ATI MEDICAL SURGICAL CMS

PROCTORED EXAM 2024 ACTUAL

EXAM COMPLETE ACCURATE

EXAM QUESTIONS WITH DETAILED

VERIFIED ANSWERS

A nurse is caring for a client who sustained a basal skull fracture. When performing morning hygiene care, the nurse notices a thin stream of clear drainage coming from out of the client's right nostril. Which of the following actions should the nurse take first? - -----ANSWER----->*Test the drainage for glucose.

Rationale: The greatest risk to a client who has a basal skull fracture is injury from cerebral spinal fluid (CSF) leak; therefore, the nurse should first test the drainage for glucose.

A nurse is caring for a client who has a spinal cord injury at T-4. The nurse should recognize that the client is at risk for autonomic dysreflexia. Which of the following interventions should the nurse take to prevent autonomic dysreflexia? - -----ANSWER----->*Prevent bladder distention.

Rationale: Autonomic dysreflexia can occur in clients who have a spinal cord injury at or above the T-6 level. Autonomic dysreflexia can occur as a result of an irritation, or stimulus to the nervous system below the level of injury.

Triggers of autonomic dysreflexia include bladder distention, insertion of rectal suppository, enemas, or a sudden change in position

A nurse is caring for a client who is being evaluated for endometrial cancer. Which of the following findings should the nurse expect the client to report? - -----ANSWER----->*Abnormal vaginal bleeding

Rationale: The nurse should expect the client to experience abnormal vaginal bleeding, including postmenopausal bleeding and bleeding between normal periods. Abnormal vaginal bleeding is the most common finding in endometrial cancer in premenopausal women.

A nurse is assisting in the care of a client who is 2 hours postoperative following a wedge resection of the left lung and has a chest tube to suction. Which of the following is the priority finding the nurse should report to the provider? - -----ANSWER----->*Abdomen is distended

Rationale: When using the airway, breathing, circulation approach to client care, the nurse should recognize the presence of abdominal distention has the potential to compromise the client's respiratory status as the distention increases abdominal pressure on the diaphragm and impairs ventilation. This is the priority finding for the nurse to report

A nurse is caring for a client following an open reduction and internal fixation of a fractured femur. Which of the following findings is the nurse's priority? - -----ANSWER----->*Altered level of consciousness

Rationale: When using the airway, breathing, circulation approach to client care, the nurse determines that the priority finding is for the nurse to monitor the client's altered level of consciousness. A fracture of one of the long bones of the body places the client is at risk for fat embolism, which causes a decrease in oxygenation and alters the client's level of consciousness.

A nurse is assisting in the plan of care for a client who had a removal of the pituitary gland. Which of the following actions should the nurse include in the plan? - -----ANSWER---->*Change the nasal drip pad as needed.

Rationale: The nurse should change the nasal drip pad as needed because the client will have nasal packing and bloody nasal drainage until the surgical site is healed.

A nurse is reinforcing discharge teaching with a client about how to care for a newly created ileal conduit. Which of the following instructions should the nurse include in the teaching? - -----ANSWER---->*Empty the ostomy pouch when it is 2/3 full.

Rationale: The ileal conduit cannot store urine the way the bladder did; urine will flow continuously into a collecting device. Emptying the device when the pouch is 2/3 full will prevent leakage, skin irritation, and infection.

A nurse is caring for a client who asks why she is being prescribed aspirin 325 mg daily following a myocardial infarction. The nurse should instruct the client that aspirin is prescribed for clients who have coronary artery disease for which of the following effects? - -----ANSWER---->*To prevent blood clotting

Rationale: Aspirin is used to prevent clot formation by reducing platelet aggregation. Therefore, the nurse should instruct the client the aspirin is prescribed for clients who have coronary artery disease to prevent myocardial infarction caused by clots in the coronary arteries.

A nurse is collecting data from a client who has open-angle glaucoma. Which of the following findings should the nurse expect? - -----ANSWER---->*Loss of peripheral vision

Rationale: The nurse should expect to find the client experiencing a gradual loss of peripheral vision with a narrowing of the visual field with open-angle glaucoma.

A nurse is collecting data from a client who has acute gastroenteritis. Which of the following data collection findings should the nurse identify as the priority? - -----ANSWER---->*Potassium 2.5 mEq/L

Rationale: When using the airway, breathing, circulation approach to client care, the nurse determines that the priority finding is a potassium level of 2.5 mEq/dL. In the presence of fluid volume deficit, potassium depletion can occur. Complications from hypokalemia include cardiac and respiratory manifestations.

A nurse is reinforcing discharge teaching with a client who had a total abdominal hysterectomy and a vaginal repair. Which of the following statements by the client indicates a need for further teaching? - -----ANSWER---->* "I will take a tub bath instead of a shower."

Rationale: To reduce the risk of infection, the client should avoid tub baths following a total abdominal hysterectomy.

A nurse is assisting with the care of a client who has a femur fracture and is in skeletal traction. Which of the following actions should the nurse take? - -----ANSWER---->*Ensure the client's weights are hanging freely from the bed.

Rationale: The nurse should ensure that the client's weights are hanging freely from the bed to maintain the client in proper body alignment and should never be removed without a provider prescription or the development of a life-threatening situation that requires removal.

A nurse in a provider's office is reinforcing teaching with a client who has anemia and has been taking ferrous gluconate for several weeks. Which of the following instructions should the nurse include? - -----ANSWER---->*Take this medication between meals.

Rationale: Although taking iron supplements with food can decrease adverse effects, it also drastically reduces the absorption of iron. Therefore, the nurse should instruct the client that taking iron is most effective when supplements are taken in between meals.

A nurse is reviewing the plan of care for a client who has cellulitis of the leg. Which of the following interventions should the nurse recommend? - -----ANSWER---->*Wash daily with an antibacterial soap.

Rationale: The nurse should plan to have the client wash the area daily with an antibacterial soap to promote tissue health and treat the infection.

A nurse is reinforcing teaching with a client who has HIV and is being discharged to home. Which of the following instructions should the nurse include in the teaching? - -----ANSWER---->*Take temperature once a day.

Rationale: The nurse should reinforce to the client to take his temperature once a daily to identify if a temperature is present due to the client's altered immune system.

A nurse is caring for a client who is postoperative following a tracheostomy, and has copious and tenacious secretions. Which of the following is an acceptable method for the nurse to use to thin this client's secretions? - -----ANSWER---->*Provide humidified oxygen.

Rationale: Increasing fluid intake as tolerated and providing adequate humidification can help thin secretions safely.

Following admission, a client with a vascular occlusion of the right lower extremity calls the nurse and reports difficulty sleeping because of cold feet. Which of the following nursing actions should the nurse take to promote the client's

comfort? - -----ANSWER---->*Obtain a pair of slipper socks for the client.

Rationale: Slipper socks with nonskid soles will help provide warmth and increase the client's level of comfort.

A nurse is caring for a client is who is 4 hr postoperative following a transurethral resection of the prostate (TURP). Which of the following is the priority finding for the nurse report to the provider? - -----ANSWER---->*Thick, red-colored urine

Rationale: The nurse should recognize viscous drainage that is red in color may indicate hemorrhage and should be reported to the provider immediately.

A nurse is caring for a client who has a temperature of 39.7° C (103.5° F) and has a prescription for a hypothermia blanket. The nurse should monitor the client for which of the following adverse effects of the hypothermia blanket? - -----ANSWER---->*Shivering

Rationale: The hypothermia blanket can cause shivering if the client is cooled too quickly. Shivering can cause the client's temperature to increase.

A nurse is reinforcing teaching about exercise with a client who has type 1 diabetes mellitus. Which of the following statements by the client indicates an understanding of the teaching? - -----ANSWER---->* "I should avoid injecting insulin into my thigh if I am going to go running."

Rationale: The nurse should reinforce that the client should avoid injecting insulin into an area that will soon be exercised to avoid increasing the absorption rate of the insulin.

A nurse notes a small section of bowel protruding from the abdominal incision of a client who is postoperative. After calling for assistance, which of the following actions should the nurse take first? - -----ANSWER---->*Cover the client's wound with a moist, sterile dressing.

Rationale: According to evidence-based practice, the nurse's first action should be to cover the wound with a moist, sterile dressing to prevent entry of bacteria into the wound and to keep the tissue moist.

A nurse is collecting data from a client who has alcohol use disorder and is experiencing metabolic acidosis. Which of the following manifestations should the nurse expect? - -----ANSWER---->*Hyperventilation

Rationale: The nurse should expect to find hyperventilation in a client who is experiencing metabolic acidosis. The system attempts to compensate or return the pH to normal by increasing the rate and depth of respirations

A nurse is reinforcing discharge teaching with a client following a cataract extraction. Which of the following should the nurse include in the teaching? - -----ANSWER---->*Avoid bending at the waist.