ATI RN ADULT MEDICAL SURGICAL 2023 FOR NGN FORM A, B & C ACTUAL EXAM EACH FORM CONTAINS 100 QUESTIONS AND CORRECT ANSWERS WITH RATIONALES |ALREADY GRADED A+

FORM A

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? - ANSWER- Ensure the client has a patient IV.

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

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 tothe provider? - ANSWER- Hgb 8 g/dL

RATIONALE: 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 oranemia.

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? -ANSWER- Stone fragments in the urine

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

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

RATIONALE: 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 isto initiate airborne precautions.

A nurse is caring for a client who is receiving total parenteral nutrition (TPN). Anew bag is not available when the current infusion is nearly completed. Which ofthe following actions should the nurse take? - ANSWER- Administer dextrose 10% in water until the new bag arrives.

RATIONALE: TPN 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 is providing teaching to a client who has hypothyroidism and is receivinglevothyroxine. The nurse should instruct the client that which of the following supplements can interfere with the effectiveness of the medication? - ANSWER- Calcium

RATIONALE: Calcium limits the development of osteoporosis in clients who are
postmenopausal and works as an antacid. Calcium supplements can interfere withthe 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 caring for a client who has emphysema and is receiving mechanical ventilation. The client appears anxious and restless, and the high-pressure alarm issounding. Which of the following actions should the nurse take first? - ANSWER-Instruct the client to allow the machine to breathe for them.

RATIONALE: 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 allowthe ventilator to work. Clients can exhibit anxiety and restlessness when trying to "fight the ventilator."

A nurse is caring for a client who has a prescription for enalapril. The nurse shouldidentify which of the following findings as an adverse effect of the medication? - ANSWER- Orthostatic hypotension

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

A nurse is caring for a client who has a stage III pressure injury. Which of the following findings contributes to delayed wound healing? - ANSWER- Urineoutput 25 mL/hr

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

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 followinginformation should the nurse include in the teaching? - ANSWER- "You should void every 4 hours to decrease the risk of urinary retention."

RATIONALE: 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 opioidanalgesics.

A nurse is caring for a client who has portal hypertension. The client is vomitingblood mixed with food after a meal. Which of the following actions should the nurse take first? - ANSWER- Obtain vital signs.

RATIONALE: The first action the nurse should take using the nursing process is
to assess the client's vital signs. A client who has portal hypertension can develop esophageal varices, which are fragile and can rupture, resulting in large amounts ofblood loss and shock. Obtaining vital signs provides information about the client's condition that can contribute to decision making.

A nurse at a provider's office is caring for a client who is 2 weeks postoperative following a gastrectomyA nurse is providing teaching for the client. Which of thefollowing instructions should the nurse include? - ANSWER- Avoid drinking fluids with meals
Eat several small meals per
dayConsume high-protein
snacks Avoid highly
seasoned foods

RATIONALE: Maintain a high carbohydrate intake is incorrect. Dumping syndrome requires a low carbohydrate diet because of reactive hypoglycemia.

Eat five servings of fresh fruit per day is incorrect. The client should limit intake tothree servings of unsweetened cooked or canned fruit per day. Avoid drinking fluids with meals is correct. The nurse should instruct the client todrink fluids 30 min before or after meals.

Eat several small meals per day is correct. The nurse should instruct the client toeat several small, frequent meals instead of three large meals per day.
Consume high-protein snacks is correct. The client should eat snacks that are high in protein and low in carbohydrates to prevent the gastric food boluses and reactivehypoglycemia in dumping syndrome.
Avoid highly seasoned foods is correct. The nurse should instruct the client toavoid excessive amounts of spices and salt.

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?
- ANSWER- Bradycardia

RATIONALE: 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 evaluating a client who has a new diagnosis of type 1 diabetes mellitus.Which of the following client statements indicates the client is successfully copingwith the change? - ANSWER- "I used to never worry about my feet. Now, I inspect my feet every day with a mirror."

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

A nurse is assessing a male client for an inguinal hernia. Which of the following areas should the nurse palpate to verify that the client has an inguinal hernia? (Youwill find hot spots to select in the artwork below. Select only the hot spot that corresponds to your answer.) - ANSWER- C

A is incorrect. The nurse should palpate this location to assess the client for a femoral hernia. A femoral hernia is composed of fat and forms in the femoral canal, which, as a result, enlarges and pulls on the peritoneum and sometimes the bladder.B is incorrect. The nurse should palpate this location to assess the client foran umbilical hernia. This type of hernia can be congenital or acquired as a result ofpregnancy or obesity and places increased pressure on the abdominal wall.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 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 nurse expect? - ANSWER- Administer an opioid analgesicto the client.

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

A nurse is caring for a client who is receiving dialysis treatment. - ANSWER- Perform a 12-lead ECG is not indicated. The client is not reporting chest pain; therefore, a 12-lead ECG is not indicated at this time.

RATIONALE: Place the client in Trendelenburg position is indicated. The client should be placed in the Trendelenburg position to increase blood flow to the heart,improving cardiac output and organ perfusion.

Administer a 0.9% sodium chloride 200 mL IV bolus is indicated. The nurse should administer 200 mL of 0.9% sodium chloride IV bolus to increase fluidvolume and the client's blood pressure.

Apply oxygen at 2 L/min via nasal cannula is indicated. The nurse should administer oxygen at 2 L/min via nasal cannula to increase the amount of oxygencarried in the blood.

Notify the provider immediately is indicated. The nurse should notify the providerimmediately as part of the nurse's role to provide an update on the client's condition.

Obtain the client's blood glucose level is not indicated. There is no indication that the client is experiencing hypoglycemia; therefore, obtaining a blood glucose levelis not indicated.

A nurse is teaching a class about client rights. Which of the following instructionsshould the nurse include? - ANSWER- A client should sign an informed consent before receiving a placebo during a research trial.

RATIONALE: 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 ofclient rights.

A nurse is providing teaching to a client who has a gastric ulcer and a new prescription for omeprazole. The nurse should instruct the client that the

medication provides relief by which of the following actions? - ANSWER-Suppressing gastric acid production

RATIONALE: Omeprazole is a proton pump inhibitor. It relieves manifestations
of gastric ulcers by suppressing gastric acid production.

A nurse is caring for a group of clients. The nurse should plan to make a referral tophysical therapy for which of the following clients? - ANSWER- A client who is receiving preoperative teaching for a right knee arthroplasty

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

A nurse and an assistive personnel (AP) are caring for a client who has bacterial meningitis. The nurse should give the AP which of the following instructions? -ANSWER- Wear a mask

RATIONALE: Bacterial meningitis requires droplet precautions; therefore, the
AP and the nurse should wear a mask when coming within 0.9 m (3 ft) of the clientuntil 24 hr after the client has begun receiving antibiotic therapy.

A nurse is providing teaching to an older adult female client who has stress incontinence and a BMI of 32. Which of the following statements by the clientindicates an understanding of the teaching? - ANSWER- "I am dieting to lose weight."

RATIONALE: Excess weight creates increased abdominal pressure that can
result in stress incontinence.

A nurse is caring for a client who has a potassium level of 3 mEq/L. Which of the following assessment findings should the nurse expect? - ANSWER- Hypoactivebowel sounds

RATIONALE: Hypokalemia decreases smooth muscle contraction in the gastrointestinal tract leading to decreased peristalsis.

The nurse is reviewing the client's diagnostic results. Which of the

following findings requires follow-up by the nurse? Select all that apply. - ANSWER- PCO2level

WBC count
Chest X-ray
Oxygen saturation levelBUN level

PCO2 level is correct. The client has an elevated PCO2 level, which indicates theretention 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 aninfection. 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, thisfinding 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-upby 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. HCO3- level is incorrect. The client's HCO3- level is within the expected referencerange. 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 thenurse.

Click to highlight the findings below that indicate that the client has a potential problem. To deselect a finding, click on the finding again. - ANSWER- Client isshort of breath and has a productive cough with yellow mucus
"I could barely breathe when I got up this morning and I had a throbbingheadache."
Crackles heard in posterior lungsClient is diaphoretic

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 apotential 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 apotential problem.
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 is within 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.

The nurse should first address the client's .. followed by the client's.. -ANSWER-Oxygen saturation
Temperature

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.

For each potential provider's prescription, click to specify if the potential prescription is anticipated, nonessential, or contraindicated for the client. -ANSWER- Cough and deep breathe every 2 hr is anticipated.
The nurse should anticipate a prescription for coughing and deep breathing to promote lung expansion and improve impaired gas exchange.
Obtain a sputum culture and sensitivity is anticipated.