ATI RN ADULT MEDICAL SURGICAL PROCTORED RETAKE EXAM NEWEST COMPLETE 120 QUESTIONS AND CORRECT DETAILED ANSWERS WITH RATIONALES (VERIFIED ANSWERS) |ALREADY GRADED A+

TEST

A nurse is caring for a client who is taking lithium and reports persistent nausea and vomiting for 2 days. Which of the following laboratory values should the nurse report to the provider?

a) Potassium 4.0 mEq/L

b) Lithium 0.9 mEq/L

c) BUN 12 mg/dL

d) Sodium 132 mEq/L - --CORRECT ANSWER----D. Sodium 132 mEq/L

Rationale:

The nurse should identify that a sodium level of 132 mEq/L is not within the expected reference range of 136 to 145 mEq/L. This finding indicates hyponatremia, which can lead to lithium accumulation and places the client at risk for lithium toxicity. The nurse should report this finding to the provider.

A nurse is caring for a client who has cancer and has a WBC count of 4,000/mm3. Which of the following actions should the nurse take?

a) Cleanse the client's toothbrush with hydrogen peroxide.

b) Instruct the client to use a disposable razor to shave.

c) Decrease the client's protein intake.

d) Encourage the client to eat unpasteurized dairy products. - --CORRECT ANSWER----A. Cleanse the client's toothbrush with hydrogen peroxide.

Rationale:

A WBC count of 4,000/mm3 is considered low and is known as leukopenia. A low WBC count can be caused by cancer or cancer treatment. The nurse should instruct the client to cleanse their toothbrush with hydrogen peroxide. People with leukemia or leukopenia should avoid using disposable razors, which can cause cuts and bleeding that can lead to infections. Instead, they recommend using an electric razor to reduce the risk of injury. Encouraging the client to eat unpasteurized dairy products is not recommended as they can contain harmful bacteria that can cause infections. Decreasing the client's protein intake is not recommended as protein is important for wound healing and immune function

TEST

A nurse enters a client's room and sees smoke coming from the bathroom. Which of the following actions should the nurse take first?

a) Activate the fire alarm system.

b) Use a fire extinguisher at the source of the

smoke.

c) Assist the client to a nearby common area.

d) Close the doors to the room and to the

bathroom. - --CORRECT ANSWER----C. Assist the client to a nearby common area.

Rationale:

use

Rescue

Alarm

Contain

Extinguish

TEST

A nurse is contributing to the plan of care for a client who reports difficulty eating due to chronic arthritis. Which of the following interventions should the nurse include in the plan?

a) Apply foam handles to the client's eating utensils.

b) Obtain a referral for physical therapy.

c) Have an assistive personnel feed the client.

d) Ask the provider for a prescription for a pureed diet. - --CORRECT ANSWER----A. Apply foam handles to the client's eating utensils.

Rationale:

To help a client with chronic arthritis who experiences difficulty eating, applying foam handles to the eating utensils can provide a larger, more comfortable grip and reduce strain on the joints. Asking for a puree diet may not be necessary unless swallowing difficulties are present. Having an assistive personnel feed the client may not promote independence. While obtaining a referral for physical therapy may be beneficial for overall mobility, it does not directly address the client's difficulty with eating.

A nurse is providing directions to an assistive personnel about moving a client up in bed.

a. "Place a pillow under the client's head prior to repositioning."

b. "Keep your feet close together while moving the client"

c "Face in the direction of the client's movement"

d. "Move the client's arms to his sides prior to repositioning." - --CORRECT ANSWER----C. "Face in the direction of the client's movement."

Rational:

When moving a client up in bed, it is important for the nurse to face in the direction of the client's movement to maintain proper body mechanics and ensure safe transfer.

1)Adjust the head of the bed to a flat position.

2)Remove all pillows from under the client.

3)Position the UAP on the side opposite the nurse.

4)Place a friction-reducing sheet under the client.

5)Ask the client to bend the legs and place the chin on the chest.

6)Grasp the sheet and move the client on the count of three.

A nurse is obtaining a medication history from a client who is to start taking nitroglycerin for chest discomfort with activity. Which of the following medications should the nurse instruct the client to avoid taking within 24 hrs of using nitroglycerin?

a) Atorvastatin

b) Metformin

c) Sildenafil

d) Omeprazole - --CORRECT ANSWER----C. Sildenafil

Rationale:

Sildenafil treats PAH (pulmonary arterial hypertension) by relaxing the blood vessels in the lungs to allow blood to flow easily.

Same as, nitroglycerin is a vaso-dilator which is primarily to treat anginal chest pain and thereby it reduces blood pressure.

Remaining drugs like omeprazole and atorvastatin can be given for patients with in 24hrs of nitroglycerin administration.

A nurse is caring for a client who has a new prescription for nitroglycerin. The nurse should monitor for which of the following adverse effects of the medication?

Nocturia

Increased saliva production

Flushing