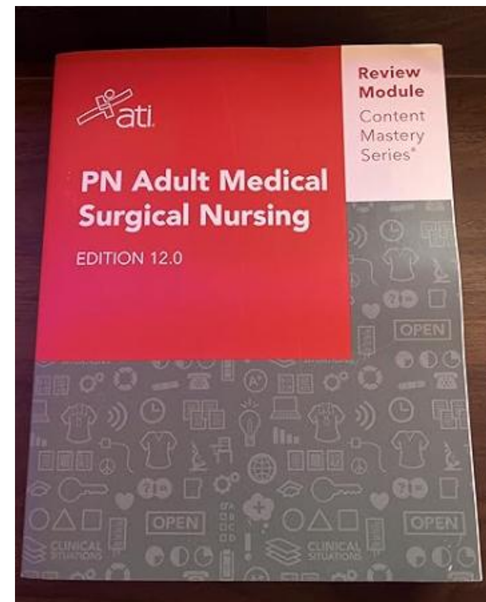
TEST BANK FOR

ATI PN Adult Medical Surgical Nursing Edition 12.0

Content Mastery Series Review Module

UNITS 1-14



UNIT 1: FOUNDATIONS OF NURSING CARE

20 Practice Questions with Rationales

---

1. Which action best prevents the spread of infection in the clinical setting?

A. Wearing gloves for all client contact
B. Performing hand hygiene before and after client contact
C. Cleaning equipment once per shift
D. Wearing a mask when entering all rooms

 Correct Answer: B
Rationale: Hand hygiene is the single most effective method to prevent transmission of microorganisms. Gloves do not replace hand hygiene.

---

2. A nurse is assisting a client to move up in bed. Which action reduces the risk of injury to the nurse?

A. Keeping feet close together
B. Bending at the waist
C. Using leg muscles to lift
D. Twisting while lifting

☐ **Correct Answer: C**
Rationale: Using leg muscles and keeping the back straight helps prevent musculoskeletal injury.

---

3. A client is at risk for aspiration. Which position is most appropriate during meals?

A. Supine
B. Side-lying
C. Semi-Fowler’s
D. High-Fowler’s

☐ **Correct Answer: D**
Rationale: High-Fowler’s position (upright) reduces the risk of aspiration during eating.

---

4. Which vital sign should be reported immediately?

A. Temperature 37.2°C (99°F)
B. Pulse 88/min
C. Respirations 10/min
D. Blood pressure 120/78 mm Hg

☐ **Correct Answer: C**
Rationale: A respiratory rate of 10/min is below normal and may indicate respiratory depression.

---

5. Which client is at highest risk for developing a pressure injury?

A. A client who ambulates with assistance
B. A client who is incontinent and immobile
C. A client with controlled diabetes
D. A client receiving oral antibiotics

☐ **Correct Answer: B**
Rationale: Immobility and moisture from incontinence significantly increase pressure injury risk.

---

6. When should a nurse use sterile gloves?

A. Administering oral medication
B. Performing catheter insertion
C. Assisting with feeding
D. Taking vital signs

 Correct Answer: B
Rationale: Sterile gloves are required for invasive procedures such as catheter insertion.

---

7. Which action demonstrates correct use of Standard Precautions?

A. Wearing gloves only if blood is visible
B. Using a mask for all client care
C. Treating all body fluids as potentially infectious
D. Isolating all clients with fever

 Correct Answer: C
Rationale: Standard Precautions assume all blood and body fluids may be infectious.

---

8. A nurse is documenting care provided. Which entry is appropriate?

A. "Client acted confused and difficult"
B. "Client appears to be in pain"
C. "Client reports pain level 7/10"
D. "Client was uncooperative today"

 Correct Answer: C
Rationale: Documentation should be objective and include the client's exact statements when possible.

---

9. Which food selection is best for a client on a clear liquid diet?

A. Applesauce
B. Milk
C. Chicken broth
D. Cream soup

 Correct Answer: C
Rationale: Clear liquids include broth, gelatin, and clear juices.

---

10. A nurse is assisting a client to ambulate for the first time after surgery. What is the priority action?

A. Encourage fast walking
B. Check blood pressure before ambulation
C. Ensure the client wears shoes
D. Walk the client to the hallway

 Correct Answer: B
Rationale: Assessing blood pressure helps identify orthostatic hypotension and prevents falls.

---

11. Which finding indicates dehydration?

A. Moist mucous membranes
B. Urine specific gravity 1.030
C. Bounding pulse
D. Decreased hematocrit

 Correct Answer: B
Rationale: Elevated urine specific gravity indicates concentrated urine, a sign of dehydration.

---

12. Which client statement shows understanding of fall prevention?

A. “I will get up without help if I feel okay.”
B. “I will wear non-skid footwear when walking.”
C. “I don’t need the call light.”
D. “I will sit on the edge of the bed before sleeping.”

 Correct Answer: B
Rationale: Non-skid footwear reduces the risk of slipping and falls.

---

13. What is the priority nursing action for a client with a fever?

A. Provide extra blankets
B. Encourage fluid intake
C. Limit oral intake
D. Apply ice packs

 Correct Answer: B
Rationale: Fever increases fluid loss; encouraging fluids helps prevent dehydration.