RN Adult Medical Surgical 2019

written by

ACEMYWORK

- **RN VATI Adult Medical Surgical 2019**
CLOSE

Question: 90 of 90

CORRECT

- **Time Remaining:** 00:38:42
- **Pause Remaining:** 00:05:00

PAUSE

FLAG

A nurse is caring for a client who has atopic dermatitis and a prescription for triamcinolone ointment. The nurse should assess the client to monitor for which of the following adverse effects?

Increased pigmentation

Topical glucocorticoid therapy can cause the adverse effect of hypopigmentation.

Localized hair loss

Long-term glucocorticoid therapy can cause hypertrichosis, or excessive hair growth, especially on the facial area.

Thinning of the skin

Thinning of the skin and delayed healing are adverse effects of topical glucocorticoid preparations. The client should only apply the ointment to dry patches of the skin because topical steroids can cause atrophy of the dermis and epidermis, which can result in thinning of the skin.

Increased sensitivity to the sun

The nurse should instruct the client to avoid excessive sun exposure when taking topical fluticasone; however, triamcinolone ointment does not cause photosensitivity.

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CORRECT

- **Time Remaining:** 00:37:45

- **Pause Remaining:** 00:05:00

PAUSE

FLAG

A nurse is assessing a client who has left-sided heart failure. Which of the following findings should the nurse identify as a manifestation of left-sided heart failure?

Dependent edema

The nurse should identify that dependent edema is a manifestation of right-sided heart failure due to right ventricular failure and fluid retention from pressure building up in the venous system.

Jugular distention

The nurse should identify that jugular vein distention is a manifestation of right-sided heart failure due to right ventricular failure and fluid retention from pressure building up in the venous system.

Weight gain

The nurse should identify that weight gain is a manifestation of right-sided heart failure due to right ventricular failure and fluid retention from pressure building up in the venous system.

Frothy sputum

The nurse should identify that frothy sputum, dyspnea, and wheezing are manifestations of left-sided heart failure. Treatment includes fluid restriction and diuretics to decrease preload and reduce pulmonary congestion. Pink-tinged frothy sputum can be an early indication of pulmonary edema and can be life-threatening. Therefore, the nurse should notify the provider immediately.

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CORRECT

- **Time Remaining:** 00:37:30
- **Pause Remaining:** 00:05:00

PAUSE

FLAG

A nurse is caring for a client who is experiencing anxiety as well as numbness and tingling of the lips and fingers. The client's ABGs are: pH 7.48, PCO_2 30 mm Hg, HCO_3^- 24 mEq/L, PaO_2 85 mm Hg. Which of the following acid-base imbalances should the nurse identify that the client is experiencing?

Respiratory alkalosis

This pH is alkaline (increased) and the PCO_2 is decreased, representing alveolar hyperventilation and resultant respiratory alkalosis.

Respiratory acidosis

This pH is alkaline (increased) and the PCO_2 is decreased. A decreased pH and an increased PCO_2 indicate respiratory acidosis.

Metabolic alkalosis

This HCO_3^- 24 mEq/L is within the expected range of 21 to 28 mEq/L and the pH is alkaline (increased). An increased pH and HCO_3^- indicate metabolic alkalosis.

Metabolic acidosis

This HCO_3^- 24 mEq/L is within the expected range of 21 to 28 mEq/L and the pH is alkaline (increased). A decreased pH and HCO_3^- indicate metabolic acidosis.

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- **Time Remaining:** 00:37:22
- **Pause Remaining:** 00:05:00

PAUSE

FLAG

A nurse is assessing a client who has Cushing's syndrome. Which of the following findings should the nurse expect?

Vitiligo

Vitiligo is the loss of pigment from areas of a client's skin, causing irregular, white patches. Vitiligo is a manifestation of adrenal-gland hypofunction.

Osteoporosis

Osteoporosis is a common finding with Cushing's syndrome. Bones become thinner as a result of mineral loss and nitrogen depletion, and the risk for fractures increases.

Myxedema

A client who has hypothyroidism can develop myxedema that causes mucinous cellular edema around the eyes, across the upper back, and in the hands and feet.

Heat intolerance

A client who has hyperthyroidism can develop heat intolerance, along with an increase in sweating.

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- **Time Remaining:** 00:37:13
- **Pause Remaining:** 00:05:00

PAUSE

FLAG

A nurse is inspecting the skin of a client who has basal cell carcinoma. The nurse should identify which of the following lesion characteristics on the client's skin?

A pearly, waxy nodule

A client who has basal cell carcinoma has a nodular lesion with well-defined borders and a pearly or waxy appearance, resulting from overexposure to the sun, especially on the face, head, and neck.

An irregular border on a variegated-colored lesion

A client who has melanoma has a lesion with irregular borders and variegated colors of red, white, and blue, most often on the upper back or lower legs.

A firm, nodular, crusty, or ulcerated lesion

A client who has squamous cell carcinoma has a firm, nodular, and crusty lesion with an ulcerated center, resulting from sun exposure, chronic irritation, burns, or irradiation to the skin.

A weeping vesicle

A client who has herpes zoster has weeping, blister-type lesions.

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CORRECT

- **Time Remaining:** 00:37:02
- **Pause Remaining:** 00:05:00

PAUSE

FLAG

A nurse is assessing a client who has hypocalcemia. In which of the following areas should the nurse tap on the client's face to detect the presence of Chvostek's sign? (You will find hot spots to select in the artwork below. Select only the hot spot that corresponds to your answer.)

A is correct. The nurse should tap the client's cheek just in front of the ear and below the zygomatic arch. The client who has hypocalcemia will display a Chvostek's sign, which is a twitching of the facial muscle.

B is incorrect. The nurse should apply upward pressure at the supraorbital ridge, below the eyebrow, to assess for tenderness and inflammation of the frontal sinuses.

C is incorrect. The nurse should palpate the jaw and mastoid muscle of a client who has temporomandibular joint dysfunction. This can be caused by misaligned teeth, arthritis, or grinding of the teeth. With palpation, the nurse might feel a click, pop, or grating sensation when the client opens or closes the jaw.

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CORRECT

- **Time Remaining:** 00:36:55
- **Pause Remaining:** 00:05:00

PAUSE

FLAG

A nurse in an emergency department is assessing a client who is overusing prescribed diuretics and has a sodium level of 127 mEq/L. Which of the following laboratory findings should the nurse expect?

High lipase

A high lipase level is associated with pancreatic dysfunction or renal failure and is not an expected finding with hyponatremia or dehydration.

Low urine specific gravity

A client who has hyponatremia as a result of diuretic overuse has a low urine specific gravity. The increased excretion of water alters the ratio of particulate matter, which affects the specific gravity.

Low hemoglobin

A client who is dehydrated as a result of diuretic overuse can have an elevated hemoglobin level because of the difference in ratio between intravascular fluid and blood cells.

High creatine kinase-MB (CK-MB)

An elevated CK-MB level indicates a myocardial infarction and is not an expected finding with hyponatremia.

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- **Time Remaining:** 00:36:47
- **Pause Remaining:** 00:05:00

PAUSE

FLAG

A home health nurse is assisting a client with planning care for a family member who has Alzheimer's disease. Which of the following instructions should the nurse include?

Remove clutter from rooms and hallways.

The nurse should instruct the family member to remove clutter from rooms and hallways so the client is able to walk without the risk of falling or tripping over objects. Later in the disease, the client can experience seizures, so cluttered areas could be a risk to the client.

Place a monthly calendar in the client's room.

The nurse should instruct the family member to place a single-date calendar in the client's room. A monthly calendar can be overwhelming and confusing to a client who has Alzheimer's disease.

Use confrontation to manage the client's behavior.

The nurse should instruct the family member to redirect the client by starting another activity when the client begins to act out or becomes overstimulated. Redirecting the client might help them gain focus.

Review the daily schedule with the client every morning.

The nurse should instruct the family member to use short, simple sentences when explaining an activity to the client. The explanation should be done immediately before the activity to aid the client's memory and ability to follow directions.

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CORRECT

- **Time Remaining:** 00:36:39

- **Pause Remaining:** 00:05:00

PAUSE

FLAG

A nurse is caring for a client who has developed acute respiratory distress syndrome (ARDS). Which of the following findings should the nurse identify as a manifestation of this syndrome?

An audible pleural friction rub

A client who has a pulmonary embolism can have a pleural friction rub along with tachypnea, tachycardia, dyspnea, and sudden, sharp chest pain. However, a pleural friction rub is not a manifestation of ARDS.

Tracheal deviation from the midline

A client who has a tension pneumothorax can have tracheal deviation with dyspnea, tachycardia, and tachypnea. On auscultation, breath sounds over the area of the pneumothorax are decreased or absent. However, tracheal deviation is not a manifestation of ARDS.

Refractory hypoxemia

ARDS is a systemic inflammatory response to trauma, sepsis, burns, pancreatitis, and blood transfusions, when excess lung fluid dilutes surfactant activity in the lungs. A client who has ARDS has refractory hypoxemia, which is hypoxemia that does not improve with oxygen therapy. Extensive pulmonary edema evident on a chest x-ray is a manifestation of ARDS.

Bloody expectorant when coughing

A client who has lung cancer or laryngeal trauma can have hemoptysis. However, bloody expectorant is not a manifestation of ARDS.

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- **Time Remaining:** 00:36:33
- **Pause Remaining:** 00:05:00

PAUSE

FLAG

An emergency room nurse is assessing a client who has asthma and difficulty breathing. Which of the following findings should indicate to the nurse that the client is experiencing status asthmaticus?

Coughing

Status asthmaticus causes labored breathing and wheezing. Coughing indicates that the client is exchanging air and is a manifestation of pneumonia, not status asthmaticus.

Flat neck veins

A client who has status asthmaticus has distended neck veins while trying to facilitate breathing due to increased pulmonary pressure.

Use of accessory muscles

A client who has status asthmaticus uses accessory muscles to help facilitate breathing, which is a manifestation of a severe airflow obstruction. The situation is life-threatening and the nurse should intervene immediately with strong systemic bronchodilators, epinephrine, corticosteroids, and oxygen.

Presence of coarse crackles

The presence of coarse crackles indicates air movement through fluid-filled airways and is a manifestation of pneumonia, not status asthmaticus.

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- **Time Remaining:** 00:36:27
- **Pause Remaining:** 00:05:00

PAUSE

FLAG

A nurse is teaching a client who has a new prescription for phenytoin to treat a seizure disorder. Which of the following adverse effects should the nurse instruct the client to report immediately to the provider?

Tender, bleeding gums

Gingival hyperplasia is an overgrowth of gum tissue that causes the gums to bleed, swell, and become tender. Gingival hyperplasia is nonurgent adverse effect when a client is taking phenytoin; therefore, there is another finding that is the priority. The nurse should advise the client to maintain good oral hygiene with a soft toothbrush and to follow up with an oral health professional.

Increased facial hair

Hirsutism, an increased growth of hair in unexpected places on the client's body, is nonurgent because it is an expected finding for a client who is taking phenytoin.

Constipation

Constipation is nonurgent because it is an expected finding for a client who is taking phenytoin.

Skin rash

When using the urgent vs. nonurgent approach to client care, the nurse should determine that the priority finding is a rash, which can have a measles-like appearance and progress to exfoliative dermatitis or Stevens-Johnson syndrome. The client should report this finding to the provider immediately.

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- **Pause Remaining:** 00:05:00

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FLAG

A nurse is monitoring a client following a lumbar laminectomy. The client has a drain and indwelling urinary catheter. The nurse should identify which of the following findings as an indication of a complication of the surgery?

Oral temperature of 37.2° C (99° F)

The nurse should expect a slight elevation of the client's temperature postoperatively. However, an increased temperature elevation or a spike can indicate an infection.

Clear drainage on the dressings

The nurse should identify clear drainage on or around the dressing as an indication of a cerebral spinal leak and should report this finding to the provider immediately.

Drain output 75 mL in 4 hr

The nurse should expect the client to have no more than 125 mL of drain output in 4 hr.

Decreased bowel sounds in all quadrants of the abdomen

The nurse should expect decreased bowel sounds when caring for a client following a laminectomy due to anesthesia and pain medication. The nurse should continue to monitor the client to assess for a paralytic ileus.

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- **Time Remaining:** 00:36:15
- **Pause Remaining:** 00:05:00

PAUSE

FLAG

A nurse is assessing a client who has right-sided heart failure. Which of the following findings should the nurse identify as a manifestation of right-sided heart failure?

S_3 gallop

An S_3/S_4 summation gallop is an expected finding with left-sided heart failure due to pulmonary congestion and increased left ventricular pressure that causes a decrease in cardiac output and poor tissue perfusion.

Weak peripheral pulses

Weak peripheral pulses are an expected finding with left-sided heart failure due to decreased cardiac output.

Increased abdominal girth

Increased abdominal girth is an expected finding with right-sided heart failure due to systemic congestion and an enlarged liver and spleen. Systemic congestion can lead to fluid retention and increased pressure in the venous system, which can manifest with edema in the lower extremities.

Wheezing

Wheezing is an expected finding with left-sided heart failure due to pulmonary congestion and systolic dysfunction.

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- **Time Remaining:** 00:36:06
- **Pause Remaining:** 00:05:00

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FLAG

A nurse is caring for a client who recently assumed the role of caregiver for their aging parents who have chronic illnesses. The nurse should identify that which of the following statements by the client indicates acceptance of the role change?

"I changed the floor plan of our home to accommodate my father's wheelchair."

The nurse should identify that the client has accepted the role change of caring for their aging parents by changing the floor plan of the home to accommodate their father's wheelchair.

"I'm so stressed out that it makes it difficult for me to manage everything."

This response indicates role overload because the client is feeling overwhelmed with having to care for their aging parents.

"At times, I get so frustrated with how to care for my parents."

This response indicates role strain, in which the client feels unsure and frustrated about caring for their aging parents. Feelings of inadequacy can also occur with role strain.

"I am learning to take care of my parents as I go."

This response indicates role ambiguity, in which the client feels unsure about how to care for their aging parents. This might create stress for the client.

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- **Time Remaining:** 00:36:00
- **Pause Remaining:** 00:05:00

PAUSE

FLAG

A nurse is caring for a client who is receiving vancomycin intermittent IV bolus therapy for methicillin-resistant *Staphylococcus aureus* (MRSA). Which of the following findings is an indication to the nurse that the client is experiencing an adverse effect of the medication?

The client's blood pressure is elevated.

The client can have an adverse effect called red man syndrome, which causes hypotension and tachycardia, due to infusing the vancomycin too rapidly. The nurse should infuse the medication over at least 60 min.

The client is becoming flushed.

Flushing is a manifestation of an infusion reaction to vancomycin that also causes a rash on the face and upper body, called red man syndrome. Red man syndrome results from

infusing vancomycin too rapidly. The nurse should infuse the medication over at least 60 min.

The client reports blurred vision.

Blurred vision is not a manifestation of an infusion reaction to vancomycin. Vancomycin can have sensory implications, however. Although rare, it can cause ototoxicity, which is generally reversible.

The client is experiencing polyuria.

Polyuria is not a manifestation of an infusion reaction to vancomycin. However, vancomycin can cause renal failure.

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CORRECT

- **Time Remaining:** 00:35:54
- **Pause Remaining:** 00:05:00

PAUSE

FLAG

A nurse is caring for a male client who has a new prescription for cyclosporine following a kidney transplant. Which of the following findings should the nurse identify as an adverse effect of this therapy?

WBC count 8,000/mm^3

A WBC count of 8,000/mm<sup3< sup=""> is within the expected reference range of 5,000 to 10,000/mm^3. If the client develops leukopenia, the nurse should notify the provider because the client is at risk for infection when taking an immunosuppressant such as cyclosporine.</sup3<>

RBC count 6 million/mm^3

An RBC count of 6 million/mm^3 is within the expected reference range of 4.7 to 6.1 million/mm^3 for men and 4.2 to 5.4 million/m^3 for women. If the client's RBC count decreases, the nurse should notify the provider because the client is at risk for bleeding following an organ transplant.

BUN 24 mg/dL

A BUN of 24 mg/dL is above the expected reference range of 10 to 20 mg/dL, indicating renal impairment. An adverse effect of cyclosporine is nephrotoxicity. The nurse should monitor the client for increases in BUN and creatinine and report any elevation to the provider. A rise in BUN could indicate transplant rejection.

Potassium 3.5 mEq/L

A potassium level of 3.5 mEq/L is within the expected reference range of 3.5 to 5 mEq/L and does not indicate nephrotoxicity. However, the nurse should report a dramatic change in potassium level to the provider.

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- **Time Remaining:** 00:35:49
- **Pause Remaining:** 00:05:00

PAUSE

FLAG

A nurse is caring for a client who has dumping syndrome following a gastric resection. The nurse should monitor the client for which of the following complications of dumping syndrome?

Weight gain

Anorexia can result from dumping syndrome because the client can easily become reluctant to eat to avoid the unpleasant manifestations of this syndrome, resulting in weight loss.

Iron-deficiency anemia

The nurse should monitor the client for manifestations of anemia, such as pallor, tachycardia, and fatigue. Rapid emptying of the stomach contents into the intestine can lead to reduced absorption of iron in the duodenum, causing iron-deficiency anemia.

Hypercalcemia

Hypocalcemia, rather than hypercalcemia, is a manifestation of dumping syndrome due to rapid gastric emptying.

Reduced heart rate

Nausea, abdominal cramping, and tachycardia are manifestations of dumping syndrome due to rapid gastric emptying.

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- **Time Remaining:** 00:35:43
- **Pause Remaining:** 00:05:00

PAUSE

FLAG

A nurse is assessing a client who takes salmeterol to treat moderate asthma. Which of the following findings should indicate to the nurse that the medication has been effective?

The client's daily peak expiratory flow (PEF) measures 85% above personal best.

A client who has asthma should use a peak flow meter twice daily to monitor asthma control. A PEF in the green zone, or 80% or above personal best, indicates the effectiveness of medication therapy.

The client's ABGs shows a pH level of 7.32.

A pH level of 7.32 indicates the client is in an acidotic state. Acidosis occurs with bronchoconstriction and indicates the medication has not been effective.

The client's forced expiratory volume is decreased after treatment with medication.

Forced expiratory volume measures the amount of air the client exhales during 1 second and is part of pulmonary function testing. Effective use of a bronchodilator should increase the client's forced expiratory volume.

The client's wheezing is limited to expiratory.

Salmeterol is a long-acting bronchodilator that helps prevent asthma attacks. Wheezing is a narrowing of the airways and indicates that the medication has not been effective.

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- **Time Remaining:** 00:35:38
- **Pause Remaining:** 00:05:00

PAUSE

FLAG

A nurse is providing teaching about health promotion activities for a client who has a new diagnosis of type 1 diabetes mellitus. Which of the following statements by the client indicates an understanding of the teaching?

"If I can keep my hemoglobin A1C less than 6.5%, I will be cured of diabetes."

Tight control of blood glucose levels can minimize complications associated with diabetes mellitus such as cardiovascular disease, nephropathy, neuropathy, and retinopathy. The nurse should instruct the client that type 1 diabetes mellitus is a chronic condition that causes the body to fail to manufacture insulin and cannot currently be cured.

"I will check my blood sugar level before exercising."

Clients who have diabetes mellitus should not exercise if their blood glucose level is less than 80 mg/dL or greater than 250 mg/dL. A client who has type 1 diabetes mellitus and is hyperglycemic can experience even higher blood glucose levels. Hypoglycemia can also occur during exercise and up to 24 hr following exercise. The nurse should instruct the client to monitor blood glucose levels before, during, and following exercise.

"I should have my eyes checked every 2 years."

Microvascular changes to the vessels in the eyes occurs with elevated blood glucose levels, which can lead to retinopathy. To monitor for changes to the eyes, the client should have eye examinations every year.

"I should soak my feet daily in warm, soapy water."

Health promotion activities for a client who has diabetes mellitus includes foot care. Clients should inspect their feet and wash them daily with warm water and soap. However, clients should not soak their feet because this can lead to maceration of the skin and skin breakdown.

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- **Time Remaining:** 00:35:31
- **Pause Remaining:** 00:05:00

PAUSE

FLAG

A nurse is providing teaching to a client who has a new prescription for warfarin. Which of the following medications should the nurse instruct the client to avoid? (Select all that apply.)

Ferrous sulfate

Echinacea

Aspirin

Dextromethorphan

Naproxen

Ferrous sulfate is incorrect. Ferrous sulfate is an iron supplement and has no known interaction with warfarin.

Echinacea is incorrect. Echinacea is a supplement that a client might take to improve the immune system and has no known interaction with warfarin.

Aspirin is correct. Aspirin is an antiplatelet medication. It can increase the risk of bleeding when taken with warfarin.

Dextromethorphan is incorrect. Dextromethorphan is a cough suppressant and has no known interaction with warfarin.

Naproxen is correct. Naproxen is an NSAID that relieves mild to moderate pain. It can increase the risk of bleeding if taken with warfarin.

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- **Time Remaining:** 00:35:25
- **Pause Remaining:** 00:05:00

PAUSE

FLAG

A nurse is assisting with the care of a client who is scheduled for a thoracentesis. Which of the following interventions should the nurse plan to take?

Inform the client that they must empty their bladder before the procedure.

A client who is undergoing a paracentesis should empty their bladder before the procedure to prevent injury to the bladder. This action is not necessary before a thoracentesis.

Weigh the client before and after the procedure.

The nurse should weigh a client who is scheduled for a paracentesis before and after the procedure to identify how much fluid the procedure removes from the client's abdomen. This action is not necessary before and after a thoracentesis.

Place the client leaning forward over the bedside table for the procedure.

The nurse should place the client leaning forward over the bedside table for a thoracentesis. This allows the provider complete access to the client's chest and back. This position also expands the spaces between the ribs where the pleural fluid accumulates.

Keep the client on bed rest after the procedure.

A client who undergoes a paracentesis remains on bed rest following the procedure. The nurse should monitor the client for shortness of breath and listen to the client's lung sounds following the procedure. Bed rest is not necessary following a thoracentesis.

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- **Time Remaining:** 00:35:19
- **Pause Remaining:** 00:05:00

PAUSE

FLAG

A nurse is providing discharge teaching about infection control at home for a client who has tuberculosis. Which of the following statements by the client indicates an understanding of the teaching?

"I will have to move out of my family's home until I am no longer contagious."

Individuals living in the same household as the client have already been exposed to the tuberculosis bacteria, so it is not necessary for the client to be isolated from others in the household. Instead, the nurse should instruct the client that all members living in the household should be tested for tuberculosis. Clients who have tuberculosis are no longer considered contagious when three consecutive sputum samples test negative for *Mycobacterium tuberculosis*, which often occurs 2 to 3 weeks after starting the medication regimen.

"I will place my used tissues in a plastic bag."

The sputum of a client who has tuberculosis is considered infectious until there are three consecutive sputum samples that test negative for *Mycobacterium tuberculosis*. Tissues that are soiled with the client's sputum should be placed in a plastic bag and sealed to avoid spreading the infection.

"I will cover my mouth with my hands when I have to cough."

The tuberculosis bacteria is easily spread through microscopic droplets, which can be spread when coughing, sneezing, talking, laughing, or singing. Placing hands over the mouth to cover the cough can result in the bacteria being present on the hands and transferred to another individual, spreading the infection. The nurse should instruct the

client to use a tissue to cover the nose and mouth when coughing or sneezing and then to dispose of the tissue by placing it in a plastic bag and sealing it.

"I will not go in public areas until I am cured."

The medication regimen for treatment of tuberculosis can last as long as 2 years. The nurse should instruct the client that the infection is contagious only until there are three consecutive sputum samples that test negative for *Mycobacterium tuberculosis*. In the interim, the client should wear a mask when in public to prevent the spread of infection.

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- **Time Remaining:** 00:35:14
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FLAG

A nurse is teaching a client who is scheduled to receive radioactive iodine therapy for treatment of hyperthyroidism. Which of the following instructions should the nurse include in the teaching?

Remain 0.3 m (1 ft) away from children.

The client who receives radioactive iodine should follow radiation precautions, which include limiting exposure to infants, children, and women who are pregnant. The nurse should instruct the client to remain at least 1 m (3 ft) away from these individuals.

Limit the time spent around women who are pregnant to 10 min daily.

The client who receives radioactive iodine has a degree of radioactivity, which can interfere with fetal development. The nurse should instruct the client to limit exposure to women who are pregnant to no more than 1 hr each day.

Use disposable utensils for meals.

The client who receives radioactive iodine has radioactivity in the body fluids, including saliva, for several weeks following treatment. The nurse should instruct the client to use

disposable utensils, plates, and cups during this time period to decrease the risk for radiation exposure to other members of the household.

Use an absorbent pad if incontinent.

If a client experiences incontinence, specific steps should be taken because body fluids are radioactive for several weeks after therapy. Male clients should use a condom catheter and a drainage bag. Urine from the drainage bag can then be poured into the toilet and flushed. Women who are incontinent should be encouraged to use facial tissues placed within their clothing to absorb the urine. The tissues can be flushed as they become soiled with urine. The use of an absorbent pad keeps the radiation in close contact with the client, which should be avoided.

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- **Time Remaining:** 00:35:08
- **Pause Remaining:** 00:05:00

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FLAG

A nurse is providing preoperative teaching to a client who is scheduled for a radical prostatectomy. Which of the following information should the nurse include in the teaching?

The client will be on bed rest while continuous bladder irrigation is in place.

It is important to initiate ambulation soon after surgery to prevent complications, such as venous thromboembolism. A client who has had an open radical prostatectomy should dangle their legs over the side of the bed and then sit in a chair on the day of surgery. Ambulation should begin the next morning.

Cold compresses will be used to manage bladder spasms.

The nurse should use oxybutynin, sitz baths, or warm compresses to relieve bladder spasms.

The client will have an NG tube in place for 48 hr postoperatively.

Clients who are undergoing gastrointestinal surgery require an NG tube. However, a client who is postoperative following an open radical prostatectomy does not require an NG tube. Bowel sounds and function should return postoperatively within the first 24 hr.

A PCA pump will be used for postoperative pain control.

A PCA pump is a common method of pain management in the first 24 hr following an open radical prostatectomy. The nurse should teach the client how to manage pain during the preoperative period rather than waiting until after surgery when the client is feeling the sedative effects of the anesthesia and pain medication.

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- **Time Remaining:** 00:35:02
- **Pause Remaining:** 00:05:00

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FLAG

A nurse is assessing a client's ECG strip and notes an irregular heart rate of 98/min with no clear P waves. Which of the following cardiac dysrhythmias should the nurse document?

First-degree heart block

With a first-degree atrioventricular (AV) block, the atrial impulses reach the ventricles through the AV node at a slower-than-normal rate. The P waves have a regular shape and appear consistently in front of the QRS complex.

Atrial fibrillation

With atrial fibrillation, multiple rapid impulses from many different foci cause depolarization of the atria in a rapid, disorganized manner. This causes a chaotic rhythm on the ECG strip that has no clear P waves, no atrial contractions, and an irregular rhythm.

Complete heart block

Complete heart block has regular rhythm with a low heart rate, and P waves are clear, but they outnumber the QRS complexes. There are two different impulses: one that stimulates the atria, thus generating the P wave, and another that stimulates the ventricles, creating the QRS complex.

Ventricular tachycardia

Ventricular tachycardia is a rapid, regular rhythm with a heart rate of 140/min or faster. P waves are rarely visible with sustained ventricular tachycardia.

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- **Pause Remaining:** 00:05:00

PAUSE

FLAG

A nurse is caring for a client who is receiving peritoneal dialysis. Which of the following actions should the nurse take?

Use an infusion pump to deliver the dialysate at a safe rate.

The nurse should infuse the dialysate by gravity into the peritoneal cavity, without an infusion pump.

Report cloudy dialysate drainage to the provider.

The most serious complication of peritoneal dialysis is peritonitis, an inflammation of the peritoneum. Assessment findings include cloudy dialysate drainage, rebound abdominal tenderness, and diffuse abdominal pain. The nurse should report these findings immediately to the provider, who can then prescribe a fluid culture, quick exchanges to wash out mediators of infection, and antibiotics.

Warm the dialysate solution using a low power level on a microwave oven.

The nurse should not use a microwave oven to warm dialysate solution. This can result in uneven heating of the solution, which can increase the risk for burns to peritoneal tissues. The nurse should warm the solution using a heating pad or place it in the warming section of the automated cycling machine.

Allow the dialysate to drain over 1 to 4 hr.

The dwell time for each exchange takes 4 to 8 hr; drainage usually takes 10 to 20 min.

- **RN VATI Adult Medical Surgical 2019**
CLOSE

Question: 64 of 90

INCORRECT

- **Time Remaining:** 00:34:52
- **Pause Remaining:** 00:05:00

PAUSE

FLAG

A nurse is assessing a client who has suspected appendicitis. Which of the following manifestations should the nurse expect? (Select all that apply.)

Elevated WBC count

Elevated amylase level

Rebound tenderness

Ascites

Anorexia

Elevated WBC count is correct. A client who has acute appendicitis will show a moderate elevation of the WBC count from 10,000 to 18,000/mm^3. If the WBC count is greater than 20,000/mm^3, it can indicate a perforated appendix.

Elevated amylase level is incorrect. Amylase levels increase with pancreatitis but not with acute appendicitis.

Rebound tenderness is correct. A client who has appendicitis develops localized pain over the right lower quadrant of the abdomen. When the area is palpated, pain occurs during release of pressure on the client's abdomen.

Ascites is incorrect. Ascites can be a manifestation of cirrhosis; however, it is not associated with appendicitis.

Anorexia is correct. A client who has acute appendicitis experiences nausea, vomiting, and reduced appetite.

- **RN VATI Adult Medical Surgical 2019**

CLOSE

Question: 63 of 90

CORRECT

- **Time Remaining:** 00:34:45
- **Pause Remaining:** 00:05:00

PAUSE

FLAG

A nurse is planning preventative strategies for a client who is at risk for pressure injuries. Which of the following actions should the nurse include in the plan?

Maintain the head of the bed greater than 45°.

The nurse should keep the head of the client's bed at 30° or lower to avoid shearing action on the skin.

Place a donut-shaped cushion under the client's sacrum.

A donut-shaped cushion or pillow damages capillary beds in the areas of pressure and can increase the risks of tissue breakdown and necrosis.

Massage bony prominences three times daily.

Massaging bony prominences damages capillary beds and can increase the risk of tissue breakdown and necrosis.

Apply moisturizer to damp skin after bathing.

Applying a moisturizer to damp skin after bathing helps prevent dry skin. The drier the skin is, the greater the risk is for skin breakdown.

- **RN VATI Adult Medical Surgical 2019**

CLOSE

Question: 62 of 90

CORRECT

- **Time Remaining:** 00:34:39
- **Pause Remaining:** 00:05:00

PAUSE

FLAG

A nurse is caring for a client who has a new diagnosis of type 1 diabetes mellitus. Which of the following findings should the nurse identify as a manifestation of type 1 diabetes?

Hypernatremia

Clients who have type 1 diabetes mellitus have a decrease in serum sodium levels because of osmotic diuresis by the kidneys.

Decreased serum osmolality

Clients who have type 1 diabetes mellitus and have hyperglycemia can develop dehydration, which increases serum osmolality. High osmolality values can lead to stupor and grand mal seizures.

Ketones in the urine

Clients who have type 1 diabetes mellitus can have ketones in the urine, which are a byproduct of the breakdown of fats for energy. Ketones in the urine are an indicator of inadequate amounts of insulin and high blood glucose levels.

Hypoglycemia

Clients who have type 1 diabetes mellitus have hyperglycemia when they produce too little insulin to metabolize glucose for energy.

- **RN VATI Adult Medical Surgical 2019**
  CLOSE

Question: 61 of 90

CORRECT

- **Time Remaining:** 00:34:33
- **Pause Remaining:** 00:05:00

PAUSE

FLAG

A nurse is caring for a client who had a surgical repair of an abdominal aortic aneurysm 3 days ago. The client's vital signs are: temperature 38.3° C (100.9° F), heart rate 80/min, respirations 16/min, and blood pressure 128/76 mm Hg. Which of the following actions is the nurse's priority?

Notify the surgeon of the temperature elevation.

The nurse should notify the surgeon of the client's temperature elevation for further assessment and intervention for possible complications; however, another action is the priority.

Encourage the client to drink more fluids.

The nurse should encourage the client to drink more fluids to replace fluid loss from fever; however, another action is the priority.

Assess the surgical incision for signs of infection.

A surgical wound infection typically appears 3 to 6 days following the surgery. Fever from the third postoperative day onward indicates that this client's greatest risk is either a wound infection or a pulmonary infection; therefore, this is the priority action the nurse should take.

Monitor vital signs every 4 hr.

The nurse should continue to monitor vital signs every 4 hr to assess improvement or deterioration of the client's condition; however, another action is the priority.

- **RN VATI Adult Medical Surgical 2019**

CLOSE

Question: 60 of 90

CORRECT

- **Time Remaining:** 00:34:27
- **Pause Remaining:** 00:05:00

PAUSE

FLAG

A nurse is providing discharge teaching to a client following a loop electrosurgical excision procedure (LEEP) for the treatment of cervical cancer. Which of the following statements by the client indicates an understanding of the teaching?

"I can resume sexual intercourse in 48 hours."

During the healing period, the client is at an increased risk for infection. Therefore, the client should refrain from sexual intercourse for the time period the provider prescribes, which is usually 3 weeks or until healing is complete.

"I can expect some heavy vaginal bleeding for 24 hours."

The client should report heavy vaginal bleeding because this can be an indication of complications. The client can expect mild spotting after the LEEP procedure, which cuts away the affected cervical tissue using a painless electrical current.

"I can use tampons when my period comes in a week."

The client should not use tampons, because they can increase the risk for infection. Following the recovery period, which is usually 3 weeks, the client can resume the use of tampons.

"I may have mild cramping for several hours."

The client should expect very little discomfort from the LEEP procedure, which is performed in ambulatory care using a painless electrical current.

- **RN VATI Adult Medical Surgical 2019**

CLOSE

Question: 59 of 90

CORRECT

- **Time Remaining:** 00:34:21
- **Pause Remaining:** 00:05:00

PAUSE

FLAG

A nurse is assessing a group of clients. For which of the following clients should the nurse make a referral to palliative care?

A client who is newly diagnosed with type 1 diabetes mellitus and cannot afford insulin

Clients who have type 1 diabetes mellitus require insulin to maintain blood glucose levels within the expected reference range. The nurse should refer clients who cannot afford to purchase medications to a social worker who has expertise in identifying resources to assist with purchasing medications at a discounted rate.

A client who has Meniere's disease and cannot safely ambulate due to vertigo

Meniere's disease is a sensorineural disorder affecting the auditory system and causes tinnitus, hearing loss, and vertigo, or dizziness. Vertigo can increase the risk for falls. The nurse should refer this client to a physical or occupational therapist, who will determine the need for assistive devices and evaluate the client's home for safety.

A client who had a stroke and cannot eat or drink without choking

A stroke can impact cranial nerve function. Impairment of cranial nerves IX and X results in dysphagia. If this occurs, the nurse should make the client NPO and make a referral to a speech-language pathologist.

A client whose medications to manage Parkinson's disease are no longer effective

Parkinson's disease is a neurodegenerative disease marked by alterations in mobility, cognition, mood, and functioning of the sympathetic nervous system. The effectiveness of medications used to manage the symptoms can decrease over time. When this occurs, the nurse should make a referral to palliative care. Palliative care is designed to maintain the

client's current quality of life through symptom management, assist with decision making regarding care needs, and work with families to identify care outcomes.

- **RN VATI Adult Medical Surgical 2019**

CLOSE

Question: 58 of 90

CORRECT

- **Time Remaining:** 00:34:15
- **Pause Remaining:** 00:05:00

PAUSE

FLAG

A nurse is providing teaching to a client who has a new prescription for cephalexin oral suspension. Which of the following statements by the client indicates an understanding of the teaching?

"I will increase my consumption of foods high in potassium."

Cephalosporins do not increase the excretion of potassium; therefore, it is not necessary for the client to increase potassium intake. Thiazide diuretics are an example of a type of medication that depletes potassium, resulting in hypokalemia.

"I will apply lotion to my skin if I feel any itching."

A common adverse effect of cephalosporins is a hypersensitivity reaction. Itching of the skin can indicate a hypersensitivity reaction, and the client should report this finding to the provider.

"I will avoid sun exposure while taking this medication."

Cephalosporins do not cause photosensitivity. However, ciprofloxacin and other fluoroquinolones have an adverse effect of photosensitivity. Photosensitivity can increase the risk of developing a sunburn when the skin is exposed to direct sunlight.

"I will keep the medication refrigerated."

The nurse should instruct the client to refrigerate the oral cephalosporin suspension to maintain its full strength until the completion of the medication regimen.

- **RN VATI Adult Medical Surgical 2019**

CLOSE

Question: 57 of 90

INCORRECT

- **Time Remaining:** 00:34:09
- **Pause Remaining:** 00:05:00

PAUSE

FLAG

A nurse is caring for a client who has acute kidney injury and a potassium level of 6.5 mEq/L. Which of the following ECG changes should the nurse expect?

Prominent P waves

P waves reflect electrical activity in the atria. Flat or absent P waves, rather than prominent P waves, are an expected finding on the ECG of a client who has hyperkalemia.

Narrowed QRS complexes

The QRS complex reflects ventricular electrical activity. QRS complexes widen when potassium levels reach critical levels and electrical conduction in the ventricles is slowing down.

Shortened PR intervals

The PR interval reflects conduction from the sinoatrial node through the atrioventricular node. A potassium level between 6.0 and 6.5 mEq/L slows the impulse conduction between the atria and the ventricles, resulting in a prolonged PR interval.

Peaked T waves

Elevated potassium levels result in tall, peaked T waves, flat or absent P waves, prolonged PR intervals, wide QRS complexes, and ectopic beats. Hyperkalemia can progress to complete heart block, ventricular fibrillation, and asystole.

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  CLOSE

Question: 56 of 90

INCORRECT

- **Time Remaining:** 00:34:00
- **Pause Remaining:** 00:05:00

PAUSE

FLAG

A nurse is caring for a client who had abdominal surgery. The client tells the nurse that "something gave way." The nurse removes the dressing and sees the wound has eviscerated. Identify the correct sequence of steps the nurse should follow. (Move the steps into the box on the right, placing them in the selected order of performance. Use all the steps.)

- Place the client in a low Fowler's position with the knees bent.
- Cover the client's wound with a sterile saline-soaked dressing.
- Notify the surgeon about the finding.
- Prepare the client for transfer to surgery.

Based on evidence-based practice, the nurse should immediately contact the surgeon and notify them of the wound evisceration. The nurse should then cover the client’s wound with a sterile saline soaked dressing to protect it from infection. The nurse should then place the client in a low Fowler's position with their knees bent and then prepare the client to be transferred to surgery.

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  CLOSE

Question: 55 of 90

CORRECT

- **Time Remaining:** 00:33:54
- **Pause Remaining:** 00:05:00

PAUSE

FLAG

A nurse is caring for a client who is hemorrhaging and hypotensive from esophageal variceal bleeding. Which of the following actions should the nurse take first?

Administer vasopressin to the client.

The nurse should administer a vasoactive medication, such as vasopressin. This medication increases blood pressure through vasoconstriction. However, there is another action the nurse should take first.

Request blood from blood bank.

The nurse should request blood from a blood bank in preparation for a blood transfusion. However, there is another action the nurse should take first. Blood should not be requested until the nurse has verified that the client has adequate IV access.

Verify that the client has adequate IV access.

When using the airway, breathing, and circulation approach to client care, the nurse should first verify that the client has at least a 20-gauge IV for the administration of blood.

Insert an indwelling urinary catheter.

The nurse should insert an indwelling urinary catheter to monitor urinary output and the effectiveness of treatments. However, there is another action the nurse should take first.

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CLOSE

Question: 54 of 90

CORRECT

- **Time Remaining:** 00:33:47
- **Pause Remaining:** 00:05:00

PAUSE

FLAG

A nurse is assessing a client who has a new diagnosis of diabetes mellitus. The nurse should identify that which of the following findings is a manifestation of hyperglycemia?

Increased thirst

The nurse should teach the client that increased thirst, or polydipsia, is a manifestation of hyperglycemia, which can lead to dehydration. Other manifestations of hyperglycemia

include an increase in appetite, or polyphagia, an increase in urine production, or polyuria, and fatigue.

Decreased urine output

The nurse should teach the client that polyuria is a manifestation of hyperglycemia.

Dry skin

The nurse should teach the client that warm, moist skin is a manifestation of hyperglycemia.

Tremors

The nurse should teach the client that tremors and anxiety are manifestations of hypoglycemia.

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  CLOSE

Question: 53 of 90

CORRECT

- **Time Remaining:** 00:33:41
- **Pause Remaining:** 00:05:00

PAUSE

FLAG

A nurse is reviewing the health histories of a group of clients. Which of the following findings should the nurse identify as an indication that a client is at an increased risk for urinary tract infections (UTIs)?

Asthma

A history of asthma does not increase the risk for UTI development. However, clients who use corticosteroids to manage their asthma have an increased risk for infections because these medications can reduce the immune response.

Diabetes mellitus

Diabetes mellitus is a predisposing factor for UTIs. Clients who have underlying diseases that compromise their immune response have an increased risk for UTIs.

Pernicious anemia

Pernicious anemia, or vitamin B_{12} deficiency, does not increase the risk for UTI development. Pernicious anemia can, however, increase the risk for gastric cancer.

Osteoporosis

Osteoporosis does not increase the risk for UTI development. Osteoporosis increases the risk for bone fractures and subsequent immobility.

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CLOSE

Question: 52 of 90

CORRECT

- **Time Remaining:** 00:33:35
- **Pause Remaining:** 00:05:00

PAUSE

FLAG

A nurse is preparing to discharge a client who is postoperative following a total hip arthroplasty. Which of the following equipment should the nurse ensure that the client has available at home prior to discharge?

Continuous passive motion device

Continuous passive motion devices promote range of motion and the prevention of scar tissue of the knee following a total knee arthroplasty. However, they are not used for the client who is postoperative following a total hip arthroplasty.

Elevated toilet seat

A client who is postoperative following a total hip arthroplasty is at risk for dislocation of the hip prosthesis. Limitations on hip flexion and adduction decrease the risk. The client should avoid flexing the hip greater than 90° and should avoid using toilet seats that are low to the ground. An elevated toilet seat should be in place in the client's home prior to the client's discharge.

Trapeze bar

A trapeze bar in unnecessary for a client who had a total knee arthroplasty because they receive physical therapy and occupational therapy during their inpatient stay regarding bed mobility and transfers.

Compression garment

Compression garments are specially designed elasticized clothing used in the treatment of burns. The compression garment places continuous pressure on the burn injury following grafting to promote healing and limit the development of scarring, which could inhibit mobility.

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CLOSE

Question: 51 of 90

CORRECT

- **Time Remaining:** 00:33:30
- **Pause Remaining:** 00:05:00

PAUSE

FLAG

A nurse is assessing a client who has a history of type 2 diabetes mellitus. The nurse should identify which of the following findings as an indication of a microvascular complication?

Coronary artery disease

Coronary artery disease is a macrovascular complication of diabetes mellitus. Macrovascular complications result from pathologic changes in large or generalized vessels as a result of hyperglycemia, hyperlipidemia, and an inflammatory process reflected in elevated C-reactive protein levels. The alterations in lipid metabolism that characterize diabetes accelerate the development of atherosclerotic plaque, which is a characteristic of coronary artery disease.

Retinopathy

Diabetic retinopathy is a microvascular complication of diabetes mellitus resulting from pathologic changes in small blood vessels, which eventually cause tissue damage, cell death in the retina, and blindness.

Cerebrovascular accident

A cerebrovascular accident, or stroke, is a macrovascular complication of diabetes mellitus. Macrovascular complications result from pathologic changes in medium or large vessels as a result of hyperglycemia, hyperlipidemia, and an inflammatory process reflected in elevated C-reactive protein levels. It is essential for a client who has diabetes mellitus to reduce risk factors that can precipitate stroke, such as cigarette smoking.

Hypertension

Hypertension is a macrovascular complication of diabetes mellitus. Macrovascular complications result from pathologic changes in large or generalized vessels as a result of hyperglycemia, hyperlipidemia, and an inflammatory process reflected in elevated C-reactive protein levels. These factors eventually lead to hypertension, other cardiovascular disorders, or cerebrovascular diseases.

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  CLOSE

Question: 50 of 90

CORRECT

- **Time Remaining:** 00:33:24
- **Pause Remaining:** 00:05:00

PAUSE

FLAG

A nurse is caring for a client who is receiving a transfusion of packed RBCs. The nurse notes that the client's blood type is AB positive and the blood infusing is labeled type B negative. Which of the following actions should the nurse take?

Stop the blood transfusion immediately.

Clients who have type AB blood are universal recipients and can receive any ABO blood type. Clients who have Rh-positive blood can receive a transfusion from a Rh-negative donor.

Prepare to administer antipyretics.

Leukocyte incompatibilities are a common cause of febrile transfusion reactions. Unless a client has a history of febrile reactions to prior transfusions or develops chills or fever, there is no reason to administer antipyretics.

Monitor the client for any adverse reactions.

Although the client is a universal recipient and can receive any ABO blood type, the nurse should continue to monitor for any adverse reactions, which is standard procedure for any blood transfusion.

Transfuse the blood over 6 hr.

The nurse should transfuse the packed RBCs within 4 hr after removing it from refrigeration to reduce the risk of bacterial contamination of the blood.

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CLOSE

Question: 49 of 90

CORRECT

- **Time Remaining:** 00:33:19
- **Pause Remaining:** 00:05:00

PAUSE

FLAG

A nurse is planning care for a client who had a lumbar laminectomy. Which of the following interventions should the nurse include in the plan of care?

Instruct the client to lift no more than 6.8 kg (15 lb) when at home.

The nurse should instruct the client to lift objects no heavier than 2.3 kg (5 lb) for several weeks following surgery to prevent reinjuring the lower back.

Turn the client by log rolling with a turning sheet.

The nurse should turn the client by log rolling with a turning sheet to keep the client's back straight and to prevent back spasms from occurring.

Inform the client to shower on the second postoperative day.

The nurse should instruct the client to shower on the third or fourth postoperative day to ensure the healing of the incision.

Remove sterile adhesive strips before discharge.

The nurse should leave the sterile adhesive strips on until the provider removes them or until the strips fall off.

- **RN VATI Adult Medical Surgical 2019**
  CLOSE

Question: 48 of 90

CORRECT

- **Time Remaining:** 00:33:12
- **Pause Remaining:** 00:05:00

PAUSE

FLAG

A nurse is teaching a client how to obtain a specimen at home for a fecal occult blood test. Which of the following actions should the nurse instruct the client to take for 3 days prior to collecting the specimen?

Take a low-dose aspirin tablet twice daily.

A client should not take any type of NSAIDs for 7 days before collecting the specimen because aspirin and NSAIDs can cause a false-positive result in a fecal occult blood test.

Avoid eating cooked vegetables.

A client can eat cooked vegetables because these foods do not cause a false-positive result in a fecal occult blood test. However, a client should not ingest raw vegetables, red meat, or citrus fruits for 3 days before collecting the specimen because these foods can cause a false-positive result in a fecal occult blood test.

Take vitamin C supplements.

A client should not take vitamin C supplements for 3 days before collecting the specimen because this supplement can cause a false-positive result in a fecal occult blood test.

Avoid eating red meat.

A client should not eat red meat for 3 days before collecting the specimen because red meat contains hemoglobin, myoglobin, and some enzymes that can cause a false-positive result in a fecal occult blood test.

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Question: 47 of 90

INCORRECT

- **Time Remaining:** 00:33:06
- **Pause Remaining:** 00:05:00

PAUSE

FLAG

A nurse is caring for a client immediately following intubation with an endotracheal (ET) tube. Which of the following methods should the nurse identify as the most reliable for verifying placement of the ET tube?

Feel for exhaled air emerging from the endotracheal tube.

The nurse should feel with the palm of the hand for exhaled air to determine if there is air exchange in both lungs. However, evidence-based practice indicates that there is a more reliable method for verifying placement of the ET tube.

Assess for bilateral breath sounds.

The nurse should assess for bilateral breath sounds to determine if there is air exchange in both lungs. However, evidence-based practice indicates that there is a more reliable method for verifying placement of the ET tube.

Observe for symmetric chest movement.

The nurse should observe for symmetric chest movement to determine if there is air exchange in both lungs. However, evidence-based practice indicates that there is a more reliable method for verifying placement of the ET tube.

Check for end-tidal carbon dioxide levels.

According to evidence-based practice, the most reliable method for verifying ET tube placement is checking for end-tidal carbon dioxide levels by using capnometry. A chest x-ray is another reliable method for verifying placement.

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CLOSE

Question: 46 of 90

CORRECT

- **Time Remaining:** 00:33:01
- **Pause Remaining:** 00:05:00

PAUSE

FLAG

A nurse notes that a client's eyes are protruding slightly from their orbits. Which of the following laboratory findings should the nurse expect?

Decreased calcium levels

Low serum calcium levels reflect hypoparathyroidism and cause tetany, not exophthalmos.

Decreased somatotropin levels

A decrease in somatotropin levels related to growth hormones is helpful in confirming hypopituitarism and adrenocortical hypofunction, but exophthalmos is not a manifestation of these conditions.

Increased glucose levels

Diabetes mellitus is the most common cause of increased serum glucose levels. Hyperglycemia, however, does not cause exophthalmos.

Increased T_4 levels

Exophthalmos, an abnormal protrusion of the eyeballs, is a classic sign of hyperthyroidism. Elevated thyroid hormone levels (T_3 and T_4) and a decreased thyroid stimulating hormone level reflect primary hyperthyroidism.

- **RN VATI Adult Medical Surgical 2019**

CLOSE

Question: 45 of 90

CORRECT

- **Time Remaining:** 00:32:54
- **Pause Remaining:** 00:05:00

PAUSE

FLAG

A nurse is preparing a teaching plan for a client who is starting to receive hemodialysis for chronic kidney disease. Which of the following instructions should the nurse include in the teaching?

"Use salt substitutes to reduce your sodium intake."

Salt substitutes can contain high amounts of potassium. The client should use herbs and spices instead of salt or salt substitutes to decrease the risk for retention of sodium, potassium, and fluids due to reduced kidney function.

"Increase your fluid intake to 1,000 mL a day."

Fluid restriction is common for clients who have chronic kidney disease. Most clients are allowed 500 mL to 700 mL of fluid intake per day plus a volume equal to the amount of urine excreted each day.

"Include phosphorus-rich foods in your diet."

A client who is starting hemodialysis needs an increased protein intake, which will also increase phosphorus intake. Phosphorus restriction is necessary to prevent renal osteodystrophy.

"Increase your intake of protein to 1 to 1.5 grams per kilogram per day."

A client who receives hemodialysis for chronic kidney disease needs protein to prevent a negative nitrogen balance and muscle wasting. A client who is receiving hemodialysis is allowed 1 g to 1.5 g of protein/kg/day.

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CLOSE

Question: 44 of 90

CORRECT

- **Time Remaining:** 00:32:48
- **Pause Remaining:** 00:05:00

PAUSE

FLAG

A nurse is caring for a client who has deep-vein thrombosis and is receiving heparin via continuous IV infusion. The client's weight is 80 kg (176.4 lb). Using the client information provided, which of the following actions should the nurse take? (Click on the "Exhibit" button below for additional information about the client. There are three tabs that contain separate categories of data.)

EXHIBIT

Stop the heparin infusion for 1 hr.

According to the titration table, when the aPTT is greater than 95, the nurse should stop the infusion for 1 hr, then restart the infusion with a decrease of 3 units/kg/hr, which is a decrease of 240 units/hr for a client who weighs 80 kg (176.4 lb).

Increase the rate of the infusion by 160 units/hr.

An aPTT greater than 95 seconds is outside the expected reference range of 60 to 70 seconds. Therefore, increasing the rate of the heparin infusion places the client at risk for hemorrhage. The nurse should monitor for manifestations of bleeding.

Administer heparin 2,400 unit IV bolus.

An aPTT greater than 95 seconds is outside the expected reference range. Therefore, administering heparin 2,400 unit IV bolus places the client at risk for hemorrhage. The nurse should monitor for manifestations of bleeding.

Continue the infusion without change.

An aPTT greater than 95 seconds is outside the expected reference range. Therefore, continuing the infusion at the current rate places the client at risk for hemorrhage. The nurse should monitor for manifestations of bleeding.

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CLOSE

Question: 43 of 90

CORRECT

- **Time Remaining:** 00:32:42
- **Pause Remaining:** 00:05:00

PAUSE

FLAG

A nurse is caring for a client who is intubated and receiving mechanical ventilation for heroin toxicity. Which of the following assessments is the nurse's priority?

WBC count

The nurse should monitor the client's WBC count to check for infection. However, there is another assessment that is the nurse's priority.

Intake and output

The nurse should monitor the client's intake and output to evaluate hydration status. However, there is another assessment that is the nurse's priority.

ABGs

When using the airway, breathing, and circulation (ABC) approach to client care, the nurse's priority assessment is to monitor the client's ABGs, including respiratory status.

Blood glucose level

The nurse should monitor the client's blood glucose level to check for hypoglycemia or hyperglycemia. However, there is another assessment that is the nurse's priority.

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Question: 42 of 90

INCORRECT

- **Time Remaining:** 00:32:33

- **Pause Remaining:** 00:05:00

PAUSE

FLAG

A nurse is assessing a client who has a new diagnosis of pericarditis. Which of the following findings should the nurse identify as a manifestation of cardiac tamponade?

Fever

Fever and an elevated WBC count are manifestations of bacterial pericarditis, not cardiac tamponade.

Atrial fibrillation

Atrial fibrillation is a manifestation of acute pericarditis, not cardiac tamponade.

Paradoxical pulse

Cardiac tamponade results from an excess of fluid in the pericardial cavity and causes a sudden drop in cardiac output. Paradoxical pulse is a systolic blood pressure of 10 mm Hg or more on expiration and is a manifestation of cardiac tamponade. The nurse should report manifestations of cardiac tamponade to the provider immediately.

Pericardial friction rub

A pericardial friction rub is a scratchy, high-pitched sound resulting from inflamed pericardial tissue and is a manifestation of acute pericarditis, not cardiac tamponade.

- **RN VATI Adult Medical Surgical 2019**

CLOSE

Question: 41 of 90

CORRECT

- **Time Remaining:** 00:32:26
- **Pause Remaining:** 00:05:00

PAUSE

FLAG

A nurse is assessing a client who is undergoing radiation therapy for breast cancer. Which of the following findings is an indication to the nurse that the client is experiencing an adverse effect of the therapy?

Stomatitis

Stomatitis is an adverse effect of chemotherapy. Stomatitis can occur with radiation of the head and neck, but not radiation of the breast. A client who is receiving radiation therapy can have an adverse effect of taste changes due to dead cell metabolism.

Vomiting

Vomiting is an adverse effect of chemotherapy and generally develops after radiation to the abdomen and pelvis. Radiation therapy to the abdomen can also cause vomiting.

Skin changes

A client who is receiving radiation therapy to the breast will have localized adverse effects of the treatment, such as skin changes, esophagitis, and lymphedema.

Hematuria

Hematuria is an adverse effect of chemotherapy and generally develops after radiation to the abdomen and pelvis, causing cystitis that can lead to bleeding.

- **RN VATI Adult Medical Surgical 2019**

CLOSE

Question: 40 of 90

CORRECT

- **Time Remaining:** 00:32:20
- **Pause Remaining:** 00:05:00

PAUSE

FLAG

A nurse is preparing to administer enoxaparin 0.75 mg/kg subcutaneously to a client who weighs 154 lb. The amount available is enoxaparin 60 mg/0.6 mL. How many mL should the nurse administer? (Round the answer to the nearest tenth. Use a leading zero if it applies. Do not use a trailing zero.)

mL

Follow these steps for the Ratio and Proportion method of calculation:

Step 1: What is the unit of measurement the nurse should calculate? kg

Step 2: Set up an equation and solve for X.

$$\frac{2.2 \text{ lb}}{1 \text{ kg}} = \frac{\textit{Client's weight in lb}}{X \text{ kg}}$$

$$\frac{2.2 \text{ lb}}{1 \text{ kg}} = \frac{154 \text{ lb}}{X \text{ kg}}$$

$$\frac{1 \text{ kg}}{X \text{ kg}}$$

X kg = 70 kg

Step 3: What is the unit of measurement the nurse should calculate? mg

Step 4: Set up an equation and solve for X.

X = *Dose per kg* × *Client's weight in kg*

X mg = 0.75 mg/kg × 70 kg

X mg = 52.5 mg

Step 5: What is the unit of measurement the nurse should calculate? mL

Step 6: What is the dose the nurse should administer? Dose to administer = Desired 52.5 mg

Step 7: What is the dose available? Dose available = Have 60 mg

Step 8: Should the nurse convert the units of measurement? No

Step 9: What is the quantity of the dose available? 0.6 mL

Step 10: Set up an equation and solve for X.

$$\frac{\textit{Have}}{\textit{Quantity}} = \frac{\textit{Desired}}{X \text{ mg}}$$

$$\frac{60 \text{ mg}}{0.6 \text{ mL}} = \frac{52.5 \text{ mg}}{X \text{ mL}}$$

$$\frac{}{X \text{ mL}}$$

X mL = 0.525 mL

Step 11: Round if necessary. 0.525 mL = 0.5 mL

Step 12: Determine whether the amount to administer makes sense. If there are 60 mg/0.6 mL and the prescription reads 0.75 mg/kg subcutaneously, it makes sense to administer 0.5 mL. The nurse should administer enoxaparin 0.5 mL subcutaneously.

Follow these steps for the Desired Over Have method of calculation:

Step 1: What is the unit of measurement the nurse should calculate? kg

Step 2: Set up an equation and solve for X.

$$X \text{ kg} = \frac{\textit{Client's weight in lb} \times 1 \text{ kg}}{154 \text{ lb} \times 1 \text{ kg}}$$

$$\frac{}{2.2 \text{ lb}}$$

$$X \text{ kg} = \frac{}{2.2\ \cancel{\text{lb}}}$$

X kg = 70 kg

Step 3: What is the unit of measurement the nurse should calculate? mg

Step 4: Set up an equation and solve for X.

X = Dose per kg × Client's weight in kg

X mg = 0.75 mg/$\cancel{\text{kg}}$ × 70 $\cancel{\text{kg}}$

X mg = 52.5 mg

Step 5: What is the unit of measurement the nurse should calculate? mL

Step 6: What is the dose the nurse should administer? Dose to administer = Desired 52.5 mg

Step 7: What is the dose available? Dose available = Have 60 mg

Step 8: Should the nurse convert the units of measurement? No

Step 9: What is the quantity of the dose available? 0.6 mL

Step 10: Set up an equation and solve for X.

$$X = \frac{\textit{Desired} \times \textit{Quantity}}{\textit{Have}}$$

$$X \text{ mL} = \frac{52.5\ \cancel{\text{mg}} \times 0.6 \text{ mL}}{60\ \cancel{\text{mg}}}$$

X mL = 0.525 mL

Step 11: Round if necessary. 0.525 mL = 0.5 mL

Step 12: Determine whether the amount to administer makes sense. If there are 60 mg/0.6 mL and the prescription reads 0.75 mg/kg subcutaneously, it makes sense to administer 0.5 mL. The nurse should administer enoxaparin 0.5 mL subcutaneously.

Follow these steps for the Dimensional Analysis method of calculation:

Step 1: What is the unit of measurement the nurse should calculate? (Place the unit of measure being calculated on the left side of the equation.)

X mL =

Step 2: Determine the ratio that contains the same unit as the unit being calculated. (Place the ratio on the right side of the equation, ensuring that the unit in the numerator matches the unit being calculated.)

$$X \text{ mL} = \frac{0.6 \text{ mL}}{60 \text{ mg}}$$

Step 3: Place any remaining ratios that are relevant to the item on the right side of the equation, along with any needed conversion factors, to cancel out unwanted units of measurement.

$$\frac{0.6 \text{ mL}}{} \quad \frac{0.75\ \cancel{\text{mg}}}{} \quad \frac{1\ \cancel{\text{kg}}}{} \quad \frac{154\ \cancel{\text{lb}}}{}$$

$$X \text{ mL} = \frac{60 \text{ mg}}{1} \times \frac{1 \text{ kg}}{2.2 \text{ lb}} \times \frac{2.2 \text{ lb}}{1 \text{ dose}} \times \frac{1 \text{ dose}}{}$$

Step 4: Solve for X.

X mL = 0.525 mL

Step 5: Round if necessary. 0.525 mL = 0.5 mL

Step 6: Determine whether the amount to administer makes sense. If there are 60 mg/0.6 mL and the prescription reads 0.75 mg/kg subcutaneously, it makes sense to administer 0.5 mL. The nurse should administer enoxaparin 0.5 mL subcutaneously.

- **RN VATI Adult Medical Surgical 2019**

CLOSE

Question: 39 of 90

CORRECT

- **Time Remaining:** 00:32:14
- **Pause Remaining:** 00:05:00

PAUSE

FLAG

A nurse is caring for a group of clients. In which of the following scenarios is the nurse acting as a client advocate?

The nurse refers a client who has chronic obstructive pulmonary disease for palliative care services.

Palliative care is an interdisciplinary approach to client care that works toward optimizing the quality of life for a client who has a chronic illness. Nurses advocate for their clients when they promote the health, safety, and rights of the client, such as providing a referral for needed services to relieve suffering and promote a client's quality of life.

The nurse provides wound care to a client at the time promised to the client.

Fidelity is the act of keeping promises. Nurses demonstrate fidelity by following the nursing code of ethics, caring for clients whose personal and political views differ from that of the nurse, and by keeping promises, such as delivering care at a specified time.

The nurse declines to inform a client's neighbor about the client's prognosis.

Federal regulations mandate that health care personnel cannot share a client's personal health information with individuals whom the client has not designated as being able to receive the information. The Health Insurance Portability and Accountability Act (HIPAA) has established fines for breaching confidentiality of personal health information.

The nurse files an incident report regarding a medication error.

Nurses demonstrate responsibility by following the policies and procedures of health care facilities, such as filing an incident report following an unusual or unexpected occurrence. Nurses have an obligation to follow through with the expectations of the facility and the profession of nursing as identified in the nursing code of ethics.

- **RN VATI Adult Medical Surgical 2019**

CLOSE

Question: 38 of 90

INCORRECT

- **Time Remaining:** 00:32:06
- **Pause Remaining:** 00:05:00

PAUSE

FLAG

A nurse is assessing a client who recently had a myocardial infarction. Which of the following findings indicates that the client might be developing pulmonary edema? (Select all that apply.)

Excessive somnolence

Epistaxis

Pink, frothy sputum

Tachypnea

Urinary frequency

Excessive somnolence is correct. Manifestations of pulmonary edema can include a change in orientation or mental status. A client who has excessive somnolence might be experiencing pulmonary edema.

Epistaxis is incorrect. Epistaxis, or a nosebleed, can be an indication of a low platelet count; however, it is not a manifestation associated with pulmonary edema.

Pink, frothy sputum is correct. A client who has pulmonary edema can develop pink, frothy sputum, wheezing, and tachypnea.

Tachypnea is correct. A client who has pulmonary edema can develop pink, frothy sputum, wheezing, and tachypnea.

Urinary frequency is incorrect. The client who is developing pulmonary edema is retaining fluid. Once treated with diuretics, the kidneys will begin excreting sodium and water.

- **RN VATI Adult Medical Surgical 2019**

CLOSE

Question: 37 of 90

INCORRECT

- **Time Remaining:** 00:32:00
- **Pause Remaining:** 00:05:00

PAUSE

FLAG

A nurse is teaching a client about preventing the transmission of HIV. Which of the following information should the nurse include?

Use a natural material condom during oral, genital, and anal intercourse.

The consistent use of latex condoms can reduce the risk for transmission of HIV. However, natural material condoms, such as lambskin condoms, do not provide protection.

Medication is available that will reduce the risk for HIV transmission.

Tenofovir/emtricitabine is an oral medication that can be used prophylactically by a client who does not have an HIV infection to reduce the risk for HIV transmission. Pre-exposure prophylaxis is recommended for men who have sexual relationships with men, clients who

are heterosexual and sexually active, noninfected partners who have a sexual relationship with a partner who has HIV, and clients who use intravenous drugs.

Use skin lotion as a lubricant when using a condom.

Lubrication products that are water-based are safe to use as a lubricant when using a condom. Other products such as skin lotion, petroleum jelly, or cold cream can cause the latex condom to break down, resulting in ineffective protection.

A diaphragm will provide protection against HIV transmission.

A diaphragm is a dome-shaped device that covers the cervix and, when used with a spermicide, prevents pregnancy. It does not, however, prevent the transmission of HIV. The use of a condom is recommended for all clients to decrease the risk of HIV transmission.

- **RN VATI Adult Medical Surgical 2019**
  CLOSE

Question: 36 of 90

INCORRECT

- **Time Remaining:** 00:31:54
- **Pause Remaining:** 00:05:00

PAUSE

FLAG

A nurse is caring for a client who has multiple leg fractures and is 24 hr postoperative following placement of skeletal traction. Which of the following actions should the nurse take?

Apply petroleum jelly to the pin sites.

The nurse should not routinely apply any ointments to the pin sites. During the first 24 to 48 hr after insertion of the pins, the nurse should administer a prophylactic broad-spectrum IV antibiotic.

Apply a sterile hydrocolloid dressing every 24 hr.

Initially, a sterile, absorbent, nonadherent dressing covers the pin sites. Hydrocolloid dressings are for necrotic or granulating wounds.

Cleanse the pin sites with isopropyl alcohol.

Although pin protocols vary, the nurse should cleanse the pin sites with chlorhexidine solution to prevent infection and subsequent development of osteomyelitis.

Inspect the pin sites at least every 8 hr.

The nurse should inspect the pin sites at least every 8 hr, noting any inflammation or evidence of infection. Expected findings after the insertion of pins include redness, warmth, and serosanguineous drainage, which should subside after 72 hr.

- **RN VATI Adult Medical Surgical 2019**
CLOSE

Question: 35 of 90

CORRECT

- **Time Remaining:** 00:31:49
- **Pause Remaining:** 00:05:00

PAUSE

FLAG

A nurse in a long-term care facility is caring for a client who has dementia. Which of the following actions should the nurse take?

Give detailed directions when addressing the client.

The nurse should provide simple directions and focus on one task at a time for a client who has dementia. The nurse should speak in a respectful tone of voice while providing direction to the client.

Provide finger food at mealtime.

The nurse should provide the client who has dementia with fingers foods. Clients who have dementia can have difficulty sitting still and tend to wander, which makes weight loss and malnutrition a concern. Therefore, foods that the client can hold while ambulating are ideal.

Use written signs to redirect the client.

The nurse should use symbols instead of written signs to redirect the client who has dementia. Written signs can confuse the client by requiring the ability to read, which can be affected by the dementia. Therefore, using symbols makes it easier to redirect the client and for them to remember.

Seat the client at a large table for meals.

The nurse should seat the client who has dementia at a small table with three or five other clients during mealtime. A larger table with multiple clients can be overwhelming and confusing to a client who has dementia.

- **RN VATI Adult Medical Surgical 2019**

CLOSE

Question: 34 of 90

CORRECT

- **Time Remaining:** 00:31:43
- **Pause Remaining:** 00:05:00

PAUSE

FLAG

A nurse is completing an admission assessment for a client who has bacterial meningitis. Which of the following personal protective equipment should the nurse use while caring for the client?

N95 respirator

An N95 respirator is required for specific diseases that have airborne transmission, such as measles, tuberculosis, and chickenpox, but it is not required with bacterial meningitis.

Goggles

Goggles are not necessary when obtaining a client's vital signs because the nurse is not at risk for any splashing of secretions.

Disposable gown

A gown is not necessary, because transmission of the micro-organisms that cause bacterial meningitis does not occur through direct contact.

Surgical mask

The nurse should adhere to droplet precautions in addition to standard precautions for clients who have bacterial meningitis, provided the causative pathogen spreads via droplets. Examples of pathogens that spread via droplets include *Haemophilus influenzae* and *Neisseria meningitidis*. The nurse should place these clients in a private room and wear a mask when within 0.9 m (3 feet) of the client to prevent acquiring the infection. Clients should wear a mask whenever they are outside their room. These precautions are essential until 24 hr after the initiation of antibiotic therapy.

- **RN VATI Adult Medical Surgical 2019**

CLOSE

Question: 33 of 90

CORRECT

- **Time Remaining:** 00:31:36
- **Pause Remaining:** 00:05:00

PAUSE

FLAG

A nurse is assessing a client for fluid volume deficit following lumbar spinal surgery. The nurse should identify which of the following findings as an indication the client is at risk for fluid volume deficit?

BUN 16 mg/dL

A BUN level of 16 mg/dL is within the expected reference range of 10 to 20 mg/dL. An elevated BUN level can indicate a risk for fluid volume deficit.

Urine output 40 mL every hour for 3 hr

Urine output of 40 mL every hour for 3 hr is within the expected reference range. A minimum of 400 mL to 600 mL of urine in 24 hr is necessary to excrete toxic waste.

Hct 42%

An Hct of 42% is within the expected reference range of 37% to 52%. An Hct above the expected reference range can indicate fluid volume deficit.

Surgical drain output 300 mL during an 8-hr shift

A client who had lumbar spinal surgery should not have more than 250 mL from a drain in the first 24 hr. Therefore, 300 mL in 8 hr can indicate that the client is at risk for fluid volume deficit.

- **RN VATI Adult Medical Surgical 2019**

CLOSE

Question: 32 of 90

CORRECT

- **Time Remaining:** 00:31:31
- **Pause Remaining:** 00:05:00

PAUSE

FLAG

A nurse is assessing a client who has a central venous catheter (CVC) with intravenous (IV) fluids infusing. The client suddenly develops shortness of breath, and the nurse notes that the IV tubing and needleless connector device are disconnected. Which of the following actions should the nurse take first?

Close the pinch clamp on the CVC.

The greatest risk to this client is air embolism resulting from accidental disconnection of the CVC tubing. Therefore, the priority action is to clamp the catheter immediately by closing the pinch clamp to prevent any further air from entering the system. When an air embolism occurs, air enters through the central vein into the right ventricle and lodges by the pulmonary valve, decreasing the amount of blood that is able to enter into the ventricle and the pulmonary arteries.

Obtain a prescription for stat ABGs.

When suspecting an air embolism, the nurse should obtain ABGs to determine the client's degree of hypoxemia. However, the nurse should take another action first.

Place the client in left Trendelenburg position.

The nurse should place the client in left lateral Trendelenburg position when an air embolism is suspected to prevent air from traveling to the pulmonary arteries. However, the nurse should take another action first.

Check the tubing for placement of a locking adaptor.

The nurse should verify that locking adaptors are on all tubing ports to reduce the risk of air embolism from a break in the system. However, the nurse should take another action first.

- **RN VATI Adult Medical Surgical 2019**

CLOSE

Question: 31 of 90

CORRECT

- **Time Remaining:** 00:31:24
- **Pause Remaining:** 00:05:00

PAUSE

FLAG

A nurse is planning care for a client who is scheduled for surgery and has a latex allergy. Which of the following actions should the nurse plan to take?

Schedule the client for the last surgery of the day.

The nurse should schedule the client for the first procedure of the day to minimize the client's exposure to latex, including latex dust.

Place monitoring cords and tubes in a stockinette.

The nurse should place monitoring devices in a stockinette to prevent direct contact with the client's skin.

Choose rubber injection ports for fluid administration.

Rubber injection ports contain latex, which places the client at risk for an allergic reaction. The nurse should ensure that latex-free products are available for this client and use stopcocks to inject medications.

Have phenytoin IV readily available.

The nurse should ensure that epinephrine is readily available in the surgical suite in case of an anaphylactic reaction.

- **RN VATI Adult Medical Surgical 2019**

CLOSE

Question: 30 of 90

CORRECT

- **Time Remaining:** 00:31:19
- **Pause Remaining:** 00:05:00

PAUSE

FLAG

A nurse is providing preoperative teaching about stool consistency to a client who will undergo a colectomy with the placement of an ileostomy. Which of the following information about stool consistency should the nurse include in the teaching?

The stool will have a tarry color.

The nurse should identify that a tarry color can indicate a GI bleed.

The stool will have a high volume of liquid.

The nurse should include in the teaching that when peristalsis returns, the client can have an initial period of high-volume liquid stool output, more than 1,000 mL/day. Later, as the proximal small bowel adapts, stool volume should decrease.

The stool will be solid and well-formed.

The nurse identify that a descending colostomy excretes solid stool similar to what the rectum would eliminate. Drainage from an ileostomy is not solid because it is not passing through the colon, where a great deal of fluid is absorbed to form stool that is more solid in consistency.

The stool will appear bloody with clots.

The nurse should identify that the first drainage from an ileostomy can appear red in color but should not contain frank blood or clots and should quickly change to a greenish-yellow color.

- **RN VATI Adult Medical Surgical 2019**

CLOSE

Question: 29 of 90

CORRECT

- **Time Remaining:** 00:31:13
- **Pause Remaining:** 00:05:00

PAUSE

FLAG

A nurse is providing teaching to a client who has a new prescription for levothyroxine to treat hypothyroidism. Which of the following statements by the client indicates an understanding of the teaching?

"If my heart starts racing, my provider might need to adjust my dosage."

Levothyroxine increases metabolism, which can increase oxygen consumption and heart rate. If the client's heart is racing, the dosage might be too high, causing thyrotoxicosis with manifestations of tachycardia, insomnia, tremors and nervousness, hyperthermia, heat intolerance, and sweating. The provider should retest the client's thyroid hormone levels and adjust the dosage accordingly.

"I will keep a journal of my daily food intake to show the provider."

Levothyroxine is a synthetic thyroid hormone for replacement therapy. Providers do not prescribe it for weight loss, so a food journal is unnecessary. However, a therapeutic response of weight loss can occur once hormone levels stabilize.

"Once my weight is back to normal, I can gradually reduce and then stop the medication."

Levothyroxine provides lifelong thyroid hormone replacement therapy. Providers do not prescribe it for weight loss. The provider might need to make periodic dosage adjustments based on thyroid hormone levels, but the client will have to continue taking it for life.

"I'm not forgetful, so I do not need a pill reminder system."

The client should take levothyroxine every morning 30 min before eating to maintain a therapeutic thyroid hormone level. Using a pill reminder system provides visual confirmation of whether or not the client took the medication each day.

- **RN VATI Adult Medical Surgical 2019**

CLOSE

Question: 28 of 90

INCORRECT

- **Time Remaining:** 00:31:07
- **Pause Remaining:** 00:05:00

PAUSE

FLAG

A nurse is assessing a client who has an exacerbation of diverticular disease. In which of the following quadrants should the nurse anticipate the client to be experiencing abdominal pain?

Left lower quadrant

Diverticula commonly develop in the sigmoid colon because of the high pressure it takes to move stool into the rectum. Therefore, the pain with this disorder is often in the left lower quadrant.

Left upper quadrant

Left upper quadrant pain is a manifestation of pancreatitis, not diverticular disease.

Right lower quadrant

Right lower quadrant pain is a manifestation of appendicitis, not diverticular disease.

Right upper quadrant

Right upper quadrant pain is a manifestation of cholecystitis, not diverticular disease.

- **RN VATI Adult Medical Surgical 2019**
CLOSE

Question: 27 of 90

INCORRECT

- **Time Remaining:** 00:31:01
- **Pause Remaining:** 00:05:00

PAUSE

FLAG

A nurse is planning care for a client who has a lump in their right breast. Which of the following findings increases the client's risk of developing breast cancer?

Menarche started at age 15

Early menarche, or menstruation, is considered a risk factor for developing breast cancer because the longer the interval is between the start of menarche and menopause, the greater the risk is for developing breast cancer.

First born child was at 20 years of age

Delivering a first child after the age of 30 increases the risk of breast cancer, as does nulliparity.

History of a fibrocystic breasts

A history of fibrocystic breasts is not a risk factor for breast cancer. Dense breast tissue increases the risk for breast cancer.

Oral contraceptives were taken for the last 6 years

Clients who take hormones, such as estrogen therapy, fertility drugs, and oral contraceptives, have an increased risk of developing breast cancer.

- **RN VATI Adult Medical Surgical 2019**
CLOSE

Question: 26 of 90

INCORRECT

- **Time Remaining:** 00:30:53
- **Pause Remaining:** 00:05:00

PAUSE

FLAG

A nurse is providing teaching for a client who has constipation-predominant irritable bowel syndrome (IBS-C). Which of the following statements should the nurse include in the teaching?

"Take a dose of loperamide each morning."

A client who has diarrhea-predominant IBS should take loperamide, which is an antidiarrheal agent that decreases peristalsis and the volume of the stool.

"Increase your fluid intake to 1,000 milliliters per day."

A client who has IBS-C should consume 2,000 to 2,500 mL of fluid each day to soften the stool in the colon and promote regular bowel movements.

"Take psyllium in the evening."

A client who has IBS-C should take a bulk-forming laxative, such as psyllium, to increase the bulk of the stool, reduce constipation, and promote regular bowel movements.

"Consume a diet that is low in protein."

A client who has IBS-C should consume a high-calorie, high-protein diet. Smaller, more frequent meals are better tolerated than larger meals.

- **RN VATI Adult Medical Surgical 2019**

CLOSE

Question: 25 of 90

CORRECT

- **Time Remaining:** 00:30:46
- **Pause Remaining:** 00:05:00

PAUSE

FLAG

A nurse is caring for a client who is receiving mechanical ventilation. Which of the following actions should the nurse implement to decrease the client's risk for ventilator-associated pneumonia (VAP)? (Select all that apply.)

Wear a protective gown when suctioning the client's airway.

Monitor for oral secretions every 2 hr.

Provide oral care every 2 hr.

Maintain the client in a supine position.

Assess the client daily for readiness of extubation.

Wear a protective gown when suctioning the client's airway is incorrect. The nurse should use standard precautions when exposure to bodily secretions is possible. However, a protective gown will not prevent VAP in the client.

Monitor for oral secretions every 2 hr is correct. The nurse should monitor for oral secretions at least every 2 hr to decrease the likelihood of micro-organisms moving from the mouth into the respiratory tract.

Provide oral care every 2 hr is correct. The nurse should provide oral care every 2 hr using chlorhexidine rinse or sodium chloride solution with swabbing or tooth brushing.

Maintain the client in a supine position is incorrect. The nurse should position the client with the head of the bed elevated at least 30° to prevent aspiration of bacteria into the airway.

Assess the client daily for readiness of extubation is correct. To lower the risk of the client acquiring VAP, the nurse should assess the client daily for neurological readiness for discontinuing mechanical ventilation.

- **RN VATI Adult Medical Surgical 2019**

CLOSE

Question: 24 of 90

CORRECT

- **Time Remaining:** 00:30:39
- **Pause Remaining:** 00:05:00

PAUSE

FLAG

A nurse is planning care for a client who is receiving intermittent IV fluids via a peripherally inserted central catheter (PICC). Which of the following information should the nurse include in the client's plan of care?

Assess the PICC infusion system systematically.

The nurse should assess the infusion system in a systematic fashion beginning with the insertion site, observing for signs of infection, and working upward and following the tubing to ensure that all connections are secure.

Use a 3-mL syringe to flush the PICC following infusions.

The nurse should use a 10-mL or larger syringe to flush the PICC because using a smaller syringe could place undue pressure on the catheter and increase the risk of rupture.

Change the needleless connector device on the IV tubing after each infusion.

The nurse should change the needleless connector device on the PICC at least once per week or in accordance with the facility's policy. Frequently changing the needleless connector device increases the risk of introducing micro-organisms into the client's bloodstream.

Provide daily dressing changes to the PICC insertion site.

Most facilities require PICC dressing changes every 5 to 7 days for transparent membrane dressings and when indicated, such as when wet, loose, or soiled. Changing the dressing daily can expose the client to the risk of bloodstream infection.

- **RN VATI Adult Medical Surgical 2019**

CLOSE

Question: 23 of 90

CORRECT

- **Time Remaining:** 00:30:34
- **Pause Remaining:** 00:05:00

PAUSE

FLAG

A nurse is performing a risk assessment for a client. Which of the following factors should the nurse identify as increasing the client's risk for falls?

The client has gastroesophageal reflux disease

A client who has gastroesophageal reflux disease is not at an increased risk for falls.

The client is 62 years old.

Clients who are older than 80 years of age are at increased risk for injury from falls. However, this client's age does not increase their risk for injury.

The client had cataract surgery 1 day ago.

A client who had recent eye surgery is at increased risk for falls. The nurse should ensure the client is wearing prescription glasses when ambulating and that environmental hazards, such as loose rugs, are removed because the client's vision might be blurred.

The client takes colesevelam.

Colesevelam is a lipid-lowering agent used to lower cholesterol levels in clients who have hyperlipidemia. Adverse effects of this medication include constipation and dyspepsia. This medication does not put the client at an increased risk of falls. The nurse should review the client's prescribed and over-the-counter medications, as well as any nutritional and herbal supplements the client takes, to determine whether any of the medications can cause confusion, limited mobility, or orthostatic hypotension.

- **RN VATI Adult Medical Surgical 2019**

CLOSE

Question: 22 of 90

CORRECT

- **Time Remaining:** 00:30:30
- **Pause Remaining:** 00:05:00

PAUSE

FLAG

A nurse is providing teaching to a group of clients about the prevention of coronary artery disease. Which of the following information should the nurse include in the teaching?

Walk 30 min daily at a comfortable pace.

The clients should walk 30 min daily at a comfortable pace to prevent weight gain and decrease the risk of coronary artery disease.

Limit saturated fat intake to 10% of total daily calories.

Limiting saturated fat intake to 5% to 6% of total daily calories can decrease the risk of coronary artery disease.

Maintain a BMI of 30.

A BMI of 30 indicates that a client is obese, and, therefore, has a greater risk of developing coronary artery disease and hypertension. Clients should strive to maintain a BMI within the range for healthy weight, which is 18.5 to 24.9.

Consume at least 2,000 mg of sodium per day.

Consuming no more than 1,500 mg sodium per day can decrease the risk of hypertension and coronary artery disease.

- **RN VATI Adult Medical Surgical 2019**

CLOSE

Question: 21 of 90

CORRECT

- **Time Remaining:** 00:30:23
- **Pause Remaining:** 00:05:00

PAUSE

FLAG

A home health nurse is inspecting a client's residence for electrical hazards as part of the agency's quality improvement plan. Which of the following findings should the nurse identify as a safety hazard?

The client's bed has a three-prong plug attached to the electrical cord.

The nurse should use appliances that have grounded plugs to reduce the risk for injury. The third prong on the cord acts as a grounding device while the other two prongs transmit the electricity.

A protective cover is inserted into an unused outlet.

The nurse should cover unused outlets with a protective cover to prevent small children who are visiting the client from being electrocuted.

An IV pump is plugged into an outlet near a sink.

The nurse should plug all electrical appliances into outlets away from wet areas. Water conducts electricity and places the client at risk for electrocution.

An electrical cord is coiled and secured to the floor.

The nurse should coil and secure electrical cords to the floor and away from heavy traffic areas to reduce the risk of injury to the client.

- **RN VATI Adult Medical Surgical 2019**

CLOSE

Question: 20 of 90

CORRECT

- **Time Remaining:** 00:30:15
- **Pause Remaining:** 00:05:00

PAUSE

FLAG

A nurse is teaching a client about self-management of their halo fixator device. Which of the following information should the nurse include in the teaching?

Give each screw a quarter turn daily using the wrench provided.

The halo fixator device is used to provide immobilization of the cervical spine following injury. It is attached with four screws into the skull. A special wrench is necessary to adjust the device and should be kept with the client at all times. However, the screws should not be adjusted by the client or the nurse. The client should be instructed to inspect the screw sites daily and report any loosening, redness, or drainage to the provider.

Apply powder liberally under the chest portion of the halo fixator device.

Powder can contribute to skin breakdown. The nurse should instruct the client to avoid powder or to use it sparingly.

Avoid the use of straws when drinking liquids.

The nurse should instruct the client to use a straw when drinking liquids. The use of a cup requires hyperextension of the neck, which should be avoided while the halo fixator device is in place.

Place a small pillow under the head while lying supine.

The halo fixator device is worn for a period of 8 to 12 weeks and immobilizes the cervical spine, preventing flexion and hyperextension of the neck. The use of a small pillow under the head provides support to the head and neck, preventing additional discomfort and pressure from the device.

- **RN VATI Adult Medical Surgical 2019**
  CLOSE

Question: 19 of 90

CORRECT

- **Time Remaining:** 00:30:11
- **Pause Remaining:** 00:05:00
  PAUSE

FLAG

A nurse is providing teaching to a client about strategies to manage menopausal symptoms. Which of the following instructions should the nurse include in the teaching?

"Drink green tea to relieve menopausal hot flashes."

Drinking green tea can potentially improve mental clarity due to the caffeine it contains. However, green tea will not relieve menopausal hot flashes.

"Take vitamin D supplements to relieve menopausal hot flashes."

Taking vitamin D supplements with calcium can prevent fractures following menopause. However, vitamin D will not relieve menopausal hot flashes.

"Use water-based lubricant during intercourse to reduce discomfort."

The nurse should instruct the client to use water-based lubricants to help relieve vaginal dryness and irritation during sexual intercourse. Atrophic vaginitis is a common manifestation of menopause.

"Apply estrogen cream during intercourse to reduce discomfort."

The nurse should instruct the client to apply topical vaginal estrogen once daily and not use it as a lubricant during intercourse. The client can use topical estrogen to prevent and treat vaginal atrophy and dryness without producing systemic effects of oral estrogen therapy.

- **RN VATI Adult Medical Surgical 2019**

CLOSE

Question: 18 of 90

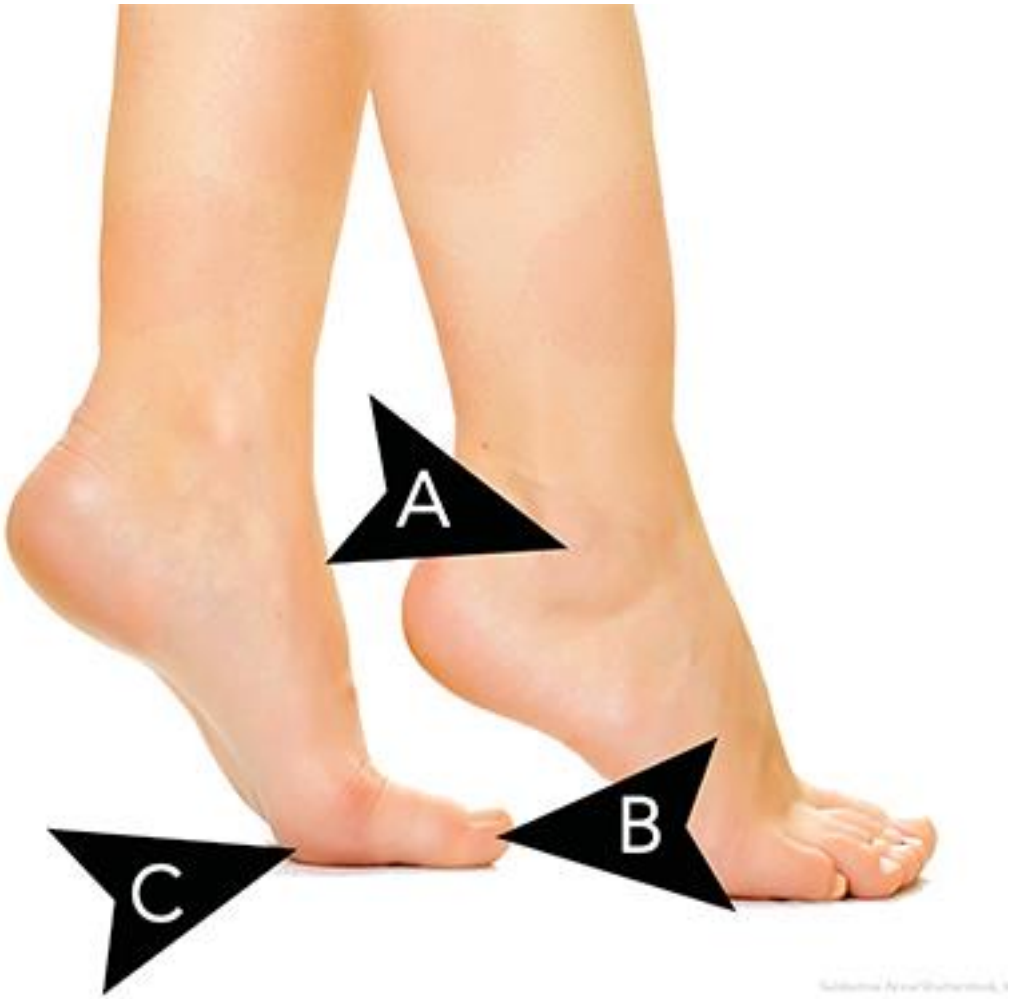
CORRECT

- **Time Remaining:** 00:30:05
- **Pause Remaining:** 00:05:00

PAUSE

FLAG

A nurse is caring for a client who has chronic venous insufficiency. Which of following areas should the nurse assess for the presence of a venous ulcer? (You will find hot spots to select in the artwork below. Select only the hot spot that corresponds to your answer.)



A is correct. The nurse should assess the medial malleolus (ankle) of a client who has chronic venous insufficiency for the presence of a venous ulcer. The ankle is the most common area for a venous ulcer. A client who has venous insufficiency can exhibit skin discoloration and edema as well as a large or superficial ulcer with irregular borders at the site of the medial or lateral malleolus that weeps exudate. A pulse is palpable in this area and the client typically experiences a moderate level of pain at the site.

B is incorrect. The nurse should assess the tip of the toe and between the toes of a client who has arterial insufficiency for the presence of an arterial ulcer. A client who has an arterial ulcer can exhibit cyanosis in the extremity, cool temperature to the touch, and weak or absent pulses.

C is incorrect. The nurse should assess the ball of the foot of a client who has diabetes mellitus. A client who has a diabetic ulcer can exhibit wounds or ulcers on the plantar or other pressure areas of the feet. These wounds are deep with pale, even edges, and little granulation in the wound bed.

- **RN VATI Adult Medical Surgical 2019**

CLOSE

Question: 17 of 90

CORRECT

- **Time Remaining:** 00:29:59
- **Pause Remaining:** 00:05:00

PAUSE

FLAG

A nurse in an emergency department is caring for a client who is confused, has a temperature of 40° C (104° F), a BP of 74/52 mm Hg, and a diagnosis of exertional heat stroke. Which of the following actions should the nurse take first?

Measure the client's urine specific gravity.

The nurse should monitor urinary output and measure specific gravity to evaluate the client's fluid status. However, there is another action the nurse should take first.

Administer oxygen using a high-concentration mask.

The first action the nurse should take when using the airway, breathing, and circulation approach to client care is to ensure that the client has a patent airway and administer oxygen using a high-concentration mask to promote oxygen perfusion to vital organs.

Initiate gastric lavage with ice water.

The nurse should lower the client's core temperature by using gastric or bladder lavage with ice water. However, there is another action the nurse should take first.

Immerse the client in cold water.

The nurse can immerse the client in cold water to cool the client rapidly. However, there is another action the nurse should take first.

- **RN VATI Adult Medical Surgical 2019**
  CLOSE

Question: 16 of 90

CORRECT

- **Time Remaining:** 00:29:54
- **Pause Remaining:** 00:05:00

PAUSE

FLAG

A nurse is caring for a client who has a prescription for lactated Ringer's by continuous IV infusion to replace output from an NG tube. Which of the following findings should indicate to the nurse that this therapy is effective?

Decreased NG tube drainage

Administering IV fluids replaces volume lost to gastric drainage, but a slowing of the gastric drainage does not indicate a balance in the client's fluid status.

Serum osmolality 350 mOsm/L

A serum osmolality above 300 mOsm/L can indicate dehydration due to a decrease in circulating fluid volume and an increase of blood particles per unit volume of serum. Therefore, this finding indicates that fluid replacement therapy is not effective for the client.

Urine specific gravity 1.020

The concentration of the urine regulated by hydration is measured by the weight of the particles in the urine. A urine specific gravity within the expected reference range of 1.005 to 1.030 indicates that fluid replacement is keeping up with fluid loss from gastric drainage.

Increased hematocrit

An increase in hematocrit can indicate hemoconcentration and hypovolemia and is an indication that fluid replacement therapy is not effective for the client.

- **RN VATI Adult Medical Surgical 2019**

CLOSE

Question: 16 of 90

CORRECT

- **Time Remaining:** 00:29:48
- **Pause Remaining:** 00:05:00

PAUSE

FLAG

A nurse is caring for a client who has a prescription for lactated Ringer's by continuous IV infusion to replace output from an NG tube. Which of the following findings should indicate to the nurse that this therapy is effective?

Decreased NG tube drainage

Administering IV fluids replaces volume lost to gastric drainage, but a slowing of the gastric drainage does not indicate a balance in the client's fluid status.

Serum osmolality 350 mOsm/L

A serum osmolality above 300 mOsm/L can indicate dehydration due to a decrease in circulating fluid volume and an increase of blood particles per unit volume of serum. Therefore, this finding indicates that fluid replacement therapy is not effective for the client.

Urine specific gravity 1.020

The concentration of the urine regulated by hydration is measured by the weight of the particles in the urine. A urine specific gravity within the expected reference range of 1.005 to 1.030 indicates that fluid replacement is keeping up with fluid loss from gastric drainage.

Increased hematocrit

An increase in hematocrit can indicate hemoconcentration and hypovolemia and is an indication that fluid replacement therapy is not effective for the client.

- **RN VATI Adult Medical Surgical 2019**

CLOSE

Question: 15 of 90

CORRECT

- **Time Remaining:** 00:29:39
- **Pause Remaining:** 00:05:00

PAUSE

FLAG

A nurse is caring for a client who is 3 hr postoperative and exhibiting signs of hypovolemia. Which of the following findings should the nurse identify as a manifestation of hypovolemia?

Distended neck veins

A client who has hypovolemia has flat neck veins due to lack of circulating fluid volume. The veins on the hands might appear flat as well. Distended neck veins can be a sign of hypervolemia.

Rapid pulse rate

A client who has hypovolemia has a rapid, weak pulse rate to compensate for the decrease in blood volume in an attempt to increase blood pressure.

Urine output 45 mL/hr

A client who has hypovolemia has a urine output less than 30 mL/hr and a specific gravity higher than 1.030 due to the lack of circulating fluid volume and kidney perfusion.

Decreased respiratory rate

A client who has hypervolemia has an increase in respiratory rate to compensate for the decrease in circulating fluid volume.

- **RN VATI Adult Medical Surgical 2019**

CLOSE

Question: 14 of 90

CORRECT

- **Time Remaining:** 00:29:32
- **Pause Remaining:** 00:05:00

PAUSE

FLAG

A nurse is planning care for a client who has tuberculosis. Which of the following precautions should the nurse implement for this client?

Contact precautions

The nurse should implement contact precautions for clients who have known or suspected infections due to micro-organisms that spread by direct contact or contact with items in the environment, such as *Clostridium difficile*, vancomycin-resistant enterococci, and methicillin-resistant *Staphylococcus aureus*.

Protective environment precautions

The nurse should implement protective environment precautions for clients who have a diminished or dysfunctional neutrophil count. A protective environment is essential for clients who have severe immunosuppression.

Droplet precautions

The nurse should implement droplet precautions for clients who have known or suspected infections transmitted by droplets that travel up to 0.9 m (3 feet) but do not remain suspended for prolonged periods, such as diphtheria, rubella, mumps, pertussis, and meningococcal pneumonia or sepsis.

Airborne precautions

Tuberculosis, like measles, chickenpox, and varicella zoster, spreads by airborne transmission of micro-organisms that suspend in the air for prolonged periods. The nurse should implement airborne precautions by placing the client in a negative-pressure airflow room and wearing an N95 respirator mask.

- **RN VATI Adult Medical Surgical 2019**

CLOSE

Question: 13 of 90

CORRECT

- **Time Remaining:** 00:29:26
- **Pause Remaining:** 00:05:00

PAUSE

FLAG

A nurse is analyzing the ABG results of a client who is in respiratory acidosis. Which of the following mechanisms should the nurse identify as responsible for this acid-base imbalance?

Breakdown of fatty acids

A breakdown of fatty acids is usually a result of diabetic ketoacidosis or starvation and can lead to metabolic acidosis.

Retention of carbon dioxide

Respiratory acidosis results from the retention of carbon dioxide. Retention of carbon dioxide can result from respiratory depression, inadequate chest expansion, airway obstruction, or decreased alveolar capillary diffusion.

Hyperventilation in response to hypoxia

Hyperventilation from any cause can result in a decrease of carbon dioxide, leading to respiratory alkalosis.

Ingestion of large amounts of bicarbonate

Ingesting large amounts of bicarbonates and citrates can cause base excess, leading to a state of metabolic alkalosis.

- **RN VATI Adult Medical Surgical 2019**

CLOSE

Question: 12 of 90

CORRECT

- **Time Remaining:** 00:29:18
- **Pause Remaining:** 00:05:00

PAUSE

FLAG

A nurse is preparing to administer propranolol to several clients. For which of the following clients should the nurse clarify the prescription with the provider before administration?

A client who had a myocardial infarction 24 hr ago

Myocardial infarction is an indication for taking propranolol. Propranolol is a beta-adrenergic blocker that decreases the heart rate by suppressing conduction through the AV

node and reducing the force of ventricular contraction. This can lead to a decrease in oxygen demand, a slower heart rate, and an increase in myocardial oxygen supply.

A client who has a heart rate of 98/min

Beta-adrenergic blockers have a chronotropic action that decreases the heart rate by suppressing conduction through the AV node and reducing the force of ventricular contraction. The nurse should clarify the prescription with the provider if the client's heart rate is slower than 60/min.

A client who has hypertension

Hypertension is an indication for taking propranolol. Propranolol is a beta-adrenergic blocker that slows the heart rate and decreases blood pressure and cardiac output by suppressing conduction through the AV node and reducing the force of ventricular contraction.

A client who has a history of asthma

Propranolol is a nonselective beta-adrenergic blocker. Contraindications include asthma, COPD, and heart failure because the blockade of $beta_2$ receptors in the lungs can cause bronchoconstriction.

- **RN VATI Adult Medical Surgical 2019**

CLOSE

Question: 11 of 90

CORRECT

- **Time Remaining:** 00:29:12
- **Pause Remaining:** 00:05:00

PAUSE

FLAG

A nurse is providing teaching for a client who has neutropenia and is receiving chemotherapy. Which of the following client statements indicates an understanding of the teaching? (Select all that apply.)

"I will avoid crowds."

"I will wash my toothbrush weekly."

"I will change my cat's litter box twice weekly."

"I will take my temperature daily."

"I will eat plenty of fresh fruits and vegetables."

"I will avoid crowds" is correct. The client who is immunocompromised should avoid crowds while undergoing chemotherapy to reduce the risk of infection.

"I will wash my toothbrush weekly" is incorrect. The client who is immunocompromised should wash their toothbrush daily in the dishwasher or rinse it in a bleach solution to prevent bacterial growth.

"I will change my cat's litter box twice weekly" is incorrect. The client who is immunocompromised should have someone else change the litter box to avoid infections.

"I will take my temperature daily" is correct. The client who is immunocompromised should take daily temperature readings and report an elevated temperature to the provider.

"I will eat plenty of fresh fruits and vegetables" is incorrect. The client who is immunocompromised should avoid food sources that contain bacteria, such as fresh fruits and vegetables, undercooked meat, fish, and eggs.

- **RN VATI Adult Medical Surgical 2019**

CLOSE

Question: 10 of 90

INCORRECT

- **Time Remaining:** 00:29:05
- **Pause Remaining:** 00:05:00

PAUSE

FLAG

A nurse is assessing a client who has a chest tube connected to a closed water-seal drainage system. Which of the following findings should the nurse report to the provider?

Fluctuation of the water level in the chamber as the client breathes

Fluctuation in the water seal chamber with the client's respirations is an expected finding and indicates a patent drainage system.

Constant bubbling in the water seal chamber

Constant bubbling in the water seal chamber can be an indication of an air leak, which is caused by a disruption in the system such as a loose connection. Pulmonary air leaks create intermittent bubbling that is synchronous with respiration. This finding should be reported to the provider immediately.

Numerous small blood clots in the drainage tubing

Numerous small blood clots in the drainage tubing are an expected finding that indicates a patent drainage system that is removing blood from the pleural space.

Water seal chamber contains 1 cm (0.39 in) of water

The water seal chamber requires at least 2 cm (0.79 in) of water to function properly. The nurse should add water to the chamber; however, this does require the nurse to notify the provider.

- **RN VATI Adult Medical Surgical 2019**

CLOSE

Question: 9 of 90

CORRECT

- **Time Remaining:** 00:28:57
- **Pause Remaining:** 00:05:00

PAUSE

FLAG

A nurse is caring for a client who has a small bowel obstruction and an NG tube in place. Which of the following actions should the nurse take?

Maintain low intermittent suction.

The nurse should maintain low intermittent suction to prevent gastric irritation and ulceration. With a small bowel obstruction, the NG tube removes gastric secretions and decompresses the bowel.

Assess patency and irrigate the NG tube every 12 hr.

The nurse should assess the patency and irrigate the NG tube at least every 4 hr to ensure patency of the tube and adequate output of gastric secretions.

Record gastric output every 8 hr.

The nurse should monitor and measure the gastric output at least every 4 hr.

Fasten the end of the tube to the client's pillow case.

The nurse should fasten the end of the tube to the client's gown and allow enough slack in the tube for movement to prevent accidental dislodgement of the NG tube.

- **RN VATI Adult Medical Surgical 2019**

CLOSE

Question: 8 of 90

INCORRECT

- **Time Remaining:** 00:28:51
- **Pause Remaining:** 00:05:00

PAUSE

FLAG

A nurse is teaching a client who has a new diagnosis of type 1 diabetes mellitus. Which of the following statements by the client indicates an understanding of the teaching?

"I am aware that my diabetes is caused by an autoimmune disorder."

Type 1 diabetes mellitus is an autoimmune disorder that destroys pancreatic beta cells. This autoimmune reaction is often triggered by a viral infection.

"I know that my diabetes developed slowly over several years."

Type 1 diabetes mellitus occurs abruptly. Type 2 diabetes mellitus progresses slowly over time and is caused by insulin resistance and the reduced secretion of insulin from the beta cells.

"If I lose weight, I may be able to stop taking insulin."

Clients who have type 1 diabetes mellitus are typically not overweight, and weight loss does not affect the ability of the pancreas to produce insulin. Type 2 diabetes mellitus often follows insulin resistance, which develops from obesity and physical inactivity.

"I have developed a resistance to insulin."

Type 1 diabetes mellitus involves pancreatic beta cell destruction, resulting in the inability of the pancreas to produce insulin. Type 2 diabetes mellitus is caused by insulin resistance, which develops from obesity and physical inactivity.

- **RN VATI Adult Medical Surgical 2019**

CLOSE

Question: 7 of 90

CORRECT

- **Time Remaining:** 00:28:45
- **Pause Remaining:** 00:05:00

PAUSE

FLAG

A nurse is monitoring a client who has a traumatic brain injury. Which of the following findings should the nurse identify as a manifestation of Cushing's triad?

Increase in temperature from 37.5º C (99.5º F) to 38.3º C (101º F)

A rise in temperature indicates that the client is at risk for infection; however, this is not a manifestation of Cushing's triad.

Increase in blood pressure from 130/80 mm Hg to 180/100 mm Hg

A change in blood pressure from 130/80 mm Hg to 180/100 mm Hg indicates a widened pulse pressure and hypertension, which are components of Cushing's triad, a sign of increased intracranial pressure.

Increase in urine output from 30 mL/hr to 100 mL/hr

Following a traumatic brain injury, an increase in urinary output indicates that the client is at risk for diabetes insipidus; however, this is not a manifestation of Cushing's triad.

Increase in heart rate from 70/min to 90/min

Bradycardia is a component of Cushing's triad, which is a classic sign of increased intracranial pressure.

- **RN VATI Adult Medical Surgical 2019**

CLOSE

Question: 6 of 90

CORRECT

- **Time Remaining:** 00:28:37
- **Pause Remaining:** 00:05:00

PAUSE

FLAG

A nurse is preparing to administer potassium chloride 10 mEq IV over 1 hr to a client. Available is potassium chloride 10 mEq in 100 mL of 0.9% sodium chloride. The nurse should set the infusion pump to deliver how many mL/hr? (Round the answer to the nearest whole number. Use a leading zero if it applies. Do not use a trailing zero.)

mL/hr

Follow these steps to calculate the infusion rate using the Ratio and Proportion or Desired Over Have method of calculation:

Step 1: What is the unit of measurement the nurse should calculate? mL/hr

Step 2: What is the volume the nurse should infuse? 100 mL

Step 3: What is the total infusion time? 1 hr

Step 4: Should the nurse convert the units of measurement? No

Step 5: Set up an equation and solve for X.

$$\frac{X \text{ mL/hr}}{} = \frac{\textit{Volume (mL)}}{}$$

Time (hr)

$$\frac{X \text{ mL/hr}}{} = \frac{100 \text{ mL}}{1 \text{ hr}}$$

X mL/hr = 100 mL/hr

Step 6: Round if necessary.

Step 7: Determine if the amount to administer makes sense. If the prescription reads potassium chloride 10 mEq in 100 mL 0.9% sodium chloride IV to infuse over 1 hr, it makes sense to administer 100 mL/hr. The nurse should set the IV pump to deliver potassium chloride 10 mEq in 100 mL 0.9% sodium chloride IV at 100 mL/hr.

Follow these steps to calculate the infusion rate using the Dimensional Analysis method of calculation:

Step 1: What is the unit of measurement the nurse should calculate? (Place the unit of measure being calculated on the left side of the equation.)

X mL/hr =

Step 2: Determine the ratio that contains the same unit as the unit being calculated. (Place the ratio on the right side of the equation, ensuring that the unit in the numerator matches the unit being calculated.)

$$\frac{X \text{ mL/hr}}{} = \frac{100 \text{ mL}}{1 \text{ hr}}$$

Step 3: Place any remaining ratios that are relevant to the item on the right side of the equation, along with any needed conversion factors, to cancel out unwanted units of measurement.

$$\frac{X \text{ mL/hr}}{} = \frac{100 \text{ mL}}{1 \text{ hr}}$$

Step 4: Solve for X.

X mL/hr = 100 mL/hr

Step 5: Round if necessary.

Step 6: Determine if the amount to administer makes sense. If the prescription reads potassium chloride 10 mEq in 100 mL 0.9% sodium chloride IV to infuse over 1 hr, it makes sense to administer 100 mL/hr. The nurse should set the IV pump to deliver potassium chloride 10 mEq in 100 mL 0.9% sodium chloride IV at 100 mL/hr.

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CLOSE

Question: 5 of 90

INCORRECT

- **Time Remaining:** 00:28:31
- **Pause Remaining:** 00:05:00

PAUSE

FLAG

A nurse is providing teaching about dietary options for a client who has cholelithiasis. Which of the following statements should the nurse include in the teaching?

"Cauliflower is a good dietary choice."

The nurse should instruct the client to avoid foods that are gas forming, such as cauliflower and cabbage. These foods can increase the client's abdominal discomfort.

"Increase the amount of egg yolks in your diet."

Clients who have acute cholelithiasis should consume a low-fat diet. Foods such as egg yolks are high in fat and trigger the release of bile from the gall bladder, which can increase the client's abdominal discomfort.

"Select desserts such as angel-food cake."

Clients who have acute cholelithiasis will be prescribed a low-fat diet. Desserts such as sherbet, gelatin, and angel food cake are dessert choices that are low in fat.

"Eat choice or prime cuts of meat."

The nurse should inform the client that select cuts of meat are lower in fat than prime or choice cuts. Select cuts are recommended for clients who have cholelithiasis and are on a low-fat diet.

- **RN VATI Adult Medical Surgical 2019**

CLOSE

Question: 4 of 90

CORRECT

- **Time Remaining:** 00:28:24
- **Pause Remaining:** 00:05:00

PAUSE

FLAG

A nurse is providing discharge teaching to a client who has COPD. Which of the following instructions should the nurse include in the teaching?

"Schedule controlled coughing exercises after meals."

The client should schedule controlled coughing exercises before meals to clear mucus, which can improve dietary intake.

"Consume a diet that is high in calories."

Dyspnea decreases energy available for eating. Therefore, the nurse should encourage the client to eat soft, high-calorie and high-protein foods to prevent weight loss.

"Practice breath-holding."

The nurse should teach the client to use pursed-lip breathing and avoid breath-holding, which can increase the amount of air that is trapped in the lungs. Pursed-lip breathing decreases the amount of stale air in the lungs and decreases dyspnea by forcefully and slowly exhaling through pinched lips, as if to whistle.

"Perform arm-reaching exercises."

The client should avoid activities involving the arms because this type of activity limits the availability of the accessory muscles essential for ventilation, which results in decreased exercise tolerance.

- **RN VATI Adult Medical Surgical 2019**

CLOSE

Question: 3 of 90

CORRECT

- **Time Remaining:** 00:28:18
- **Pause Remaining:** 00:05:00

PAUSE

FLAG

A nurse is assessing a client's understanding of a surgical procedure prior to witnessing their signature on the informed consent form. The nurse determines that the client does not

understand what the procedure will involve. Which of the following actions should the nurse take?

Provide teaching about the surgical procedure for the client.

The responsibility of discussing the surgical procedure, including the risks, benefits, and alternative therapies, belongs to the provider who will be performing the procedure. If the information the nurse gives to the client is incorrect or incomplete, the nurse is liable and might face legal action.

Instruct the client's spouse to sign the consent form.

Any client who is competent should sign their own surgical consent form. A spouse or guardian can sign the form if the client is incompetent, incapacitated, or a minor.

Read the consent form to the client using words the client will understand.

The consent form should be read to a client who is unable to read. However, the nurse should recognize that the consent form does not contain all of the educational information regarding the procedure that the provider shared with the client. Therefore, reading the consent form to the client will not increase the client's understanding of the procedure, risks, benefits, and alternative treatments.

Contact the provider who will be performing the procedure.

The nurse should advocate for the client by informing the provider if the client does not understand the procedure. It is the responsibility of the provider to discuss the procedure more fully with the client.

- **RN VATI Adult Medical Surgical 2019**

CLOSE

Question: 2 of 90

CORRECT

- **Time Remaining:** 00:28:11
- **Pause Remaining:** 00:05:00

PAUSE

FLAG

A nurse is providing teaching to a client who is scheduled for a bronchoscopy. Which of the following statements should the nurse include in the teaching?

"You will not be able to eat or drink after the procedure until you are able to cough."

A client who had a bronchoscopy received a local anesthetic that can suppress the cough reflex. The cough reflex protects the client from aspirating fluids or food. Therefore, the client should not eat or drink until the cough reflex returns.

"You will drink a contrast solution 30 minutes prior to the procedure."

A bronchoscopy allows for direct visualization of bronchial structures and does not require the use of a contrast solution. The client should be NPO for 4 to 8 hr prior to the test.

"The purpose of this procedure is to remove excess fluid from your lungs."

A bronchoscopy allows for direct visualization of bronchial structures to identify disorders, collect specimens, remove foreign bodies or secretions, stop bleeding, remove lesions, or provide brachytherapy or radiation to the endobronchial area. A thoracoscopy removes excess fluid from the pleural cavity.

"You will need to lie on your back for 4 to 6 hours following the procedure."

Following a bronchoscopy, the client is at risk for hypoxia and dyspnea. Therefore, the nurse should elevate the head of the client's bed.

- **RN VATI Adult Medical Surgical 2019**

CLOSE

Question: 1 of 90

CORRECT

- **Time Remaining:** 00:28:06
- **Pause Remaining:** 00:05:00

PAUSE

FLAG

A nurse is caring for a client who is 24 hr postoperative following a total hip arthroplasty. Which of the following actions should the nurse take?

Place the affected leg in external rotation.

The nurse should keep the affected extremity in a neutral position to prevent dislocation. Manifestations of a dislocation of the hip include inward rotation of the affected leg, sudden severe pain, and shortening of the surgical extremity.

Encourage the client to use the incentive spirometer every shift.

The nurse should encourage the client to cough, breathe deeply, and use the incentive spirometer every 2 hr to prevent pneumonia and atelectasis, which is the collapse of alveoli. Atelectasis can lead to poor oxygen exchange and pneumonia.

Instruct the client to lean forward when rising from a chair.

To prevent dislocation of the hip, the client should not flex the hip more than 90º at any time. Leaning forward when rising from a chair flexes the hip more than 90º.

Maintain abduction of the affected extremity.

The nurse should ensure that the affected extremity is in a position of abduction to prevent hip dislocation. The nurse should place an abductor pillow or several pillows between the client's legs to keep the affected extremity in abduction while the client is in bed.