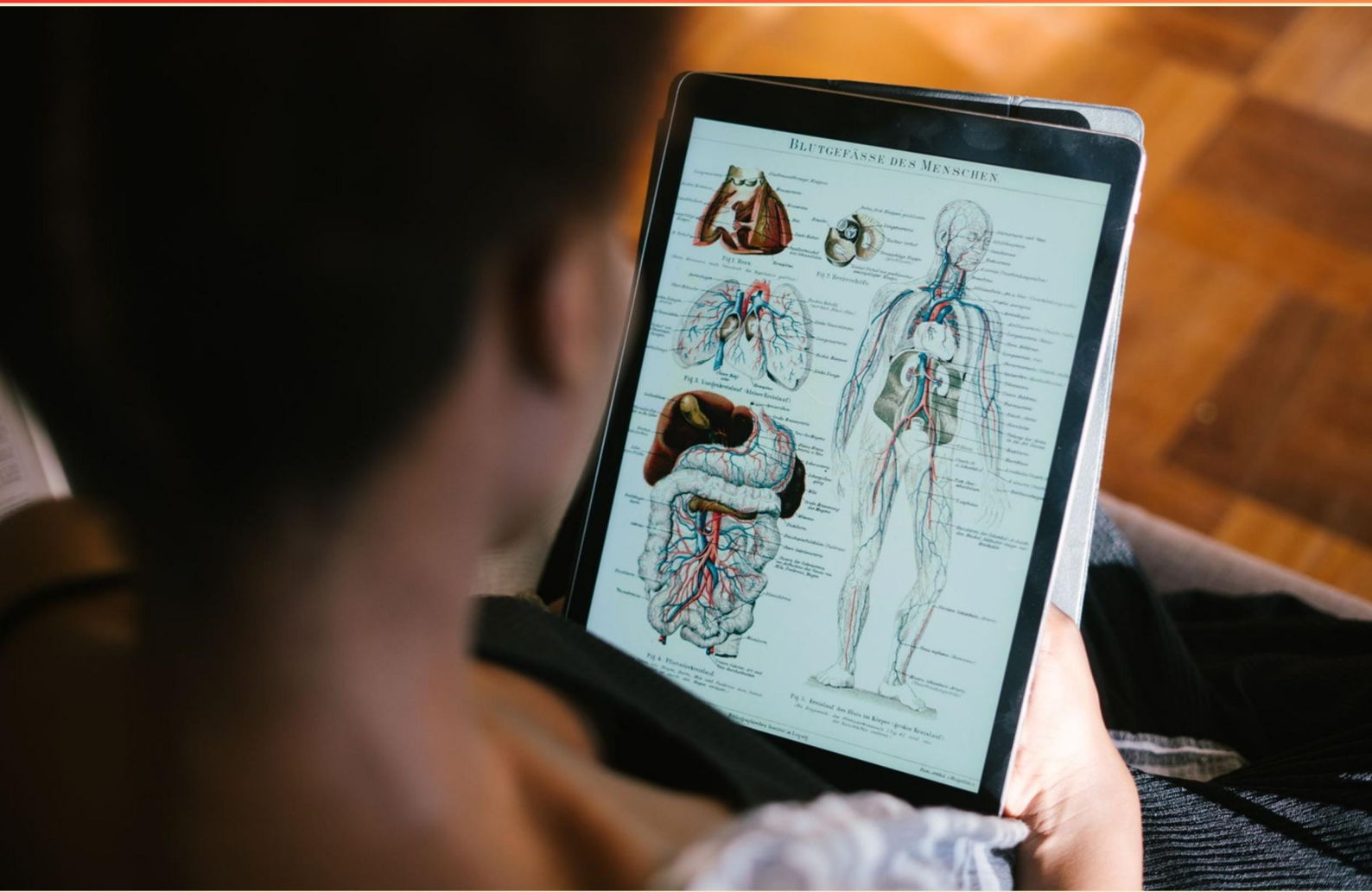


ATI PRACTICAL NURSE (PN) COMPREHENSIVE EXIT PRACTICE EXAM (SAMPLE)

STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

VISIT US ONLINE FOR
THE FULL VERSION STUDY GUIDE

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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

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- 1. What action should a nurse take to verify a client's identity before administering medications?**
 - A. Ask the client for their last name.
 - B. Scan the facility identification board.
 - C. Check the client's wristband.
 - D. Review the medical record for the client's photo.
- 2. What is the first step a nurse should take when preparing to insert an indwelling urinary catheter for a female client?**
 - A. Open the outer package flap of the catheterization kit towards her body.
 - B. Open the outer package flap of the catheterization kit away from her body.
 - C. Ensure the client is in a supine position.
 - D. Gather all necessary supplies before starting the procedure.
- 3. A client states, "I don't think I can go through this again" after losing a job. What is the nurse's priority action?**
 - A. Determine if the client is experiencing psychotic thinking.
 - B. Provide resources for job assistance.
 - C. Encourage the client to talk about their feelings.
 - D. Refer the client to a psychiatrist.
- 4. What demonstrates that a preoperative client understands how to use an incentive spirometer?**
 - A. The client attempts to elevate the cylinder by inhaling deeply.
 - B. The client blows into the spirometer to see the gauge move.
 - C. The client holds the spirometer at eye level while using it.
 - D. The client uses the spirometer for less than 5 minutes at a time.
- 5. What is a significant risk associated with untreated lactose intolerance in children?**
 - A. Dehydration
 - B. Weight gain
 - C. Delayed growth and development
 - D. Increased risk of infections

- 6. Which finding should a nurse report to the provider for a client who is 24 hours postoperative from an open colon resection?**
- A. Client reports vomiting green-tinged fluid
 - B. Client has a stable vital sign
 - C. Client has minimal abdominal discomfort
 - D. Client is tolerating a clear liquid diet
- 7. During patient handoff, what is the most critical information to communicate?**
- A. The patient's medication allergies.
 - B. The patient's previous medical history.
 - C. Key changes in the patient's condition.
 - D. The patient's socioeconomic status.
- 8. For a patient expressing despair about their illness, what is an appropriate nursing intervention?**
- A. Ignore their feelings and focus on treatment
 - B. Provide reassurance and validate their feelings
 - C. Redirect the conversation to a more positive topic
 - D. Encourage them to see the bright side of their situation
- 9. If caring for a client with multiple sclerosis, what manifestation should the nurse expect?**
- A. Muscle weakness
 - B. Ataxia
 - C. Vision loss
 - D. Seizures
- 10. What is a common outcome the nurse should expect from a client participating in active ROM exercises twice daily?**
- A. Increased muscle stiffness
 - B. Enhanced joint flexibility
 - C. Increased fatigue
 - D. Decreased range of motion

Answers

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

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Explanations

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1. What action should a nurse take to verify a client's identity before administering medications?

- A. Ask the client for their last name.
- B. Scan the facility identification board.**
- C. Check the client's wristband.
- D. Review the medical record for the client's photo.

The most effective action for a nurse to take in verifying a client's identity before administering medications is to check the client's wristband. This method allows for immediate access to the client's official identification information, which typically includes their name, date of birth, and medical record number. By using the wristband, the nurse can confirm that the medication is being administered to the correct individual, thereby significantly reducing the risk of medication errors. The wristband also provides a standardized method of identification that aligns with hospital protocols, ensuring consistency across care providers. This approach is typically part of a two or three-step verification process, where the nurse will also cross-reference the client's information with the medication administration record. While asking the client for their last name can provide some verification, it is less reliable since clients may have memory issues or may not recall their full name accurately, especially in high-stress situations or for those with cognitive impairments. Scanning the facility identification board is not a direct verification method and may lack specific, relevant details about the individual client. Reviewing the medical record for the client's photo is also not practical as it is not typically available at the moment of medication administration, and further, privacy regulations may inhibit access. Overall, checking the wristband is a

2. What is the first step a nurse should take when preparing to insert an indwelling urinary catheter for a female client?

- A. Open the outer package flap of the catheterization kit towards her body.
- B. Open the outer package flap of the catheterization kit away from her body.**
- C. Ensure the client is in a supine position.
- D. Gather all necessary supplies before starting the procedure.

The first step a nurse should take when preparing to insert an indwelling urinary catheter for a female client is to open the outer package flap of the catheterization kit away from her body. This is crucial for maintaining a sterile environment and ensuring that the inside of the kit remains uncontaminated. By opening away from the body, any potential contaminants that might be on the nurse or the surrounding area are kept from entering the sterile field necessary for the procedure. Maintaining sterility is paramount in catheterization procedures to prevent urinary tract infections or other complications. Proper technique in handling the sterile kit contributes significantly to patient safety and effective care. Other options may seem relevant, but they do not prioritize maintaining sterility in the setup process like opening the package away from the body. For instance, while ensuring the correct positioning of the client is important, the immediate priority in the procedural setup is the integrity of the sterile equipment. Similarly, gathering supplies is necessary, but the first action should focus on preventing contamination as the nurse prepares to initiate the procedure.

3. A client states, "I don't think I can go through this again" after losing a job. What is the nurse's priority action?

- A. Determine if the client is experiencing psychotic thinking.**
- B. Provide resources for job assistance.
- C. Encourage the client to talk about their feelings.
- D. Refer the client to a psychiatrist.

In this scenario, the client's statement reflects feelings of distress and potential emotional turmoil due to a job loss. The priority action for the nurse is to assess the client's mental state to ensure their safety and determine the level of distress they are experiencing. Identifying whether the client is displaying psychotic thinking is crucial because it provides insight into their mental health status and the urgency of the situation. If the client is exhibiting signs of psychotic thinking, such as delusions or hallucinations, immediate intervention is necessary to ensure they receive appropriate care. This assessment can influence the subsequent steps in care, including whether they may need more structured support or psychiatric intervention. Understanding the client's mental safety is paramount in guiding the nurse's response and ensuring the individual's well-being. Other options, while beneficial in their own right, do not address the immediate need for a mental health assessment. Providing resources for job assistance might be helpful in the long term, but without first ensuring the client is stable, they may not be in a place to effectively utilize those resources. Similarly, encouraging the client to talk about their feelings or referring them to a psychiatrist can be important next steps, but they are most appropriate after first determining the client's current mental state and ensuring their safety. Through this comprehensive evaluation,

4. What demonstrates that a preoperative client understands how to use an incentive spirometer?

- A. The client attempts to elevate the cylinder by inhaling deeply.**
- B. The client blows into the spirometer to see the gauge move.
- C. The client holds the spirometer at eye level while using it.
- D. The client uses the spirometer for less than 5 minutes at a time.

Using an incentive spirometer correctly is essential for a preoperative client to enhance lung expansion and prevent complications such as atelectasis. When the client understands how to use the spirometer, it demonstrates their ability to perform the essential technique of deep inhalation to achieve the desired results. The correct choice—elevating the cylinder by inhaling deeply—indicates that the client knows the primary goal of the spirometer is to inspire air deeply, which causes the gauge to rise. This action reflects an understanding of the need to take slow, deep breaths to maintain good alveolar expansion, which is crucial post-surgery for promoting optimal respiratory function. In contrast, blowing into the spirometer does not achieve the intended purpose, as the device is designed to measure inhalation rather than exhalation. Holding the spirometer at eye level can be a proper technique, but it does not necessarily imply effective use of the device since the focus should be more on the breathing technique itself. Lastly, using the spirometer for less than 5 minutes at a time does not align with the recommended usage guidelines, which typically encourage extended use to promote adequate lung expansion and maintain respiratory health.

5. What is a significant risk associated with untreated lactose intolerance in children?

- A. Dehydration
- B. Weight gain
- C. Delayed growth and development**
- D. Increased risk of infections

Untreated lactose intolerance in children can lead to significant nutritional deficiencies, particularly if they avoid dairy products without finding suitable alternatives. Lactose intolerance can cause gastrointestinal symptoms such as bloating, diarrhea, and abdominal pain when lactose is consumed. These symptoms might lead to a reduction in food intake and avoidance of important nutritional sources, specifically calcium and vitamin D, which are crucial for bone development and overall growth. When children do not receive adequate nutrition, particularly during critical growth periods, this can result in delayed growth and development. This can manifest not only in physical growth but also in cognitive and emotional development, leading to long-term implications for health and well-being. While dehydration is a possible concern due to the diarrhea that may accompany lactose intolerance, the primary risk associated with untreated lactose intolerance is inadequate nutrient absorption, which directly affects growth and development. Thus, addressing lactose intolerance effectively is essential for ensuring that children receive the necessary nutrients for healthy growth.

6. Which finding should a nurse report to the provider for a client who is 24 hours postoperative from an open colon resection?

- A. Client reports vomiting green-tinged fluid**
- B. Client has a stable vital sign
- C. Client has minimal abdominal discomfort
- D. Client is tolerating a clear liquid diet

Reporting the finding of vomiting green-tinged fluid is important because it could indicate a problem that requires immediate attention. In the context of a client who is 24 hours postoperative from an open colon resection, the presence of bile in the vomit, represented by the green-tinged color, may signal complications such as bowel obstruction, ileus, or other gastrointestinal disturbances. These conditions can lead to increased complications if not addressed promptly. Stable vital signs, minimal abdominal discomfort, and tolerating a clear liquid diet are expected post-operative findings, indicating that the patient is recovering normally. Stable vital signs suggest the absence of acute distress or complications. Minimal abdominal discomfort can be managed with appropriate analgesia and is often a normal part of the recovery process after surgery. Tolerating a clear liquid diet shows that the gastrointestinal system is functioning adequately enough to handle initial post-operative nutrition without complications. Thus, among the options presented, the green-tinged vomiting stands out as an abnormal finding that should prompt further evaluation by the healthcare provider.

7. During patient handoff, what is the most critical information to communicate?

- A. The patient's medication allergies.
- B. The patient's previous medical history.
- C. Key changes in the patient's condition.**
- D. The patient's socioeconomic status.

During patient handoff, communicating key changes in the patient's condition is essential because it directly impacts the immediate care and safety of the patient. This information can include any recent alterations in vital signs, symptoms, or responses to treatment that have occurred since the last assessment. Understanding these changes allows the receiving healthcare provider to prioritize interventions, ensure appropriate monitoring, and make informed decisions about further management. While knowing the patient's medication allergies is important for preventing adverse reactions, or previous medical history provides context for care, these details do not have the immediate urgency that changes in the patient's condition do. Similarly, socioeconomic status may aid in understanding the patient's environment or support system, but it is not a priority during a critical handoff when the focus should be on the clinical aspects that could affect patient safety and care in the short term. Therefore, emphasizing key changes in the patient's condition is vital to providing safe, effective care.

8. For a patient expressing despair about their illness, what is an appropriate nursing intervention?

- A. Ignore their feelings and focus on treatment
- B. Provide reassurance and validate their feelings**
- C. Redirect the conversation to a more positive topic
- D. Encourage them to see the bright side of their situation

Validating a patient's feelings and providing reassurance are crucial components of effective nursing care, especially when a patient expresses despair about their illness. By acknowledging their emotional distress, the nurse demonstrates empathy and shows the patient that their feelings are both recognized and understood. This supportive approach fosters trust and can help the patient feel more comfortable sharing their thoughts and fears, which is essential for building a therapeutic relationship. Addressing emotional needs is an integral part of holistic care. When patients feel heard and supported, they are often more willing to engage in their treatment process, which can positively impact their overall health outcomes. This intervention can also lead to patients feeling more empowered to cope with their illness, knowing that their emotional experiences are valid and important. In contrast, ignoring the patient's feelings could lead to a sense of isolation and frustration, as they might feel dismissed or undervalued. Redirecting the conversation or encouraging a focus on positivity can minimize the seriousness of their situation and may prevent them from discussing their true feelings, which could hinder their emotional healing. Therefore, providing reassurance and validating feelings is the most appropriate intervention in this context.

9. If caring for a client with multiple sclerosis, what manifestation should the nurse expect?

- A. Muscle weakness
- B. Ataxia**
- C. Vision loss
- D. Seizures

When caring for a client with multiple sclerosis (MS), ataxia is a common manifestation due to the disease's impact on the central nervous system. Multiple sclerosis is characterized by demyelination of neurons, which can lead to impaired coordination and balance—hallmarks of ataxia. This can affect the client's ability to walk and perform daily activities with precision, often resulting in a clumsiness or a staggering gait. While muscle weakness, vision loss, and seizures may occur in MS, ataxia specifically relates to the loss of proprioception and coordination, making it a direct manifestation of the neurological deficits that characterize the condition. The presence of ataxia is indicative of the disease's progression and severity in many patients, reflecting the disruption of communication between the brain and the body's motor pathways. Thus, recognizing ataxia is critical for tailoring appropriate interventions and support for the client.

10. What is a common outcome the nurse should expect from a client participating in active ROM exercises twice daily?

- A. Increased muscle stiffness
- B. Enhanced joint flexibility**
- C. Increased fatigue
- D. Decreased range of motion

Engaging in active range of motion (ROM) exercises is designed to improve muscle strength, maintain joint flexibility, and promote better circulation within the body. When a client participates in these exercises routinely, particularly twice daily, one of the primary outcomes expected is enhanced joint flexibility. This improvement occurs as the muscles and ligaments surrounding the joints are regularly stretched and strengthened, allowing for a broader range of motion over time. In contrast, increased muscle stiffness, increased fatigue, and decreased range of motion are not typical outcomes of regular active ROM exercises. Instead, with consistent practice, the client would generally experience the opposite effects: muscle elasticity improves, leading to less stiffness, reduced feelings of fatigue due to improved endurance, and an overall increase in the range of motion. Thus, the expected outcome of enhanced joint flexibility substantiates the benefits of incorporating active ROM exercises into a client's daily routine.

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://atipncomprehensiveexit.examzify.com>

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

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