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- 1. A nurse is collecting data from a client following a lumbar puncture. The nurse should identify which of the following findings as a potential adverse effect of this procedure?
  - A. Fluid Overload
  - B. Diarrhea

#### C. Headache

### D. Difficulty voiding THEXAMS

Rationale: The nurse should identify that a headache can be an adverse effect following a lumbar puncture. To minimize the client's discomfort, the nurse should administer analgesics, other fluids, and maintain the client in a dorsal recumbent position for the length of time prescribed by the provider).

- 2. A nurse is evaluating the crutch-walking technique of a client who is required to keep weight off their right leg. Which of the following is the proper crutch gait for this client?
  - A. Four-point
  - **B.** Three-point

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#### D. Swing-through

Rationale: The nurse should identify that the client needs to be able to bear weight on the unaffected leg; therefore, a three-point gait provides at least two points of support at all times.

- 3. A nurse assisting with the admission of a 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.



Rationale: The nurse should identify that pallor along with scaly skin can indicate malnutrition. The skin should be smooth and have the same hue as other areas of sun-exposed skin in clients who are well-nourished).

- 4. A nurse is assisting with the care of a client who has a prescription for IV therapy. The client tells the nurse that they have 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.

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- C. Seafood.
- D. Bee stings.

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).

5. A nurse is caring for a client who has an indwelling urinary catheter. Which of the following actions should the nurse take?

A. Clean the perineal area at least once a day.

- B. Empty the drainage bag when it is three-fourths full.
- C. Flush the catheter with sterile water daily.
- D. Disconnect the drainage bag when emptying and measuring urine.

Rationale: The nurse should clean the perineal area at least once a day to reduce the risk for infection).

- 6. A nurse is contributing to the plan of care for four clients. For which of the following clients should the nurse initiate airborne precautions?
  - A. A client who has pneumonia.

**B. A client who has measles.** 

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- C. A client who has pertussis.
- D. A client who has methicillin-resistant Staphylococcus aureus (MRSA).

Rationale: The nurse should initiate airborne precautions for a client who has measles).

- 7. A nurse is reinforcing teaching with a client who speaks a different language than the nurse. Which of the following actions should the nurse take?
  - A. Avoid using gestures when communicating with the client.
  - B. Communicate with the client using a translation dictionary.
  - C. Speak loudly when communicating with the client.

#### D. Use printed materials written in the client's language. Campatible Campati

Rationale: The nurse should use printed materials written in the client's language to reinforce teaching for the client and promote understanding).

- 8. A nurse is assisting with the admission of older adult client to an acute care facility. The client states that they are afraid to go to sleep, fearing they will not wake up. Which of the following is a therapeutic response the nurse should make?
  - A. "I will have the nursing staff check on you frequently during the night."
  - B. "You are right to be afraid. This is a new place for you?"
  - C. "I will give you your prescribed sleeping medication to help you fall asleep."