ATI MED-SURG

Version-1

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 infection, 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.)

3) "You will remain NPO for 8 hours before the procedure."

4) "You will be awake while the procedure is performed."

A nurse is caring for a client who is difficult to arouse and very sleepy for several hours following a generalized tonic-clonic seizure. Which of the following descriptions should the nurse use when documenting this finding in the medical record?**1) Aura phase**

2) Presence of automatisms

3) Postictal phase

4) Presence of absence seizures

A nurse is reinforcing teaching with a client who reports right shoulder pain following a laparoscopic cholecystectomy. Which of the following statements should the nurse make?

1) "The pain results from lying in one position too long during surgery."

2) "The pain occurs as a residual pain from cholecystitis."

3) "The pain will dissipate if you ambulate frequently."

4) "The pain is caused from the nitrous dioxide injected into the abdomen."

A nurse is checking the suction control chamber of a client's chest tube and notes that there is no bubbling in the suction control chamber. Which of the following actions should the nurse take?

1) Notify the provider.

Answer Rationale:

The nurse should check for kinks and take other measures before notifying the provider.

2) Verify that the suction regulator is on.

3) Continue to monitor the client because this is an expected finding.

4) Milk the chest tube to dislodge any clots in the tubing that may be occluding it.

29. A nurse is reinforcing teaching with the parent of a school-age client who has asthma about the use of a peak flow meter. Which of the following statements about the yellow zone should the nurse include in the teaching? (Select all that apply.)

1) The child should increase his routine medications.

2) The child is having an exacerbation of the asthma.

INCORRECT

3) The child is blowing too hard into the meter.

INCORRECT

4) The child needs to go to the hospital.

INCORRECT

5) The child can participate in strenuous physical activity.

Answer Rationale:

The child should increase his routine medications is correct. A peak flow reading in the yellow zone indicates a decrease in airflow. The child should increase the prescribed routine medications and recheck the peak flow rate several minutes after using a relief medication.**The child is having an exacerbation of the asthma is correct.** A peak flow reading in the yellow zone signals that usual airflow has decreased, indicating an exacerbation of the asthma.**The child is blowing too hard into the meter is incorrect.** A reading in the yellow zone is an indication that the child's breathing is less than baseline measures. In order to use a peak flow meter, the child should blow into the device as hard and quickly as possible.**The child needs to go to the hospital is incorrect.** A child whose peak flow is in the yellow zone should increase his prescribed medication and recheck the peak flow rate. A child with a red zone reading needs to go to the hospital if he is still in the red zone after taking his medications.**The child can participate in strenuous physical activity.** A child whose peak flow rate is in the green zone can perform his usual activities. A child whose rate is in the yellow zone can perform some activities. However, he will be limited in the amount of physical exertion he can expend because this may aggravate his shortness of breath and further exacerbate the asthma symptoms.

30. A nurse is giving a presentation to a community group about preventing atherosclerosis. Which of the following should the nurse include as a modifiable risk factor for this disorder? (Select all that apply.)

INCORRECT

1) Genetic predisposition

INCORRECT

3) Blood in the stool

Answer Rationale:

Blood in the stool can be a sign of gastrointestinal disease.

4) Abnormal vaginal bleeding

Answer Rationale:

The nurse should expect the client to experience abnormal vaginal bleeding, including postmenopausal bleeding and bleeding between normal periods. Abnormal vaginal bleeding is the most common finding in endometrial cancer in premenopausal women.

A nurse is caring for a client following an open reduction and internal fixation of a fractured femur. Which of the following findings is the nurse's priority?

1) Altered level of consciousness

Answer Rationale:

When using the airway, breathing, circulation approach to client care, the nurse determines that the priority finding is for the nurse to monitor the client's altered level of consciousness. A fracture of one of the long bones of the body places the client is at risk for fat embolism, which causes a decrease in oxygenation and alters the client's level of consciousness.

INCORRECT

2) Oral temperature of 37.7° C (100° C)

Answer Rationale:

The nurse should monitor the client's temperature, as this can be a risk for infection or a fat embolism; however, another action is the priority.

INCORRECT

3) Muscle spasms

Answer Rationale:

1) "If you just sit quietly with your mother, I'm sure she will calm down."

Answer Rationale:

This response is non-therapeutic because it ignores the feelings of the son and provides false reassurance.

INCORRECT

2) "I'll talk with your mother and see if I can comfort her."

Answer Rationale:

This response is nontherapeutic because it is closed-ended and ignores the son's feelings of distress.

3) "It must be hard to see your mother so ill and upset."

Answer Rationale:

This response is therapeutic because it demonstrates empathy and acknowledges the son's feelings of helplessness and powerlessness.

INCORRECT

4) "Your mother's crying seems to bother you more than it does her."

Answer Rationale:

This response is nontherapeutic because it belittles or rejects the son's feelings.

A nurse is reinforcing teaching with the family of a client who has primary dementia. Which of the following manifestations of dementia should the nurse include in the teaching?

INCORRECT

1) Temporary, reversible loss of brain function

Answer Rationale:

Dementia is a progressive, irreversible, decline that affects thinking and motor skills.

2) Forgetfulness gradually progressing to disorientation

Answer Rationale:

4) Align the joints of the CPM machine with the knee gatch in the client's bed.

A nurse is collecting data from a client who has emphysema. Which of the following findings should the nurse expect? (Select all that apply.)

1) Dyspnea

2) Barrel chest

3) Clubbing of the fingers

4) Shallow respirations

5) Bradycardia

A nurse is caring for a client who sustained a basal skull fracture. When performing morning hygiene care, the nurse notices a thin stream of clear drainage coming from out of the client's right nostril. Which of the following actions should the nurse take first?

1) Take the client's temperature.

2) Place a dressing under the client's nose.

3) Notify the charge nurse.

4) Test the drainage for glucose.

A nurse is caring for a client who has a spinal cord injury at T-4. The nurse should recognize that the client is at risk for autonomic dysreflexia. Which of the following interventions should the nurse take to prevent autonomic dysreflexia?

1) Monitor for elevated blood pressure.

2) Provide analgesia for headaches.

3) Prevent bladder distention.

4) Elevate the client's head.

A nurse is caring for a client who is being evaluated for endometrial cancer. Which of the following findings should the nurse expect the client to report?

1) Hot flashes

a) Adventitious lung sounds

b) Decrease in exertional dyspnea (A decrease in exertional dyspnea indicates the antibiotics are resolving the infection and the albuterol treatments are facilitating effective ventilation. Therefore, the nurse should evaluate the therapeutic regimen as effective for the client.)

c) Respiratory rate of 26/min while sitting in a chair

d) Elevation of the head of the bed is required to sleep

101. A nurse is monitoring a client who has a wrist cast and reports intense itching underneath the cast. Which of the following actions should the nurse take?

a) Blow cool air into the cast using a blow dryer on a cool setting. (Using a blow dryer on a cool setting to blow cold air into the cast is an effective way to relieve the client's itching without damaging the skin.)

b) Obtain a prescription for pregabalin.

c) Ask the provider to bivalve the cast.

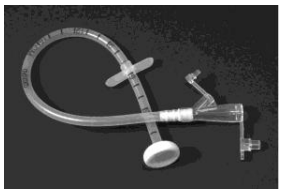
d) Provide the client with a tongue blade to rub the skin under the cast.

102. A nurse is preparing to insert a double-lumen gastric (Salem) sump tube for a client who has peptic disease and has developed gastrointestinal bleeding. Which of the following images indicates the tube that the nurse should select?

a.

In a double-lumen gastric (Salem) sump tube, the clear portion of the tube allows for aspiration of stomach contents. The blue portion of the tube, or the "pig tail", vents the tube to the atmosphere, which prevents the tube from becoming lodged against the wall of the stomach and protects the stomach from damage.

b.



Rationale: During a major burn, the initial phase will activate the Sympathetic nervous system. MS ATI PDF 10.0-page 481 Hypovolemia and shock can result from fluid shifts from the intercellular and intravascular space to the interstitial space. Additional findings include hypotension, tachycardia, and decreased cardiac output.

60. A nurse in an emergency department is assessing a client who has cirrhosis of the liver. Which of the following is a priority finding?

a. Spider angiomas (Normal findings for patient have cirrhosis)

b. Palmar erythema (Normal findings for patient have cirrhosis)

c. Mental confusion- may lead to portal systemic encephalopathy; neuro is deteriorating.

d. Yellow Sclera (Normal findings for patient have cirrhosis)

Rationale: ATI MS pg. 356; ATI PG 358 MS

61. A nurse is providing instructions about foot care for a client who has a peripheral arterial disease. The nurse should identify which of the following statements by the client indicates an understanding of the teaching?

a. "I apply a lubricating lotion to the cracked areas on the soles of my feet every morning"

b. "I use my heating pad on a low setting to keep my feet warm." (Minimal sensation)

c. "I soak my feet in hot water before trimming my toenails" (Minimal sensation for PAD)

d. I rest in my recliner with my feet elevated for about an hour every afternoon"

Rationale: ATI MS pg. 215 Tell the client to never apply direct heat, such as a heating pad, to the affected extremity because sensitivity is decreased, and this can cause a burn. Tell the client to elevate the legs to reduce swelling, but not to elevate them above the level of the heart because extreme elevation slows arterial blood flow to the feet.

19. Which finding is **most** important for the nurse to communicate to the health care provider when caring for a patient who is receiving negative pressure wound therapy?

a.	Low serum albumin level
b.	Serosanguineous drainage
c.	Deep red and moist wound bed
d.	Cobblestone appearance of wound

ANS: A

20. After the home health nurse teaches a patient's family member about how to care for a sacral pressure ulcer, which finding indicates that additional teaching is needed?

a.	The family member uses a lift sheet to reposition the patient.
b.	The family member uses clean tap water to clean the wound.
c.	The family member places contaminated dressings in a plastic grocery bag.
d.	The family member dries the wound using a hair dryer set on a low setting.

ANS: D

SHORT ANSWER

1. A patient's temperature has been 101° F (38.3° C) for several days. The patient's normal caloric intake to meet nutritional needs is 2000 calories per day. Knowing that the metabolic rate increases 7% for each Fahrenheit degree above 100° in body temperature, how many total calories should the patient receive each day?

ANS:

2140 calories

6. A patient undergoing an emergency appendectomy has been using St. John's wort to prevent depression. Which complication would the nurse expect in the postanesthesia care unit?

a.	Increased pain
b.	Hypertensive episodes
c.	Longer time to recover from anesthesia
d.	Increased risk for postoperative bleeding

ANS: C

St. John's wort may prolong the effects of anesthetic agents and increase the time to waken completely after surgery. It is not associated with increased bleeding risk, hypertension, or increased pain.

DIF: Cognitive Level: Apply (application) REF: 320

TOP: Nursing Process: Assessment MSC: NCLEX: Physiological Integrity

7. The surgical unit nurse has just received a patient with a history of smoking from the postanesthesia care unit. Which action is **most** important at this time?

a.	Auscultate for adventitious breath sounds.
b.	Obtain the patient's blood pressure and temperature.
c.	Remind the patient about harmful effects of smoking.
d.	Ask the health care provider about prescribing a nicotine patch.

ANS: A

The nurse should first ensure a patent airway and check for breathing and circulation (airway, breathing, and circulation [ABCs]). Circulation and temperature can be assessed after a patent airway and breathing have been established. The immediate postoperative period is not the optimal time for patient teaching about the harmful effects of surgery. Requesting a nicotine patch may be appropriate, but is not a priority at this time.

c.	"My nose will look normal after 24 hours when the swelling goes away."
d.	"I will keep my head elevated for 48 hours to minimize swelling and pain."

ANS: D

2. The nurse plans to teach a patient how to manage allergic rhinitis. Which information should the nurse include in the teaching plan?

a.	Hand washing is the primary way to prevent spreading the condition to others.
b.	Use of oral antihistamines for 2 weeks before the allergy season may prevent reactions.
c.	Corticosteroid nasal sprays will reduce inflammation, but systemic effects limit their use.
d.	Identification and avoidance of environmental triggers are the best way to avoid symptoms.

ANS: D

3. The nurse discusses management of upper respiratory infections (URI) with a patient who has acute sinusitis. Which statement by the patient indicates that additional teaching is needed?

a.	"I can take acetaminophen (Tylenol) to treat my discomfort."
b.	"I will drink lots of juices and other fluids to stay well hydrated."
c.	"I can use my nasal decongestant spray until the congestion is all gone."
d.	"I will watch for changes in nasal secretions or the sputum that I cough up."

320

30: Nursing Assessment: Hematologic System

Test Bank

MULTIPLE CHOICE

1. The nurse is caring for a patient who is being discharged after an emergency splenectomy following an automobile accident. Which instructions should the nurse include in the discharge teaching?

a.	Watch for excess bruising.
b.	Check for swollen lymph nodes.
c.	Take iron supplements to prevent anemia.
d.	Wash hands and avoid persons who are ill.

ANS: D

Splenectomy increases the risk for infection, especially with gram-positive bacteria. The risks for lymphedema, bleeding, and anemia are not increased after a person has a splenectomy.

DIF: Cognitive Level: Apply (application) REF: 618

TOP: Nursing Process: Implementation MSC: NCLEX: Physiological Integrity

2. The nurse assesses a patient who has numerous petechiae on both arms. Which question should the nurse ask the patient?

a.	"Do you take salicylates?"
b.	"Are you taking any oral contraceptives?"
c.	"Have you been prescribed antiseizure drugs?"

a.	Schedule the patient for regular blood pressure (BP) checks in the clinic.
b.	Instruct the patient about the need to decrease stress levels.
c.	Tell the patient how to self-monitor and record BPs at home.
d.	Inform the patient that ambulatory blood pressure monitoring will be needed.

ANS: C

12. Which blood pressure (BP) finding by the nurse indicates that no changes in therapy are needed for a patient with stage 1 hypertension who has a history of diabetes mellitus?

a.	102/60 mm Hg
b.	128/76 mm Hg
c.	139/90 mm Hg
d.	136/82 mm Hg

ANS: B

13. Which information should the nurse include when teaching a patient with newly diagnosed hypertension?**

a.	Increasing physical activity will control blood pressure (BP) for most patients.
b.	Most patients are able to control BP through dietary changes.
c.	Annual BP checks are needed to monitor treatment effectiveness.
d.	Hypertension is usually asymptomatic until target organ damage occurs.

11. The nurse establishes the nursing diagnosis of ineffective health maintenance related to lack of knowledge regarding long-term management of rheumatic fever when a 30-year-old recovering from rheumatic fever without carditis says which of the following?

a.	"I will need prophylactic antibiotic therapy for 5 years."
b.	"I will need to take aspirin or ibuprofen (Motrin) to relieve my joint pain."
c.	"I will call the doctor if I develop excessive fatigue or difficulty breathing."
d.	"I will be immune to further episodes of rheumatic fever after this infection."

ANS: D

12. When developing a community health program to decrease the incidence of rheumatic fever, which action would be most important for the community health nurse to include?

a.	Vaccinate high-risk groups in the community with streptococcal vaccine.
b.	Teach community members to seek treatment for streptococcal pharyngitis.
c.	Teach about the importance of monitoring temperature when sore throats occur.
d.	Teach about prophylactic antibiotics to those with a family history of rheumatic fever.

ANS: B

13. When caring for a patient with mitral valve stenosis, it is most important that the nurse assess for*

a.	diastolic murmur.
b.	peripheral edema.

A:Metabolic alkalosis

R:An elevated pH and HCO3 with a PaCO2 within the expected reference rangeindicates me

22

Evaluate presence and degree of coronary artery blockage. Unstable angina and ECG chang keep affected leg straight, to prevent clots admin, heparin, clopidegrel, aspirin.

136

Cardiac tamponade- signs and symptoms/ definition

Result from fluid accumulation in the pericardial sac. Hypotension, Jvd, muffled heart sound

137

Cardio version

Delivery or synchronized and direct counter shock to the heart.

138

Defibrillation

Asynchronous counter shock to the heart.

139

Top 3 organic composition

Urea

Creatinine

Uric acid

140

Top 3 Inorganic Composition

Chloride

258

Squamous epi cells in urine

normal semen motility (4)

•based on % of movement

•50-60% or greater with grade 2 is normal

• grade 0 = immobile

•grade 4 = mobile with strong progressive movemnt

351

---

normal semen morphology

(2)

•oval-shaped head

•long flagellar tail

352

synovial fluid

---

def? aka? color

•plasma ultrafiltrate

•"joint fluid"

•clear to straw color

353

synovial fluid function

20

What are risks following a cerebrovascular accident? Which is the highest priority?

Dysphagia (diff swallowing), aphasia (diff using or comprehending language), ataxia (impaire (impaired vision in half of the visual field of one or both eyes). Dysphagia is the highest risk

21

Is meperidine (Demerol) a good choice for older adults?

No because of the potential accumulation of the toxic metabolite normeperidine, which can r toxicities.

22

What is paradoxic chest movement a sign of?

Flail chest.

23

What is a sign of a tension pneumothorax?

Chest asymmetry

24

What position should a patient be placed in with low blood pressure and nausea?

Side lying: head flat to prevent a further drop in blood pressure and side-lying to prevent asp

25

When should colostomy pouches be emptied?

When they are 1/4 to 1/2 full - to avoid leakage of feces and detachment of the pouch.

63

What is a lymphoma?

A neoplasm of lymph origin:

Hodgkin's Lymphoma

Non-Hodgkin's Lymphoma

64

What is Hodgkin's Disease?

The presence of Reed-Sternberg tissue in lymph nodes. Familial pattern, suspected viral eti again after 50.

S/Sx: swollen, painless lymph nodes; fever, sweats, fatigue, unexplained weight loss.

Tx: chemotherapy, radiation -- determined by stage.

Prognosis: Excellent, with 70% cure rate.

65

What is Non-Hodgkin's Lymphoma (NHL)?

Lymphoid cells become infiltrated with malignant cells. Spread is unpredictable, but localize 60, increasing with age. More common in men.

Cause: unkown, but increased risk with autoimmune disorders and immunosuppressive diso

Tx: interferon, chemo, and/or radiation.

Prognosis: varies, depending on stage and type.

66

What is Multiple Myeloma?

4.5 - 8.0

188

---

pH reagent strip

cystine crystal

shape, color, disease (2)

A client who has PSE is admitted with an elevated ammonia level. The client asks the nurse for dinner. Which of the following is an appropriate response by the nurse?

You need to limit your protein intake, but you can have more fruits or vegetables

---

400

A client with peptic ulcer disease is prescribed a medication to decrease the production of h anticipate administering which of the following medications

---

Zantac

401

A nurse is teaching a client with cholecystitis is about her diet after discharge from the hosp teaching was effective when the client selects which of the following foods?

Bananas

402

A nurse is teaching a client how to prepare for a colonoscopy scheduled for the following aft the nurse include in the teaching?

Drink clear liquids for 24 hr prior to the procedure

403

A nurse should plan to take which of the following actions when caring for a client following s shunt for treatment of cirrhosis?

Measure abdominal girth daily

404

When assessing a client with colorectal cancer, the nurse should expect which of the followi

ATI Med-Surg

FLAG

A nurse is reinforcing teaching with the family of a client who has a cervical injury and has a halo vest in place. Which of the following safety precautions should the nurse include in the teaching?

Clean the pin sites every 72 hr.

INCORRECT

The nurse should instruct the family to clean the pin sites every day to decrease the risk for infection.

Use the halo ring to reposition the client when in bed.

INCORRECT

The nurse should instruct the family to never lift or reposition the client by pulling on the halo ring, which can cause further cervical injury.

Change the sheepskin liner weekly.

CORRECT! My Answer

The nurse should provide instruction regarding the care and maintenance of the vest. The instruction should include changing the sheepskin liner when soiled, or at least once per week, to prevent skin irritation.

Tighten the traction bar as needed.

INCORRECT

The nurse should instruct the family to call a provider if the pins or traction bar is loose. The pin sites or traction bar supports should not be manipulated in any way because it could cause injury to the client.

46. A nurse is reinforcing discharge teaching with a client who has AIDS. which of the following statements should the nurse include?
    a. “You should clean bathroom surfaces with a bleach and water solution.”
47. A nurse is contributing to the plan of care for a client who is thrombophlebitis. Which of the following action should the nurse recommend for the plan of care?
    a. Place compression stockings on the lower extremities.
48. A nurse is caring for a client filling a hip arthroplasty. The nurse should place an abduction pillow on the client for which of the following purposes?
    a. Preventing dislocation of the hip during position changes or movement
49. a nurse is reinforcing teaching with a client who has a history of tonic clonic seizures and is scheduled for a standard electroencephalogram (EEG). which of the following instruction should the nurse include in the team?
    a. thoroughly shampoo hair prior to the EEG
50. in verses reinforcing discharge teaching with a client who has infective endocarditis about how to prevent recurrence. Which of the following statements by the client indicates an understanding of the teaching?
    a. “I will notify my doctor before I have dental procedures.”

119. A nurse is caring for an adult client with sickle cell disease who has a history of having received many transfusions. The nurse realizes that because of this history, the client is at risk for which of the following?

Iron toxicity
Excessive iron may come from overuse of supplements or from receiving frequent blood transfusions, as in sickle cell anemia. Clients who have a history of repeated, frequent transfusions are at risk for development of hemosiderosis

120. A nurse is caring for a client with right sided congestive heart failure (CHF). The nurse knows that a manifestation of right sided CHF is which of the following?

Peripheral edema
Peripheral edema is caused by weakness in the right side of the heart caused by a blood backup into the venous system. Blood return from the venous system to the right atrium is impaired by a weakened right heart. The subsequent systemic venous backup leads to development of edema.

121. A nurse assesses a client who has fluid volume excess. Which of the following manifestations indicates fluid volume excess? (Select all that apply.)

Jugular vein distension- The increase in venous pressure due to excessive circulating blood volume results in neck vein distension.

Decreased hematocrit- The hematocrit measures packed cell volume of red blood cells expressed as a percentage of total blood volume. With fluid volume excess, the hematocrit can decrease because of excessive hemodilution.

Fever- Fluid volume excess or hypervolemia is an expansion of fluid volume in the extracellular fluid compartment. This results in increased heart rate and bounding pulses.

122. A nurse is preparing to transfuse a unit of blood to a client. The nurse must verify which factor?

Expiration date and time
Checking the expiration date on all medications and intravenous products is a standard of nursing practice. In addition, the nurse is responsible for ensuring the client receives the correct unit of blood by checking the identity of the blood product, the client, and the compatibility (blood type and Rh factor) of the blood and the client.

123. A nurse is caring for a client diagnosed with angina pectoris and is scheduled to undergo a percutaneous transluminal coronary angioplasty (PTCA). The nurse explains to the client that PTCA is used to do which of the following?

Dilate an obstructed coronary artery

C) Apply oxygen via nasal cannula.

D) Check oxygen saturation level.

E) Begin cardiopulmonary resuscitation.

79. Medical Surgical-Immune/Hematology-Blood transfuse reaction

A client receiving a blood transfusion complains of itchy skin and appears flushed. What action should the nurse take first?

A- Check the blood type on the bag

B- Notify the healthcare provider

C- Assess the client's temperature

D- Stop the blood transfusion.

80. Medical Surgical-Immune/Hematology/Integumentary-Sunburn-severe reaction

Pt expuesto al sol y no se puso sunblock and blisters. Que s/s vas a ver.

Posible asw: headache
No es chills and fever

Signs of **Sunburn**. When you get a **sunburn**, your skin turns red and hurts. If the burn is severe, you can develop swelling and **sunburn** blisters. You may even feel like you have the flu -- feverish, with chills, nausea, headache, and weakness.

81. Medical Surgical-Immune/Hematology/Integumentary/Trauma/Emergency-Dogbite-adult

ANS: A ; B ; D ; E .

19- Which laboratory test result is most important for the nurse to report to the surgeon prior to a client's scheduled abdominal surgery?

- Potassium level of 4 mEq/liter
- Blood glucose of 90 mg/dl
- Serum creatinine of 5 mg/dl (POSSIBLE ANSWER)
- Hemoglobin level of 13 grams

ANS: D

20- A client who has a history of long-standing back pain treated with methadone (Dolophine), is admitted to the surgical unit following urological surgery. What modifications in the plan of care should the nurse make for this client's pain management during the postoperative period?

- Use minimal parenteral opioids for surgical pain, in addition to oral methadone
- Maintain client's methadone, and medicate surgical pain based on pain rating
- Consult with surgeon about increasing methadone in lieu of parenteral opioids
- Make no changes in standard pain management for this surgery and hold methadone.

ANS: B

21- The nurse applies an automatic external defibrillator (AED) to a client who collapsed in an exam room at a community clinic. What action should the nurse take next?

A nurse is reinforcing teaching with a client who has asthma. Which of the following client statements indicates an understanding of the use of budesonide and albuterol inhalers? (Select all that apply.)

FLAG

- [ ] "I should expect to feel sleepy after using my albuterol inhaler."
- [x] "I never forget to rinse my mouth after using my budesonide inhaler."
- [x] "Between office visits, I keep a record of how many times I use my albuterol inhaler."
- [x] "I use my albuterol inhaler before I go swimming."
- [ ] "I should use my budesonide inhaler before using my albuterol inhaler."

CORRECT! My Answer

"I should expect to feel sleepy after using my albuterol inhaler" is incorrect. The client should recognize that albuterol stimulates the sympathetic nervous system, which can cause nervousness and insomnia, along with increased heart rate and blood pressure.

"I never forget to rinse my mouth after using my budesonide inhaler" is correct. The client should rinse his mouth after using a budesonide inhaler t reduce the risk for oral fungal infection.

"Between office visits, I keep a record of how many times I use my albuterol inhaler" is correct. The client should record the number of times that he uses his albuterol inhaler. This information can assist the provider to determine the effectiveness of the medication.

"I use my albuterol inhaler before I go swimming" is correct. The client should use the albuterol inhaler before exercise to prevent exercise-induced bronchospasms.

"I should use my budesonide inhaler before using my albuterol inhaler" is incorrect. The client should first use the albuterol inhaler, a bronchodilator, to open the airway and enhance the absorption of the budesonide, which is an inhaled corticosteroid.

FLAG

Following a blood draw procedure for a fasting blood sugar (FBS) test, a client tells the nurse, "I'm glad they took my blood because I'm really hungry. All I've had since midnight is water and some juice." Which of the following actions should the nurse take?

Offer the client breakfast then repeat the FBS request.

INCORRECT

An FBS test requires the client to have no food or juice for at least 8 hr. The result of the FBS test would be invalid after the client had breakfast.

Reschedule the FBS test for early the next morning.

CORRECT! My Answer

An FBS test requires the client to have no food or juice for at least 8 hr. The result of the FBS test would be invalid because the client drank juice during the fasting time period. The nurse should reinforce with the client to only drink water and have no food or other beverages for 8 hr before the phlebotomist obtains the blood specimen.

Request that the phlebotomist obtain another specimen.

INCORRECT

The client had juice within the past 8 hr. The nurse should request that the phlebotomist obtain another specimen when the client has ingested no food or other beverages for 8 hr.

Ask the laboratory technician to repeat the test on the same specimen.

INCORRECT

Repeating the test on the same specimen will yield the same result, which will also be invalid.

Elevated bilirubin level

A nurse is teaching a client who has venous insufficiency about self-care. Which of the following statements should the nurse identify as an indication that the client understands the teaching?

"I will wear clean graduated compression stockings every day"

A nurse is caring ofr a client who is postoperative following a total hip arthroplasty. Which of the following laboratory values should the nurse report to the provider?

Hgb 8 g/dL

A nurse is caring ofr a client who has a stage III pressure injury. Which of the following findings contributes to delayed wound healing?

Urine output 25 mL/hr

A nurse is caring for a client who is undergoing hemodialysis to treat ESKD. The client reports muscle cramps and tingling sensation in their hands. Which of the following should the nurse plan to administer?

Calcium carbonate