer's solution, are used for fluid volume replacement. Sodium chloride, a crystalloid, is a physiologic isotonic solution that replaces lost volume in the blood stream and is the only solution to use when infusing blood products.

A nurse is caring for a client who has hemophilia. The client reports pain and swelling in a joint following an injury. Which of the following actions should the nurse take?

Obtain blood samples to test platelet function.

INCORRECT

Coagulation tests that measure platelet function, such as bleeding time, are used to diagnose, not treat, hemophilia.

Prepare for replacement of the missing clotting factor.

CORRECT My Answer

Hemophilia is a hereditary bleeding disorder in which blood clots slowly and abnormal bleeding occurs. It is caused by a deficiency in the most common clotting factor, factor VIII (hemophilia A). Aggressive factor replacement is initiated to prevent hemarthrosis that can result in long-term loss of range of motion in repeatedly affected joints.

Administer aspirin for the client's pain.

INCORRECT

Medications that interfere with clotting function, such as aspirin, NSAIDS, and some herbal supplements, should be avoided.

Place the bleeding joint in the dependent position.

INCORRECT

The affected joint should be elevated to allow the blood to drain away from the joint.

A nurse is assessing a client who has fluid volume overload from a cardiovascular disorder. Which of the following manifestations should the nurse expect? (Select all that apply.)

- [x] Jugular vein distension
- [x] Moist crackles
- [ ] Postural hypotension
- [x] Increased heart rate
- [ ] Fever

CORRECT My Answer

Jugular vein distension is correct. The increase in venous pressure due to excessive circulating blood volume results in neck vein distension.

Moist crackles is correct. This is an indicator of pulmonary edema that can quickly lead to death.

Postural hypotension is incorrect. Fluid volume excess, or hypervolemia, is an expansion of fluid volume in the extracellular fluid compartment. This results in hypertension and tachycardia.

Increased heart rate is correct. Fluid volume excess, or hypervolemia, is an expansion of fluid volume in the extracellular fluid compartment. This results in increased heart rate and bounding pulses.

Fever is incorrect. Fever is common in clients who are experiencing dehydration, not fluid volume excess.

A nurse is assessing a client who has late-stage heart failure and is experiencing fluid volume overload. Which of the following findings should the nurse expect?

Weight gain 1 kg (2.2 lb) in 1 day

CORRECT My Answer

A weight gain of 1 kg (2.2 lb) in 1 day alerts the nurse that the client is retaining fluid and is at risk of fluid volume overload. This is an indication that the client's heart failure is worsening.

Pitting edema +1

INCORRECT

Pitting edema, a visible finger indentation after application of pressure, alerts the nurse that the client has retained fluid and demonstrates that there is fluid in the client's tissues. Pitting edema is rated on a scale of mild (+1) to severe (+3). Pitting edema of +3 is an indication that the client has developed fluid volume overload and the heart failure is worsening.

Client report of nocturnal cough

INCORRECT

The client who is in the early stages of heart failure might report a cough that is irritating, occurs at night, and is nonproductive.

B-Type Natriuretic Peptide (BNP) level of 100 pg/mL

INCORRECT

BNP levels increase as the result of the ventricular hypertrophy that occurs in heart failure. A BNP level above 100 pg/mL is indicative of heart failure. Levels continue to increase with the severity of the heart failure.

A nurse is assessing a client for manifestations of aplastic anemia. Which of the following findings should the nurse expect?

Plethoric appearance of facial skin

INCORRECT

The client who has polycythemia vera will have a plethoric (dark, flushed) manifestation of the facial skin and mucous membranes.

Glossitis and weight loss

INCORRECT

The client who has pernicious anemia will have manifestation of glossitis (smooth, beefy-red tongue) and weight loss.

Jaundice with an enlarged liver

INCORRECT

The client who has sickle cell anemia will have manifestations of jaundice with an enlarged liver and spleen.

Petechiae and ecchymosis

CORRECT My Answer

The client who has aplastic anemia will have manifestations of petechiae and ecchymosis. Dyspnea on exertion also can be present. In aplastic anemia, all three major blood components (red blood cells, white blood cells, and platelets) are reduced or absent, which is known as pancytopenia. Manifestations usually develop gradually.

A nurse is providing teaching to a client who has anemia and a new prescription for epoetin alfa. Which of the following information should the nurse include in the teaching?

Hospitalization is required when administering each treatment.

INCORRECT

The nurse should teach the client that epoetin alfa can be self-administered at home.

The maximum effect of the medication will occur in 8 months.

INCORRECT

The nurse should teach that the maximum effect of epoetin alfa will occur in 2 to 3 months.

Hypertension is a common adverse effect of this medication.

CORRECT My Answer

The nurse should teach that a common adverse effect of epoetin alfa is hypertension because of the rise in the production of erythrocytes and other blood cell types. Epoetin alfa is a synthetic version of human erythropoietin. Epoetin alfa is used to treat anemia associated with kidney disease or medication therapy. It increases and maintains the red blood cell level.

Blood transfusions are needed with each treatment.

INCORRECT

The nurse should teach that epoetin alfa is administered to decrease the need for periodic blood transfusions.

A nurse is caring for a client who has an abdominal aortic aneurysm and is scheduled for surgery. The client's vital signs are blood pressure 160/98 mm Hg, heart rate 102/min, respirations 22/min, and SpO_2 95%. Which of the following actions should the nurse take?

- Administer antihypertensive medication for blood pressure.
  CORRECT My Answer
  The nurse should administer antihypertensive medication for the elevated blood pressure because hypertension can cause a sudden rupture of the aneurysm due to pressure on the arterial wall.
- Monitor that urinary output is 20 mL/hr.
  INCORRECT
  The nurse should monitor that the client has adequate kidney profusion determined by urinary output of at least 30 mL/hr. Oliguria can indicate a rupture of the aneurysm.
- Withhold pain medication to prepare for surgery.
  INCORRECT
  The nurse should administer pain medication because pain occurs due to pressure from the aneurysm on the lumbar nerves. Pain can also cause hypertension.
- Take vital signs every 2 hr.
  INCORRECT
  The nurse should take the client's vital signs at least every 15 min in order to monitor for a sudden drop in blood pressure, which can indicate a rupture of the aneurysm.

A nurse is assessing for cardiac tamponade on a client who had coronary artery bypass grafts. Which of the following actions should the nurse take?

- Check for hypertension.
  INCORRECT
  The client who has cardiac tamponade will have hypotension because of the sudden decrease in cardiac output from the fluid compressing the atria and ventricles.
- Auscultate for loud, bounding heart sounds.
  INCORRECT
  The client who has cardiac tamponade will have muffled heart sounds on auscultation due to the fluid compressing the atria and ventricles.
- Auscultate blood pressure for pulsus paradoxus.
  CORRECT My Answer
  The client who has cardiac tamponade will have pulsus paradoxus when the systolic blood pressure is at least 10 mm Hg higher on expiration than on inspiration. This occurs because of the sudden decrease in cardiac output from the fluid compressing the atria and ventricles.
- Check for a pulse deficit.
  INCORRECT
  The nurse will not detect cardiac tamponade by checking for a pulse deficit. This is performed by checking the apical and radial pulses simultaneously to determine if the rate is the same. If the rate is different, the findings indicate a cardiac dysrhythmia.

A nurse is caring for a client who has heart failure and whose telemetry reading displays a flattening of the T wave. Which of the following laboratory results should the nurse anticipate as the cause of this ECG change?

- Potassium 2.8 mEq/L
  CORRECT My Answer
  A flattened T wave or the development of U waves is indicative of a low potassium level.
- Digoxin level 0.7 ng/mL
  INCORRECT
  The client has a digoxin level within the therapeutic range of 0.5 to 0.8 ng/mL. Atrioventricular block, ventricular fibrillation, and ventricular tachycardia are a few of the dysrhythmias occurring with toxic digoxin levels.
- Hemoglobin 9.8 g/dL
  INCORRECT
  The client who has low hemoglobin will manifest tachycardia on the ECG rhythm because of the compensatory mechanism that provides oxygen to vital organs. The ECG pattern anticipated with low hemoglobin is tachycardia.
- Calcium 8.0 mg
  INCORRECT
  The client who has hypocalcemia can have a prolonged S-T interval and a prolonged Q-T interval, but not a flattened T wave.

A nurse is administering a unit of packed red blood cells (RBCs) to a client who is postoperative. The client reports itching and has hives 30 min after the infusion begins. Which of the following actions should the nurse take first?

- Maintain the IV access with 0.9% sodium chloride.
  INCORRECT
  Maintaining IV access by initiating an infusion of 0.9% sodium chloride solution using a new IV administration set is important. However, there is another action that is the nurse's priority.
- Stop the infusion of blood.
  CORRECT My Answer
  The nurse should apply the urgent vs. nonurgent priority-setting framework. Using this framework, the nurse should consider urgent needs the priority because they pose more of a threat to the client. The nurse might also need to use Maslow's hierarchy of needs, the ABC priority-setting framework, or nursing knowledge to identify which finding is the most urgent. The nurse should stop the infusion of blood because the client has manifestations of an allergic reaction.
- Send the blood container and tubing to the blood bank.
  INCORRECT
  The nurse should send the blood container and tubing to the blood bank for a repeat typing and culture. However, there is another action that is the nurse's priority.
- Obtain a urine sample.
  INCORRECT
  The nurse should obtain a urine sample from the client to determine if hemoglobin is in the urine. However, there is another action that is the nurse's priority.

A nurse is planning care for a client who has pernicious anemia. Which of the following interventions should the nurse include in the plan?

- Administer ferrous sulfate supplementation.
  INCORRECT
  The nurse should administer ferrous sulfate to a client who has iron deficiency anemia, which is a decrease in the red blood cells caused by inadequate intake of dietary iron.
- Increase dietary intake of folic acid.
  INCORRECT
  The nurse should increase the intake of food containing folic acid for a client who has megaloblastic anemia, which is a decrease in the red blood cells caused by folate deficiency.
- Initiate weekly injections of vitamin B_{12}.
  CORRECT My Answer
  The nurse should initiate weekly injections of vitamin B_{12} for a client who has pernicious anemia, and then decrease to monthly. Pernicious anemia is caused by a lack of intrinsic factor needed to absorb vitamin B_{12} from the gastrointestinal tract.
- Initiate a blood transfusion.
  INCORRECT
  The nurse should initiate a blood transfusion for a client who has aplastic anemia when bleeding is life-threatening from a low platelet count or if a client has blood loss from trauma or surgery.

A nurse is assessing a client who has an abdominal aortic aneurysm. Which of the following manifestations should the nurse expect?

- Midsternal chest pain
  INCORRECT
  The nurse should assess for mid or lower abdominal pain to the left of the midline because of the enlarged artery mass.
- Thrill
  INCORRECT
  The nurse should auscultate for a bruit heard over the location of the mass.
- Pitting edema in lower extremities
  INCORRECT
  Pitting edema is a manifestation of heart failure. This is not an assessment the nurse should find with an abdominal aortic aneurysm.
- Lower back discomfort
  CORRECT My Answer
  Abdominal aortic aneurysm involves a widening, stretching, or ballooning of the aorta. Back and abdominal pain indicate that the aneurysm is extending downward and pressing on lumbar spinal nerve roots, causing pain.