VERSION 3

ATI MED-SURG PROCTORED EXAM PRACTICE QUESTIONS WITH ANSWERS (100 Q/A)

1. A nurse is caring for a client who has a closed head injury and has an intraventricular catheter placed. Which of the following findings indicates that the client is experiencing increased ICP?
    a. Flat jugular veins
    b. GCS score of 15
    c. Sleepiness exhibited by the client
    d. Widening pulse pressure

e. Decerebrate posturing
f. **Flat jugular veins is incorrect.** With increased ICP, the jugular veins are typically distended.

A Glasgow Coma Scale score of 15 is incorrect. A Glasgow Coma Scale score of 15 indicates neurological functioning within the expected reference range for eye opening, motor, and verbal response.

Sleepiness exhibited by the client is correct. Sleepiness or difficulty arousing the client from sleep is an indication of increased ICP.

Widening pulse pressure is correct. A widening pulse pressure (increase in systolic with concurrent decrease in diastolic blood pressure) is an indication of increased ICP.

Decerebrate posturing is correct. Both decerebrate and decorticate posturing indicate increased ICP.

2. A nurse is preparing a client who has supraventricular tachycardia for elective cardioversion. Which of the following prescribed medications should the nurse instruct the clients to withhold for 48hr prior to cardioversion?
   a. Enoxaparin
   b. Metformin
   c. Diazepam
   d. Digoxin
   e. Anticoagulants can be beneficial during cardioversion due to their ability to prevent blood clots that can be released into the client's circulatory system after cardioversion. This medication should not be withheld.
   f. Metformin
   g. Metformin might be withheld for a client scheduled for cardiac catheterization or other procedures involving contrast dye in order to prevent damage to the kidneys. However, metformin should not be withheld prior to cardioversion.
   h. Diazepam
   i. Sedatives are generally administered to clients prior to cardioversion to reduce anxiety and minimize the discomfort associated with the procedure. This medication should not be withheld.
   j. Digoxin: ANSWER
   k. 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.

3. A nurse is assessing a client who has acute cholecystitis. which of the following findings is the nurse's priority?
    a. Anorexia
    b. Abdominal pain radiating to the right shoulder
    c. Tachycardia
    d. Rebound abdominal tenderness
        i.
        Anorexia
        ii. Anorexia is nonurgent because it is an expected finding for a client who has acute cholecystitis. Therefore, there is another finding that is the nurse's priority.
        iii. Abdominal pain radiating to the right shoulder
        iv. MY ANSWER
        v. Abdominal pain radiating to the right shoulder is nonurgent because it is an expected finding for a client who has acute cholecystitis. Therefore, there is another finding that is the nurse's priority.
        vi. Tachycardia
        vii. 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.
        viii. Rebound abdominal tenderness
        ix. Rebound abdominal tenderness is nonurgent because it is an expected finding for a client who has acute cholecystitis. Therefore, there is another finding that is the nurse's priority.

4. A nurse is preparing to admit a client who has dysphagia. The nurse should plant to place which of the following items at the client's bedside?
    a. Suction machine
    b. Wire cutters
    c. Padded clamp
    d. Communication board
    e. Suction machine: ANSWERThe 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.
    f. Wire cutters: The nurse should ensure wire cutters are at the bedside of a client who has an inner maxillary fixation to cut the wires in case the client vomits. This enables the client to clear their airway and reduce the risk for aspiration.

g. Padded clamp: The nurse should ensure a padded clamp is at the bedside of a client who has a chest tube to clamp the tube and prevent air from entering the client's chest if there is an interruption in the sealed drainage system.

h. Communication board: The nurse should ensure a communication board is at the bedside of a client who has aphasia to assist the client with communicating.

5. A nurse is caring for a client who is having a seizure. Which of the following intervention is the nurse's priority?
    a. Loosen the clothing around the client's neck
    b. Check the client's pupillary response
    c. Turn the client to the side.
    d. Move furniture away from the client
        i. Loosen the clothing around the client's neck: The nurse should loosen any restrictive clothing the client is wearing to prevent injury to the client. However, another action is the priority.
        ii. Check the client's pupillary response: The nurse should perform neurologic checks after the seizure to monitor the client's recovery. However, another action is the priority.
        iii. Turn the client to the side.: The greatest risk to this client is hypoxia from an impaired airway. Therefore, the priority intervention the nurse should take is to place the client in a side-lying position to prevent aspiration.
        iv. Move furniture away from the client.: AThe nurse should move furniture away from the client to prevent self-injury. However, another action is the priority.

6. A nurse is providing teaching to aclient who has hypothyroidism and is receiving levothyroxine. The nurse should instruct the client that which of the following supplements can interfere with the effectiveness of the medication?
    a. Ginkgo biloba
    b. Glucosamine
    c. Calcium
    d. Vitamin C
        i. Ginkgo biloba
        ii. Ginkgo biloba reduces the pain associated with peripheral vascular disease by promoting vasodilation. It can interact with medications that have anticoagulant properties, but it is not known to interfere with the absorption of levothyroxine.

iii. Glucosamine: Glucosamine treats osteoarthritis by decreasing inflammation and stimulating the body's production of synovial fluid and cartilage. It can interact with medications that have antiplatelet or anticoagulant properties, but it is not known to interfere with the absorption of levothyroxine.

iv. Calcium:NSWER

v. Calcium limits the development of osteoporosis in clients who are postmenopausal and works as an antacid. Calcium supplements can interfere with the metabolism of a number of medications, including levothyroxine. The nurse should instruct the client to avoid taking calcium within 4 hr of levothyroxine administration.

vi. Vitamin C: Vitamin C promotes wound healing. It can cause a false negative in fecal occult blood tests, but it is not known to interfere with the absorption of levothyroxine.

7. A nurse is planning to irrigate and dress a clean, granulation wound for a client who has a pressure injury. Which of the following actions should the nurse take?
   a. Apply a wet-to-dry gauze dressing
   b. Irrigate with hydrogen peroxide solution
   c. Use a 30-ml syringe
   d. Attach a 24-gauge angiocatheter to the syringe.

8.
   a. Apply a wet-to-dry gauze dressing.: The nurse should not apply wet-to-dry dressings to clean, granulating wounds as they interrupt viable, healing tissues when they are removed. Appropriate dressings for a wound that is developing granulation tissue include a hydrocolloid dressing and a transparent film dressing.

   b. Irrigate with hydrogen peroxide solution: the nurse should use hydrogen peroxide to clean contaminated surfaces. Hydrogen peroxide should not be used on a pressure injury wound because it destroys newly granulated tissue. Instead, the nurse should use solutions specifically designed as wound cleansers or 0.9% sodium chloride irrigation to irrigate the wound.

   c. Use a 30-mL syringe: NSWERThe nurse should use a 30-mL to 60-mL syringe with an 18- or 19-gauge catheter to deliver the ideal pressure of 8 pounds per square inch (psi) when irrigating a wound. To maintain healthy granulation tissue, the wound irrigation should be delivered at between 4 and 15 psi.

   d. Attach a 24-gauge angiocatheter to the syringe:the nurse should use an 18- or 19-gauge catheter that will apply the appropriate irrigation pressure. A 24-gauge angiocatheter delivers solutions at a higher pressure than necessary for irrigation and a can potentially damage the developing granulation tissues.

1. a nurse Is assessing a client who has Graves' disease. Thich of the collowing images should undicate to the nurse that the client has exophthalmos:

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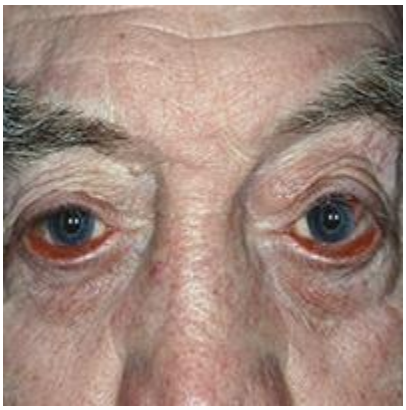
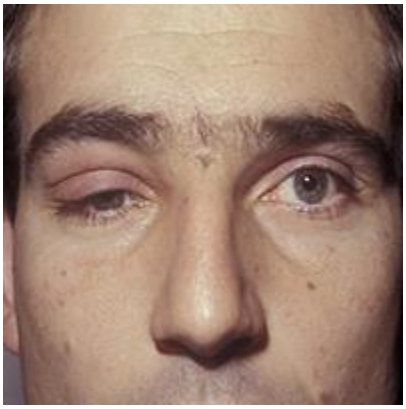
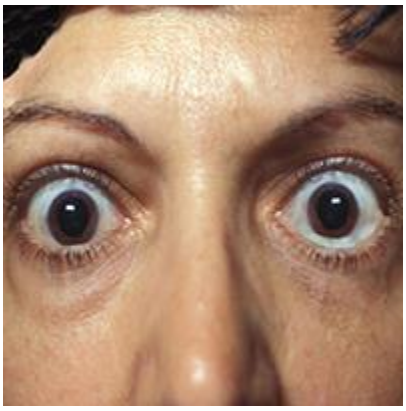
- This image depicts entropion, which occurs when the skin of the eyelids turns inward, causing the eyelids to rub the eye. Entropion is caused by spasms of the eyelid muscle or trauma and occurs most often in older adult clients due to the loss of supportive tissue.
- 
- This image depicts ectropion, which occurs when the skin of the eyelids turns outward, causing sagging of the lower lids due to muscle weakness. Ectropion occurs with aging and can cause drying of the cornea and ulceration.
- 
- This image depicts ptosis, which occurs when excess skin of the upper eyelid drops down over the eye. Ptosis can occur due to aging or at any age due to diabetes, myasthenia gravis, or stroke.

- 
- MY ANSWER
- The nurse should identify an outward protrusion of the eyes as 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.

11. the nurse is providing teaching to a female client who has a history of UTI's. which of the following information should the nurse include in the teaching?
    a. Avoid foods that are high in ascorbic acid
    b. Add oatmeal to the water when taking a tub bath
    c. Urinate every 6 hours
    d. Take daily cranberry supplements?
12. A nurse is providing teaching to a client who has esophageal cancer and is to undergo radiation therapy. Which off the following statements should the nurse identify as an indication that the client understands the teaching?
    a. " I will wash the ink markings off the radiation area after each treatment."
    b. "I will use my hands rather than a washcloth to clean the radiation area."
    c. "I will be able to be out in the sun 1 month after my radiation treatments are over."
    d. "I will use a heating pad on my neck it if becomes sore during the radiation therapy."
        i. "I will wash the ink markings off the radiation area after each treatment."
        ii. The ink markings designate the exact radiation area. The client should not remove these markings until they complete the entire radiation treatment.
        iii. "I will use my hands rather than a washcloth to clean the radiation area."
        iv. MY ANSWER
        v. The client should gently wash the radiation area with their hands using warm water and mild soap to protect the skin from further irritation.

vi. "I will be able to be out in the sun 1 month after my radiation treatments are over."

vii. Radiation therapy causes skin to become sensitive to the effects of sun exposure and increases the risk for developing skin cancer. The client should avoid direct sunlight during the radiation treatments and for at least 1 year following the conclusion of the therapy.

viii. "I will use a heating pad on my neck if it becomes sore during the radiation therapy."

ix. The client should avoid exposing the treatment area to heat as this can cause further irritation to the skin.

13. 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?
    a. Initiate oxygen at 2 L via nasal cannula
    b. Apply firm pressure to the insertion site
    c. Take the client's vital signs
    d. Obtain a stat order for an aPTT

        i. Initiate oxygen at 2 L/min via nasal cannula.: The nurse can apply oxygen to promote adequate tissue oxygenation. However, another intervention is the priority.

        ii. Apply firm pressure to the insertion site.: MY ANSWERThe 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.

        iii. Take the client's vital signs.: The nurse should take the client's vital signs to further determine the client's status. However, another intervention is the priority.

        iv. Obtain a stat order for an aPTT.: The nurse can request laboratory data to provide information about the client's coagulation status. However, another intervention is the priority.

14. 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?
    a. Obtain ABGs
    b. Administer propofol to the client
    c. Instruct the client to allow the machine to breathe for them
    d. Disconnect the machine and manually ventilate the client.

        i. Obtain ABGs. The nurse should monitor ABG results to determine the effectiveness of mechanical ventilation, but this is not the first action the nurse should take.

ii. Administer propofol to the client.: The nurse might need to administer propofol to provide sedation and increase the client's tolerance of mechanical ventilation, but this is not the first action the nurse should take.

iii. 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."

iv. Disconnect the machine and manually ventilate the client.: Many factors can cause a high-pressure alarm to sound. The nurse might have to disconnect the machine and manually ventilate the client if the ventilator fails or the client experiences respiratory distress, but this is not the first action the nurse should take.

15. A nurse is reviewing the lab results of a client who has cirrhosis. Which of the following laboratory values should the nurse expect?
    a. Decreased prothrombin time
    b. Elevated bilirubin level
    c. Decreased ammonia level
    d. Elevated albumin level
        i. Decreased prothrombin time: liver disease and severe liver cell damage causes the liver cells to produce less prothrombin, which prolongs prothrombin time.
        ii. Elevated bilirubin level: Bilirubin levels reflect the liver's ability to conjugate and excrete bilirubin, a byproduct of the hemolysis of red blood cells. Bilirubin levels rise with liver disease and clinically reflect the client's degree of jaundice.
        iii. Decreased ammonia level: The liver converts ammonia to urea. When this process is interrupted, as it is with liver disease or liver failure, ammonia levels rise.
        iv. Elevated albumin level: Albumin forms in the liver. When liver function is impaired, as it is with cirrhosis, albumin levels decrease.

16. A nurse is teaching a client who has venous insufficiency about self-care. Which of the following statements should the nurse identify as an indication that the client understands the teaching?
    a. " I should avoid walking as much as possible."
    b. "I should sit down and read for several hours a day"
    c. "I will wear clean graduatied compression stockings every day."
    d. "I will keep my legs level with my body when I sleep at night."

i. "I should avoid walking as much as possible.": A client who has venous insufficiency should maintain an exercise regimen, such as routine walking, to decrease venous stasis.

ii. "I should sit down and read for several hours a day.": A client who has venous insufficiency should avoid sitting or standing for prolonged periods of time due to the risk of developing deep-vein thrombosis or skin breakdown.

iii. "I will wear clean graduated compression stockings every day.": Y ANSWERThe client should apply a clean pair of graduated compression stockings each day and clean soiled stockings with mild detergent and warm water by hand.

iv. "I will keep my legs level with my body when I sleep at night.": A client who has venous insufficiency should elevate the legs above heart level while in bed to facilitate venous return and avoid venous stasis.

17. 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?
    a. Potassium 4 mEq/L
    b. WBC count 10,000/mm3
    c. Hct 45%
    d. Hgb 8 g/dL

i.

Potassium 4 mEq/L: A potassium level of 4 mEq/L is within the expected reference range.

ii. WBC count 10,000/$mm^{3:}$ A WBC count of 10,000/mm^3 is within the expected reference range.

iii. Hct 45%: An Hct level of 45% is within the expected reference range.

iv. Hgb 8 g/dL: Y ANSWERThe 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.

18. A nurse is caring for a client who has a stage III pressure injury. Which of the following findings contributes to delayed would healing?
    a. WBC count 6K
    b. BMI 24
    c. Urine output 25ml/hr
    d. Albumin 4

- WBC count 6,000/$mm^{3:}$ ANSWERWBCs fight infection and respond to foreign bodies. Increased amounts are seen in clients who have an infectious process, and decreased amounts are seen in clients who are immunocompromised. A WBC count of 6,000/mm^3 is within the expected reference range.