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Correct Answer: A**Expert Rationale:**

The nurse should first increase the oxygen flow rate to 6 L/min via nasal cannula. This client is exhibiting signs of acute respiratory distress with hypoxemia (SpO_2 88%) despite receiving 4 L/min of supplemental oxygen. The nurse's immediate priority is to improve oxygenation. Increasing the oxygen flow rate is an independent nursing intervention that can be performed immediately without a provider's order and directly addresses the client's hypoxemia. The nurse should titrate oxygen to maintain an SpO_2 of at least 90% (or 88–92% for clients with COPD, per some guidelines, but in acute distress, higher oxygenation is generally prioritized). After increasing the oxygen, the nurse should reassess the client's respiratory status, including respiratory rate, work of breathing, and oxygen saturation.

Option B (administering the scheduled nebulizer treatment) is an important intervention for bronchospasm, but it is not the first priority when the client is acutely hypoxemic. Oxygenation takes precedence. The nurse can administer the nebulizer after initiating oxygen therapy. Option C (obtaining a stat ABG sample) is an important diagnostic step to assess oxygenation and ventilation, but it should not delay the immediate intervention of improving oxygen delivery. Option D (notifying the provider) is a critical action, but the nurse should first initiate the independent intervention of increasing oxygen and then notify the provider with a complete assessment, including the client's response to the increased oxygen. The nurse should not delay immediate life-saving intervention to make a phone call.

This question tests the nurse's ability to recognize acute respiratory distress, prioritize the ABCs (specifically oxygenation), and take immediate independent nursing actions while preparing to escalate care. The correct answer reflects the principle that in a hypoxemic client, improving oxygen delivery is the most urgent priority.

Question 3

A nurse is preparing to administer a blood transfusion to a 54-year-old client who has a hemoglobin of 7.2 g/dL secondary to gastrointestinal bleeding. The nurse has obtained the unit of packed red blood cells from the blood bank and has verified the blood product with a second nurse. The nurse has primed the IV tubing with 0.9% sodium chloride and has obtained the client's baseline vital signs: blood pressure 118/72 mm Hg, heart rate 88 beats/min, respiratory rate 18 breaths/min, and temperature 37.0°C

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The nurse should administer the digoxin as ordered. The nurse's decision to administer digoxin is based on the apical pulse rate and the digoxin level. The general guideline is to hold digoxin if the apical pulse is below 60 beats/min in adults. However, this client's apical pulse is 58 beats/min, which is slightly below 60. The nurse must use clinical judgment here. The digoxin level of 1.2 ng/mL is within the therapeutic range, indicating that the client is not toxic. The potassium level of 3.6 mEq/L is within the normal range (3.5–5.0 mEq/L). Some protocols allow administration if the pulse is 50–59 beats/min, provided the client is asymptomatic and the digoxin level is therapeutic. The nurse should assess the client for signs of decreased cardiac output (dizziness, fatigue, shortness of breath) and then administer the medication if the client is stable. If the nurse is unsure, the safest action is to hold the medication and notify the provider. However, based on the information provided (therapeutic digoxin level, normal potassium, and only slightly low pulse), administering the medication is appropriate. The nurse should continue to monitor the client's pulse and digoxin level.

Option B (holding the digoxin and notifying the provider) may be appropriate if the nurse is concerned about the pulse rate, but the therapeutic digoxin level and normal potassium suggest that administration is safe. Option C (administering digoxin and rechecking the pulse in 1 hour) is not necessary; the nurse should assess the pulse before administration, not after. Option D (holding digoxin and administering potassium) is inappropriate. The potassium level is normal, and administering potassium without an order is outside the nurse's scope of practice.

This question tests the nurse's ability to apply clinical judgment when administering digoxin, interpret laboratory values, and prioritize patient safety. The correct answer reflects the principle that medication administration decisions should be based on a comprehensive assessment, not just a single vital sign.

Question 37

A nurse is caring for a 45-year-old client who is admitted to the medical unit with a diagnosis of acute alcohol withdrawal. The provider has ordered lorazepam 2 mg IV every 4 hours as needed for agitation and vital signs every 4 hours. The client's most recent vital signs are: blood pressure 158/92 mm Hg, heart rate 118 beats/min, respiratory rate 24 breaths/min, and temperature 37.8°C (100.0°F). The client is tremulous, diaphoretic, and reports seeing "bugs on the wall."

Which of the following actions should the nurse take first?

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This question tests the nurse's ability to recognize signs of hypovolemia, prioritize assessment of orthostatic vital signs, and make appropriate clinical decisions. The correct answer reflects the principle that assessment precedes intervention.

Question 65

A nurse is caring for a 45-year-old client who is admitted to the medical unit with a diagnosis of acute pancreatitis. The client is experiencing severe abdominal pain, nausea, and vomiting. The provider has ordered the client to be NPO, IV fluids with lactated Ringer's, and pain management with hydromorphone. The nurse is preparing to administer the hydromorphone and is reviewing the client's vital signs and laboratory results. The client's vital signs are: blood pressure 108/62 mm Hg, heart rate 104 beats/min, respiratory rate 22 breaths/min, temperature 37.8°C (100.0°F), and oxygen saturation 94% on room air. The client's most recent laboratory results are: lipase 850 U/L, amylase 620 U/L, calcium 8.2 mg/dL, and blood glucose 210 mg/dL.

Which of the following findings should the nurse identify as the priority concern?

- A. Blood glucose of 210 mg/dL
- B. Calcium level of 8.2 mg/dL
- C. Respiratory rate of 22 breaths/min
- D. Lipase level of 850 U/L

Correct Answer: C

Expert Rationale:

The nurse should identify the respiratory rate of 22 breaths/min as the priority concern. This client has acute pancreatitis, and the nurse is preparing to administer hydromorphone, an opioid analgesic. The most significant adverse effect of opioids is respiratory depression. A respiratory rate of 22 breaths/min is slightly elevated (normal adult range is 12–20 breaths/min), which could indicate that the client is in pain or experiencing respiratory compromise. However, the priority concern is that opioids can cause respiratory depression, and the nurse must assess the client's respiratory status before administering the medication. If the respiratory rate were to drop below 12 breaths/min, the nurse should withhold the opioid and notify the provider. Additionally, the nurse should monitor for other signs of respiratory depression, such as decreased oxygen saturation, shallow breathing, and sedation. The elevated respiratory rate of 22

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could also be a compensatory response to pain, but the nurse must remain vigilant for the potential for respiratory depression after administering the opioid.

Option A (blood glucose of 210 mg/dL) indicates hyperglycemia, which is common in acute pancreatitis due to pancreatic endocrine dysfunction. While it requires monitoring and treatment, it is not the immediate priority. Option B (calcium level of 8.2 mg/dL) indicates mild hypocalcemia, which can occur in acute pancreatitis due to saponification of calcium in necrotic fat. Normal calcium is typically 8.5–10.5 mg/dL, so this is slightly low. It requires monitoring and possibly supplementation, but it is not the priority concern. Option D (lipase level of 850 U/L) is elevated, which is a hallmark of acute pancreatitis. An elevated lipase level confirms the diagnosis, but it is not a priority concern for the nurse in this moment. The nurse's priority is to ensure safe administration of the opioid and monitor for adverse effects.

This question tests the nurse's ability to prioritize concerns based on the medication being administered, assess for potential adverse effects, and apply the nursing process to a client with acute pancreatitis. The correct answer reflects the principle that when administering opioids, respiratory assessment is the highest priority.

Question 66

A nurse is caring for a 62-year-old client who is admitted to the surgical unit following a total knee arthroplasty. The client has a history of type 2 diabetes mellitus, hypertension, and obesity. The provider has ordered enoxaparin 40 mg subcutaneously daily for venous thromboembolism (VTE) prophylaxis, and the nurse is preparing to administer the first dose. The client's most recent laboratory results are: platelet count 145,000/mm³, hemoglobin 11.8 g/dL, hematocrit 35%, and creatinine 1.1 mg/dL.

Which of the following findings should the nurse identify as a contraindication to administering enoxaparin?

- A. Platelet count of 145,000/mm³
- B. History of type 2 diabetes mellitus
- C. History of hypertension
- D. Creatinine of 1.1 mg/dL

Correct Answer: A

Expert Rationale:

Question 92

A nurse is caring for a 28-year-old client who is at 38 weeks of gestation and has been admitted to the labor and delivery unit in active labor. The client's prenatal history is significant for gestational diabetes mellitus (GDM) controlled with diet and exercise, and a previous cesarean delivery at 39 weeks for breech presentation. The client has been in active labor for 6 hours and has received an epidural for pain management. The nurse notes the following findings: cervical dilation 6 cm, effacement 90%, station -1, and fetal heart rate (FHR) baseline 145 beats/min with moderate variability. Suddenly, the client reports a gush of fluid and a feeling of something coming through the vagina. The nurse performs a sterile vaginal examination and visualizes the umbilical cord protruding through the cervix. The FHR tracing now shows a prolonged deceleration to 90 beats/min that lasts for 2 minutes.

Which of the following actions should the nurse take first?

- A.** Administer a bolus of IV fluids.
- B.** Call for immediate assistance and prepare for an emergency cesarean delivery.
- C.** Place the client in a knee-chest or Trendelenburg position and lift the presenting part off the cord.
- D.** Increase the epidural infusion rate to manage the client's pain.

Correct Answer: C

Expert Rationale:

The nurse should first place the client in a knee-chest or Trendelenburg position and use a sterile gloved hand to lift the presenting part off the umbilical cord. This scenario describes a cord prolapse, which is an obstetric emergency that requires immediate intervention to relieve compression on the umbilical cord and restore fetal oxygenation. Cord prolapse occurs when the umbilical cord descends through the cervix ahead of the presenting part, leading to cord compression and subsequent fetal hypoxia. The prolonged fetal deceleration to 90 beats/min confirms that the fetus is in distress. The priority nursing action is to manually elevate the presenting part off the cord while simultaneously positioning the client to use gravity to shift the fetus away from the cord. The knee-chest or Trendelenburg position (head down, hips elevated) helps reduce pressure on the cord by allowing the fetus to fall back into the upper uterus. The nurse should maintain the sterile hand in place to keep the presenting part elevated until the provider arrives and a cesarean delivery can be performed.

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breaths/min, blood pressure 98/62 mm Hg, temperature 37.9°C (100.2°F), and oxygen saturation 91% on room air. The provider has ordered albuterol via nebulizer every 20 minutes for three doses, oral prednisolone, and continuous pulse oximetry. After the first albuterol treatment, the nurse reassesses the child and notes that the respiratory rate is now 42 breaths/min, the oxygen saturation is 89% on room air, and the child is becoming increasingly lethargic. Breath sounds are now diminished bilaterally with minimal wheezing.

Which of the following actions should the nurse take next?

- A.** Administer the second scheduled albuterol nebulizer treatment.
- B.** Administer the oral prednisolone as ordered.
- C.** Prepare for immediate endotracheal intubation and mechanical ventilation.
- D.** Apply supplemental oxygen via a non-rebreather mask and notify the provider immediately.

Correct Answer: D

Expert Rationale:

The nurse should apply supplemental oxygen via a non-rebreather mask and notify the provider immediately. This child is showing signs of impending respiratory failure, which is a life-threatening emergency. The progression from diffuse wheezing to diminished breath sounds bilaterally, combined with increasing lethargy, tachypnea (42 breaths/min), and worsening hypoxemia (SpO₂ 89% on room air), indicates that the child's airways are becoming so obstructed that air movement is severely limited. The absence of wheezing does not indicate improvement — in fact, it is an ominous sign that the child is no longer able to move enough air to produce wheezing. Lethargy in a child with respiratory distress is a critical warning sign of hypoxia and impending respiratory arrest. The nurse's immediate priority is to improve oxygenation and escalate care. Applying a non-rebreather mask delivers a high concentration of oxygen (up to 95–100%) and can be initiated immediately by the nurse without a provider's order. Notifying the provider is essential because the child may require advanced airway management, including intubation and mechanical ventilation, which is beyond the nurse's independent scope of practice.

Option A (administering the second albuterol treatment) is not the priority. While albuterol is the first-line treatment for bronchospasm, the child is deteriorating despite the first treatment. Continuing with the scheduled regimen without addressing the worsening hypoxemia and pending respiratory failure would delay life-saving

Expert Rationale:

The charge nurse should delegate the administration of oral metoprolol to a stable client with hypertension to the LPN. This task falls within the LPN's scope of practice, which includes administering oral and certain parenteral medications to stable clients with predictable outcomes. The client is described as "stable," and metoprolol is an oral medication with a well-established administration protocol. The LPN can safely perform this task under the supervision of an RN. Delegating this task to the LPN frees the RN to focus on the more complex patients who require ongoing assessment, IV medication titration, and critical decision-making.

Option A (administering IV push furosemide) is not appropriate for an LPN in most states. IV push administration of high-alert medications like furosemide requires an RN due to the need for rapid assessment of the client's response, potential for adverse effects (e.g., ototoxicity, electrolyte imbalances), and the complexity of IV push medication administration. Option B (performing an initial admission assessment) is an RN responsibility. The initial assessment is a comprehensive evaluation that requires the clinical judgment and critical thinking skills of an RN. The LPN may contribute to data collection, but the initial assessment and care plan development must be performed by the RN. Option D (teaching a client about warfarin) is also an RN responsibility. Client teaching, especially for high-risk medications like warfarin (which requires monitoring of INR, dietary restrictions, and bleeding precautions), requires the assessment and evaluation skills of an RN. The LPN can reinforce teaching that has already been done by the RN, but cannot perform the initial teaching.

This question tests the nurse's understanding of delegation principles, scope of practice, and the five rights of delegation (right task, right circumstance, right person, right direction/communication, right supervision/evaluation). The correct answer reflects the principle that tasks should be delegated to the least restrictive, most appropriate level of personnel based on the complexity of the task, the stability of the client, and the legal scope of practice for each role.

Question 123

A nurse is serving as the charge nurse on a busy medical-surgical unit during a 12-hour day shift. The unit has 32 beds and is currently at 28 patients. The staffing for the shift includes: the charge nurse, four registered nurses (RNs), two licensed practical nurses (LPNs), and three unlicensed assistive personnel (UAPs). One of the RNs has called in

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evaluation skills of an RN. The LPN can reinforce teaching that has already been done by the RN, but cannot perform the initial teaching.

This question tests the nurse's understanding of delegation principles, scope of practice, and the five rights of delegation (right task, right circumstance, right person, right direction/communication, right supervision/evaluation). The correct answer reflects the principle that tasks should be delegated to the least restrictive, most appropriate level of personnel based on the complexity of the task, the stability of the client, and the legal scope of practice for each role.

SECTION 8: COMMUNITY HEALTH (Questions 126–130)

Question 126

A community health nurse is investigating an outbreak of hepatitis A in a rural county. Over the past 4 weeks, 24 new cases of hepatitis A have been reported among food-service workers at three different restaurants in the same town. The nurse has been asked to identify the most significant antecedent (risk factor) and the most significant consequence (outcome) of this outbreak.

Task: Select the ONE most significant antecedent and the ONE most significant consequence from the lists below.

Antecedents (Risk Factors):

- A. Poor hand hygiene practices among food-service workers
- B. Consumption of undercooked pork at a local festival
- C. Contaminated municipal water supply
- D. Recent flooding in the county

Consequences (Outcomes):

1. Closure of the affected restaurants
2. Increased incidence of chronic liver disease in the community
3. Secondary transmission to household contacts and customers
4. Increased vaccination rates among the general population

Correct Answer: Antecedent A; Consequence 3