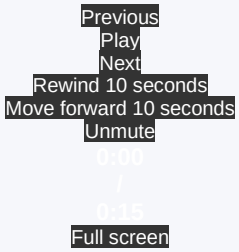
ATI RN CONCEPT-BASED ASSESSMENT LEVEL 2 STUDY GUIDE AND PRACTICE EXAM 2024/2025 | ACCURATE REAL EXAM QUESTIONS WITH VERIFIED ANSWERS | EXPERT VERIFIED FOR A GUARANTEED PASS | LATEST UPDATE

A nurse is providing postoperative education for a client following a laparoscopic cholecystectomy for cholelithiasis. Which of the following client statements indicates an understanding of the teaching?

a- "The adhesive bandages on my incision will fall off as the incision heals."
b- "I will be able to take a shower in 1 week."
c- "I will need to follow a liquid diet for the first 3 days after surgery."
d- "I can begin to resume my normal activity level in 2 weeks.
CORRECT: a- The nurse should instruct the client that the small adhesive bandages will lose their adhesiveness in 7 to 10 days. The client can then remove the bandages or allow the bandages to fall off over time as the incision heals.
INCORRECT:
b- The nurse should instruct the client that she can shower or bathe the day following the surgery.
c- The nurse should instruct the client to resume a regular diet following surgery and slowly introduce foods containing fat to determine tolerance.
d- The nurse should instruct the client to rest for the first 24 hours following surgery and then begin resuming normal activities. The client should be able to resume usual activities within 1 week.
A nurse is assessing a client who has Graves' disease. Which of the following findings should the nurse expect?

a- Somnolence
b- Cold intolerance
c- Exophthalmos
d- Dry, scaly skin
CORRECT: c- The nurse should expect a client who has Graves' disease, an autoimmune form of hyperthyroidism, to experience exophthalmos, which is protrusion of the eyeballs.
INCORRECT:
a- The nurse should expect a client who has hyperthyroidism to experience insomnia. Somnolence is a common manifestation of HYPOthyroidism.
b- The nurse should expect a client who has hyperthyroidsim to experience heat intolerance. cold intolerance is a common manifestation of HYPOthyroidism

d- The nurse should expect a client who has hyperthyroidism to exhibit warm, moist, and smooth skin. Cool, dry scaly skin is a common manifestation of HYPOthyroidsim.



A nurse is teaching a client who has scabies about a new prescription for lindane lotion. Which of the following client statements indicates an understanding of the treatment for this parasitic infection?

a- "I will apply the lotion once a day for 1 week."
b_ "I will rub the lotion thoroughly from my face to my toes."
c- "I will wash the lotion off 12 hours after I apply it."
d- " I should avoid bathing for 6 hours prior to applying the lotion."
CORRECT: c- The nurse should instruct the client to apply the lotion and leave it in place fore 8 to 12 hours and then remove it by washing it off.
INCORRECT:
a- The nurse should instruct the client to apply the lotion, once. If live mites are still present, the nurse should instruct the client to reapply a second application one week following the first application.
b- The nurse should instruct the client to apply approximately 60mL of the lotion in a thin film covering the body from the neck down.
d- The nurse should instruct the client to bathe with soap and water, dry the skin well, and allow it to cool prior to applying the lotion.
A nurse is teaching a client who has GERD about ways to prevent reflux. Which of the following information should the nurse include in the teaching?

a- Drink tomato juice with the breakfast meal.
b- Suck on peppermint when having indigestion.
c- Elevate the head of the bed 10 cm (4 in) using wooden blocks
d- Plan to finish eating at least 3 hours before bedtime.
CORRECT: d- The nurse should encourage the client not to eat anything at least 3 hours before bedtime to prevent reflux.
INCORRECT:
a- The nurse should tell the client not to drink tomato juice or any acidic beverages because acidic beverages can increase reflux.
b- The nurse should encourage the client not to suck on peppermint because it increases reflux.
c- The nurse should instruct the client to elevate the head of the bed 15.2 to 30.5 cm (6 to 12 in) by placing a foam wedge under the head of the bed to decrease reflux.

A nurse is teaching a client who has a deep-vein thrombosis about a new prescription for warfarin. Which of the following client statements indicates an understanding of the teaching?

a- "I will stop taking the medication immediately if I experience nausea."
b- "I should contact my provider if I notice a pink-tinged color to my urine."
c- "I will increase my dietary intake of spinach."
d- "I will not be able to use an electric razor while I am taking this medication."
CORRECT: b- The nurse should instruct the client to monitor for blood in the urine. The client should report a pink-tinged urine color to the provider.
INCORRECT:
a- The nurse should instruct the client not to abruptly stop taking this medication. If the client needs to discontinue the medication, the provider will taper the dose gradually.
c- The nurse should review foods that are high in vitamin K with the client and instruct the client to maintain consistent intake of these foods. Inconsistent intake of these foods, such as increasing the intake of spinach, can result in a fluctuation of prothrombin time or INR levels.
d- The nurse should instruct the client to use an electric razor for shaving to reduce the risk of the risk of bleeding from a bladed razor cut.
A nurse is reviewing the medical record of a client who has a peptic ulcer. Which of the following findings is a priority to report to the provider?

a- Melena stools
b- Hemoglobin 7.6 mg/dL
c- Weight gain of 1.4kg (3lb) in 2 weeks
d- Dyspepsia during the day
CORRECT: b - When using the urgent vs nonurgent approach to client care, the nurse should determine that the priority finding to report to the provider is the hemoglobin below the expected reference range, which is an indication of the peptic ulcer that is chronically bleeding.
INCORRECT:
a- Melena stools are nonurgent because they are an expected finding for a client who has a peptic ulcer that bleeds; therefore, there is another finding that is the nurse's priority.
c- Weight gain is nonurgent because it is an expected finding due to the manifestation of indigestion that can occur for a client who has a peptic ulcer and the urge to eat to decrease dyspepsia; therefore, there is another finding that is the nurse's priority.
d- Dyspepsia, or indigestion, is nonurgent because it is an expected finding that can occur for a client who has a peptic ulcer; therefore, there is another finding that is the nurse's priority.
A nurse is providing teaching to a client who has diabetes mellitus and a new prescription for extended-release metformin. Which of the following client statements indicates an understanding of the teaching?

a- "I will avoid drinking grapefruit juice."
b- "I will chew the medication if I can't swallow it whole."

c- "I will call the doctor if I have muscle pain in my back."
d- "I will take this medication on an empty stomach."
CORRECT: c- Metformin, a biguanide, can cause lactic acidosis, which is a life-threatening complication manifesting as muscle aches, sleepiness, malaise, and hyperventilation. If these manifestations develop, the client should stop taking the medication and notify the provider immediately.
INCORRECT:
a- Grapefruit juice can alter the effects of many medications, including lovastatin, cyclosporine, and buspirone, but it does not affect extended-release metformin.
b- Extended-release metformin is designed to be metabolized over a prolonged period of time. Chewing or crushing the tablets can result in excessive absorption of the medication all at once.
d- The client should take extended-release metformin once a day with his evening meal to help improve absorption due to the slower gastrointestinal transit time overnight.
A community health nurse is teaching a group of older adult clients about interventions to prevent pneumonia. Which of the following instructions should the nurse include in the teaching?

a- "Obtain a pneumococcal vaccination every 2 years."
b- "Contact your provider if you have a fever that lasts 18 hours."
c- "Wash your hands when you return home from running errands."
d- "Avoid exposure to cold air by shopping inside enclosed malls."
CORRECT: c- The nurse should instruct clients that handwashing is one way to avoid organisms that can cause pneumonia. Handwashing after using the restroom or being in public areas can minimize the risk of developing pneumonia.
INCORRECT:
a- The nurse should recommend that clients who have chronic health conditions and those over the age of 65 obtain a pneumococcal vaccination. Some providers will administer a second vaccination after 5 years.
b- The nurse should instruct clients who have a cold or influenza to notify their provider if they have a fever lasting more than 24 hours, if manifestations last longer than 7 days, or if manifestations worsen. Addressing viral or bacterial infections in the early stages can help prevent the development of pneumonia.
d- The nurse should instruct clients to avoid crowded public areas, such as a shopping mall, during cold and flu season, which occurs during the winter. Being in an enclosed space with a group of people increases the risk of transmission of respiratory bacteria.
A nurse is assessing a client whose ABG results are pH 7.51, $PaCO_2$ 29 mmHg, and HCO_3^- 24 mEq/L. Which of the following findings should the nurse expect?

a- Paresthesias
b- Bradycardia
c- Muscle flaccidity
d- Respiratory depression