ATI RN Adult Medical Surgical Proctored EXAM WITH NGN Questions AND Answers 2023/2024 | ATI MED-SURG PROCTORED EXAM

A 24-year-old female client diagnosed with a human papillomavirus infection (HPV) is angry at her ex-boyfriend and says she is not going to tell him that he is infected. What response is best for the nurse to provide?
A) You do not have to tell him because this is not a reportable disease.
B) Because there is no cure for this disease, telling him is of no benefit to him or to you.
C) Even though you are angry, he should be told, so he can take precautions to prevent the spread of infection.
D) You should tell him, so he can feel as guilty and miserable as you do now, knowing that you have this disease. - ✓✓ANSW✓✓..👌Anger is a common emotional reaction when confronted with the diagnosis of a STI, and often lay blame and project this anger at the sexual partner. Although HPV is not
a reportable disease in many states, all contacts should be informed of the infection, treatment, transmission, and precautions to minimize infecting others (C). (A and B) provide false information and increase the risk of complications and transmission. (D) is not

therapeutic.

A client is admitted to the emergency department after being lost for four days while hiking in a national forest. Upon review of the laboratory results, the nurse determines the client's serum level for thyroid-stimulating hormone (TSH) is elevated. Which additional assessment should the nurse make?

A) Body mass index.
B) Skin elasticity and turgor.
C) Thought processes and speech.
D) Exposure to cold environmental temperatures. - ✓✓ANSW✓✓..👌TSH influences the amount of thyroxine secretion which increases the rate of metabolism to maintain body temperature near normal. Prolonged exposure to cold environmental temperatures (D) stimulates the hypothalamus to secrete thyrotropin-releasing hormone, which increases anterior pituitary serum release of TSH. (A) may reflect weight loss from lack of food. Tenting of the skin (B) is indicative of dehydration. Slow or confused thought processes (C) or speech patterns may be related to sleep deprivation.

A client is admitted to the hospital with a traumatic brain injury after his head violently struck a brick wall during a gang fight. Which finding is most important for the nurse to assess further?

A) A scalp laceration oozing blood.
B) Serosanguineous nasal drainage.
C) Headache rated 10 on a 0-10 scale.
D) Dizziness, nausea and transient confusion. - ✓✓ANSW✓✓..👌Any nasal discharge should be evaluated (B) to determine the presence of cerebral spinal fluid which indicates a tear in the dura making the client susceptible to meningitis. The scalp is highly vascular and results in blood oozing from wounds (A). Pain is expected and can be treated after further assessment of the presence of nasal discharge (C). Dizziness, nausea, and transient confusion (D) are expected manifestations following a traumatic brain injury and need ongoing monitoring, but (B) is most important.

A client is receiving a continuous bladder irrigation at 1000 ml/hour after a prostatectomy. The nurse determines the client's urine output for the past hour is 200 ml. What action should the nurse implement first?

A) Notify the healthcare provider.
B) Stop the irrigation flow.
C) Document the finding and continue to observe.
D) Irrigate the catheter with a large piston syringe. - ✓✓ANSW✓✓..👌The urinary output should be at least the volume of irrigation input plus the client's actual urine. A significant decrease in output indicates obstruction in the drainage system, and the irrigation flow should be stopped (B) to prevent severe bladder distention. The next action is to check the external system for kinks or obstruction. If no output occurs, the catheter is irrigated with 30 to 50 ml of normal saline using a large iston syringe (D). If the obstruction is not resolved, then the healthcare provider (A) should be implemented.

A client who has a chronic cough with blood-tinged sputum returns to the unit after a bronchoscopy. What nursing interventions should be implemented in the immediate post-
procedural period?

A) Keep the client on bed rest for eight hours.

B) Check vital signs every 15 minutes for two hours.

C) Allow the client nothing by mouth until the gag reflex returns.

D) Encourage fluid intake to promote elimination of the contrast media. - ✓✓ANSW✓✓..👌The nasal pharynx and oral pharynx are anesthetized with local anesthetic spray prior to bronchoscopy, and the bronchoscope is coated with lidocaine (Xylocaine) gel to inhibit the gag reflex and prevent laryngeal spasm during insertion.

The client should be NPO until the client's gag reflex returns (C) to prevent aspiration from any oral intake or secretions. (A, B, and D) are not indicated after bronchoscopy.

A client who returns to the unit after having a percutaneous transluminal coronary angioplasty (PTCA) complains of acute chest pain. What action should the nurse implement next?

A) Inform the healthcare provider.

B) Obtain a 12-lead electrocardiogram.

C) Give a sublingual nitroglycerin tablet.

D) Administer prescribed analgesic. - ✓✓ANSW✓✓..👌After a percutaneous transluminal coronary angioplasty (PTCA), a client who experiences acute chest pain may be experiencing cardiac ischemia related to restenosis, stent thrombosis, or acute coronary syndrome involving any coronary artery. The first action is to administer nitroglycerin (C) to dilate the coronary arteries and increase myocardial oxygenation. Then, (A, B, and D) are implemented.

A client with a fractured right radius reports severe, diffuse pain that has not responded to the prescribed analgesics. The pain is greater with passive movement of the limb than with active movement by the client. The nurse recognizes that the client is most likely exhibiting symptoms of which condition?

A) Acute compartment syndrome.

B) Fat embolism syndrome.

C) Venous thromboembolism.

D) Aseptic ischemic necrosis. - ✓✓ANSW✓✓..👌A These signs are specific indications of Acute Compartment Syndrome (A), and should be treated as an emergency situation. The signs do not indicate (B, C, or D).

A client with a markedly distended bladder is diagnosed with hydronephrosis and left hydroureter after an IV pyelogram. The nurse catheterizes the client and obtains a residual urine volume of 1650 ml. This finding supports which pathophysiological cause of the client's urinary tract obstruction?

A) Obstruction at the urinary bladder neck.
B) Ureteral calculi obstruction.
C) Ureteropelvic junction stricture.
D) Partial post-renal obstruction due to ureteral stricture. - ✓✓ANSW✓✓..👌Hydroureter (dilation of the renal pelvis), vesicoureteral reflux (backward movement of

urine from the lower to upper urinary tracts), and hydronephrosis (dilation or enlargement of the renal pelvis and calyces) result from post-renal obstruction which can consequently result in chronic pyelonephritis and renal atrophy. Ascending urinary reflux occurs when normal ureteral peristaltic pressure is met with an increase in urinary pressure occurring during bladder filling if the urinary bladder neck is obstructed (A). A large residual urine does not occur with (B, C, and D) because the urine can not get to the bladder.

A client with acute appendicitis is experiencing anxiety and loss of sleep about missing final examination week at college. Which outcome is most important for the nurse to include in the plan of care?

A) Sleeping six to eight hours.

B) Achieve a sense of control.

C) Utilize problem solving skills.

D) Increased focus of attention. - ✓✓ANSW✓✓..👌The experience of psychological discomfort may be as real as physical pain for the client and should be seen as a priority in care. Because the client is experiencing anxiety, achieving a sense of control is a key need (B) before (A, C and D) are addressed.

A client with acute pancreatitis is admitted to the medical unit. During the nurse's admission interview, which assessment has the highest priority?
A) History of alcohol intake.
B) Time of last meal.
C) Frequency of vomiting.
D) Intensity of pain. - ✓✓ANSW✓✓..👌The hallmark sign of pancreatitis is severe abdominal pain (D), due to autodigestion of the pancreas by the enzymes amylase and lipase. (A, B, and C) are also important but are of less priority then (D).

A client with Ménière's disease is incapacitated by vertigo and is lying in bed grasping the side rails and staring at the television. Which nursing intervention should the nurse implement?

A) Encourage fluids to 3000 ml per day.

B) Change the client's position every two hours.

C) Keep the head of the bed elevated 30 degrees.

D) Turn off the television and darken the room. - ✓✓ANSW✓✓..👌To decrease the client's vertigo during an acute attack of Ménière's disease, any visual stimuli or