Med surg- proctored ATI Real Test Questions (125 Terms) with Correct Answers and Rationales, Graded A+ Update 2023.

An older adult is brought to an emergency department by a family member. Which of the following assessment findings should cause the nurse to suspect that the client has hypertonic dehydration? - **Correct ANS:** Urine Specific gravity 1.045

A urine specific gravity greater than 1.030 indicates a decrease in urine volume and an increase in osmolarity, which is a manifestation of hypertonic dehydration.

A nurse in a community clinic is caring for a client who reports an increase in the frequency of migraine headaches. To help reduce the risk for migraine headaches, which of the following foods should the nurse recommend the client avoid? - **Correct ANS:** Aged cheese

Foods that contain tyramine, such as aged cheese and sausage, can trigger migraine headaches.

A nurse is planning teaching for a client who has bladder cancer and is to undergo a cutaneous diversion procedure to establish a ureterostomy. Which of the following statements should the nurse include in the teaching? - **Correct ANS:** "You should cut the opening of the skin barrier one-eight inch wider than the stoma."

The client should cut the opening of the skin barrier 0.3 cm (1/8in) wider than the stoma to minimize irritation of the skin from exposure to urine.

A nurse is providing teaching to a client who has hypothyroidism and is receiving levothyroxine. The nurse should instruct the client that which of the following supplements can interfere with the effectiveness of the medication? - **Correct ANS:** Calcium

Calcium limits the development of osteoporosis in clients who are postmenopausal and works as an antacid. Calcium supplements can

interfere with the metabolism of a number of medications, including levothyroxine. The nurse should instruct the client to avoid taking calcium within 4 hr of levothyroxine administration.

A nurse is conducting an admission history for a client who is to undergo a CT scan with an IV contrast agent. The nurse should identify that which of the following findings requires further assessment? - **Correct ANS:** History of asthma

A client who has a history of asthma has a greater risk of reacting to the contrast dye used during the procedure. Other conditions that can result in a reaction to contrast media include allergies to foods, such as shellfish, eggs, milk, and chocolate.

A nurse in an ICU is assessing a client who has a traumatic brain injury. Which of the following findings should the nurse identify as a component of Cushing's triad? - **Correct ANS:** Bradycardia

A client who has increased intracranial pressure from a traumatic brain injury can develop bradycardia, which is one component of Cushing's

triad. The other components of Cushing's triad are severe hypertension and a widened pulse pressure.

A nurse is planning to irrigate and dress a clean, granulating wound for a client who has a pressure injury. Which of the following actions should the nurse take? - **Correct ANS:** Use a 30-mL syringe

The nurse should use a 30-mL to 60-mL syringe with an 18- or 19- gauge catheter to deliver the ideal pressure of 8 pounds per square inch (psi) when irrigating a wound. To maintain healthy granulation tissue, the wound irrigation should be delivered at between 4 and 15 psi.

A nurse in an emergency department is reviewing the provider's prescriptions for a client who sustained a rattlesnake bite to the lower leg. Which of the following prescriptions should the expect? - **Correct ANS:** Administer an opioid analgesic to the client.

The nurse should expect a prescription for an opioid analgesic to promote comfort following a rattlesnake bite.

A nurse is reviewing the health record of a client who is scheduled for allergy skin testing. The nurse should postpone the testing and report to the provider which of the following findings? (Click on the "Exhibit" button for additional information about the client). - **Correct ANS:** Current medications

The nurse should review the client's medication record and identify medications, including ACE inhibitors, beta blockers, theophylline, nifedipine, and glucocorticoids, such as prednisone, that can alter the allergy skin test results. These medications can diminish the client's reaction to the allergens. The nurse should notify the provider and instruct the client to discontinue prednisone for 2 weeks before allergy skin testing.

A nurse is a caring for a client who is on bed rest and has a new prescription for enoxaparin subcutaneous. Which of the following actions should the nurse take? - **Correct ANS:** Inject the medication into the anterolateral abdominal wall.

The nurse should inject the medication into the anterolateral or posterolateral abdominal wall to enhance medication absorption and prevent hematoma formation.

A nurse is caring for a client who has a stage III pressure injury. Which if the following findings contribute to delayed wound healing? - **Correct ANS:** Urine output 25 mL/hr

Urinary output reflects fluid status. Inadequate urine output can indicate dehydration, which can delay wound healing.

A nurse is caring for a client who has a new prescription for total parenteral nutrition (TPN). The client is to receive 2,000 kcal per day. The TPN solution has 500kcal/L. The IV pump should be set at how many mL/hr? (Rounding to the nearest whole number.) - **Correct ANS:** 167 mL/hr

A nurse is teaching a client who has a family history of colorectal cancer. To help mitigate this risk, which of the following dietary alterations should the nurse recommend? - **Correct ANS:** Add cabbage to the diet.

To help reduce the risk for colorectal cancer, the client should consume a diet that is high in fiber, low in fat, and low in refined carbohydrates. Brassica vegetables such as cabbage, cauliflower, and broccoli, are high in fiber.

A nurse is caring for a client who has a prescription for silver sulfadiazine cream to be applied to her burn wounds. The nurse should evaluate the client for which of the following laboratory findings? -

Correct ANS: Leukopenia

Transient leukopenia is an adverse effect of silver sulfadiazine.

A nurse is teaching a client with systemic erythematosus who has a new prescription for prednisone. The nurse should instruct the client to monitor for which of the following adverse effects of this medication? -

Correct ANS: Infection

The nurse should instruct the client to avoid contact with people who are ill and monitor for manifestations of an infection such as a fever or a sore throat. Prednisone can suppress the client's immune response and mask the manifestations of an infection.

A nurse is providing preoperative teaching to a client who will undergo a total laryngectomy. Which of the following statements indicates that the client understands the impact of the surgery? - **Correct ANS:** "I understand that I will have a permanent tracheostomy after the surgery."

With a partial laryngectomy, the tracheostomy is temporary. This client will have a total laryngectomy, so the tracheostomy will be permanent.

A nurse is assessing a client who has systemic scleroderma. Which of the following findings should the nurse expect? - **Correct ANS:** Finger contractures

Scleroderma is a chronic disease that can cause thickening, hardening, or tightening of the skin, blood vessels, and internal organs. There are 2

types of scleroderma: localized scleroderma, which mainly affects the skin, and systemic scleroderma, which can affect internal organs. Manifestations include skin changes, Raynaud's phenomenon, arthritis, muscle weakness, and dry mucous membranes. With scleroderma the body produces and deposits too much collagen, causing thickening and hardening. In addition to the client's skin and subcutaneous tissues becoming increasingly hard and rigid, the extremities stiffen and lose mobility. Contractures develop with advanced systemic scleroderma unless clients follow a regimen of range-of-motion and muscle-strengthening exercises.

A nurse is caring for a client who has tracheostomy and is receiving mechanical ventilation. When the low-pressure alarm on the ventilator sounds, it indicates which of the following to the nurse? - **Correct ANS:** A leak within the ventilator's circuitry

The low-pressure alarm means that either the ventilator tubing has come apart or the tubing detached from the client. Low-pressure alarms are often the result of a malfunction or displacement of connections somewhere between the endotracheal or tracheostomy tube and the ventilator.

A nurse is monitoring a client following a thyroidectomy for the presence of hypoparathyroidism. Which of the following findings should the nurse expect? - **Correct ANS:** Involuntary muscle spasms

The nurse should identify involuntary muscle spasms as an indication of hypoparathyroidism, which can occur if the parathyroid glands are damaged or removed during a thyroidectomy. Muscle twitching and paresthesias can result due to decreased parathyroid hormone levels and calcium deficiency.

A nurse is providing discharge teaching to client who has osteoarthritis. Which of the following instructions should the nurse include? - **Correct ANS:** "Rest frequently after periods of activity."

The joint pain in osteoarthritis is caused by deterioration of the synovial membranes and often worsens after activity. Rest usually helps relieve the pain, so performing activities at a comfortable pace with periods of rest is appropriate.

A nurse is teaching a client with arthritis who is experiencing joint pain that impairs mobility. Which of the following instructions should the nurse include? - **Correct ANS:** "Apply heat to your joints prior to exercising."

The nurse should instruct the client to apply heat to the joints prior to exercising to increase mobility and reduce pain.

A nurse is caring for a client who is receiving total parenteral nutrition (TPN) therapy and has just returned to the room following physical therapy. The nurse notes that the infusion pump for the client's TPN is turned off. After restarting the infusion pump the nurse should monitor the client for which of the following findings? - **Correct ANS:** Diaphoresis

The nurse should recognize that this client has the potential to develop hypoglycemia due to the sudden withdrawal of the TPN solution. In addition to diaphoresis, other potential manifestations of hypoglycemia can include weakness, anxiety, confusion, and hunger.

A nurse is assessing a client who has an abdominal aortic aneurysm. Which of the following manifestations should the nurse expect? - **Correct ANS:** Lower back discomfort

An abdominal aortic aneurysm involves widening, stretching, or ballooning of the aorta. Back pain and abdominal pain indicate that the aneurysm is extending downward and pressing on lumbar spinal nerve roots, causing pain.

A nurse is evaluating the laboratory values of a client who is in the resuscitation phase following a major burn. Which of the following laboratory findings should the nurse expect? - **Correct ANS:** Sodium 132 mEq/L

This laboratory finding is below the expected reference range. The nurse should anticipate a low sodium level because sodium is trapped in interstitial space.

The normal sodium level is 135-145 mEq/L

A nurse is assessing a client who is 1 week postoperative following a living donor kidney transplant. Which of the following findings indicates the client is experiencing acute kidney rejection? - **Correct ANS:** Blood pressure 160/90 mmHg

Due to the kidney's role in fluid and blood pressure regulation, a client who is experiencing rejection can have hypertension.

A nurse is caring for a client whom the respiratory therapist has just removed the endotracheal tube. Which of the following actions should the nurse take first? - **Correct ANS:** Evaluate the client for stridor

The first action the nurse should take using the nursing process is to assess the client. After extubation, the nurse should continuously evaluate the client's respiratory status. Stridor is a high-pitched sound during inspiration that indicates laryngospasm or swelling around the glottis. Stridor reflects a narrowed airway and might require emergency reintubation.

A nurse is planning care for a client who has Cushing's syndrome due to chronic corticosteroid use. Which of the following actions should the nurse include in the plan of care? - **Correct ANS:** Check the client's urine specific gravity

The nurse should check the client's urine specific gravity to assess for fluid volume overload.

A nurse is providing dietary teaching for a client with AIDS who has stomatitis of the mouth. Which of the following instructions should the nurse include in the teaching? - **Correct ANS:** "You can suck on popsicles to numb your mouth."

The nurse should instruct the client to suck on popsicles or ice chips, which can numb the mouth.

A nurse is assessing a client who is postoperative following a transurethral resection of the prostate (TURP) and has continuous bladder irrigation. The nurse notes no drainage in the client's urinary

drainage bag over 1 hour. Which of the following should the nurse take? - **Correct ANS:** Irrigate the indwelling urinary catheter with a syringe.

No drainage in the urinary drainage bag indicates an obstruction. The nurse should gently irrigate the indwelling urinary catheter as prescribed to clear the obstruction and allow urine and irrigating fluid to drain.

A nurse is caring for a postmenopausal client who is concerned that she might have an elevated risk of breast cancer. After conducting a risk assessment, the nurse should identify which of the following factors as increasing the client's breast cancer risk? (Select all that apply) - **Correct ANS:** Increased breast density

BMI of 32

Undergoing hormonal replacement therapy for 10 years

Women who have dense breast tissue are at an increased risk for developing breast cancer because they have more connective and glandular breast tissue. Postmenopausal obesity increases the risk for developing breast cancer. Hormone-related risks for developing breast

cancer include the long-term use of oral contraceptives or hormone replacement therapy, early menarche, late menopause, and first pregnancy after 30 years of age.

A nurse is teaching a client with chronic kidney disease about predialysis dietary recommendations. The nurse should recommend restricting the intake of which of the following nutrients? - **Correct ANS:** Protein

Dietary restrictions for clients who have chronic kidney disease vary based on the degree of kidney function; however, most clients need protein limitations. Predialysis protein restriction can help preserve some kidney function.

A nurse is providing teaching to a client who is preoperative prior to a transurethral resection of the prostate (TURP). Which of the following client statements indicates an understanding of the information? - **Correct ANS:** "I will feel the urge to urinate following this procedure."

After a TURP, the client will feel the urge to urinate. The nurse should reassure him that he will receive analgesics to help relieve this discomfort.

A nurse is caring for client who is postoperative following a frontal craniotomy. The nurse should place the client in which if the following positions? - **Correct ANS:** Semi-fowler's

To prevent an increase in intracranial pressure, the nurse should position the client with his head midline and the head of the bed elevated 30 degrees. This positioning permits blood flow to the client's brain while allowing venous drainage, thereby decreasing the postoperative risk of increased intracranial pressure.

A nurse is caring for a client who has a 20-year history of COPD and is receiving oxygen at 2 L/min nasal cannula. The client is dyspneic and has an oxygen saturation via pulse oximetry of 85%. Which of the following actions should the nurse take? - **Correct ANS:** Increase the oxygen flow and request an arterial blood gas determination.

The client requires oxygen therapy at a rate that will keep the oxygen saturation between 88% and 92%. The nurse should increase the client's oxygen flow and evaluate its effectiveness with ABG results and oxygen saturation via pulse oximetry measurements.

A nurse is assessing a client who has Graves disease. Which of the following findings should the nurse expect the client to display? - **Correct ANS:** Difficulty sleeping

A client who has Graves' disease can have difficulty sleeping and anxiety due to the overproduction of thyroid hormone.

A nurse is monitoring the electrocardiogram of a client who has hypocalcemia. Which of the following findings should the nurse expect? - **Correct ANS:** Prolonged QT intervals

Manifestations of hypocalcemia include tingling, numbness, seizures, prolonged QT intervals, and laryngospasm. Causes include hypoparathyroidism, chronic kidney disease, and diarrhea.

A nurse is providing teaching to a client who has a new diagnosis of myasthenia gravis (MG). Which of the following pieces of information should the nurse include? - **Correct ANS:** Set an alarm to ensure medication dosages are taken on time

The nurse should instruct the client to take medication dosages on time to maintain a therapeutic blood level. Dosages should not be missed or postponed because this can cause an exacerbation of the disease.

A nurse is caring for a client who has receptive aphasia. Which of the following communication problems should the nurse expect when assessing the client? - **Correct ANS:** The client is unable to understand words or sentences they hear have receptive aphasia.

A nurse in a dermatology clinic is using the ABCDE method while screening several skin lesions for skin cancer on a client. Which of the following findings should the nurse report to the provider? - **Correct ANS:** Color variation within a lesion

The C in the ABCDE method of screening for skin cancer stands for color variation within a lesion. The E stands for evolving or changing in any feature of the lesion.

A nurse is caring for a client who has acute diverticulitis. While the client has active inflammation, the nurse should instruct the client to include which of the following foods in her diet? - **Correct ANS:** White bread and plain yogurt

Because of the acute inflammation of diverticulitis, the client should maintain a diet very low in fiber. The client can consume low-fiber foods like white bread, low-fat milk, yogurt with active cultures, poached eggs and canned soft fruit.

A nurse is caring for a client with Addison's disease who has been admitted with muscle weakness, dehydration, and nausea and vomiting for the past 2 days. Which of the following prescribed medications should the nurse plan to administer? - **Correct ANS:** Hydrocortisone