

ATI Practical Nurse (PN) Comprehensive Exit Practice Exam (Sample)

Study Guide



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SAMPLE

Questions

- 1. What information should a nurse include in a report to demonstrate quality improvement at a long-term care facility?**
 - A. The facility had 12% fewer urinary tract infections over the past 6 months.**
 - B. The facility hired more nursing staff this quarter.**
 - C. The facility received additional funding for renovations.**
 - D. The facility established new meal plans for residents.**
- 2. What are advance directives?**
 - A. Oral instructions regarding care**
 - B. Written instructions regarding end-of-life care**
 - C. Verbal agreements between family members**
 - D. Legal documents for healthcare proxies**
- 3. Which intervention should a nurse prioritize for a client receiving IV fluids for diverticulitis?**
 - A. Monitoring blood pressure**
 - B. Assuring proper IV placement**
 - C. Educating on dietary adjustments**
 - D. Evaluating pain management**
- 4. When should a nurse instruct assistive personnel to collect a sputum specimen from a client with tuberculosis?**
 - A. After lunch**
 - B. Before bedtime**
 - C. As soon as the client wakes up**
 - D. During physical therapy**
- 5. Which statement by a client post-mastectomy indicates an understanding of discharge teaching regarding safety precautions?**
 - A. "I will wear rubber gloves whenever I wash dishes or do yard work."**
 - B. "I will avoid physical activity for at least one month."**
 - C. "I should not lift anything heavier than 10 pounds."**
 - D. "I can resume driving once I feel comfortable."**

- 6. What action should a nurse take for a client with schizophrenia who is experiencing auditory hallucinations?**
- A. Offer the client headphones to listen to music**
 - B. Encourage the client to discuss the hallucinations**
 - C. Redirect the client to focus on relaxation techniques**
 - D. Provide written material to review**
- 7. In caring for a client with a chest tube, what is critical for maintaining the function of the drainage system?**
- A. Keeping the system upright**
 - B. Ensuring the drainage system is below the chest level**
 - C. Monitoring for clots in the tubing**
 - D. Flushing the tubing regularly**
- 8. Which strategy should a nurse recommend to a client who is trying to reduce solid fat consumption due to elevated cholesterol levels?**
- A. Purchase ground beef**
 - B. Purchase beef that is a loin cut**
 - C. Choose fatty fish as a primary protein**
 - D. Eat more full-fat dairy products**
- 9. What should a nurse document when reporting suspected child abuse?**
- A. Only physical injuries**
 - B. Personal biases and opinions**
 - C. Detailed observations and factual findings**
 - D. General remarks about the family**
- 10. When can a child with varicella return to school?**
- A. Immediately after starting treatment**
 - B. When lesions have scabbed over**
 - C. After 5 days of being symptom-free**
 - D. When a medical clearance is provided**

Answers

SAMPLE

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

SAMPLE

Explanations

SAMPLE

1. What information should a nurse include in a report to demonstrate quality improvement at a long-term care facility?

A. The facility had 12% fewer urinary tract infections over the past 6 months.

B. The facility hired more nursing staff this quarter.

C. The facility received additional funding for renovations.

D. The facility established new meal plans for residents.

Including the statistic of a 12% reduction in urinary tract infections over the past six months provides concrete evidence of a measurable improvement in patient outcomes and care quality. This kind of data is critical when demonstrating quality improvement efforts because it indicates that specific interventions or changes in practices have had a direct positive impact on the health and well-being of residents. Such metrics not only highlight successful initiatives but also serve to inform future strategies in patient care. In contrast, hiring more nursing staff, obtaining funding for renovations, or establishing new meal plans, while relevant to the operational aspects of the facility, do not directly quantify improvements in patient health outcomes. These actions are important but do not provide the same level of clear, measurable impact on quality of care that the reduction in infections does. Quality improvement is best showcased through data that reflect tangible changes in resident safety and health, making the first choice the most compelling indicator of positive progress.

2. What are advance directives?

A. Oral instructions regarding care

B. Written instructions regarding end-of-life care

C. Verbal agreements between family members

D. Legal documents for healthcare proxies

Advance directives are primarily written instructions regarding end-of-life care, allowing individuals to communicate their preferences about medical treatment should they become unable to do so themselves. This can include choices about life-sustaining treatment, resuscitation efforts, and other aspects of care that reflect the individual's values and wishes. The purpose of advance directives is to guide healthcare providers and family members in making decisions that honor the patient's desires, ensuring that their treatment aligns with what they would have chosen. While oral instructions, verbal agreements, and documents for healthcare proxies may play roles in discussing or executing one's healthcare preferences, they do not fully encapsulate the comprehensive nature of advance directives. Advance directives must be in written form to provide clear, legally recognized guidance when the patient is no longer able to communicate their wishes. Thus, written directives ensure that the intentions of the individual are documented and can be acted upon legally by healthcare teams and family members alike.

3. Which intervention should a nurse prioritize for a client receiving IV fluids for diverticulitis?

- A. Monitoring blood pressure**
- B. Assuring proper IV placement**
- C. Educating on dietary adjustments**
- D. Evaluating pain management**

Prioritizing the monitoring of blood pressure for a client receiving IV fluids for diverticulitis is crucial because it helps assess the client's hemodynamic status and response to treatment. IV fluids can significantly impact blood pressure, particularly if the client is dehydrated or has other complications. Monitoring blood pressure allows the nurse to quickly identify any signs of hypotension or shock, which may indicate complications from diverticulitis, such as perforation or sepsis. While assuring proper IV placement is also important to ensure effective fluid delivery, it is generally assessed at the start of IV therapy rather than continuously monitored throughout treatment. Educating the client about dietary adjustments is essential for long-term management of diverticulitis, but it is of lesser priority during acute treatment. Evaluating pain management is critical for client comfort, but assessing vital signs, including blood pressure, takes precedence in determining the immediate safety and stabilization of the client receiving IV fluids.

4. When should a nurse instruct assistive personnel to collect a sputum specimen from a client with tuberculosis?

- A. After lunch**
- B. Before bedtime**
- C. As soon as the client wakes up**
- D. During physical therapy**

Collecting a sputum specimen from a client with tuberculosis is most effective when done as soon as the client wakes up. This timing is important because overnight, the respiratory secretions accumulate, and the early morning is typically when these secretions are most concentrated in the lungs. This leads to a higher yield of bacteria or disease markers in the sputum, which can provide more accurate diagnostic information. In contrast, other times of day, such as after lunch or during physical therapy, may yield less effective samples because the respiratory secretions may be less concentrated or mixed with other substances from food intake or physical activity. Additionally, collecting a specimen before bedtime is not ideal since it is less likely to capture the overnight buildup of secretions. Therefore, instructing assistive personnel to collect the sputum specimen in the early morning maximizes the chances of obtaining a quality sample necessary for diagnostic testing in tuberculosis cases.

5. Which statement by a client post-mastectomy indicates an understanding of discharge teaching regarding safety precautions?

- A. "I will wear rubber gloves whenever I wash dishes or do yard work."**
- B. "I will avoid physical activity for at least one month."**
- C. "I should not lift anything heavier than 10 pounds."**
- D. "I can resume driving once I feel comfortable."**

The statement indicating an understanding of discharge teaching regarding safety precautions is that the client plans to wear rubber gloves while washing dishes or doing yard work. This demonstrates an awareness of the need to protect the surgical site and minimize the risk of infection, which is a key consideration after mastectomy surgery. Wearing rubber gloves can help prevent dirt and bacteria from coming into contact with healing skin. It reflects an understanding of the importance of hygiene and care in activities that could potentially expose the surgical area to harmful substances. This level of precaution is vital, especially in home environments where exposure to various irritants is likely. In contrast, the other statements suggest a misunderstanding or lack of comprehensive knowledge about postoperative care. For instance, avoiding physical activity for at least one month may not align with guidelines that typically encourage gradual resumption of activity. Limiting lifting to no more than 10 pounds is often advised, but it may vary based on individual recovery plans and may not fully capture the necessary precautions. Lastly, while it is true that one can resume driving once comfortable, this sentence does not encompass specific safety guidelines post-surgery, such as ensuring one's ability to move the arms without restriction or discomfort.

6. What action should a nurse take for a client with schizophrenia who is experiencing auditory hallucinations?

- A. Offer the client headphones to listen to music**
- B. Encourage the client to discuss the hallucinations**
- C. Redirect the client to focus on relaxation techniques**
- D. Provide written material to review**

Offering the client headphones to listen to music serves as a helpful strategy for managing auditory hallucinations in patients with schizophrenia. This action can create an environment that helps distract from the hallucinations and provides an alternative auditory input. Engaging a client with pleasant and soothing music can reduce anxiety and help them cope with the distress caused by the hallucinations. It's also important to consider that while encouraging the client to discuss the hallucinations might seem beneficial, it could potentially reinforce the hallucination experience and lead to increased anxiety for the client. Redirecting the client to relaxation techniques can be useful; however, it may not directly address the impact of the auditory hallucinations. Providing written material to review might not be engaging or effective, as the client may struggle to concentrate or may not be interested in reading when they are experiencing auditory disturbances. Therefore, the use of music through headphones directly addresses the sensory overload that can accompany auditory hallucinations, making it a practical and supportive intervention.

7. In caring for a client with a chest tube, what is critical for maintaining the function of the drainage system?

- A. Keeping the system upright**
- B. Ensuring the drainage system is below the chest level**
- C. Monitoring for clots in the tubing**
- D. Flushing the tubing regularly**

In managing a client with a chest tube, it is essential to ensure that the drainage system remains below chest level because this positioning allows gravity to facilitate the drainage of fluid or air from the pleural space effectively. When the drainage system is lower than the chest, it helps maintain negative pressure within the pleural cavity, promoting lung expansion and preventing complications such as pneumothorax or accumulation of fluid. Additionally, when the drainage system is correctly positioned, it minimizes the risk of backflow into the chest cavity, which could hinder recovery and potentially lead to serious complications. This principle helps guide nurses in ensuring that both the patient's safety and the effectiveness of the chest tube remain optimal during care. Maintaining the proper function and positioning of the drainage system is foundational to effective chest tube management and directly affects patient outcomes.

8. Which strategy should a nurse recommend to a client who is trying to reduce solid fat consumption due to elevated cholesterol levels?

- A. Purchase ground beef**
- B. Purchase beef that is a loin cut**
- C. Choose fatty fish as a primary protein**
- D. Eat more full-fat dairy products**

Choosing beef that is a loin cut is a beneficial strategy for a client aiming to reduce solid fat consumption, especially with elevated cholesterol levels. Loin cuts of beef are typically leaner than other cuts, meaning they contain less saturated fat and cholesterol. This is significant because reducing saturated fat intake is often recommended for managing cholesterol levels. Opting for lean cuts helps individuals enjoy beef while minimizing the intake of solid fats that can contribute to elevated cholesterol. Lean meats can still be a good source of protein and important nutrients without the added saturated fat that comes from fattier cuts. In contrast, other options like purchasing ground beef may lead to higher fat content, especially if it is not labeled as lean. Choosing fatty fish does provide health benefits, but it does not align with the original goal of reducing solid fat from cuts of meat. Consuming more full-fat dairy products would likely increase saturated fat intake, which is counterproductive for someone attempting to lower cholesterol levels. Thus, selecting lean cuts such as loin cuts of beef is a sensible and effective strategy for managing dietary fat intake related to cholesterol control.

9. What should a nurse document when reporting suspected child abuse?

- A. Only physical injuries**
- B. Personal biases and opinions**
- C. Detailed observations and factual findings**
- D. General remarks about the family**

Documenting suspected child abuse requires a comprehensive approach that focuses on factual and objective observations. By recording detailed observations and factual findings, the nurse ensures that the information is credible, reliable, and can be used in any necessary investigations or legal actions. This documentation should include specific behaviors, reported statements from the child, physical signs of abuse, and the context in which these observations were made. Objective details support the case while maintaining the integrity of the information, which is crucial for protecting the child and providing the appropriate support and resources. In contrast, documenting only physical injuries would provide an incomplete picture of the situation. Personal biases and opinions can cloud the facts and might lead to misunderstandings or misinterpretations. General remarks about the family lack the specificity needed to address the legal and procedural requirements that come with suspected abuse cases. Thus, the emphasis is on clear, detailed, and factual documentation to support the child's safety and well-being.

10. When can a child with varicella return to school?

- A. Immediately after starting treatment**
- B. When lesions have scabbed over**
- C. After 5 days of being symptom-free**
- D. When a medical clearance is provided**

A child with varicella, commonly known as chickenpox, can return to school when the lesions have scabbed over. This is important because varicella is highly contagious, especially before the onset of the rash and during the blister phase. The scabbing period indicates that the child is no longer contagious and that the risk of spreading the virus to others is significantly reduced. The other options do not align with the established guidelines for returning to school after varicella. Starting treatment does not reduce the contagious period, being symptom-free for a set number of days may not ensure that the child is no longer infectious, and obtaining medical clearance, while beneficial, is not the specific condition for returning to school after varicella. The key factor is the scabbing of lesions, which represents the end of contagiousness.