MEDICAL SURGICAL EXAMS: ATI Final Exam Test Bank

A nurse is assessing a client who has acute cholecystitis. Which of the following

findings is the nurse's priority?

C. Tachycardia

When using the urgent vs. nonurgent approach to client care, the nurse should determine that the priority finding is tachycardia. Tachycardia is a manifestation of biliary colic, which can lead to shock. The nurse should position the head of the client's bed flat and report this finding immediately to the provider

A nurse is caring for a client who is undergoing hemodialysis to treat end-stage kidney disease (ESKD). The client reports muscle cramps and a tingling sensation in their hands. Which of the following medications should the nurse plan to administer?

D. Calcium carbonate

Hypocalcemia is a manifestation of ESKD and an adverse effect of dialysis. Often occurring late in the dialysis session, hypocalcemia can cause the client to experience muscle cramping and tingling to extremities. The nurse should plan to administer a calcium supplement, such as calcium carbonate, as a calcium replacement.

A nurse is providing teaching to a client who is receiving chemotherapy and has a new prescription for epoetin alfa. Which of the following client statements indicates an understanding of the teaching?

A. "I will monitor my blood pressure while taking this medication" Common side effect of epoetin alfa is hypertension

The client should monitor their blood pressure while taking this medication because hypertension is a common adverse effect and can lead to hypertensive encephalopathy.

A nurse is caring for a group of clients. The nurse should plan to make a referral to physical therapy for which of the following clients?

A. A client who is receiving preoperative teaching for a right knee arthroplasty

The nurse should make a referral to physical therapy for a client who is receiving preoperative teaching for a knee arthroplasty so the client can begin understanding postoperative exercises and physical restrictions

A nurse is providing teaching to a female client who has a history of urinary tract infections (UTIs). Which of the following information should the nurse include in the teaching?

D. Take daily cranberry supplements

The client should take cranberry supplements or drink low-fructose cranberry juice because it contains compounds that adhere to the urinary tract wall, decreasing the risk for developing a UTI

A nurse is providing instructions to a client who has type 2 diabetes mellitus and a new prescription for metformin. Which of the following statements by the client indicates an understanding of the teaching?

B. "I should take this medication with a meal."

The client should take metformin with or immediately following meals to improve absorption and to minimize gastrointestinal distress

A nurse is caring for a client who is receiving total parenteral nutrition (TPN). A new bag is not available when the current infusion is nearly completed. Which of the following actions should the nurse take?

C. Administer dextrose 10% in water until the new bag arrives

TP solutions have a high concentration of dextrose. Therefore, if a TPN solution is temporarily unavailable, the nurse should administer dextrose 10% or 20% in water to avoid a precipitous drop in the client's blood glucose level.

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 to avoid?

B. Aged cheese

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

A nurse is preparing a client who has supraventricular tachycardia for elective cardioversion. Which of the following prescribed medications should the nurse instruct the client to withhold for 48 hr prior to cardioversion?

C. Digoxin

There is an increased risk of ventricular arrhythmias developing in patients taking digoxin during electrical cardioversion. Reduce dosage or withhold therapy for 1 to 2 days before elective cardioversion

Cardiac glycosides, such as digoxin, are withheld prior to cardioversion. These medications can increase ventricular irritability and put the client at risk for ventricular fibrillation after the synchronized countershock of cardioversion

A nurse is caring for a client who has anorexia, low-grade fever, night sweats, and a productive cough. Which of the following actions should the nurse take first?

D. Initiate airborne precautions

This client is exhibiting manifestations of tuberculosis. The greatest risk in this client situation is for other people in the facility to acquire an airborne disease from this client. Therefore, the first action the nurse should take is to initiate airborne precautions

A nurse is caring for a client who has a stage III pressure injury. Which of the following findings contributes to delayed wound healing?

D. 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 emphysema and is receiving mechanical ventilation. The client appears anxious and restless, and the high-pressure alarm is sounding. Which of the following actions should the nurse take first?

C. Instruct the client to allow the machine to breathe for them.

When providing client care, the nurse should first use the least restrictive intervention. Therefore, the first action the nurse should take is to provide verbal instructions and emotional support to help the client relax and allow the ventilator to work. Clients can exhibit anxiety and restlessness when trying to "fight the ventilator."

A nurse is caring for a client who has hepatic encephalopathy that is being treated with lactulose. The client is experiencing excessive stools. Which of the following findings is an adverse effect of this medication?

A. Hypokalemia

Lactulose works by stimulating the production of excess stools to rid the body of excess ammonia. These excessive stools can result in hypokalemia and dehydration.

A nurse in an emergency department is caring for a client who reports vomiting and diarrhea for the past 3 days. Which of the following findings should indicate to the nurse that the client is experiencing fluid volume deficit?

A. Heart rate 110/min

A client who has a 3-day history of vomiting and diarrhea is likely to have fluid volume deficit and an elevated heart rate.

A nurse is caring for a client who has pancreatitis. The nurse should expect which of the following laboratory results to be below the expected reference range?

D. Calcium

A client who has pancreatitis is expected to have decreased calcium and magnesium levels due to fat necrosis.

A nurse is assessing a client who has Graves' disease. Which of the following images should indicate to the nurse that the client has exophthalmos?

D. The nurse should identify an outward protrusion of the eyes is exophthalmos a common finding of graves disease.

An overproduction of the thyroid hormone causes edema of the extraocular muscle and increases fatty tissue behind the eye, which results in the eyes protruding outward.
Exophthalmos can cause the client to experience problems with vision, including focusing on objects, as well as pressure on the optic nerve.

A nurse is caring for a client who was just admitted from the emergency department

(ED). Exhibit 1:

Nurses' Notes
0945:
Client is experiencing a sickle cell crisis. Client states that they began experiencing pain in the lower extremities 3 days ago and is now experiencing pain in the chest, rating it as 4 on scale of 0 to 10.
Oxygen at 3 L/min via nasal cannula in
place. Oral mucosa pink, no cyanosis.
Pulses palpable in all four extremities, no peripheral edema noted.
Respirations even and slightly labored; lung sounds with slight wheezing in left upper lobe.
Abdomen soft and nontender, bowel sounds active in all four quadrants.
0.45% sodium chloride IV at 200 mL/hr infusing to left hand with no reports of pain or swelling at the site.

1200:
Client is sitting up in high-Fowler's position and appears anxious. Client reports shortness of breath and severe chest pain as 9 on a scale of 0 to 10. Client states that they have started coughing and are expectorating pink-tinged mucus.
Lung sounds with increased wheezing in left lung and clear on the right side. Equal chest expansion noted. Neck veins flat. No peripheral edema observed.

Exhibit 2:

Vital Signs
0945:
Blood pressure 132/88 mm
Hg Respiratory rate 22/min
Temperature 38° C (100°
F) Heart rate 98/min
SaO_2 95% on 3 L/min via nasal cannula

1200:
Blood pressure 136/90 mm
Hg Respiratory rate 32/min

pneumonia
acute chest syndrome
right-sided heart failure
fluid volume overload
pneumothorax

Temperature 38.7° C (101.6° F) Heart rate 110/min
SaO_2 90% on 3 L/min via nasal cannula

Drag words from the choices below to fill in each blank in the following sentence.

The client is most likely experiencing and .

Word Choices

Fluid volume overload is incorrect. While the client is experiencing an increased respiratory rate and shortness of breath, fluid volume overload typically includes moist crackles on auscultation, pitting edema in dependent areas, neck vein distension, and hypertension.

Right-sided heart failure is incorrect. While clients who have sickle-cell disease are at risk for developing heart failure, the client does not have manifestations of right-sided heart failure. Right-sided heart failure typically presents with signs of fluid volume overload, which includes jugular vein distention, dependent edema, and blood pressure alterations.

Acute chest syndrome is correct. The client is most likely experiencing acute chest syndrome, which can be caused by respiratory infections and debris from sickled cells. The client is displaying manifestations of acute chest syndrome, which include cough, shortness of breath, wheezing, tachypnea, fever, and chest pain.

Pneumonia is correct. The client is most likely experiencing pneumonia as evidenced bythe manifestations of cough, shortness of breath, fever, tachypnea, blood-tinged sputum, and chest pain.

Pneumothorax is incorrect. While the client is experiencing increased respiratory distress, a pneumothorax typically presents with reduced or absent breath sounds and unequal chest expansion.

A nurse in an acute care facility is caring for a client who is at risk for seizures. Which of the following precautions should the nurse implement?

D. Ensure that the client has a patent IV.

The nurse should ensure the client has IV access in the event that the client requires medication to stop seizure activity.

A nurse is assessing a client who has had a plaster cast applied to their left leg 2 hr ago. Which of the following actions should the nurse take?

B. Check that one finger fits between the cast and the leg.

To make sure the cast is not too tight, the nurse should be able to slide one finger under the cast. It is not uncommon for casts to loosen as swelling subsides, but that should not be an issue 2 hr after application.

A nurse is caring for a client 1 hr following a cardiac catheterization. The nurse notes the formation of a hematoma at the insertion site and a decreased pulse rate in the affected extremity. Which of the following interventions is the nurse's priority?

B. Apply firm pressure to the insertion site

The greatest risk to the client is bleeding. Therefore, the priority intervention is for the nurse to apply firm pressure to the hematoma to stop the bleeding.

A nurse is assessing a male client for an that the client has an inguinal hernia?

C is correct. The nurse should palpate this location to assess the client for an inguinal hernia. An inguinal hernia forms from the peritoneum, which contains part of the intestine, and can protrude into the scrotum in men.

A nurse is teaching a class about client rights. Which of the following instructions should the nurse include?

A. A client should sign an informed consent before receiving a placebo during a research trial.

A nurse should ensure a client has provided informed consent before administering a placebo. The nurse should not administer a placebo to a client who thinks it is an active medication, because this action is a violation of client rights.

A nurse in a provider's office is caring for a client who requests sildenafil to treat erectile dysfunction, Which of the following statements should the nurse make?

D. "You will not be able to use sildenafil if you are taking nitroglycerin."

The client should not use sildenafil when taking nitroglycerin because both medications can cause vasodilation and lead to significant hypotension.

A nurse is caring for a client has who has chronic glomerulonephritis with oliguria. Which of the following findings should the nurse identify as a manifestation of chronic glomerulonephritis?

B. Hyperkalemia

The nurse should identify that a client who has chronic glomerulonephritis can experience hyperkalemia as a result of kidney failure. Kidney failure results in decreased excretion of potassium.

A nurse is assessing a client who has had a suspected stroke. The nurse should place the priority on which of the following findings?

A. Dysphagia

Dysphagia indicates that this client is at greatest risk for aspiration due to impaired sensation and function within the oral cavity. Therefore, the nurse should place priority on this finding.

A nurse is caring for a client who has a prescription for enalapril. The nurse should identify which of the following findings as an adverse effect of the medication?

C. Orthostatic Hypotension

The nurse should identify that dilation of arteries and veins causes orthostatic hypotension, which is an adverse effect of enalapril.

A nurse is assessing a client who had extracorporeal shock wave lithotripsy (ESWL) 6 hr ago. Which of the following findings should the nurse expect?

A. Stone fragments in the urine

ESWL is an effort to break the calculi so that the fragments pass down the ureter, into the bladder, and through the urethra during voiding. Following the procedure, the nurse should strain the client's urine to confirm the passage of stones.

A nurse is caring for a client who is postoperative following abdominal

surgery Exhibit 1:

Nurses' Notes

1100:
Client received from PACU; initial vital signs recorded. Client is drowsy, but arouses to verbal stimuli. Oriented x3, moves all extremities. Normal sinus rhythm. Chest clear. Dressing to abdomen intact, small amount of serosanguinous drainage noted and marked. No bowel sounds x 4 quadrants. Indwelling urinary catheter in place, draining clear yellow urine. Lactated Ringer's infusing at 100 mL/hr via IV catheter to right forearm.

1200:
Client reports nausea and pain as 8 on a scale of 0 to 10. Abdominal dressing intact, no further drainage noted. Urine output 15 mL since arrival from PACU. Analgesic and antiemetic administered as prescribed.

1230:
Client reports relief from nausea and pain as 4 on a scale of 0 to 10. SaO_2 96%. Repositioned for comfort. Encouraged to turn, cough, and deep breathe.

1300:
No additional urine output since 1200.

A nurse is caring for a client who is postoperative. Which of the following actions should the nurse take? Select all that apply.

Instruct the client to splint the abdomen with a pillow for coughing.

Report urinary output to the provider

Ask the client to rate their pain on a 0 to 10 pain scale Apply oxygen via a face mask

Plan to ambulate the client as soon as possible

Apply oxygen via a face mask is incorrect. It is not necessary to place a face mask onthe client because their SaO_2 is within the expected reference range of 95% to 100%.

Instruct the client to splint the abdomen with a pillow for coughing is correct. It is important for the client to turn, cough, and deep breathe to reduce the risk for respiratory complications. The nurse should instruct the client to splint the incision while performingthese actions to reduce the risk of complications to the surgical incision.

Plan to ambulate the client as soon as possible is correct. The nurse should plan toambulate the client as soon as possible to promote ventilation and decrease the risk ofthrombosis.

Report urinary output to the provider is correct. The client should produce at least 30mL of urine per hour. Therefore, the nurse should report this finding to the provider.

Ask the client to rate their pain on a 0 to 10 pain scale is correct. The nurse should have the client rate their pain prior to and following the administration of pain medicationto evaluate its effectiveness.

A nurse is providing teaching to a client who has chronic kidney disease and a new prescription for erythropoietin. Which of the following statements by the client indicates an understanding of the teaching?

B. A nurse is providing teaching to a client who has chronic kidney disease and a newprescription for erythropoietin. Which of the following statements by the client indicates an understanding of the teaching?

The goal of erythropoietin therapy is to increase the level of hematocrit in clients who have anemia. When the medication is effective, the client should have a decrease in fatigue and an improvement in activity tolerance.

A nurse is creating a plan of care for a client who has neutropenia as a result of chemotherapy. Which of the following interventions should the nurse include in the plan?

A. Monitor the client's temperature every 4 hr.

The nurse should monitor the temperature of a client who has neutropenia every 4 hr because the client's reduced amount of leukocytes greatly increases the client's risk for infection.

A nurse is evaluating a client who has a new diagnosis of type 1 diabetes mellitus. Which of the following client statements indicates the client is successfully coping with the change?

B. "I used to never worry about my feet. Now, I inspect my feet every day with amirror."

This statement indicates that the client is successfully coping with the change because the client is performing preventive foot care to reduce the risk for complications.

A nurse is planning care to decrease psychosocial health issues for a client who is starting dialysis treatments for chronic kidney disease. Which of the following interventions should the nurse include in the plan?

C. Tell the client that it is possible to return to similar previous levels of activity.

The nurse should help the client develop realistic goals and activities to have a productive life.

A nurse is providing teaching to an older adult client who has cancer and a new prescription for an opioid analgesic for pain management. Which of the following information should the nurse include in the teaching?

C. "You should void every 4 hours to decrease the risk of urinary retention."

The nurse should instruct the client to void at least every 4 hr to decrease the risk of urinary retention, which is an adverse effect of opioid analgesics.

A nurse is providing preoperative teaching for a client who is scheduled for an open cholecystectomy. Which of the following actions should the nurse take?

C. Demonstrate ways to deep breathe and cough.

The nurse should demonstrate deep breathing and coughing exercises and explain the importance of splinting the incision to reduce the risk for respiratory complications.

A nurse is caring for a

client. Exhibit 1:

Nurses' Notes

1000:
Client is alert and oriented and reports not feeling well for a few days. Client is on continuous ambulatory peritoneal dialysis (CAPD) and reports dialysate appeared cloudythis morning.
Reports abdominal pain as 4 on a scale of 0 to
10. Bowel sounds active in all quadrants.
Peritoneal dialysis access site red, warm to touch, with a small amount of purulent drainage noted on dressing.

1300:
Client is lying in bed with the knees flexed, guarding the abdomen. Abdomen is slightly distended, hypoactive bowel sounds. Client reports nausea. Reports pain as 6 on a scale of 0 to 10. Provider notified and updated with client condition and diagnostic results.

Exhibit 2:

Vital Signs

pneumonia
dysrhythmias
peritonitis
myxedema coma

1000:
Blood pressure 142/90 mm
Hg Respiratory rate 18/min
Temperature 38.3° C (101°
F) Heart rate 90/min
Oxygen saturation 96% on room
air Exhibit 3:

Diagnostic Results
1300:
WBC count 17,000/mm³ (5,000 to 10,000/
mm³) Potassium 4.8 mEq/L (3.5 to 5.0 mEq/
L)
Free thyroxine (Free T4) 1.4 ng/dL (0.8 to 2.8 ng/dL)
Thyroid stimulating hormone (TSH) 4.5 µU/mL (0.3 to 5 µU/
mL) Platelet count 220,000/mm³ (150,000 to 400,000/mm³)

Abdominal x-ray result:
Fluid noted in the abdominal cavity and inflammation noted in the large intestines.

Drag 1 condition and 1 client finding to fill in each blank in the following sentence.
The client is experiencing manifestations of Condition due to Client Finding.

Condition
Client Finding

platelet count
potassium level
oxygen
saturation

Dropdown 1
Peritonitis is correct. The client is experiencing manifestations of peritonitis, such as abdominal pain, cloudy dialysate, and an elevated white blood cell count.
Myxedema coma, hemorrhage, dysrhythmias and pneumonia are incorrect. The client does not exhibit manifestations of any of these conditions based on assessment andlaboratory findings.

Dropdown 2
X-ray results are correct. The client's abdominal x-ray shows fluid in the abdomen along with inflammation, both of which are indications of peritonitis.

Thyroid level, platelet count, potassium level and oxygen saturation are incorrect. These laboratory findings and the oxygen saturation are within the expected reference range and do not indicate peritonitis.

A nurse is caring for a client who presents to a clinic for a 1-week follow-up visit after hospitalization for heart failure. Based on the information in the client's chart, which of the following findings should the nurse report to the provider?

Exhibit 1:

Prescriptions
Digoxin 0.25 mg PO
daily Furosemide 40 mg
PO daily
Potassium chloride 20 mEq/L PO
daily Exhibit 2:

History and Physical
Discharge:
Weight 66.7 kg (147 lb)
SaO_2 94%
2+ pedal
edema Heart
rate 74/min

Current:
Weight 67.1 kg (148 lb)
SaO_2 92%
1+ pedal
edema Heart
rate 55/min
Exhibit 3:

Laboratory Results
Discharge:
Sodium 137 mEq/L
Potassium 4.2 mEq/L
Digoxin 1.2 ng/dL

Current:
Sodium 135 mEq/L
Potassium 4.1 mEq/L
Digoxin 1.8 ng/dL

B. Heart rate 55/min

The client's heart rate of 55/min is a decrease from the client's baseline of 74/min, and it can indicate the development of digoxin toxicity. The nurse should report this finding to the provider.

A nurse is preparing to admit a client who has dysphagia. The nurse should plan to place which of the following items at the client's bedside?

A. Suction machine

The nurse should ensure that a suction machine is at the bedside of a client who has dysphagia to clear the client's airway as needed and reduce the risk for aspiration.

A nurse is caring for a client who has amyotrophic lateral sclerosis (ALS) and is being admitted to the hospital with pneumonia. Which of the following assessment findings is the nurse's priority?

B. Increased respiratory secretions

Using the airway, breathing, circulation approach to client care, the nurse should determine that the priority assessment finding is increased respiratory secretions. These secretions place the client at risk for aspiration pneumonia due to respiratory muscle weakness caused by the ALS and the pneumonia.

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?

B. 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 providing teaching to a client who has esophageal cancer and is to undergo radiation therapy. Which of the following statements should the nurse identify as an indication that the client understands the teaching?

B. “I will use my hands rather than a washcloth to clean the radiation area.”

The client should gently wash the radiation area with their hands using warm water and mild soap to protect the skin from further irritation.

A nurse is caring for a client who is postoperative following a total hip arthroplasty. Which of the following laboratory values should the nurse report to the provider?

D. Hgb 8 g/dL

The nurse should report an Hgb level of 8 g/dL, which is below the expected reference range and is an indicator of postoperative hemorrhage or anemia.

A nurse is caring for a

client. Exhibit 1:

Nurses' Notes

Day 1

1000:

Client is short of breath and has a productive cough with yellow mucus. Client reports feeling sick for the last few days and states, "I could barely breathe when I got up this morning and I had a throbbing headache."

Client is alert and oriented to person, place, and time.

Capillary refill less than 2 seconds. Client is diaphoretic. Crackles heard in posterior lungs. Pedal pulses +2 bilaterally.

Client reports decreased appetite for the past 2 days.

Exhibit 2:

Diagnostic Results

Day 1

1000:

Sodium 150 mEq/L (136 to 145 mEq/L)

Potassium 4.8 mEq/L (3.5 to 5 mEq/L)

Calcium 9.5 mg/dL (7.6 to 10.4 mg/dL)

BUN 24 mg/dL (10 to 20 mg/dL)

WBC count 12,000/mm^3 (5,000 to 10,000/mm^3)

ABGs:

pH 7.25 (7.25 to 7.45)

PCO_2 50 mm Hg (35 to 45 mm Hg)

HCO^- 24 mEq/L (22 to 26 mEq/L)

Chest x-ray reveals increased opacity in the bilateral posterior lobes.

Exhibit 3:

Graphic Record

Day 1

1000:

Temperature 38.6° C

(101.5° F) Heart rate 98/min

Respiratory rate 24/min

Blood pressure 110/56 mm Hg

Oxygen saturation 88% on

room air

The nurse is reviewing the client's diagnostic results. Which of the following findings requires follow-up by the nurse?

Select all that apply.

Calcium level

WBC count

BUN level

PCO2 level

HCO3 level

Oxygen saturation level

Chest x-ray

PCO_2 level is correct. The client has an elevated PCO_2 level, which indicates the retention of carbon dioxide. Therefore, this finding requires follow-up by the nurse.

WBC count is correct. The client has an elevated WBC count, which indicates an infection. Therefore, this finding requires follow-up by the nurse.

Chest x-ray is correct. The client's chest x-ray indicates increased opacity in the bilateral posterior lobes, which is a manifestation of pneumonia. Therefore, this finding requires follow- up by the nurse.

Oxygen saturation level is correct. The client's oxygen saturation is decreased, which is a manifestation of pneumonia. Therefore, this finding requires follow-up by the nurse.

Calcium level is incorrect. The client's calcium level is within the expected reference range. Therefore, this finding does not require follow-up by the nurse.

HCO^- level is incorrect. The client's HCO^- level is within the expected reference range. Therefore, this finding does not require follow-up by the nurse.

BUN level is correct. The client's BUN is elevated, which is a manifestation of dehydration or kidney disease. Therefore, this finding requires follow-up by the nurse.

A nurse is caring for a client. Exhibit 1:

Nurses' Notes
Day 1
1000:
Client is short of breath and has a productive cough with yellow mucus. Client reports feeling sick for the last few days and states, "I could barely breathe when I got up this morning and I had a throbbing headache."
Client is alert and oriented to person, place, and time.
Capillary refill less than 2 seconds. Client is diaphoretic. Crackles heard in posterior lungs. Pedal pulses +2 bilaterally.
Client reports decreased appetite for the past 2 days.

Exhibit 2:

Diagnostic Results
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WBC count 12,000/mm^3 (5,000 to 10,000/mm^3)

ABGs:
pH 7.25 (7.25 to 7.45)
PCO_2 50 mm Hg (35 to 45 mm Hg)
HCO - 24 mEq/L (22 to 26 mEq/L)

Chest x-ray reveals increased opacity in the bilateral posterior lobes.

Exhibit 3:

Graphic Record

Day 1
1000:
Temperature 38.6° C
(101.5° F) Heart rate 98/min
Respiratory rate 24/min
Blood pressure 110/56 mm Hg
Oxygen saturation 88% on
room air

The nurse is reviewing the client's medical record.

Click to highlight the findings below that indicate that the client has a potential problem.To deselect a finding, click on the finding again.

Nurses' Notes

Client is short of breath and has a productive cough with yellow mucus.
"I could barely breathe when I got up this morning and I had a throbbing headache."
Capillary refill less than 2 seconds.
Client is diaphoretic.
Crackles heard in posterior
lungs. Pedal pulses +2
bilaterally.

Client is short of breath and has a productive cough with yellow mucus is correct. Shortness of breath, along with a productive cough with yellow mucus, indicates a potential problem.
"I could barely breathe when I got up this morning and I had a throbbing headache" is correct. Difficulty breathing and a throbbing headache indicates a potentialproblem.
Crackles heard in posterior lungs is correct. Crackles heard in the posterior lowerlobes indicate a potential problem.
Capillary refill less than 2 seconds is incorrect. A capillary refill less than 2 seconds iswithin the expected reference range and indicates adequate perfusion.
Client is diaphoretic is correct. Diaphoresis is a manifestation of an elevated temperature or hypoglycemia and indicates a potential problem.
Pedal pulses +2 bilaterally is incorrect. Pedal pulses +2 bilaterally is within the expected reference range and indicates adequate perfusion.

A nurse is caring for a client. Exhibit 1:

Nurses' Notes

Day 1

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Diagnostic Results

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PCO_2 50 mm Hg (35 to 45 mm Hg)
HCO^- 24 mEq/L (22 to 26 mEq/L)

Chest x-ray reveals increased opacity in the bilateral posterior lobes.

Exhibit 3:

Graphic Record

Day 1

1000:

Temperature 38.6° C (101.5° F) Heart rate 98/min
Respiratory rate 24/min
Blood pressure 110/56 mm Hg
Oxygen saturation 88% on room air

A nurse is prioritizing client care.

Complete the following sentence by using the lists of options.

The nurse should first address the client's Select... , followed by the client's Select... .

Options 1:

Loss of appetite
Oxygen saturation
BUN level

Option 2:

Headache
Temperature
Heart rate

Dropdown 1

Oxygen saturation is correct. The first action the nurse should take when using the airway, breathing, and circulation approach to client care is to address the client's oxygen saturation. The client's oxygen saturation is 88%, which indicates hypoxemia and requires supplemental oxygen.

Loss of appetite is incorrect. The nurse should address the client's loss of appetite, which is a manifestation of an infection. However, there is another finding the nurse should address first.

BUN level is incorrect. The nurse should address the client's BUN level because it is elevated. However, there is another finding the nurse should address first.

Dropdown 2

Heart rate is incorrect. The nurse should address the client's elevated heart rate, which can result in decreased cardiac output. However, there is another finding the nurse should address first.

Temperature is correct. The nurse should next address the client's elevated temperature,which is a manifestation of an infection. The client's elevated temperature can cause an increase in other vital signs, such as heart rate.

Headache is incorrect. The nurse should address the client's headache, which is a manifestation of an infection. However, there is another finding the nurse should address first.

A nurse is caring for a client. Exhibit 1:

Nurses' Notes

Day 1

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PCO_2 50 mm Hg (35 to 45 mm Hg)
HCO^- 24 mEq/L (22 to 26 mEq/L)

Chest x-ray reveals increased opacity in the bilateral posterior lobes.

Exhibit 3:

Graphic Record

Day 1
1000:
Temperature 38.6° C
(101.5° F) Heart rate 98/min
Respiratory rate 24/min
Blood pressure 110/56 mm Hg
Oxygen saturation 88% on room air

The nurse is planning care for the client.

Potential Provider Prescription	Anticipated	Nonessential	Contraindicated
Cough and deep breathe every 2 hr.	◉	○	○
Administer oxygen at 3 L/min via nasalcannula.	◉	○	○
Obtain a sputum culture and sensitivity.	◉	○	○
Limit the client's fluid intake to 1,500 mLper day.	○	○	◉

For each potential provider's prescription, click to specify if the potential prescription isanticipated, nonessential, or contraindicated for the client.