

ATI Fundamentals II Practice Exam (Sample)

Study Guide



Everything you need from our exam experts!

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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	16

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

- 1. In a staff education program about advocacy, what key point should the nurse include?**
 - A. Advocacy is primarily about promoting new policies**
 - B. Advocacy ensures clients' safety, health, and rights**
 - C. Advocacy is the responsibility of social workers**
 - D. Advocacy focuses on reducing healthcare costs**
- 2. When assessing an older patient for fall risks, which assessments are recommended?**
 - A. Pupil clarity and visual acuity**
 - B. Heart rate and blood pressure**
 - C. Neurological status and muscle strength**
 - D. Blood glucose and hydration status**
- 3. What is the normal range for adult body temperature?**
 - A. 95°F (35°C) to 99°F (37.2°C)**
 - B. 97°F (36.1°C) to 100.4°F (38°C)**
 - C. 96.8°F (36°C) to 98.6°F (37°C)**
 - D. 99°F (37.2°C) to 101°F (38.3°C)**
- 4. Which of the following are signs of hypoxia?**
 - A. Fever, cough, and fatigue**
 - B. Weight loss, nausea, and vomiting**
 - C. Cyanosis, confusion, restlessness, and shortness of breath**
 - D. Headache, dizziness, and blurred vision**
- 5. What type of transmission precautions should a nurse initiate for a patient with a purulent drainage wound?**
 - A. Airborne Precautions**
 - B. Contact Precautions**
 - C. Droplet Precautions**
 - D. Standard Precautions**

- 6. What is the initial step a nurse should take to prepare a patient for a procedure?**
- A. Obtain consent**
 - B. Make sure the patient is fasting**
 - C. Explain the procedure, address any concerns, and obtain consent**
 - D. Check the patient's vital signs**
- 7. How can nurses effectively promote patient mobility?**
- A. By recommending bed rest for all patients**
 - B. By encouraging regular physical activity and assisting with ambulation**
 - C. By providing wheelchairs to all patients**
 - D. By only allowing patients to move during therapy sessions**
- 8. Which condition could be worsened by inadequate fluid replacement?**
- A. Hypertension**
 - B. Hypoglycemia**
 - C. Hypovolemia**
 - D. Hyperthermia**
- 9. Which of the following accurately lists the five steps of the nursing process?**
- A. Assessment, Diagnosis, planning, Implementation, Evaluation**
 - B. Evaluation, Diagnosis, Implementation, Planning, Assessment**
 - C. Assessment, Planning, Evaluation, Diagnosis, Monitoring**
 - D. Diagnosis, Evaluation, Assessment, Planning, Revision**
- 10. Which of the following best describes the role of a nurse in discussing advance directives with patients?**
- A. To ensure the patient signs the documents**
 - B. To provide information and answer questions without coercion**
 - C. To complete the forms on behalf of the patient**
 - D. To direct the patient to legal counsel**

Answers

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

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Explanations

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1. In a staff education program about advocacy, what key point should the nurse include?

- A. Advocacy is primarily about promoting new policies**
- B. Advocacy ensures clients' safety, health, and rights**
- C. Advocacy is the responsibility of social workers**
- D. Advocacy focuses on reducing healthcare costs**

The focus of advocacy in nursing encompasses ensuring that clients' safety, health, and rights are upheld. This is a fundamental aspect of patient care, as nurses play a crucial role in supporting and defending the interests of patients. Advocacy involves actively working to ensure that individuals receive the appropriate care they need, are treated with respect, and have their voices heard in healthcare decisions that affect them. Incorporating this key point into a staff education program emphasizes the nurse's responsibility to be a strong ally for their patients. It underscores the importance of recognizing and addressing patients' needs, respecting their autonomy, and safeguarding their well-being. Promoting new policies, while valuable, is a narrower aspect of advocacy that does not encompass the complete scope. Advocacy is a broader concept that is not limited only to legislative change or policy promotion. Similarly, while social workers do have a role in advocacy, stating that advocacy is solely their responsibility misrepresents the collaborative nature of advocacy in healthcare, where nurses are integral advocates for patients. Lastly, reducing healthcare costs can be a consideration in healthcare systems but does not encapsulate the primary aim of advocacy, which is focused on the patient's rights and quality of care.

2. When assessing an older patient for fall risks, which assessments are recommended?

- A. Pupil clarity and visual acuity**
- B. Heart rate and blood pressure**
- C. Neurological status and muscle strength**
- D. Blood glucose and hydration status**

When assessing an older patient for fall risks, evaluating pupil clarity and visual acuity is crucial because vision plays a significant role in balance and spatial orientation. Many older adults experience age-related changes in vision, such as cataracts or macular degeneration, which can impair their ability to see obstacles, changes in terrain, and other environmental cues critical for safe movement. Inadequate vision can lead to missteps or inability to navigate surroundings properly, thus heightening the risk of falls. Therefore, routinely assessing vision health and clarity enables healthcare providers to identify those who may benefit from visual corrections or other interventions to help minimize fall risks. Assessing heart rate and blood pressure is important for overall health, but it is less directly related to falls compared to vision assessments. Similarly, while neurological status and muscle strength are important considerations in fall risk assessments, they can be more related to mobility and overall functional status rather than specifically targeting visual factors. Lastly, blood glucose and hydration status are vital in many clinical contexts but do not directly correlate with the immediate risks of falls. Thus, prioritizing visual assessments ensures that one of the most critical factors contributing to falls in older adults is thoroughly evaluated.

3. What is the normal range for adult body temperature?

- A. 95°F (35°C) to 99°F (37.2°C)
- B. 97°F (36.1°C) to 100.4°F (38°C)**
- C. 96.8°F (36°C) to 98.6°F (37°C)
- D. 99°F (37.2°C) to 101°F (38.3°C)

The normal range for adult body temperature is typically recognized as being between 97°F (36.1°C) and 100.4°F (38°C). This range accounts for what is considered a normal physiological variation based on factors such as the time of day, the individual's age, activity level, and the method of measurement. Body temperature can fluctuate throughout the day, usually being slightly lower in the early morning and higher in the late afternoon and evening. The upper limit of 100.4°F marks the threshold for what is generally considered fever, indicating that temperatures above this could suggest an underlying infection or illness. The other ranges provided are either too broad or do not align with the established medical consensus regarding normal body temperature. Understanding this range is essential for healthcare providers when assessing a patient's health status, recognizing deviations from the norm that may indicate a need for further evaluation or intervention.

4. Which of the following are signs of hypoxia?

- A. Fever, cough, and fatigue
- B. Weight loss, nausea, and vomiting
- C. Cyanosis, confusion, restlessness, and shortness of breath**
- D. Headache, dizziness, and blurred vision

Signs of hypoxia primarily relate to a deficiency in the amount of oxygen reaching the tissues. The manifestation of cyanosis, confusion, restlessness, and shortness of breath indicates that the body is not receiving adequate oxygen. Cyanosis refers to a bluish discoloration of the skin and mucous membranes, which occurs when there is insufficient oxygen in the blood. Confusion and restlessness are neurological signs that can arise due to inadequate oxygen supply to the brain, affecting cognitive function and creating a sense of anxiety or agitation. Shortness of breath is a direct symptom associated with hypoxia, as the body attempts to compensate for the reduced oxygen levels by increasing the respiratory rate. These signs collectively illustrate a clear picture of a person experiencing hypoxia, making this choice the most accurate representation of the condition.

5. What type of transmission precautions should a nurse initiate for a patient with a purulent drainage wound?

- A. Airborne Precautions**
- B. Contact Precautions**
- C. Droplet Precautions**
- D. Standard Precautions**

For a patient with a purulent drainage wound, Contact Precautions are necessary because the presence of a wound with purulent drainage indicates the potential for transmission of infectious agents through direct or indirect contact with surfaces, medical equipment, or individuals. These precautions help to prevent the spread of pathogens that may be present in the wound drainage. Contact Precautions typically involve wearing appropriate personal protective equipment (PPE), such as gloves and gowns, when interacting with the patient or handling items that may be contaminated. This approach is essential to safeguard healthcare providers and other patients within the healthcare environment from the risk of infection related to the wound drainage. Other precautionary measures like Airborne, Droplet, and Standard Precautions do not apply here to the same extent, as they are designed for different modes of transmission. Airborne Precautions are used for infections that can be transmitted through tiny droplets in the air, such as tuberculosis, while Droplet Precautions are for illnesses spread through larger respiratory droplets. Standard Precautions would be generally applied to all patients but do not provide the specific protections needed for handling potentially contaminated drainage from a wound, which is why Contact Precautions are the most appropriate choice in this scenario.

6. What is the initial step a nurse should take to prepare a patient for a procedure?

- A. Obtain consent**
- B. Make sure the patient is fasting**
- C. Explain the procedure, address any concerns, and obtain consent**
- D. Check the patient's vital signs**

The initial step a nurse should take to prepare a patient for a procedure is to explain the procedure, address any concerns, and obtain consent. This step is crucial because it ensures that the patient is fully informed about what will happen, which can help to alleviate anxieties or fears they may have. Understanding the procedure also enables the patient to make an informed decision about their care. Providing a thorough explanation fosters trust and encourages open communication between the nurse and the patient. Additionally, obtaining consent is an ethical and legal requirement that protects both the patient's rights and the healthcare provider. The nurse must ensure that the patient is competent to make decisions and that they have comprehended the information provided before proceeding with any further preparations, such as checking vital signs or ensuring fasting. This comprehensive approach lays the groundwork for a safe and effective healthcare experience.

7. How can nurses effectively promote patient mobility?

- A. By recommending bed rest for all patients
- B. By encouraging regular physical activity and assisting with ambulation**
- C. By providing wheelchairs to all patients
- D. By only allowing patients to move during therapy sessions

Promoting patient mobility is vital to enhancing recovery, preventing complications such as deep vein thrombosis, and maintaining overall health. Encouraging regular physical activity and assisting with ambulation is important because it directly helps patients regain strength, improve cardiovascular function, and enhance their range of motion. Nurses play a critical role in providing support and motivation for patients to engage in physical activity, whether it's walking, performing basic exercises, or participating in rehabilitation activities. Assistance with ambulation not only ensures safety but also fosters a sense of independence and confidence in patients. This holistic approach to mobility considers individual patient capabilities, promotes gradual improvements, and can lead to better outcomes in their recovery process. The other choices do not effectively support patient mobility. Recommending bed rest for all patients could lead to deconditioning and increased risks of complications. Providing wheelchairs to all patients does not encourage active participation in their own mobilization and may lead to dependency. Allowing movement only during therapy sessions restricts the opportunities for physical activity, reducing potential benefits.

8. Which condition could be worsened by inadequate fluid replacement?

- A. Hypertension
- B. Hypoglycemia
- C. Hypovolemia**
- D. Hyperthermia

Inadequate fluid replacement directly contributes to hypovolemia, a condition characterized by a decrease in the volume of blood in the body. When the body does not have enough fluid, it cannot maintain adequate blood volume, which can lead to various complications. Hypovolemia can occur due to dehydration, excessive bleeding, or inadequate fluid intake. Fluid replacement is essential for restoring the proper volume of blood and maintaining blood pressure, which are critical for ensuring that tissues receive adequate oxygen and nutrients. If fluid loss is not adequately compensated for, it can worsen hypovolemia, leading to symptoms such as dizziness, weakness, confusion, and even shock in severe cases. Other conditions listed, while they may be affected by fluid status in some context, are not primarily worsened by inadequate fluid replacement in the way that hypovolemia is. For instance, hypertension might be influenced by fluid intake, but it is primarily related to blood vessel resistance and other factors. Hypoglycemia pertains to low blood sugar levels, which directly relates to glucose metabolism rather than fluid balance. Hyperthermia can be influenced by hydration status, but it primarily involves the body's ability to regulate temperature and can occur even in a hydrated state.

9. Which of the following accurately lists the five steps of the nursing process?

A. Assessment, Diagnosis, planning, Implementation, Evaluation

B. Evaluation, Diagnosis, Implementation, Planning, Assessment

C. Assessment, Planning, Evaluation, Diagnosis, Monitoring

D. Diagnosis, Evaluation, Assessment, Planning, Revision

The five steps of the nursing process are indeed accurately listed as Assessment, Diagnosis, Planning, Implementation, and Evaluation. This framework serves as a systematic method for nurses to ensure patient care is both efficient and effective. Starting with Assessment, nurses gather comprehensive data about the patient's health status through observations, interviews, physical examinations, and diagnostic tests. This foundational step is crucial as it informs the subsequent stages of the process. Following assessment, the Diagnosis step involves analyzing the collected data to identify nursing diagnoses or patient problems. This step is critical for tailoring care plans to address the specific needs identified in the first step. Planning involves developing a comprehensive care plan that outlines measurable goals and anticipated outcomes. This part of the process ensures that there is a clear direction for delivering care and monitoring progress. The Implementation step involves carrying out the established care plan. Nurses provide interventions that are based on scientific knowledge and best practices to help meet the patient's goals. Finally, Evaluation is the process where nurses assess the effectiveness of the care provided. This step is vital, as it determines whether the goals were met, and if not, it prompts a review and possible revision of the care plan. Understanding the correct sequence of these steps is vital for nursing practice, directly influencing patient outcomes

10. Which of the following best describes the role of a nurse in discussing advance directives with patients?

A. To ensure the patient signs the documents

B. To provide information and answer questions without coercion

C. To complete the forms on behalf of the patient

D. To direct the patient to legal counsel

The role of a nurse in discussing advance directives with patients primarily involves providing information and answering questions without coercion. This means that nurses must create an open environment where patients feel comfortable expressing their thoughts and feelings regarding their end-of-life preferences. Nurses are responsible for clarifying what advance directives are, explaining the significance of these documents, and ensuring that patients understand their options. They should facilitate a discussion where patients can explore their values and wishes regarding healthcare decisions in the event that they are unable to communicate those wishes in the future. By doing so, nurses empower patients to make informed decisions about their care, respecting their autonomy while ensuring that there is no pressure to make specific choices. In contrast to the other options presented, the emphasis for nurses is on education and support rather than on obtaining signatures, completing forms for patients, or directing them to legal counsel. While these tasks may be part of the broader scope of advance directive processes, they do not capture the essential role of the nurse as an advocate and educator in this context.

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://atufundamentals2.examzify.com>

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