ATI MED-SURG PART A EXAM (Questions and Answers) LATEST 2020 |Complete Solution Guides

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 infectiona, 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.)