ATI/ NCLEX style stuff Exit Exam with All Questions and Answers

A client has been prescribed medications by the physician. the nurse providing the client with instructions on taking the medications and knows that which type of medication can be powdered and mixed with liquids or soft foods for oral administration?
A. Enteric-coated tablets
B. Immediate release tablets
C. Capsulated medication
D. orally disintegrated tablets - ✓✓ANSW✓✓..B. Immediate release tablets

rationale: The nurse should tell the client that only immediate release tablets can be powdered and mixed with liquids and soft foods
for oral administration. However, they should be taken immediately. Capsulated medication, immediate release tablets, and orally disintegrated tablets are not powdered. A capsule's tablet makes it easier to swallow than a tablet, which may dissolve in mouth if not swallowed quickly.

A nurse at a community center is speaking to group of healthy older adult clients about health promotion. Which of the following health examinations should the nurse recommend to all clients over 50 years of age performed annually?
A. Electrocardiogram (EKG)
B. Colonoscopy examination
C. chest x-ray
D. Glaucoma examination - ✓✓ANSW✓✓..D. Glaucoma examination

A nurse at a community outreach clinic should recognize which of the following as an example of co-morbidity in an older adult client who is homeless?
A. Inadequate shelter & clothing for weather
B. malnutrition & poverty
C. dementia & tuberculosis
D. lack of preventative healthcare and immunizations - ✓✓ANSW✓✓..C. dementia and tuberculosis

rationale: the term co-morbidity refers to medical conditions that co-exist in a client. The number of co-morbid conditions is used to provide an indication of the health status (and risk of death) of clients. Dementia (a mental illness) and Tuberculosis (a physical illness) occurring in an individual client is an example of co morbidity increases client's risk

A nurse in a long term facility is caring for an older adult client who has dementia. Which of the following finding should the nurse recognize most likely seen in this client?
A. obsessive thoughts
B. phobia
C. agnosia
D. hallucinations - ✓✓ANSW✓✓..C. agnosia

rationale: disorders that cause dementia include conditions that impair the vascular or neurologic structure of the brain. Agnosia the inability to identify familiar objects,is a key to finding dementia

A nurse is assisting with tympanometry. The nurse should identify the risk for which of the following manifestations during tympanometry?
A. Sensorineural hearing loss
B. Confusion
C. Transient Vertigo
D. Disequilibrium and dizziness - ✓✓ANSW✓✓..C. Transient vertigo
rationale: tympanometry measures variations in air pressure in the external ear canal. This test may cause transient vertigo, dizziness and nausea

A nurse is caring a group of healthy older adult clients at an adult day care center. The nurse is discussing the normal effects of aging on the sexual response. The nurse should include information on the possibility of which of the following?
A. a decreased sexual desire in both sexes
B. vaginal wall thickening
C. decreased refractory time in men
D. painful orgasms in women - ✓✓ANSW✓✓..D. painful orgasms in women

A nurse is caring for a 65 year old male client who reports dribbling after voiding and an inability to empty his bladder completely. The nurse should recognize these manifestations are most consistent with which of the following?
A. urinary tract infection
B. urethral obstruction
C. stress incontinence
D. mental deterioration - ✓✓ANSW✓✓..B. urethral obstruction

A nurse is caring for a client who has a serum potassium level of 3.1 mEq/ L. Which of the following actions should the nurse take first?
A. obtain an ECG
B. administer oral potassium
C. encourage potassium rich foods
D. monitor I & O - ✓✓ANSW✓✓..A. obtain an ECG
rationale: will assist in determining dysrhythmias

A nurse is caring for a client with kidney dysfunction. Which of the following may the client experience as a possible complication subsequent to the administration of the medication?
A. Excretion before therapeutic effect is archived
B. Accumulation of toxic levels in drugs
C. prolongation of the effect of medication
D. Excretion of medication in its original form - ✓✓ANSW✓✓..B. Accumulation of toxic levels in drugs

rationale: A client with kidney dysfunction who has been administered a medication could have accumulation of toxic levels in blood if kidneys are unable to filter out excess medication

A nurse is caring for a confused older adult client who is on strict bed rest. Which of the following nursing interventions will best provide for the client's safety?
A. provide opportunities for regular toileting and include this info in the client's care plan
B. Avoid using night lights since they tend to distort images
C. Discuss with the client the need for restraints if the client gets out of bed unassisted
D. Move the client to a room away from noise and confusion of the nursing station - ✓✓ANSW✓✓..A. provide opportunities for regular toileting and include this info in the client's care plan

A nurse is caring for a mildly confused older adult client who was brought to the hospital following a motor vehicle accident. To determine if the client is experiencing pain the nurse should plan to use which of the following?
A. Behavioral indicators and affect
B. Pulse and blood pressure findings
C. Facial expressions and grimaces
D. A self report pain rating scale - ✓✓ANSW✓✓..D. A self report pain rating scale (rationale: mild confusion does not necessarily mean that the client is unable to reliably report her pain. When planning to monitor a client for pain, it is best to always use subjective method, such as client report, rather than an objective method, such as something the health care provider is able to observe. As self -report pain scale is a subjective method. The FACES pain rating scale has proven reliable with clients of all ages, even with clients of mild cognitive impairment or mild confusion)

A nurse is caring for an older adult client who had a total hip arthroplasty and is learning how to ambulate with a standard walker. Which of the following actions, witnessed by the nurse indicates the client is using the walker correctly? - ✓✓ANSW✓✓..The client lifts the walker in front while balancing on both feet, then walks into the walker, supporting his body weight on his hands, while advancing his affected side

A nurse is caring for an older adult client who has osteoarthritis of the right hip and lower lumbar of the vertebrae. Which of the following client statements should indicate to the nurse further instruction is necessary?
A. " a warm shower will help me release morning stiffness when I get out of bed"

B. " to release the pressure on my back and spine, i can use a cane while ambulating"
C. " I will take my NSAID every 6 hours as prescribed, to help control my pain"
D. " I will remain constantly active throughout the day to prevent stiffness" - ✓✓ANSW✓✓..D. " I will remain constantly active throughout the day to prevent stiffness"
rationale: Goals for clients who have arthritis, include balancing rest with activity. The client should be instructed to take frequent rest periods & avoid any activity that causes pain or discomfort

A nurse is caring for an older adult client who is admitted to the hospital with abdominal pain. When talking to the client, the nurse notes the client just nods and smiles in response to questions asked. What developmental concern is this client exhibiting? - ✓✓ANSW✓✓..hearing loss

A nurse is caring for an older adult client who is receiving multiple medications. Which of the following is an appropriate statement by the nurse?
A. dosage intervals are often shorter when receiving multiple medications
B. higher does are often needed when receiving multiple medications
C. only prescription medications need to be included in your medication list
D. Receiving multiple medications can lead to drug interactions - ✓✓ANSW✓✓..D. Receiving multiple medications can lead to drug interactions

A nurse is caring for an older adult client who is recovering from CVA. The nurse is concerned with the possibility of urge incontinence. Which of the following should the nurse recognize as an appropriate short-term outcome for this client?
A. consume 1,000 ML of fluid in 24 hours
B. remain free of daytime accidents
C. void whenever placed on toilet
D. be continent 75 % of the time - ✓✓ANSW✓✓..C. void whenever placed on toilet

(rationale: in the early stage of bladder retaining, the client may still have accidents between toileting times, but placing the client on the toilet to void approximately every 2 hours is a primary intervention in bladder training management. Voiding whenever placed on toilet is initial success)

A nurse is caring for an older adult who recently experienced a myocardial infarction (MI). The client calls the nurse to report experiencing some manifestations similar to those experienced with days of MI. Which of the following client reports should alarm the nurse? choose all that apply.
- Nausea & vomiting
- Diaphoresis & dizziness
- Chest & left arm pain
- anxiety & feeling of dooms
- leg cramps & restlessness
-insomnia & depression - ✓✓ANSW✓✓..- Nausea and vomiting
- Diaphoresis and dizziness