Version 9

ATI MED-SURG PART A

1. **A nurse is reinforcing discharge teaching about wound care with a family member of a client who is postoperative. Which of the following should the nurse include in the teaching?**
    a) Administer an analgesic following wound care. (The nurse should remind the family member to administer an analgesic prior to wound care to prevent discomfort.)
    b) Irrigate the wound with povidone iodine. (The nurse should remind the family member to irrigate the wound with 0.9% sodium chloride.)
    c) Cleanse the wound with a cotton-tipped applicator. (The nurse should remind the family member to avoid using a cotton-tipped applicator to cleanse the wound because the fibers can become embedded in the wound, cause infection, and delay wound healing.)
    d) Report purulent drainage to the provider. (The nurse should remind the family member to report signs of infection, including purulent drainage.)
2. **A nurse is caring for a client who has bacterial meningitis. Upon monitoring the client, which of the following findings should the nurse expect?**
    a) Flaccid neck (The nurse should recognize that nuchal rigidity, rather than a flaccid neck, is a manifestation of meningitis.)
    b) Stooped posture with shuffling gait (The nurse should recognize that a stooped posture with shuffling gait is a manifestation of Parkinson's disease, not a manifestation of meningitis.)
    c) Red macular rash (The nurse should expect to find a red macular rash, sometimes called a petechial rash, which is a manifestation of meningococcal meningitis.)

d) Masklike facial expression (The nurse should recognize that a masklike expression is a manifestation of Parkinson's disease, not a manifestation of meningitis.)

3. **A nurse is contributing to the plan of care for an older adult client who is at risk for osteoporosis. Which of the following interventions should the nurse include to prevent bone loss?**
   a) Increase fluid intake. (Fluid intake is beneficial for general health and wellness, and it helps to treat some disorders. Caffeine and alcohol intake can increase the client's risk of developing osteoporosis. However, fluid intake does not prevent bone loss.)
   b) Encourage range-of-motion exercises. (Range-of-motion exercises are beneficial for general health and wellness, and they help to maintain flexibility and prevent contractures. However, range-of-motion exercises do not prevent bone loss.)
   c) Massage bony prominences. (Massaging bony prominences should be avoided because it can traumatize deep tissues.)
   d) Encourage weight-bearing exercises. (Weight-bearing exercises, such as walking, can maintain bone mass by reducing bone demineralization, thus helping to prevent osteoporosis.)
4. **A nurse is collecting data from a client and notices several skin lesion. Which of the following findings should the nurse report as possible melanoma?**
   a) Scaly patches (The nurse should report scaly patches as possible basal or squamous cell carcinoma.
   b) Silvery white plaques (The nurse should report silvery white plaques as possible psoriasis.)
   c) Irregular borders (The nurse should report irregular borders of a skin lesion to the provider because it can indicate malignant melanoma.)
   d) Raised edges (The nurse should report raised edges of a skin lesion as possible basal cell carcinoma.)
5. **A nurse is reinforcing discharge teaching to prevent dumping syndrome for a client following a partial gastrectomy for ulcers. Which of the following information should the nurse include in the teaching?**
   a) Avoid liquids at mealtimes. (The nurse should remind the client to avoid drinking liquids at mealtimes to prevent the food from emptying into the small bowel too quickly.)
   b) Exclude eating starchy vegetables. (The nurse should remind the client to include starchy vegetables in the meal plan to slow gastric emptying.)
   c) Avoid eating high-protein meals. (The nurse should remind the client to eat high-protein meals to help slow gastric emptying.)
   d) Plan to increase intake of sweetened fruits. (The nurse should remind the client to exclude sweetened fruits from the diet to help slow gastric emptying.)

6. **A nurse is collecting data on a client who is scheduled for a cardiac catheterization. Which of the following laboratory levels should the nurse review prior to the procedure?**
    a) Albumin (Albumin levels determine the amount of protein the liver produces in the body and is an indication of hepatic function and nutritional status. However, it is not impacted by contrast media used for cardiac catheterization. Therefore, the nurse does not need to review this laboratory level prior to a cardiac catheterization.)
    b) Phosphorus (Phosphorus is an electrolyte that combines with calcium to maintain bone health and is involved as an energy source in metabolism. However, it is not impacted by contrast media used for cardiac catheterization. Therefore, the nurse does not need to review this laboratory level prior to a cardiac catheterization.)
    c) TSH (TSH levels determine thyroid function. However, it is not impacted by contrast media used for cardiac catheterization. Therefore, the nurse does not need to review this laboratory level prior to a cardiac catheterization.)
    d) BUN (BUN levels indicate kidney function. Contrast media used during cardiac catheterization can cause renal failure. The nurse should review this laboratory level to determine if the client can tolerate the IV contrast dye during the procedure.)
7. **A nurse is reinforcing glycosylated hemoglobin (HbA1c) testing with a client who has diabetes mellitus. Which of the following statements indicates that the client understands the teaching?**
    a) "The HbA1c test should be performed 2 hr after I eat a meal that is high in carbohydrates." (The nurse should remind the client that carbohydrate consumption is not required for HbA1c testing.)
    b) "The HbA1c test can help detect the presence of ketones in my body." (The nurse should remind the client that urine testing can detect ketone bodies.)
    c) "I will have my HbA1c checked twice per year." (An HbA1c test provides the client's average glucose level for the preceding 3 months. The nurse should instruct the client to have her HbA1c tested twice yearly to manage her glucose.)
    d) "I will plan to fast before I have my HbA1c tested." (The nurse should remind the client that fasting is not required for HbA1C testing.)
8. **A nurse is examining a client's IV site and notes a red line up his arm. The client reports a throbbing, burning pain at the IV site. The nurse should identify that the client's manifestations indicate which of the following complications of IV therapy?**
    a) Thrombophlebitis (The nurse should identify pain, warmth, and a red streak up the arm as indications of thrombophlebitis.)
    b) Infiltration (The nurse should identify swelling and cool skin at the IV site as indications of infiltration.)

c) Hematoma (The nurse should identify swelling and bruising as indications of a hematoma that can develop by not holding enough pressure after discontinuing the IV.)
d) Venous spasms (The nurse should identify cramping at or above the insertion site and numbness as indications of venous spasms.)

9. A nurse is reinforcing teaching about management of constipation with a client who has hypothyroidism. Which of the following should the nurse include in the teaching?

a) Increase intake of fiber-rich foods. (The nurse should instruct the client to increase the amount of fiber-rich foods in his diet. Dried beans and brown rice are examples of fiber-rich foods.)
b) Take a laxative every morning. (The nurse should instruct the client to initially take a laxative in the evening to stimulate the evacuation of stool. However, the nurse should instruct the client to use laxatives sparingly.)
c) Maintain a fluid intake of 1200 mL per day. (The nurse should instruct the client to increase his fluid intake to 2,000 mL per day to maintain soft stools.)
d) Limit activity to preserve energy. (The nurse should instruct the client to increase activity to stimulate the evacuation of stool.)

10. A nurse is caring for a client who is at risk for developing pressure ulcers. Which of the following actions should the nurse take?

a) Position pillows between the bony prominences. (The nurse should use positioning devices to keep bony prominences from being in direct contact with each other, which will prevent skin breakdown and pressure ulcer development.)
b) Check for incontinence every 3 hr. (The nurse should check the client for incontinence at least every 2 hr to prevent skin breakdown.)
c) Massage reddened areas of the skin. (The nurse should avoid massaging reddened areas of the skin, which can lead to the formation of a pressure ulcer by damaging underlying tissue.)
d) Elevate the head of the bed to 45°. (The nurse should avoid elevating the head of the bed to an angle greater than 30°. An angle greater than 30° can cause shearing of the skin, which leads to tissue injury and pressure ulcer development.)

11. A nurse is contributing to the plan of care for a client who has peripheral arterial disease (PAD) of the lower extremities. Which of the following interventions should the nurse include?

a) Place moist heat pads on the extremities. (The nurse should avoid applying heat to the client's extremities to prevent injury due to decreased sensation.)
b) Perform manual massage of the affected extremities. (The nurse should avoid massaging the client's lower extremities if the client is having pain from ischemia. A warm environment and keeping the client warm will help with circulation to the extremities and decrease pain through vasodilation.)

c) Dangle the extremities off the side of the bed. (The nurse should include in the plan of care to have the client dangle the lower extremities off the side of the bed to aid in reducing pain by increasing arterial blood flow. The client should not raise the lower extremities above the level of the heart when resting in bed because it impairs arterial blood flow.)

d) Apply support stockings before getting out of bed. (The nurse should avoid applying support stockings to the lower extremities because support stockings interfere with the arterial blood flow to the lower extremities.)

12. A nurse is caring for a client who has meningococcal pneumonia. Which of the following personal protective equipment should the nurse use?

a) Gown (The nurse should wear a gown when caring for a client who requires contact precautions.)

b) Mask (The nurse should identify that a client who has Meningococcal pneumonia requires droplet precautions, which include wearing a mask when providing care within 3 feet of the client.)

c) Sterile gloves (The performance of sterile dressing changes or tracheostomy care requires the nurse to wear sterile gloves. However, clean gloves are used to provide medical aseptic care.)

d) Protective eyewear A nurse should wear protective eyewear when there is a risk for splashing, such as during the irrigation of a wound.)

13. A nurse is assisting with the care of a client who has a cardiac catheterization via the right femoral artery. Which of the following actions should the nurse take to prevent postprocedure complications (Select all that apply?)

a) Should wait at least 2 hours after eating before going to bed." (The client should wait to lie down or go to bed at least 2 hr after eating to minimize reflux.)

b) "I should eat three meals a day without eating snacks between meals." (The client should eat four to six small meals per day rather than three large meals to minimize bloating and abdominal distention.)

c) "I should season my food with garlic." (The client should avoid spicy foods, including garlic, to minimize reflux.)

d) "I should drink my liquids through a straw." (The client should avoid drinking through a straw, which can promote belching and reflux.)

14. A nurse is caring for a client who is postoperative and has an epidural infusion. Which of the following findings should the nurse recognize as the priority?

a) Pruritus (The nurse should identify pruritus as an adverse effect of an epidural infusion. However, another finding is the priority.)

b) Nausea (The nurse should identify nausea as an adverse effect of an epidural infusion. However, another finding is the priority.)

c) Urinary retention (The nurse should identify urinary retention as an adverse effect of an epidural infusion. However, another finding is the priority.
d) Dyspnea (When using the airway, breathing, circulation approach to client care, the nurse should determine that the priority finding is dyspnea, which is a complication of the epidural infusion.)

15. A nurse is reinforcing teaching about gastroesophageal reflux disease (GERD) with a client. Which of the understanding of the teaching?

a) I should wait at least 2 hours after eating before going to bed." (The client should wait to lie down or go to bed at least 2 hr after eating to minimize reflux.)
b) "I should eat three meals a day without eating snacks between meals." (The client should eat four to six small meals per day rather than three large meals to minimize bloating and abdominal distention.)
c) "I should season my food with garlic." (The client should avoid spicy foods, including garlic, to minimize reflux.)
d) "I should drink my liquids through a straw." (The client should avoid drinking through a straw, which can promote belching and reflux.)

16. A nurse is reinforcing teaching with a client who is taking insulin glargine. Which of the following information should the nurse include in the teaching?

a) This type of insulin should be given at the same time every day." (Insulin glargine is released in the body over a 24 hr period. The nurse should instruct the client to administer the insulin at the same time each day to maintain consistent serum levels for optimal therapeutic effect.)
b) "This insulin can be mixed with short-acting insulin in a single syringe." (The nurse should remind the client that insulin glargine should not be mixed with any other insulin.)
c) "This type of insulin can be used in a pump." (The nurse should inform the client insulin glargine is a long-acting insulin that is administered once daily at the same time and is not to be administered intravenously.)
d) "This insulin has an increased risk for hypoglycemia." (The nurse should inform the client that insulin glargine has a low risk for hypoglycemia because serum levels of the insulin do not peak and remain consistent over time.)

17. A nurse is preparingto administer phytonadione 7 mg subcutaneously to a client who has an INR of 4. Available is phytonadione 10 mg/mL. How many mL should the nurse administer? (Round the answer to the nearest tenth. Use a leading zero if it applies. Do not use a trailing zero.)

Ratio and Proportion
Step 1: What is the unit of measurement the nurse should calculate? mL
Step 2: What is the dose the nurse should administer? Dose to administer = Desired 7 mg
Step 3: What is the dose available? Dose available = Have 10 mg

Step 4: Should the nurse convert the units of measurement? No
Step 5: What is the quantity of the dose available? 1 mL
Step 6: Set up an equation and solve for X.
Have/Quantity = Desired/X
10 mg/1 mL = 7 mg/X mL
X = 0.7
Step 7: Round if necessary.
Step 8: Reassess to determine whether the amount to administer makes sense. If there are 10 mg/mL and the provider prescribed 7 mg, it makes sense to administer 0.7 mL. The nurse should administer phytonadione 0.7 mL subcutaneously.
Desired Over Have
Step 1: What is the unit of measurement the nurse should calculate? mL
Step 2: What is the dose the nurse should administer? Dose to administer = Desired 7 mg
Step 3: What is the dose available? Dose available = Have 10 mg
Step 4: Should the nurse convert the units of measurement? No
Step 5: What is the quantity of the dose available? 1 mL
Step 6: Set up an equation and solve for X.
Desired x Quantity/Have = X
7 mg x 1 mL/10 mg = X mL
0.7 = X
Step 7: Round if necessary.
Step 8: Reassess to determine whether the amount to administer makes sense. If there are 10 mg/mL and the provider prescribed 7 mg, it makes sense to administer 0.7 mL. The nurse should administer phytonadione 0.7 mL subcutaneously.
Dimensional Analysis
Step 1: What is the unit of measurement the nurse should calculate? mL
Step 2: What is the quantity of the dose available? 1 mL
Step 3: What is the dose available? Dose available = Have 10 mg
Step 4: What is the dose the nurse should administer? Dose to administer = Desired 7 mg
Step 5: Should the nurse convert the units of measurement? No
Step 6: Set up an equation and solve for X.
X = Quantity/Have x Conversion (Have)/Conversion (Desired) x Desired/
X mL = 1 mL/10 mg x 7 mg/
X = 0.7
Step 7: Round if necessary.
Step 8: Reassess to determine whether the amount to administer makes sense. If there are 10 mg/mL and the provider prescribed 7 mg, it makes sense to administer 0.7 mL. The nurse should administer phytonadione 0.7 mL subcutaneously.

18. A nurse is reinforcing teaching with an adolescent client regarding testicular self-examination. Which of the following statements by the client demonstrates an understanding of the teaching?

a) “I will perform the exam before I shower.” (Clients should perform a testicular self-examination after a warm shower.)
b) “I will check my testicles every 6 months.” (Clients should perform a testicular self-examination monthly.)
c) "I understand that testicular cancer is painless." (Clients should report a lump that is not painful because testicular cancer is typically painless.)
d) "I understand that pea-sized lumps are normal." (Clients should report pea-sized lumps in the testes to a provider.)

19. A nurse is caring for a client who is scheduled for surgery and is experiencing anxiety. Which of the following interventions should the nurse identify as the priority?

a) Determine the client's understanding of the procedure. (Using the nursing process, the first action the nurse should take is to collect data from the client. Therefore, the nurse should determine the client's understanding of the procedure to provide necessary teaching, which can help manage his anxiety.)
b) Encourage the client to express his feelings. (Encouraging the client to express his feelings can reduce anxiety. However, this is not the first action the nurse should take.)
c) Allow the client's family to stay with him. (Allowing the client's family to stay with him can reduce anxiety. However, this is not the first action the nurse should take.)
d) Provide music as a distraction. (Providing music as a distraction can reduce anxiety. However, this is not the first action the nurse should take.)

20. A nurse is reinforcing teaching about home care with a client who had a knee arthroplasty. Which of the following factors should the nurse identify as an indication that a barrier to learning might be present?

a) The client asks questions each time the nurse stops talking. (The nurse should identify that asking questions indicates active listening by the client and enhances learning.)
b) The client stops the nurse and asks for pain medication. (The nurse should identify that a client who is in pain will not be able to concentrate, which can interfere with his ability to learn.)
c) While the nurse is speaking, the client refers to the written materials. (The nurse should identify that clients learn in different ways. Using multiple methods of teaching, including hands-on practice and providing written materials, enhances learning.)

d) A family member who is present asks the client to repeat important points. (The nurse should identify that family member who are actively engaged in the teaching session and ask questions can enhance learning.)

21. A nurse is reinforcing discharge instructions with a client who is postoperative following a right hip arthroplasty. Which of the following statements should the nurse make?

a) You may cross your legs in 60 days." (The nurse should instruct the client to wait 90 days before crossing her legs. Crossing her legs early in the postoperative period can result in dislocation of the replacement hip.)

b) "Avoid lying on your operative side." (The nurse should inform the client that she may lie on her operative side with a pillow between her legs. This will not injure the suture site or cause dislocation of the replacement hip.)

c) "Avoid bending your hips more than 90 degrees." (The nurse should instruct the client to avoid bending her hips more than 90° to prevent dislocation of the replacement hip.)

d) "You may sleep on a soft mattress." (The nurse should instruct the client to sleep on a firm mattress to avoid potential dislocation of the replacement hip.)

22. A nurse is caring for a client who has a compound fracture of the femur and was placed in balanced suspension skeletal traction 4 days ago. Which of the following actions should the nurse take?

a) Perform pin site care daily. (The nurse should perform pin site care daily with chlorhexidine solution or use a solution according to facility protocol. The nurse should also monitor the pin sites for manifestations of infection.)

b) Remove the overbed trapeze.(The nurse should ensure the client has an overbed trapeze to aid in lifting the upper body off the bed when necessary and to help prevent skin breakdown of the heels and elbows with client repositioning.)

c) Remove the boot every 2 hr. (The nurse should identify that balanced suspension skeletal traction is managed through the use of pins, pulleys, weights, and frames and that the client does not wear a boot.)

d) Keep the weights on a stable, flat surface. (The nurse should ensure the weights hang freely at all times.)

23. A nurse is assisting the charge nurse with developing an in-service about caring for clients who have internal sealed radiation implants. Which of the following information should the nurse include?

a) Restrict the time pregnant women are allowed in the client's room to 15 min. (Pregnant women and children should not be allowed to visit a client who is receiving internal radiation therapy because of the risk for exposure to radiation emissions.)

b) Pick up a radiation implant with a double-gloved hand if it becomes dislodged. (The nurse should use forceps to pick up a radiation implant if it becomes dislodged.
c) Limit time spent in the client's room to 2 hr during an 8 hr shift. (The nurse should limit time spent in the client's room to 30 min during an 8 hr shift.)
d) Dispose of radiation implants in a lead container. (Lead impairs the emission of radiation. Therefore, the nurse should dispose of radiation implants in a lead container in accordance with facility protocol.)

24. A nurse in a long-term care facility is collecting data from a client who reports fullness in the rectum and abdominal cramping. Which of the following findingsshould indicates to the nurse that the client might have a fecal impaction?

a) Halitosis (Halitosis, or bad breath, is associated with the ingestion of certain foods and medications, and it can also be an indication of infection.)
b) Hemorrhoids (Hemorrhoids indicate that the client is straining when defecating. However, the presence of hemorrhoids does not indicate fecal impaction.)
c) Rebound tenderness (Rebound tenderness is an indication of appendicitis. A client who has a fecal impaction can experience abdominal cramping and distention.)
d) Small liquid stools (Small liquid stools can be the result of fecal material being expelled around an impaction.)

25. A nurse is providing discharge teaching for the family of a client who has Parkinson's disease. Which of the following information should the nurse include in the teaching?

a) Place the client on a low-calorie diet to prevent weight gain. (The nurse should instruct the client's family to provide the client with extra calories and protein to prevent unintentional weight loss from expenditure of energy due to tremors, dyskinesia, and difficulty swallowing.)
b) Remind the client to avoid watching her feet when walking. (The nurse should instruct the client's family to frequently remind the client to maintain correct posture and prevent falls by not watching her feet when walking.)
c) Use small area rugs in the client's home for traction. (The nurse should instruct the client's family to avoid using area rugs in the client's home because her foot may drag or be stiff and catch on an area rug, which can cause a fall.)
d) Instruct the client to take tub baths instead of showers. (The nurse should instruct the family to encourage the client to take walk-in, sit-down showers, because skeletal muscle rigidity can cause difficulty in moving, coordination, and balance, which increases the risk of a fall.)

26. A home health nurse is reinforcing teaching with a client about preventing complications of peripheral vascular disease. Which of the following statements indicates that client is adhering to the nurse's instructions?