ATI Targeted Medical Surgical Neurosensory and Musculoskeletal Test Challenge with Solutions 2023-2024

A nurse is planning care for a client who has a closed traumatic brain injury from a fall and is receiving mechanical ventilation. Which of the following intervention is the nurse's priority?

A. Maintain a PaCO2 of approx. 35 mmHg

B. Provide small doses of fentanyl via bolus for pain management

C. Measure body temperature every 1-2hr - **Correct ANS:** A. Maintain a PaCO2 of approx. 35 mmHg

The greatest risk to this client is injury from increased intracranial pressure. Therefore, the nurse's priority action is to maintain the PaCO2 at approximately 35 mm Hg to prevent hypercarbia and subsequent vasodilation effects that lead to increase in intracranial pressure.

A nurse is caring for a client who has a retinal detachment. which of the following findings should the nurse expect?

A. Photophobia

B. Complete vision loss

C. Flashes of bright light

D. Cloudiness of the lends - **Correct ANS:** C. Flashes of bright light

The nurse should expect a client who has a retinal detachment to see flashes of bright light or floating dark spots in the affected eye as the retinal layers separate.

Photophobia - The nurse should expect photophobia in a client who has a migraine headache.

Complete vision loss

-The nurse should expect a client who has a retinal detachment to have some visual field loss in the area of the detachment, but complete vision loss is not an expected finding.

Cloudiness of the lens- The nurse should expect a client who has cataracts to experience cloudiness of the lens

A nurse is caring for a client who has a spastic bladder following a spinal cord injury. Which of the following actions should the nurse take to help stimulate micturition?

A. Encourage the client to use the Valvalsa maneuver

B. Stroke the client's inner thigh

C. Perform the Crede maneuver

D. Administer a diuretic - **Correct ANS:** B. Stroke the client's inner thigh

The nurse should stimulate micturition by stroking the client's inner thigh. Other techniques include pinching the skin above the groin and providing digital anal stimulation.

Perform the Credé maneuver. The nurse should apply direct pressure over the client's bladder, also known as the Credé maneuver, to express urine from a flaccid bladder. It is not effective for clients who have a spastic bladder due to the spasticity of the external sphincter. Administer a diuretic. Antispasmodics such as oxybutynin, rather than diuretics, can be effective for treating mild spastic bladder problems. Encourage the client to use the Valsalva maneuver. -The nurse should encourage the client to hold their breath and bear down, also known as the Valsalva maneuver, to express urine from a flaccid bladder. It is not effective for clients who have a spastic bladder due to the spasticity of the external sphincter.

A nurse is caring for a client who has viral meningitis. Which of the following actions should the nurse take?

A. Assess the client's neurologic status every 8 hr

B. Initiate droplet precautions

C. Check capillary refill at least every 4 hr

D. Place the client in a well-lit environment - **Correct ANS:** C. Check capillary refill at least every 4hr-The nurse should perform a complete vascular assessment at least every 4 hr to monitor for vascular compromise

Place the client in a well-lit environment.
The nurse should minimize the client's exposure to light from windows and overhead lights because photophobia, or light sensitivity, is a manifestation of viral meningitis.
Assess the client's neurologic status every 8 hr. The nurse should assess the client's vital signs and neurologic status at least every 2 to 4 hr.
Initiate droplet precautions. -The nurse should implement droplet precautions for clients who have bacterial meningitis. Standard precautions are sufficient for clients who have viral meningitis.

A nurse is caring for a client who has a history of status epilepticus and requires seizure precautions. Which of the following actions should the nurse take?

A. Assess hourly for a spike in blood pressure

B. Keep the client on bed rest

C. Keep a padded tongue blade at the bedside

D. Establish IV access - **Correct ANS:** D. Establish IV access-The nurse should plan to establish IV access with a large-bore catheter and administer 0.9% sodium chloride if seizures are imminent. If the client is stable, the nurse should initiate a saline lock.

Assess hourly for a spike in blood pressure. The nurse should check the client's vital signs and perform neurological checks after a seizure. However, a change in blood pressure does not correlate with an increased incidence of seizure activity.

Keep the client on bed rest. A client who is at risk for seizures does not require bed rest. However, if seizures are imminent or frequent, the nurse should institute safety measures, such as placing the mattress on the floor or raising the side rails, according to agency policy.

Keep a padded tongue blade at the bedside.my answer, The nurse should not plan to place objects, such as a padded tongue blade, in the client's mouth during a seizure because it can injure teeth and put the client at risk for aspirating tooth fragments. The tongue blade could also obstruct the client's airway.

A nurse is teaching a client and her family about the diagnosis and treatment of Alzheimer's disease. Which of the following statements should the nurse identify as an indication that the family understands the teaching?

A. "There is a test for Alzheimer's disease that can establish a reliable diagnosis"
B. "The goal of medication therapy is to reverse the degenerative changes that can occur in brain tissue"
C. "Early manifestations of Alzheimer's disease include mild tremors and muscular rigidity"
D. "The medications that treat Alzheimer's disease can help delay cognitive changes" - **Correct ANS:** D. "The medications that treat Alzheimer's disease can help delay cognitive changes."-Medications that treat Alzheimer's disease enhance the availability of acetylcholine, which can slow cognitive decline in some clients.

"There is a test for Alzheimer's disease that can establish a reliable diagnosis. “There is no specific test for identifying Alzheimer's disease, except direct examination of the brain on autopsy. Providers diagnose Alzheimer's disease based on manifestations and by ruling out other diseases.

"The goal of medication therapy is to reverse the degenerative changes that can occur in brain tissue."None of the medications currently available reverse the course of Alzheimer's disease.
"Early manifestations of Alzheimer's disease include mild tremors and muscular rigidity."Early manifestations include short-term memory loss, forgetfulness, and a shortened attention span. Mild tremors and muscular rigidity are manifestations of Parkinson's disease.

A nurse is assessing a client who has a new diagnosis of osteoarthritis. Which of the following findings should the nurse expect? (Select all that apply)

A. Crepitus with joint movement
B. Decreased range of motion of the affected joint
C. Low-grade fever
D. Spongy tissue over the joints
E. Joint pain that resolves with rest - **Correct ANS:** Crepitus with joint movement is correct. Osteoarthritis is a degenerative joint disease. Crepitus, a grating sound, is an expected finding with clients who have osteoarthritis as loosened bone and cartilage move around in the fluid inside the joint.

Decreased range of motion of the affected joint is correct. Decreased range of motion is an expected finding with clients who have osteoarthritis because the client's pain limits movement.
Low-grade fever is incorrect. Osteoarthritis does not cause systemic manifestations. Rheumatoid arthritis causes many systemic manifestations, including low-grade fever, weakness, anorexia, and paresthesias.
Spongy tissue over the joints is incorrect. Spongy joint tissue is an expected finding with rheumatoid arthritis, which is an inflammatory disease, not a degenerative disease.
Joint pain that resolves with rest is correct. Joint pain that resolves with rest is an expected finding with clients who have osteoarthritis. A client who has osteoarthritis experiences increased pain with activity and decreased pain with rest.

A nurse is teaching a client who has osteoporosis and has a new prescription for alendronate. Which of the following information should the nurse include in the teaching?

A. "Take this medication with 8 oz of milk"
B. "Remain upright for 30 min after taking this medication"
C. "Wait 1 hr after taking other medications to take alendronate"

D. "Take vitamin C to promote absorption of this medicaton" - **Correct ANS:** B. "Remain upright for 30 minutes after taking this medication."- To prevent esophagitis or esophageal ulcers, which can result from alendronate therapy, the client should sit upright for 30 min after taking this medication.

"Take this medication with 8 ounces of milk."
The nurse should instruct the client to take alendronate with 240 mL (8 oz) of water, not milk. Foods or beverages containing calcium can reduce medication absorption.
"Wait 1 hour after taking other medications to take alendronate."The nurse should instruct the client to take alendronate first thing in the morning, at least 30 min before other medications.
"Take vitamin C to promote absorption of this medication."Vitamin C intake does not increase alendronate absorption and some sources, such as orange juice, decrease absorption. However, the nurse should encourage the client to take vitamin D, which promotes calcium absorption.

A nurse is planning care for a client following a lumbar puncture. Which of the following actions should the nurse plan to take?

A. Apply pressure dressing to the site for 8 hr

B. Restrict the client's fluid intake for 24 hr

C. Ensure that the client lies flat for up to 12 hr

D. Inform the client that neck stiffness is an expected outcome of the procedure - **Correct ANS:** C. Ensure that the client lies flat for up to 12 hr.-The client should lie flat for up to 12 hr to prevent cerebrospinal fluid leakage from the puncture site, which can cause a headache

Apply a pressure dressing to the site for 8 hr.The nurse should apply pressure to the site and then apply an adhesive bandage, not a pressure dressing.

Restrict the client's fluid intake for 24 hr.The client should increase fluid intake to replace the cerebrospinal fluid the provider removed during the procedure.

Inform the client that neck stiffness is an expected outcome of the procedure.

The nurse should instruct the client to report complications of a lumber puncture such as voiding difficulties, fever, stiffness of the back or neck, nausea, and vomiting.

A nurse is assessing a client who has rheumatoid arthritis. Which of the following findings should the nurse expect?