ATI PN FUNDAMENTALS LATEST TEST BANK 2023-2024 REAL EXAM 300+ QUESTIONS AND CORRECT ANSWERS WITH RATIONALES|PN FUNDAMENTALS ATI PROCTORED EXAM 2023|AGRADE

A nurse is assisting with the care of a client who has a prescription for IV therapy. The client tells the nurse that he has numerous allergies. Which of the following allergies should the nurse bring to the attention of the charge nurse prior to the initiation of the therapy?
a. eggs
b. latex
c. seafood
d. bee stings - ANSWER- b. latex
RATIONALE:-Nurses use products containing latex, including gloves, tourniquets, and IV tubing, to deliver IV therapy. Clients who have an allergic reaction to latex can have a wide range of manifestations, such as itching and hives, or a more serious reaction, such as dyspnea or laryngospasm.

A nurse is caring for a client who has a prescription for a high-protein diet to promote wound healing following surgery. The client's religion prohibits eating meat on particular days. Which of the following actions should the nurse take?
a. encourage the client to eat meat during this time to promote healing
b. advise the client to eat everything on the tray except the meat
c. suggest the client receive high-protein enteral feedings
d. ask the dietitian to recommend alternative food choices for the client - ANSWER- d. ask the dietitian to recommend alternative food choices for the client
RATIONALE:--The dietitian is a useful resource for the recommendation of alternative high-protein food choices for this client. The dietitian can also help find ways to incorporate other nutrients essential for wound healing, such as vitamin A, vitamin C, and zinc.

A nurse is reinforcing teaching with a client about self-administration of ophthalmic drops. Which of the following instructions should the nurse include?
a. "You will need to look to the side when you put the drops in your eye."

b. "You should put the drops directly in the center of your eyeball."
c. "You should cleanse your eye from the inner to the outer edge prior to putting in the drops."
d. "You should avoid pressing on your tear duct after putting the drops in your eye." - ANSWER- c. "You should cleanse your eye from the inner to the outer edge prior to putting in the drops."
RATIONALE:--The nurse should instruct the client to cleanse the eye from the inner to the outer canthus to prevent contamination of the lacrimal duct.

A nurse is collecting data from a client who is 2 days postoperative following a colostomy. Which of the following findings should the nurse report to the provider?
a. a purple-colored stoma
b. protrusion of the stoma
c. a small amount of bleeding from the stoma
d. intestinal gas in the pouch - ANSWER- a. a purple-colored stoma
RATIONALE:--The stoma should be reddish-pink and moist. A purple colored stoma is an indication of poor circulation, and the nurse should report this finding to the provider immediately.

A nurse is reinforcing teaching about carbohydrate counting with a client who has a new diagnosis of diabetes mellitus. Which of the following actions should the nurse take first?
a. use pictures of different food groups to help the client plan a daily menu
b. ask the client what he already knows about meal planning
c. give the client a brochure with sample menus for all meals
d. involve the family in the discussion of the client's meal plan - ANSWER- b. ask the client what he already knows about meal planning
RATIONALE:--The first action the nurse should take using the nursing process is to collect data to determine the client's current level of knowledge. Then, the nurse can plan education to meet the client's needs.

A nurse is assisting with the admission of an adult client to a medical-surgical unit. Which of the following findings should the nurse identify as an indication that the client is malnourished?
a. heart rate 89/min
b. pink mucous membranes
c. pale, scaly skin
d. body mass index 23 - ANSWER- c. pale, scaly skin

RATIONALE:--The nurse should identify that pale, scaly skin can indicate malnutrition. The skin should be smooth and pink in light-skinned individuals who are well-nourished.

A nurse is reinforcing teaching about advance directives with a client who has end-stage renal disease. Which of the following client statements indicates an understanding of the teaching?
a. "I know that i can change my advance directives if I need to in the future."
b. "My health care proxy will make my health care decisions as soon as I have signed the power of attorney."
c. "My family can overrule the decisions made by my health care proxy."
d. "Advance directives from one state are valid in any other state." - ANSWER- a. "I know that i can change my advance directives if I need to in the future."
RATIONALE:--The client can change her advance directives at her discretion.

A nurse is preparing a client for a Romberg test. Which of the following statements should the nurse make?
a. "Stand with your feet together and your arms at your sides."
b. "After I place the tuning fork, tell me when you no longer hear the sound"
c. "I'm going to stroke the lateral side of the bottom of your foot."
d. "Touch each fingertip as quickly as possible with your thumb." - ANSWER- a. "Stand with your feet together and your arms at your sides."
RATIONALE:--The Romberg test measures stability with and without the eyes closed. The nurse should instruct the client to stand with his feet together and his arms at his sides.

A nurse is preparing to administer a medication to a preschooler and must convert the child's weight from pounds to kilograms. The child weighs 30 lb. How many kilograms does the child weigh?
(Round the answer to the nearest tenth. Use a leading zero if it applies. Do not use a trailing zero.) - ANSWER- 13.6 Kg
30/2.2

A nurse is contributing to the plan of care for a client who is dying. Which of the following interventions should the nurse recommend to include the client's family in the plan of care? (Select all that apply.)
a. keep the family updated about the client's status
b. Suggest the family members return home at night to allow the client to rest
c. encourage the family to comb the clients hair
d. tell the client's family what to expect as the client's death nears

e. ask the family to encourage the client to eat - ANSWER- a. keep the family updated about the client's status

RATIONALE:--the nurse should keep the family updated about the client's status to assist the family in planning for the near future

b. Suggest the family members return home at night to allow the client to rest

the nurse should encourage a family member to stay throughout the night to lessen the client's feelings of isolation

c. encourage the family to comb the clients hair

-the nurse should find simple care activities for the family to perform, such as combing the client's hair

d. tell the client's family what to expect as the client's death nears

-Many family members do not know what to expect. The nurse should explain the manifestations of impending death to reduce the family members' anxiety and stress.

e. ask the family to encourage the client to eat

-The nurse should inform the family that forcing the client to eat can increase discomfort.

A nurse is checking a client for a pulse deficit after detecting an irregular heart rate. Which of the following actions should the nurse take?

a. count the client's radial and apical pulses simultaneously with another nurse.

b. calculate the client's pulse for 30 seconds and multiply by 2

c. assist the client to a side-lying position

d. auscultate the area of the client's chest over the Erb's point - ANSWER- a. count the client's radial and apical pulses simultaneously with another nurse.

RATIONALE:--The nurse should have another nurse count the radial pulse as he counts the apical pulse. A pulse deficit occurs when there are differences between the radial and apical pulse rates.

A nurse is reinforcing teaching with a client who is scheduled for a bladder scan. Which of the following instructions should the nurse include in the teaching?

a. "You will need to sign a consent form before we begin the procedure."

b. "I will place a gel pad directly above your pubic area before I place the probe."

c. "You will need to hold your urine for 1 hour prior to the procedure."

d. "You will receive a contrast dye through an IV catheter prior to the scan." - ANSWER- b. "I will place a gel pad directly above your pubic area before I place the probe."

RATIONALE:--The nurse should use a gel pad, which promotes ultrasound transmission and accurate measurement. The correct placement of the ultrasound device is just above the symphysis pubis.