ATI COMPREHENSIVE ATI A

1. A nurse in a LTC facility notices a client who has Alzheimer's disease standing at the exit door at the end of the hallway. The client appears to be anxious & agitated. What action should the nurse take?
   ANS: Escort the client to a quiet area on the nursing unit.
- A client c Alzheimer experiences chronic confusion. Guiding the client to a quiet, familiar area will help decrease agitation. They will be unable to follow instructions/commands.
2. A nurse is assisting with the plan of care for a client who has a continent urinary diversion. Which intervention should the nurse plan to implement to facilitate urinary elimination?
   ANS: Use intermittent urinary catheterization for the client at regular intervals.
- A continent urinary diversion contains valves that prevent urine from exiting the pouch; therefore, the nurse should plan to insert a urinary catheter at regular intervals to drain urine from the client's pouch.
3. A nurse is assisting with an education program about car restraint safety for a group of parents. Which statement by the parent indicates an understanding of the instructions?
   ANS: "My 12YO child should place the shoulder-lap seatbelt low across his hips."
- When a child is old enough to only use a shoulder-lap seatbelt, he should place it low across his hips rather than over the abdomen to reduce risk for injury during motor vehicle crash.
4. A nurse is reinforcing teaching about strategies to promote eating with a client who has COPD. Which instructions should the nurse include in the teaching?
   ANS: Drink high-protein and high-calorie nutritional supplements.
- The nurse should instruct the client to drink high-protein and high-calorie nutritional supplements to maintain respiratory muscle function. COPD causes respiratory stress that leads to hypermetabolism and wasting of the client's muscle mass.
5. When removing PPE after direct care for a client who requires airborne & contact precautions, which PPE is removed first?
   ANS: Gloves
- The greatest risk is contamination from pathogens that might be present on the PPE; therefore, the priority action for the AP is to remove the gloves, which are considered the most contaminated.
6. A nurse is inspecting the skin of a newborn. Which finding should the nurse report to the PCP?
   ANS: Generalized Petechiae
- Petechiae are an expected finding over the presenting part of the newborn, such as on the forehead in a brow presentation, & also anywhere on the head of infants who had a nuchal cord, w/c is an umbilical cord around the neck. However, petechiae all over the newborn's body can indicate infection or decreased platelet count and should be reported to the provider.
7. A nurse is contributing to a teaching plan for a group of male adolescents about the A/E of anabolic steroid use. Which manifestations should the nurse include?
   ANS: Reduced height potential
- Use of anabolic steroids in adolescence can lead to premature epiphyseal closure, thus reducing full height potential. A/E includes: Liver disorders, hyperlipidemia, breast enlargement, acne, and edema.
8. A nurse is reinforcing teaching with an older adult client who has severe L-sided HF. Which statement should the nurse make?
   ANS: Rest for 15 minutes between activities.
- The nurse should instruct to increase his activity gradually & to rest for a period of 15 min if he becomes tired. Clients who have HF should balance activity c rest to reduce cardiac workload.
9. A nurse in a LTC facility is documenting the care of an older adult client. Which information should be included in weekly nursing care summary?
   ANS: Hydration Status
- Older adult client are at risk for dehydration. Therefore, the nurse should be vigilant about monitoring the client's hydration status & include this information in the weekly nursing care summary.

10. A nurse is caring for a client who has a head injury. Using the Glasgow Coma Scale to collect data, the nurse should obtain which information?
    ANS: Motor Response
- The nurse should collect data about the client's motor response & assign the response a score of 1-6, according to the Glasgow Coma Scale.

11. A home health nurse is reinforcing teaching with a client about the use of elastic stockings to decrease peripheral edema. Which instruction should the nurse include?
    ANS: Apply the stocking in the morning.
- The nurse should instruct the client to apply the elastic stocking in the morning and remove them at the end of the day before bedtime.

12. A nurse is obtaining health hx from a client who is scheduled to undergo cardiac catheterization in 2 days. Which questions is the priority for the nurse to ask?
    ANS: "Do you know if you're allergic to iodine?"
- The greatest risk to the client is an allergic reaction to the contrast agent, which contains iodine.

13. A nurse is planning to administer nystatin oral suspension to a client who has oral candidiasis. Which instructions should the nurse give?
    ANS: "Hold the medication in your mouth for several minutes prior to swallowing"
- The client should swish & hold the liquid in the mouth for at least 2 min to facilitate contact of the medication with the organism. The client should then swallow or spit out the medication.

14. A nurse is preparing to care for the assigned clients on her upcoming shift. Which time management strategies should the nurse plan to use?
    ANS: Prepare a priority list of client needs for the shift.
- The nurse should prepare a client priority-to-do list, which could include administering time-critical medications. This will allow the nurse to determine which clients should receive care first.

15. After witnessing the consent, what action should the nurse take next?
    ANS: Ask client what he understands about the procedure.
16. Which task should the nurse assign to an AP for a pt 2 days post-op ff Total knee arthroplasty?
    ANS: Reapply antiembolitic stockings to the client ff a shower.
17. A nurse is reinforcing teaching with a client who is receiving radiation therapy for cancer of the larynx. Which statement made by the client indicates understanding of the teaching?
    ANS: "I will wear a soft scarf around my neck when I am outside"
- Wash it with plain water without soap. NO heat source therapy. Only use electric razor if necessary, for shaving.

18. A nurse is using FLACC scale to determine the level of pain for an 11-months-old infant who sis port-op. Which factor should the nurse consider when using this pain scale?
    ANS: Level Of Activity
- The nurse should consider the infants level of activity when using FLACC pain scale. The FLACC is determined by five categories of behavior: Facial Expression, Leg Movement, Activity, and Consolability.

19. A nurse is collecting data from a 5YO child at a well-child visit. Parent reports that the child is having frequent nightmares. Which statements by the parents indicates to the nurse that the child Is experiencing sleep terrors rather than nightmares?
    ANS: "My child goes back to sleep right away."
- The nurse should realize that going back to sleep quickly is an indication of sleep terrors, rather than nightmares. A child who is experiencing nightmare has difficulty returning to sleep because of continued fear.

20. A nurse is assisting with the care of a school-age child immediately ff surgery. The child weighs 21.8 kg (48 lb) & has a chest tube applied to suction. Which finding should the nurse report to PCP?
    ANS: 250 mL of sanguineous drainage over the last 3 hr
- More than 3 mL/kg/hr of sanguineous drainage occurs for more than 2-3 consecutive hr ff surgery. It indicates active hemorrhaging.

21. A nurse is reinforcing teaching with an older adult client who has osteoarthritis. Which instructions should the nurse include?
    ANS: Apply capsaicin cream 4x/day
- Apply it topically to provide warmth & relieve joint pain.
22. A nurse is reinforcing teaching about managing manifestation of anxiety with a client who has generalized anxiety disorder. Which information should the nurse include?
    ANS: Say the word “STOP” when upsetting thoughts occur.
23. A nurse in a LTC facility is collecting data form a client who has been receiving betaxolol to treat glaucoma. Which findings is an A/E if this medication?
    ANS: Bradycardia
- Betaxolol is a beta blocker that can produce systemic effects, including bradycardia.
24. A nurse in an outpatient surgery center is reinforcing discharge teaching with a client ff a lithotripsy for uric acid stones. Which instructions should the nurse plan to include?
    ANS: Strain the urine to collect stone fragments.
25. A nurse in a provider’s office is reinforcing teaching with a client who is to follow a 2,000 mg sodium-restricted diet. Which client food selections indicates understanding of the teaching?
    ANS: Canned Peaches.
26. A nurse is preparing to perform a bladder scan for a client. Which action should the nurse take?
    ANS: Tell the client she should not experience any discomfort.
27. A nurse is contributing to the plan of care for a client who has a prescription for ROM exercises of the shoulder. Which exercise should the nurse recommend promoting shoulder hyperextension?
    ANS: Move her arm behind her body with her elbow straight.
28. A nurse is collecting data from an older adult client who has a gastric ulcer. Which finding should the nurse identify as a complication to report to the provider?
    ANS: Hematemesis
29. A nurse is discussing the use of epidural analgesia with a newly licensed nurse. Which statement by the newly licensed nurse indicates understanding of this method of pain control?
    ANS: “I should report leaking at the insertion site to the anesthesiologist”
30. A nurse is contributing to the plan of care for a client who is receiving continuous bladder irrigation immediately ff a transurethral resection of the prostate (TURP). Which of the ff interventions should the nurse include?
    ANS: Maintain a drainage flow rate to keep the urine diluted to a reddish-pink color.
31. A nurse is caring for a client who is scheduled for a mastectomy the ff day. The client is tearful & tells the nurse that she is not ready to have this procedure done at this time. What response should the nurse give?
    ANS: “Would you like for me to talk to the surgeon with you?”
32. A nurse is collecting data from a school-age child who has hypoglycemia. What is the manifestation to expect?
    ANS: Sweating
33. A nurse is assisting with a community education program for parents of preschoolers about recommended activities to promote physical development. Which of the ff statement should the nurse make?
    ANS: “You should provide unorganized play activities for your child each day.”
34. A nurse is collecting data from a client who has chronic pancreatitis and is receiving pancrelipase. Which findings indicates the client is experiencing a therapeutic response to this medication?
    ANS: Report of a decrease in the number of stools.
- Pancrelipase is administered as a replacement therapy for a deficiency in pancreatic enzymes, which results in steatorrhea, or fatty stools.
35. A nurse is caring for a client who is 12-hour post-op ff total knee arthroplasty. What action should the nurse take?
    ANS: Place an abduction wedge between the client’s legs when he is in bed.

36. A nurse is reinforcing teaching regarding puberty with a group of prepubescent female clients. Which information should the nurse include in the teaching?
    ANS: “You will gain weight before you start to get taller.”
37. NO ORAL CONTARCEPTIVES for CAD
38. A nurse is caring for a client who is at 34 weeks gestation and has mild preeclampsia. Which finding indicates a progression from mild to severe preeclampsia?
    ANS: Client reports of blurred vision.
39. A nurse is reinforcing teaching with a client who has asthma & has a prescription of theophylline. What statement should the nurse make?
    ANS: Discontinue drinking caffeinated beverages.
40. A/E of metronidazole: Reddish-brown urine.
41. A home health nurse is collecting data from an older adult client who has generalized anxiety disorder. The client lives at home with her partner & sibling. Which responses by the client’s partner is the priority for the nurse to address?
    ANS: “Her prescription isn’t generic, so we can’t afford it anymore.”
42. Patient having difficulty using eating utensils. Refer patient to OT.
43. Child who have ingested full bottle of acetaminophen, instruct parents to take the child to the ER
44. A client requesting information from a nurse about creating a health care proxy. Which statement should the nurse make?
    ANS: “The person you appoint will make health care decisions for you if you cannot do so yourself.”
45. Venipuncture = antecubital fossa
46. The nurse should stop the infusion if the patient is having edema above the catheter insertion site.
47. A nurse is contributing to the plan of care for a client who has pneumonia. Which entries should the nurse include in the plan?
    ANS: “Client prefers bathing in the evening.”
48. Strategies to teach parents about pediculosis capitis (Head lice) management:
    ANS: Store child clothing in a separate cubicle when at school. Boil brushed and combs in water for 10 min. Dry bed linens & clothing in a hot dryer for at least 20 min.
49. Caring for a client who has GTube. What actions should the nurse take?
    ANS: Flush the tube with 50-60 mL of warm water if the tube becomes clogged.
50. Caring for client who is 4 hr post-op ff GI surgery & NG is placed for decompression. Which action should the nurse take?
    ANS: Keep the plugged tube above the level of the stomach when the client is ambulating.
51. Reinforcing teaching with a client who is scheduled for an exercise electrocardiography (ECG) stress test. What instruction to give?
    ANS: Recommend the client wear comfortable shoes during the test.

- Informed consent must be signed, Instruct client to eat 2-3 hr before test and then remain NPO to prevent GI upset during test.

52. A client who is Orthodox Judaism with terminal illness. The nurse should assure the client family member will stay with his body after death.
53. A client who has pneumonia and is currently receiving oral antibiotic may be discharged to have more rooms for new admission patient.
54. Avoid Ibuprofen when taking “PRIL” medications.
55. A nurse observes a client in labor. What interventions should the nurse recommend?
    ANS: Squatting using a birth ball, Counter pressure to the sacral area, & leaning forward while kneeling.
56. Sitting and leaning forward using both hands for support is an expected finding for a 7-month old infant.
57. Type 1 DM, patient indicates understanding of patient teaching when he/she states that, “I will dispose of my needles in a plastic laundry detergent container”.

- It is puncture-proof!

58. Offer client a whole grain cracker before bedtime if they are having difficulty sleeping.
59. Red meat = iron
60. Peanut butter = protein
61. External rotation is a clinical manifestation to expect to a client with hip fx
62. “Let’s give the medication to your doll first” is an action the nurse should take prior to performing an immunization to a preschooler.
63. Dark green and viscous is the stool to expect 24 hrs after birth of an infant.
64. Atorvastatin A/E: Muscle Pain
65. Suggest walking outside with a staff member to a patient with bipolar disorder & in a manic phase.
66. An infection with gonorrhea may result to infertility. STI pt teaching
67. Physical neglect indication when collecting a from a toddler is when “the toddler is inadequately dressed for the weather”
68. Overdose digoxin? Check VS
69. Anorexia Nervosa care plan? Record I&O
70. Documenting client care in the medical record, entries to include would be “Client remains NPO until X-Ray procedure is complete”
71. To initiate Babinski reflex? Stroke the sole of the infant’s foot upward & toward the great toe.
72. Report an ECG result with PR interval 0.24 seconds.
73. When patient report of nuchal rigidity, H/A, along with fever & chills. The nurse should anticipate the MD to order what diagnostic tests?
    ANS: Cerebrospinal fluid analysis
- The client findings are consistent with bacterial meningitis. A lumbar puncture should be performed to obtain cerebrospinal fluid to confirm the diagnosis.
74. Post-Op Lumbar puncture: Instruct patient to increase fluid intake.
75. The client must take montelukast once daily at bedtime.
76. Perform daily gum massage when taking phenytoin as a measure to assist with the possible A/E.
77. Lung sound: Wheezes
78. Morphine A/E: Respiratory Rate of 10/min
79. Document findings as a variance
80. pH 7.5 is a complication of mechanical ventilation
81. Recent confirmation of pregnancies
82. Spaghetti with red meat sauce
83. Urine specific gravity of 1.002 for pt with DI

ATI comprehensive:

1. 4hr postpartum, boggy uterus with heavy lochia. Which of the following actions should the nurse take?
    - Massage the uterus to expel clots
    - Rationale: ABC approach, priority is to massage uterus to expel clots and increase uterine firmness, resulting in decreased bleeding
2. Deficit in Cranial nerve 2: results in visual impairment and lead to falls
    - clear objects from the walking area
3. indicate the progression of labor and are a benign finding
   -nurse should continue to monitor FHR
4. Review ABGs
5. A nurse is interviewing a client who has just lost her home due to a natural disaster. After ensuring the client's safety, which of the following actions should the nurse take first?
    - Determine the client's perception of the personal impact of the crisis
    - First thing in the nursing process is assessment so assess client’s feelings and understanding of the natural disaster and its personal impact

6. An assistive personnel (AP) and a nurse are turning a client on to her right side. Which of the following actions by the AP requires the nurse to intervene?
    - Places a pillow under the client's right arm
7. A nurse in a community center is providing an educational session to a group of women about ovarian cancer. For which of the following manifestations should the nurse instruct the women to contact their providers?
    - Abd bloating
    - The nurse should include the presence of abdominal bloating as an early indication of ovarian cancer as well as other manifestations which include an increase in abdominal girth, pelvic or abdominal pain, early satiety, and urinary frequency or urgency.
8. Hypokalemia
    - signs and symptoms: muscle weakness and decreased deep tendon reflexes
9. Hypocalcemia
    - numbness and tingling of the extremities and around the mouth
10. Car safety, d/c teaching
    - secure the retainer clip at the level of your baby's armpits
    - The nurse should instruct the client to secure the retainer clip at the level of the newborn's axillae. The bones of the rib cage and sternum provide protection to underlying organs in the event of a collision. Placing the clip on the abdomen increases the risk for injury to internal organs.
11. Nurse in ED is admitting a client who has cardiac tamponade, which assessment finding should the nurse expect?
    - pulsus paradoxus
    - The nurse should identify pulsus paradoxus, a finding in which the systolic BP is 10 mm Hg or greater on expiration than inspiration, as an expected finding of cardiac tamponade, along with jugular vein distention, bradycardia, and hypotension.
12. Allowable foods for a client who has a hx of uric-acid based urinary calculi formation. Which of the following foods should the nurse recommend that the client include in his diet?
    - Citrus fruits such as oranges
    - Avoid animal-based proteins and alcohol
13. A nurse is caring for a client who has rheumatoid arthritis and has moderate to severe pain in multiple joints. Which of the following actions should the nurse take to provide comfort to this client?
    - Allow for frequent rest periods throughout the day
    - To maintain muscle strength, joint function and ROM
    - Warm shower instead of warm TUB baths
14. first trimester with an acupressure on wrist, indicates that this therapy is having desired effects?
    - I have not vomited for the past two weeks
    - Using an acupressure band on the wrists is a type of complementary and alternative therapy that applies pressure to a specific part of the body the client can use to alleviate nausea and vomiting.
15. Risk of development of a pressure ulcer?
    - Recent weight loss
16. 4hr post op following a total vaginal hysterectomy, actions to take first?
    - Measure client's VS
    - The first action the nurse should take when using the nursing process is to assess the client. The nurse should measure the client's vital signs to assess for respiratory depression and hypotension resulting from anesthesia.
17. A nurse in an emergency department is reviewing the prescriptions of an older adult client who has type 1 DM. reports of severe ankle pain after falling from a stepstool at home. Which order should the nurse verify with the provider?
    - Apply a cold pack to the edematous area on the client's ankle for 30mins every other hour
    - The nurse should verify a prescription for a cold pack because type 1 diabetes mellitus is a contraindication for receiving cold therapy. A client who has type 1 diabetes mellitus can have impaired circulation due to arteriosclerosis and a loss of sensory perception due to neuropathy.
18. Discharge teaching for a client who has colorectal cancer and is post op following a new colostomy
    - **Arrange for a referral to social services is correct.** Arranging for a referral to social services is appropriate for a client who faces challenges with self-care, as well as with paying for medical equipment and supplies.

Initiate a consult with an enterostomal therapist is correct. Initiating a consult with an enterostomal therapist can assist the client in learning to care for the colostomy.

Provide the client with information about the American Cancer Society is correct. The client can learn about helpful resources from the American Cancer Society.

Postpone the client's discharge is incorrect. There is no indication that the client should remain in the facility.

Give the client information about local support groups is correct. A client who has cancer and a new colostomy can get help with coping from a support group.

19. Alprazolam/Xanax
    - Initiate fall precautions
    - Can cause orthostatic hypotension, dizziness, drowsiness and fainting upon arising
20. Celiac dx diet teaching
    - Gluten free diet

1. An 8-year-old client is returned to the recovery room after a bronchoscopy. The nurse should position the client
1. in semi-Fowler's position.
2. prone, with the head turned to the side.

3. with the head of the bed elevated 45° and the neck extended.
4. supine, with the head in the midline position.: 1

2. A 23-year-old man is admitted with a subdural hematoma and cerebral
edema after a motorcycle accident. Which of the following symptoms should

the nurse expect to see INITIALLY? 1. Unequal and dilated pupils.
2. Decerebrate posturing.
3. Grand mal seizures.

4. Decreased level of consciousness.: 4

3. A 23-year-old woman at 32-weeks gestation is seen in the outpatient

clinic. Which of the following findings, if assessed by the nurse, would
indicate a possible complication?
1. The client's urine test is positive for glucose and acetone. 2. The client has 1+ pedal edema in both feet at the end of the day.

3. The client complains of an increase in vaginal discharge. 4. The client says she feels pressure against her diaphragm when the baby moves.: 1

4. A 38-year-old woman is returned to her room after a subtotal

thyroidectomy for treatment of hyperthyroidism. Which of the following, if
found by the nurse at the patient's bedside, is nonessential?

1. Potassium chloride for IV administration. 2. Calcium gluconate for IV administration. 3. Tracheostomy set-up.
4. Suction equipment.: 1

5. A 59-year-old woman with bipolar disorder is receiving haloperidol

(Haldol) 2 mg PO tid. She tells the nurse, "Milk is coming out of my
breasts." Which of the following responses by the nurse is BEST?

1. "You are seeing things that aren't real."
2. "Why don't we go make some fudge."

3. "You are experiencing a side effect of Haldol."
4. "I'll contact your physician to change your medication.": 3

6. A 69-year-old client is undergoing his second exchange of intermittent

peritoneal dialysis (IPD). Which of the following would require an intervention by the nurse?
1. The client complains of pain during the inflow of the dialysate.

2. The client complains of constipation.
3. The dialysate outflow is cloudy.
4. There is blood-tinged fluid around the intra-abdominal catheter.: 3

7. The ABC framework identifies, in order, the three basic needs for sustaining life: Airway
Breathing
Circulation

8. An adolescent client is ordered to take tetracycline HCL (Achromycin) 250 mg PO bid. Which of the following instructions should be given to this

client by the nurse?
1. "Take the medication on a full stomach, or with a glass of milk."
2. "Wear sunscreen and a hat when outdoors."
3. "Continue taking the medication until you feel better." 4. "Avoid the use of soaps or detergents for two weeks.": 2

9. Adverse effect of Verapamil: Avoid grapefruit juice

10. Adverse effects of ferrous sulfate: constipation; upset stomach; black or dark-colored stools; or.
temporary staining of the teeth.

11. After abdominal surgery, a client has a nasogastric tube attached to low suctioning. The client becomes nauseated, and the nurse observes a

decrease in the flow of gastric secretions. Which of the following nursing interventions would be MOST appropriate?
1. Irrigate the nasogastric tube with distilled water.

2. Aspirate the gastric contents with a syringe. 3. Administer an antiemetic medicine.
4. Insert a new nasogastric tube.: 2

12. After a client develops left-sided hemiparesis from a cerebral vascular accident (CVA), there is a decrease in muscle tone. Which of the following

nursing diagnoses would be a priority to include in his care plan?
1. Alteration in mobility related to paralysis.
2. Alteration in skin integrity related to decrease in tissue oxygenation.

3. Alteration in skin integrity related to immobility.
4. Alteration in communication related to decrease in thought processes: 2

13. After sustaining a closed head injury and numerous lacerations and abrasions to the face and neck, a five-year-old child is admitted to the

emergency room. The client is unconscious and has minimal response to noxious stimuli. Which of the following assessments, if observed by the

nurse three hours after admission, should be reported to the physician?
1. The client has slight edema of the eyelids.
2. There is clear fluid draining from the client's right ear. 3. There is some bleeding from the child's lacerations.

4. The client withdraws in response to painful stimuli.: 2

14. After teaching a group of students about the various organs of the upper gastrointestinal tract and possible disorders, the instructor determines that the teaching was successful when the students identify which of the following structures as possibly being affected?

a) Large intestine b) Ileum
c) Stomach
d) Liver: C

15. Alcohol Use Manifestations of Withdrawal: Body burns 0.5 oz of alcohol per hour
* Withdrawal appears within 4-12 hours
* Irritability + Tremors + Anxiety

* Nausea + Vomiting + HA * Diaphoresis
* Sleep Disturbances
* TACHYCARDIA + HTN

Use Benzodiazepines = tx
Diazepam (Valium), lorazepam (Ativan), and chlordiazepoxide (Librium)

16. alcohol withdrawal
heroin withdrawal
nicotine withdrawal
alcohol abstinence
opioid over dose: chlordiazeproxide(Librium) methadone(dolophine)

bupropion (wellbutrin) disulfiram (antabuse) naloxone (narcan)

17. At what age does bone loss begin with osteoporotis what are normal Calcium levels?: at age 35 (women) 8.6-10 mg/dL

18. Baclofen (Lioresal) therapeutic outcome:: Decrease the frequency and severity of muscle spasms (MS).

19. Bladder retraining for the treatment of urge incontinence:: • Use timed voidings to increase intervals between voidings/decrease voiding frequency.
• Perform pelvic floor (Kegel) exercises.

• Perform relaxation techniques.
• Offer undergarments while the client is retraining.
• Teach the client not to ignore the urge to void.
• Provide positive reinforcement as client maintains continence. • Eliminate or decrease caffeine drinks.
• Take diuretics in the morning.

20. Bowel elimination how to get a specimen collection: Collect stool specimens for serial fecal occult blood (guaiac) testing 3 times from 3 different defecations. Stool samples should come from fresh stools that are not contaminated with water or urine.

21. Case Management nursing involves:: *Decreasing cost by improving client outcomes
* Providing education to optimize health participation
* Advocating for services + client's rights

22. A charge nurse is discussing the responsibility of nurses carig for clients who have C. difficile. Which of the following information should the nurse include in the teaching?

a) Assign the client to a room with a negative air-flow system
b) Use alcohol-based hand sanitizer when leaving the clients room

c) clean contaminated surfaces in the clients room with a phenol solution
d) have family members wear a gown and gloves when visiting: D

23. A client diagnosed with dementia wanders the halls of the locked nursing unit during the day. To ensure the client's safety while walking in the halls, the nurse should do which of the following?

1. Administer PRN haloperidol (Haldol) to decrease the need to walk.
2. Assess the client's gait for steadiness.
3. Restrain the client in a geriatric chair.

4. Administer PRN lorazepam (Ativan) to provide sedation.: 2

24. A client has a history of oliguria, hypertension, and peripheral edema.
Current lab values are: BUN -25, K+ -4.0 mEq/L. Which nutrient should be

restricted in the client's diet? 1. Protein.
2. Fats.
3. Carbohydrates.

4. Magnesium.: 1

25. a client has a new prescription for spironilactone (aldactone) which of the following laboratory value should the nurse recognized as a reason to withhold the morning dose of the medication and notify the provider: serum potassium 5.2

26. a client has prescription for valproic (Depakote) which of the following laboratory value should the nurse anticipate monitor for the client taking this medication: thrombocytes, amylase count and liver function test

27. A client is admitted with a diagnosis of acute appendicitis. When assessing the abdomen, the nurse would expect to find rebound tenderness at which location?
a) Left lower quadrant

b) Left upper quadrant
c) Right upper quadrant
d) Right lower quadrant: D

28. A client is being discharged with sublingual nitroglycerin (Nitrostat).

The client should be cautioned by the nurse to
1. take the medication five minutes after the pain has started.
2. stop taking the medication if a stinging sensation is absent.
3. take the medication on an empty stomach.
4. avoid abrupt changes in posture.: 4

29. The client is exhibiting symptoms of myxedema. The nursing assessment should reveal
1. increased pulse rate.
2. decreased temperature.

3. fine tremors.
4. increased radioactive iodine uptake level.: 2

30. A client is given morphine 6 mg IV push for postoperative pain.

Following administration of this drug, the nurse observes the following:
pulse 68, respirations 8, BP 100/68, client sleeping quietly. Which of the

following nursing actions is MOST appropriate?
1. Allow the client to sleep undisturbed.
2. Administer oxygen via facemask or nasal prongs. 3. Administer naloxone (Narcan).
4. Place epinephrine 1:1,000 at the bedside.: 3

31. A client is receiving total parenteral nutrition (TPN). To determine the
client's tolerance of this treatment, the nurse should assess for which of the

following?
1. A significant increase in pulse rate.
2. A decrease in diastolic blood pressure.
3. Temperature in excess of 98.6°F (37°C).
4. Urine output of at least 30 cc per hour.: 4