

ATI FUNDAMENTALS 5 PRACTICE TEST (SAMPLE)

STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

VISIT US ONLINE FOR
THE FULL VERSION STUDY GUIDE

<https://atifunds5.examzify.com>



Copyright © 2026 by Examzify - A Kaluba Technologies Inc. product.

ALL RIGHTS RESERVED.

No part of this book may be reproduced or transferred in any form or by any means, graphic, electronic, or mechanical, including photocopying, recording, web distribution, taping, or by any information storage retrieval system, without the written permission of the author.

Notice: Examzify makes every reasonable effort to obtain accurate, complete, and timely information about this product from reliable sources.

SAMPLE

Table of Contents

Copyright	1
Table of Contents	2
Introduction	3
How to Use This Guide	4
Questions	5
Answers	8
Explanations	10
Next Steps	15

SAMPLE

Introduction

Preparing for a certification exam can feel overwhelming, but with the right tools, it becomes an opportunity to build confidence, sharpen your skills, and move one step closer to your goals. At Examzify, we believe that effective exam preparation isn't just about memorization, it's about understanding the material, identifying knowledge gaps, and building the test-taking strategies that lead to success.

This guide was designed to help you do exactly that.

Whether you're preparing for a licensing exam, professional certification, or entry-level qualification, this book offers structured practice to reinforce key concepts. You'll find a wide range of multiple-choice questions, each followed by clear explanations to help you understand not just the right answer, but why it's correct.

The content in this guide is based on real-world exam objectives and aligned with the types of questions and topics commonly found on official tests. It's ideal for learners who want to:

- Practice answering questions under realistic conditions,
- Improve accuracy and speed,
- Review explanations to strengthen weak areas, and
- Approach the exam with greater confidence.

We recommend using this book not as a stand-alone study tool, but alongside other resources like flashcards, textbooks, or hands-on training. For best results, we recommend working through each question, reflecting on the explanation provided, and revisiting the topics that challenge you most.

Remember: successful test preparation isn't about getting every question right the first time, it's about learning from your mistakes and improving over time. Stay focused, trust the process, and know that every page you turn brings you closer to success.

Let's begin.

How to Use This Guide

This guide is designed to help you study more effectively and approach your exam with confidence. Whether you're reviewing for the first time or doing a final refresh, here's how to get the most out of your Examzify study guide:

1. Start with a Diagnostic Review

Skim through the questions to get a sense of what you know and what you need to focus on. Your goal is to identify knowledge gaps early.

2. Study in Short, Focused Sessions

Break your study time into manageable blocks (e.g. 30 – 45 minutes). Review a handful of questions, reflect on the explanations.

3. Learn from the Explanations

After answering a question, always read the explanation, even if you got it right. It reinforces key points, corrects misunderstandings, and teaches subtle distinctions between similar answers.

4. Track Your Progress

Use bookmarks or notes (if reading digitally) to mark difficult questions. Revisit these regularly and track improvements over time.

5. Simulate the Real Exam

Once you're comfortable, try taking a full set of questions without pausing. Set a timer and simulate test-day conditions to build confidence and time management skills.

6. Repeat and Review

Don't just study once, repetition builds retention. Re-attempt questions after a few days and revisit explanations to reinforce learning. Pair this guide with other Examzify tools like flashcards, and digital practice tests to strengthen your preparation across formats.

There's no single right way to study, but consistent, thoughtful effort always wins. Use this guide flexibly, adapt the tips above to fit your pace and learning style. You've got this!

Questions

SAMPLE

- 1. Which action best helps you determine the patient's immediate status during respiratory distress?**
 - A. Administer oxygen as ordered
 - B. Assess oxygenation
 - C. Monitor vitals
 - D. Escalate care as needed
- 2. Which item is not typically included in a patient education plan?**
 - A. Assess learning needs
 - B. Scheduling follow-up appointments
 - C. Teaching methods
 - D. Evaluating understanding
- 3. During respiratory distress, which action is essential for ongoing assessment of the patient's status?**
 - A. Administer oxygen as ordered
 - B. Assess oxygenation
 - C. Monitor vitals
 - D. Escalate care as needed
- 4. After discovering that a postoperative client's wound has eviscerated, which action should be performed first?**
 - A. Cover the incision with a moist sterile dressing
 - B. Have the client lie on his back with his knees flexed
 - C. Call the client's surgeon
 - D. Reassure the client
- 5. For bladder scanner post-void residual assessment, which action is correct?**
 - A. Have client urinate 10 minutes before scan
 - B. Position the scanner head at the symphysis pubis
 - C. Apply light pressure to the scanner head
 - D. Assist the client into a semi-Fowler's position

- 6. What is the purpose of using SBAR in clinical communication?**
- A. To document all medications taken daily
 - B. To schedule patient rounds
 - C. To record daily tasks
 - D. To structure concise and clear information: Situation, Background, Assessment, Recommendation
- 7. Which statement accurately reflects the delegation guidelines between RNs and CNAs in patient care?**
- A. RNs assess, plan, and supervise; CNAs perform basic care tasks under supervision; delegation must stay within CNA scope and exclude assessment/evaluation.
 - B. CNAs can independently assess and develop care plans.
 - C. RNs must only supervise medication administration; CNAs perform the rest.
 - D. Delegation may include CNA assessment and evaluation with general supervision.
- 8. What is therapeutic communication?**
- A. Communication that shows empathy, active listening, and clear, supportive responses to facilitate understanding
 - B. Engaging with patients using rapid technical terms only
 - C. Disregarding patient concerns
 - D. Avoiding eye contact and rushing conversations
- 9. Which intervention best supports nonpharmacologic pain relief for a client?**
- A. Instruct the client to practice tai chi
 - B. Place a jasmine-scented air freshener in the client's room
 - C. Encourage the client to listen to soft music
 - D. Offer the client ginger tea
- 10. What is the Teach-Back method used for?**
- A. To confirm patient understanding by asking them to restate the information in their own words
 - B. To document patient consent
 - C. To schedule follow-up visits
 - D. To assess caregiver knowledge

Answers

SAMPLE

1. C
2. B
3. C
4. A
5. C
6. D
7. C
8. A
9. C
10. A

SAMPLE

Explanations

SAMPLE

1. Which action best helps you determine the patient's immediate status during respiratory distress?

- A. Administer oxygen as ordered
- B. Assess oxygenation
- C. Monitor vitals**
- D. Escalate care as needed

Gauging a patient in respiratory distress starts with checking vital signs and mental status to see how stable they are right now. These measurements give a quick, real-time picture of how well oxygen is reaching tissues and how the heart and brain are reacting to the stress. Key indicators to watch include respiratory rate and work of breathing, which show how hard the patient is fighting to breathe; oxygen saturation, which reflects current oxygenation; heart rate and blood pressure, which indicate perfusion and cardiovascular stress; and mental status, which can change quickly with hypoxia or poor perfusion. Tracking these together, and noticing trends over time, lets you determine if the patient is deteriorating or stabilizing. While giving oxygen is important to treat hypoxia and assessing oxygenation directly informs you about oxygen levels, neither alone provides the complete snapshot of immediate stability as effectively as continuous vital-sign monitoring does. Deciding to escalate care comes after you've assessed the trends and current status from those vital signs.

2. Which item is not typically included in a patient education plan?

- A. Assess learning needs
- B. Scheduling follow-up appointments**
- C. Teaching methods
- D. Evaluating understanding

Understanding patient education planning involves focusing on how to teach effectively. The educational plan centers on identifying what the patient needs to learn, choosing teaching methods that fit the learner, and checking whether the learning happened. Assessing learning needs lets you tailor content to the patient's current knowledge and gaps. Selecting teaching methods ensures the information is presented in a way the patient can understand and apply. Evaluating understanding confirms that learning has occurred and guides any needed re-teaching. Scheduling follow-up appointments, while important for ongoing care and continuity, is not part of the education plan itself. That task belongs more to care coordination or discharge planning, outlining the next steps in the overall care plan rather than the teaching activities. So, scheduling follow-up is not typically included in a patient education plan because the education plan focuses on teaching and learning, not on arranging future care appointments.

3. During respiratory distress, which action is essential for ongoing assessment of the patient's status?

- A. Administer oxygen as ordered
- B. Assess oxygenation
- C. Monitor vitals**
- D. Escalate care as needed

Continuous monitoring of vital signs provides the ongoing picture of a patient's status in respiratory distress. Vital signs—especially respiratory rate, heart rate, blood pressure, oxygen saturation, and level of consciousness—can change rapidly as breathing worsens or improves. By tracking trends over time, you can detect early deterioration (for example, a rising rate, increased work of breathing, falling oxygen saturation, or a decline in mental status) and assess how the patient is responding to interventions like oxygen therapy. This makes vitals the most informative single measure for ongoing assessment because they reflect multiple physiologic systems and give objective, actionable data in real time. Administering oxygen is an important treatment step, but it's an intervention rather than the continuous picture of the patient's status. Assessing oxygenation is critical, yet it's encompassed within the overall vitals data (such as SpO₂). Escalating care is a decision guided by assessment findings, not the ongoing assessment itself. In practice, you monitor vitals repeatedly and use the trend alongside clinical observations like work of breathing and breath sounds to guide further actions.

4. After discovering that a postoperative client 9s wound has eviscerated, which action should be performed first?

- A. Cover the incision with a moist sterile dressing**
- B. Have the client lie on his back with his knees flexed
- C. Call the client 9s surgeon
- D. Reassure the client

When wound evisceration occurs, the first priority is to protect the exposed internal organs. Cover the viscera with a moist sterile dressing (saline-soaked gauze) to keep the tissue moist, prevent drying, and reduce the risk of contamination. Do not try to push the organs back inside. After protecting the tissues, promptly notify the surgeon for urgent intervention and position the patient to minimize abdominal pressure (for example, with the knees flexed to relax the abdomen). Reassurance alone doesn't address the immediate physical risk.

5. For bladder scanner post-void residual assessment, which action is correct?

- A. Have client urinate 10 minutes before scan
- B. Position the scanner head at the symphysis pubis
- C. Apply light pressure to the scanner head**
- D. Assist the client into a semi-Fowler 9s position

In post-void bladder scanning, getting an accurate residual volume depends on good contact between the probe and the skin so the ultrasound can clearly visualize the bladder. The best action is to lightly press the scanner head against the lower abdomen. This light pressure helps the ultrasound waves pass through the tissue, reduces artifacts from air or gas, and improves visualization of the bladder, leading to a more accurate measurement. It's important not to press hard, which can compress the bladder and distort the reading, and to place the probe on the lower abdomen just above the pubic bone rather than directly at the pubic symphysis. The scan is done after the client voids, not before or long after, and the patient is typically positioned supine rather than semi-Fowler's.

6. What is the purpose of using SBAR in clinical communication?

- A. To document all medications taken daily
- B. To schedule patient rounds
- C. To record daily tasks
- D. To structure concise and clear information: Situation, Background, Assessment, Recommendation**

SBAR is a structured way to communicate critical health information quickly and clearly, especially during handoffs or fast-paced situations. It standardizes how you present details so the listener can grasp the situation right away and know what actions are needed. The best choice uses four specific parts: Situation, Background, Assessment, and Recommendation. This framework ensures you state what's happening now, what led up to it, your current professional assessment, and what you think should be done next. That clarity helps other team members understand the urgency and coordinate a timely response, which supports patient safety and efficient care. The other options describe different administrative tasks—recording all medications, scheduling rounds, or logging daily tasks—and they aren't about conveying a concise, structured clinical message to a teammate.

7. Which statement accurately reflects the delegation guidelines between RNs and CNAs in patient care?

- A. RNs assess, plan, and supervise; CNAs perform basic care tasks under supervision; delegation must stay within CNA scope and exclude assessment/evaluation.
- B. CNAs can independently assess and develop care plans.
- C. RNs must only supervise medication administration; CNAs perform the rest.**
- D. Delegation may include CNA assessment and evaluation with general supervision.

Understanding delegation in nursing practice hinges on keeping tasks within each role's scope. The nurse is responsible for evaluating the patient, creating the plan of care, and supervising how it's carried out. CNAs handle routine, basic care tasks under supervision and report any changes or concerns to the nurse. They do not perform assessments or develop care plans, and they do not administer medications or make clinical decisions about care. Medications and related decisions stay with the RN (and, where applicable, other licensed clinicians). Therefore, the statement that accurately reflects delegation guidelines is: RNs assess, plan, and supervise; CNAs perform basic care tasks under supervision; delegation stays within the CNA scope and excludes assessment and evaluation. The ideas that CNAs can independently assess, develop care plans, or handle medication administration do not fit these guidelines.

8. What is therapeutic communication?

- A. Communication that shows empathy, active listening, and clear, supportive responses to facilitate understanding
- B. Engaging with patients using rapid technical terms only
- C. Disregarding patient concerns
- D. Avoiding eye contact and rushing conversations

Therapeutic communication is a purposeful, patient-centered approach that uses empathy, active listening, and clear, supportive responses to help the patient feel understood and safe to share information. It includes giving the patient time to speak, reflecting feelings, asking open-ended questions, and providing nonjudgmental feedback. By focusing on the patient's concerns and adapting language to their level of understanding, it builds trust, reduces anxiety, and improves the quality of information exchange and adherence to care plans. Using rapid technical terms can confuse the patient and hinder understanding, disregarding concerns shuts down dialogue and erodes trust, and avoiding eye contact or rushing conveys disinterest and undermines the therapeutic relationship.

9. Which intervention best supports nonpharmacologic pain relief for a client?

- A. Instruct the client to practice tai chi
- B. Place a jasmine-scented air freshener in the client's room
- C. Encourage the client to listen to soft music
- D. Offer the client ginger tea

Nonpharmacologic pain relief focuses on methods that help a person cope with pain without medications, often by reducing anxiety, promoting relaxation, or providing distraction. Listening to soft music fits this well because it directly helps the brain process pain more calmly. Music acts as a distraction, lowers patient anxiety, and activates relaxation responses in the nervous system. As the body relaxes, stress hormones decrease and endorphins can be released, which together can lessen the perception of pain. It's easy to implement at the bedside, has no side effects, and can be used alongside other strategies. Tai chi can support overall well-being and physical function, but it requires space, instruction, and active participation, making it less practical for immediate pain relief in a clinical setting. A jasmine-scented air freshener changes mood through scent but doesn't target pain perception as reliably. Ginger tea may be soothing, yet it isn't a direct analgesic approach for acute pain relief.

10. What is the Teach-Back method used for?

- A. To confirm patient understanding by asking them to restate the information in their own words
- B. To document patient consent
- C. To schedule follow-up visits
- D. To assess caregiver knowledge

Teach-Back is a communication technique used to confirm patient understanding by asking them to restate the information in their own words. This approach shows whether the patient truly grasped the instructions, not just heard them. If the patient can accurately explain the plan, medications, and follow-up steps, teaching was effective; if not, you re-teach in plain language, use demonstrations, and check again until understanding is demonstrated. This practice enhances safety, improves adherence, and helps patients manage their care after leaving a healthcare setting. Other tasks like documenting consent, scheduling follow-up visits, or assessing caregiver knowledge serve different purposes and aren't about verifying the patient's understanding of the instructions.

Next Steps

Congratulations on reaching the final section of this guide. You've taken a meaningful step toward passing your certification exam and advancing your career.

As you continue preparing, remember that consistent practice, review, and self-reflection are key to success. Make time to revisit difficult topics, simulate exam conditions, and track your progress along the way.

If you need help, have suggestions, or want to share feedback, we'd love to hear from you. Reach out to our team at hello@examzify.com.

Or visit your dedicated course page for more study tools and resources:

<https://atifunds5.examzify.com>

We wish you the very best on your exam journey. You've got this!

SAMPLE