ATI CAPSTONE ADULT MEDICAL SURGICAL ASSESSMENT CORRECT QNS & ANS COMPLETE A+ GUIDE.

- A nurse is caring for an adult client who asks about vaccinations against communicable diseases.The nurse should inform the client that which of the following vaccines are available? (Select allthat apply)

Hepatitis A vaccine
Hepatitis B vaccine
Pneumococcal vaccine
Hepatitis C vaccine
Helicobacter pylori vaccine

Adult vaccines currently available to prevent contracting communicable diseases include those for hepatitis A & B influenza and pneumonia. No vaccine is currently available for hep C/H. pylori = A, B, C

- A nurse is providing discharge instructions to a client who has a peptic ulcer. Which of the followingdietary modifications should the nurse include?

Provide a snack at bedtime
Choose decaffeinated coffee
Restrict intake of fried foods
Avoid drinking liquids with meals

The nurse should instruct the client to avoid fried foods, spicy foods, and acid-producing foods, such as coffee and chocolate. Spicy foods, such as chili pepper, red pepper, and black pepper can cause mucosaldamage. The nurse should instruct the client to avoid decaffeinated and caffeinated beverages and snacks at bedtime, which can stimulate gastric acid secretion. A client with dumping syndrome, rather than peptic ulcer should avoid liquids with meals = C

- A nurse is caring for a client who is postoperative immediately following a pheochromocytomaremoval. Which of the following actions is the nurse's priority?

Increase hydration
Monitor blood pressure
Measure urine output
Provide a calm environment

The greatest risk to this client is injury from hypertension due to the release of catecholamines duringsurgery or hypotension from the sudden loss of catecholamines after the tumor has been removed.
Therefore, the priority intervention the nurse should take is to monitor the client's blood pressure = B

- A nurse is caring for a client who is using a ventilator when the low-pressure ventilator alarmsounds. Which of the following actions should the nurse take?

Suction secretions from the endotracheal tubeCheck
the ventilator tubing connections Administer
intravenous sedation and analgesia
Reassure the client and instruct them not to bite on the tube

A low-pressure alarm indicates a loss of volume due to a disconnection, cuff link or tube displacement

= B

- A nurse is assessing a client who is receiving a blood transfusion. Which of the following findingsindicates the client might be experiencing a hemolytic transfusion reaction?

Hypertension
Report of urticaria
Distended neck veins
Report of chest pain

Chest pain is a manifestation of a hemolytic transfusion reaction. Other manifestations includeheadache, low back pain, and hypotension = D

- A nurse is assessing a client who has right lower lobe pneumonia. Which of the following findingsshould the nurse expect?

Dull percussion sounds
Increased anteroposterior chest
diameter
Distended neck veins
Pitting edema

The consolidation that occurs with pneumonia will result in dull chest percussion over the involved lobes

= A

- A nurse is providing teaching to a newly licensed nurse about caring for a client who is receiving asealed radioactive implant. Which of the following information should the nurse include in the teaching?

Place soiled linens in a lead container
Allow children who are over 10 years old
to visit
Limit visitors to 1 hr per day
Wear a lead apron during care

The nurse should wear a lead apron at all times during care of a client who has a sealed radioactiveimplant = D

- A nurse is caring for a client who has a cervical spinal cord injury. Which of the following interventions should the nurse include in the plan of care to prevent autonomic dysreflexia?

Monitor bowel movement regularity

Use a fan to promote air circulation to the client's room

Tuck the top bedsheet tightly around the client's torso

Monitor for cerebral spinal fluid leakage

Autonomic dysreflexia occurs secondary to the stimulation of the sympathetic nervous system andinadequate compensatory response by the parasympathetic nervous system. Common causes of autonomic dysreflexia include distended bladder, fecal impaction, cold stress, tight clothing, and

undiagnosed injury or illness. The nurse should monitor the client's bowel movements to reduce the riskof fecal impaction which can lead to autonomic dysreflexia = A

- A nurse is assessing a client who has tension pneumothorax following blunt chest trauma. Which ofthe following findings should the nurse expect?

Tracheal deviation to the unaffected side

Pleural friction rub

Frothy, pink-tinged sputum

Increased breath sounds on the affected side

Tracheal deviation to the unaffected side occurs with tension pneumothorax because air fills the pleuralspace on the affected side pushing the trachea and great vessels to the unaffected side = A

- A nurse is providing instructions to a newly licensed nurse about NG intubation for a client who ispostoperative following a colectomy. Which of the following statements should the nurse include?

"Tube drainage should be rust-colored."

"Nutrition will be provided through the tube."

"The tube decreases pressure within the stomach."

"The tube should be irrigated with sterile water."

The purpose of the tube for the client immediately following a colectomy is to promote rest and healingof the gastrointestinal tract by decompressing and draining abdominal fluid = C

- A nurse is teaching a client who has glaucoma and is to start taking timolol. Which of the followinginformation should the nurse include?

"Notify the provider if you experience a stinging sensation following administration."
"Watch for a decreased heart rate while using this medication."
"You can expect to develop a harmless darkening of the iris."
"This medication can cause the lashes of the affected eye to lengthen."

Timolol is a beta blocker medication applied topically for treatment of glaucoma. The client should monitor their heart rate twice daily and notify the provider if it is consistently below 58/min. Clients who have existing cardiac issues, such as sinus bradycardia and atrioventricular heart block should nottake this medication = B

- A triage nurse finds a school-age child lying in the road following a school bus crash with multiplecasualties. The child has a respiratory rate of 8/min, is unresponsive to verbal commands, and groans to painful stimuli. The nurse should assign the client which of the following triage tags?

Red
Yellow
Green
Black

It indicates a life-threatening injury that requires immediate intervention. A client who has a slow respiratory rate and a possible head injury requires immediate intervention. Yellow tag is assigned toclients who can wait 30 min to 2 hr before receiving care. A green tag is assigned to clients who havenonurgent injuries and can wait longer 2 hr before receiving care. A black tag is assigned to clients whose injuries are severe and are not expected to survive = A

- A nurse is caring for client who is postoperative following a below-the-knee amputation. Which ofthe following actions should the nurse take?

Maintain a loose bandage on the residual limb
Turn the client from side to side once every 4 hr
Request a soft mattress for the client
Place the client prone for 20 min every 3 hr

The nurse should place the client in a prone position for 20 to 30 mins every 3 to 4 hr to reduce the riskfor hip contractures = D

- A nurse is assessing a client who has Gilliam-Barré syndrome. Which of the following findingsshould the nurse report to the provider immediately?

Decreasing leg strength

Decreasing voice volume Decrease deep tendon
reflexes
Decrease sensation in the arms

When using the airway, breathing, circulation approach to client care, the nurse should determine thatthe priority finding is a decrease in voice volume. A decrease in voice volume can indicate progressive ascending neuropathy towards the laryngeal area, which can lead to respiratory compromise. The nurse should notify the provider of the finding immediately = B

- A nurse is caring for a client who had surgery 2 days ago and reports incisional pain. Which of thefollowing actions should the nurse take first?

Determined the time the last dose of pain medication was administered
Repositioned the client to assist with reduction of pain
Ask the client to describe the pain and rate it on a scale of 0
to 10
Check the clients medical record for type of PRN pain
medication

The first action the nurse should take using the nursing process is to assess the client by asking the client to describe and rate the pain. The nurse should use the clients self-report of pain when possible todetermine what type of pain intervention is indicated = C

- A nurse is teaching a client who has angina pectoris about nitroglycerin sublingual tablets. Which ofthe following statements should indicate to the nurse that the client understands the teaching?

"I will keep the tablets in the original container"

"I should keep the container in my shirt or pants pocket"

"I should begin to feel relief within 20 minutes of taking the medication"

"I will drive myself to the emergency room if three nitroglycerin tablets do not relieve my pain"

Nitroglycerin sublingual tablets should be kept in the original glass container or especially made metalcontainer because the tablets can lose their potency if they are exposed to air or moisture = A

- A nurse is assessing a client who has a herniated lumbar disc. Which of the following findingsshould the nurse expect?

The client reports relief from pain when lying in the prone position
The client reports that her low-back pain radiates upward toward one
scapula
The client reports tingling and a burning sensation in one foot
The client reports decreased pain when the affected leg is raised and straightened