

ATI Reduction of Risk Potential Practice Test (Sample)

Study Guide



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SAMPLE

Questions

SAMPLE

- 1. When inserting an indwelling urinary catheter in a female client, what instruction should the nurse provide?**
 - A. Relax and breathe deeply**
 - B. Bear down**
 - C. Push as hard as possible**
 - D. Do not move**
- 2. What is the recommended number of suctioning passes during tracheostomy care according to nursing protocols?**
 - A. One to two times with a 60-second pause**
 - B. Two to three times with a 60-second pause**
 - C. Three to four times without pauses**
 - D. Two times without any pauses**
- 3. Which feedback loop can enhance patient safety in medication administration?**
 - A. Using handwritten medication orders**
 - B. Implementing a Barcode Medication Administration system**
 - C. Relying on verbal orders**
 - D. Conducting random checkups on patients**
- 4. Which client is at the greatest risk for falling during a fall risk assessment?**
 - A. An elderly adult who is confused and has urinary frequency**
 - B. A young adult with a sprained ankle**
 - C. An older adult with no history of falls**
 - D. Middle-aged client with stable medical conditions**
- 5. Which client is at the highest risk for aspiration?**
 - A. A client who is receiving oral medication**
 - B. A client with dysphagia**
 - C. A client receiving a continuous enteral feeding through NG tube**
 - D. A client who is positioned upright**

- 6. What is a key intervention for patients at high risk of infection?**
- A. Administering antibiotics before procedures**
 - B. Maintaining strict sterile techniques during procedures**
 - C. Increasing visitors to the patient's room**
 - D. Reducing the use of personal protective equipment**
- 7. When identifying an infiltration at the IV catheter site, what is the first action the nurse should take?**
- A. Apply warm or cold compress**
 - B. Remove IV catheter**
 - C. Stop the infusion**
 - D. Elevate the extremity**
- 8. Which assessment tool is used for identifying a patient's risk of developing a deep vein thrombosis (DVT)?**
- A. The Timed Up and Go Test**
 - B. The Wells criteria**
 - C. The Berg Balance Scale**
 - D. The Braden Scale**
- 9. What is the correct sequence of actions for suctioning a client with a tracheostomy?**
- A. Adjust suction, don sterile gloves, check catheter function, hyperoxygenate, insert catheter with suction**
 - B. Don gloves, insert catheter, adjust suction, hyperoxygenate, apply suction**
 - C. Check suction function, don sterile gloves, hyperoxygenate, adjust suction, apply suction**
 - D. Adjust suction, don sterile gloves, check catheter function, hyperoxygenate, insert catheter without suction**
- 10. Which of the following actions should a nurse include in demonstrating diaphragmatic breathing to a preoperative client?**
- A. Exhale quickly through the mouth**
 - B. Inhale slowly and evenly through her nose**
 - C. Take shallow breaths through the chest**
 - D. Breathe rapidly and loudly**

Answers

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

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Explanations

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1. When inserting an indwelling urinary catheter in a female client, what instruction should the nurse provide?

- A. Relax and breathe deeply**
- B. Bear down**
- C. Push as hard as possible**
- D. Do not move**

The instruction for a female client to "bear down" during the insertion of an indwelling urinary catheter is correct because this action helps facilitate the passage of the catheter through the urethra and into the bladder. When a person bears down, it can help to open the urethra and make the insertion process smoother and less uncomfortable. It mimics the natural actions during urination, making it easier for the nurse to navigate the catheter into the appropriate position. Encouraging relaxation and deep breathing, while also beneficial for some clients, would not specifically assist during the catheterization process in the same way that bearing down would. Advising to push as hard as possible could cause undue strain and discomfort, potentially leading to injury or complications. Instructing the client not to move does not promote any active participation in the process, which may be counterproductive in helping to position the catheter correctly.

2. What is the recommended number of suctioning passes during tracheostomy care according to nursing protocols?

- A. One to two times with a 60-second pause**
- B. Two to three times with a 60-second pause**
- C. Three to four times without pauses**
- D. Two times without any pauses**

The recommended number of suctioning passes during tracheostomy care is two to three times with a 60-second pause in between each pass. This practice allows for effective clearance of secretions while minimizing trauma to the airway. The pauses are critical because they provide the patient with time to recover, ensuring adequate oxygenation in between suctioning attempts. Additionally, this approach balances the need to clear secretions with the potential risks associated with repeated suctioning, such as hypoxia or irritation of the airway lining. Proper suctioning techniques, including the recommended number of passes and rest periods, are crucial for maintaining airway patency and overall respiratory health in patients with tracheostomies.

3. Which feedback loop can enhance patient safety in medication administration?

- A. Using handwritten medication orders**
- B. Implementing a Barcode Medication Administration system**
- C. Relying on verbal orders**
- D. Conducting random checkups on patients**

Implementing a Barcode Medication Administration (BCMA) system is critical in enhancing patient safety during medication administration. This technology functions by assigning a unique barcode to each medication and a corresponding barcode to the patient. When a nurse or healthcare provider administers medication, they scan both the medication and the patient's barcode. The system then cross-references this information with the patient's medication orders in real-time. This process significantly reduces the likelihood of medication errors, such as administering the wrong drug, the wrong dosage, or giving medication to the wrong patient. The immediate feedback provided by the scanning process alerts healthcare providers to discrepancies, allowing for prompt corrections. Consequently, BCMA serves as a robust safety net, enhancing the reliability of the medication administration process and ultimately improving patient outcomes. Other options lack the same level of effectiveness in ensuring safety. For instance, handwritten medication orders are prone to misinterpretation due to illegible handwriting, while relying on verbal orders can lead to miscommunication and errors. Conducting random checkups, although beneficial for overall care, does not specifically target the accuracy of medication administration like a BCMA system does.

4. Which client is at the greatest risk for falling during a fall risk assessment?

- A. An elderly adult who is confused and has urinary frequency**
- B. A young adult with a sprained ankle**
- C. An older adult with no history of falls**
- D. Middle-aged client with stable medical conditions**

The choice indicating that an elderly adult who is confused and has urinary frequency is at the greatest risk for falling is correct due to several critical factors. Elderly adults are naturally at a higher risk for falls due to physical changes associated with aging, such as decreased balance, muscle strength, and coordination. Confusion further compounds this risk because it can lead to impaired judgment and poor spatial awareness. A confused individual may not recognize their surroundings or understand hazards, making them more vulnerable to accidents. Additionally, urinary frequency suggests that the individual may need to get up frequently to use the restroom, potentially leading to hurried movements and a greater likelihood of losing balance or misstepping, particularly during the night when visibility is lower and the individual may be disoriented. In comparison, the other scenarios present lower risks: a young adult with a sprained ankle might be cautious and take measures to avoid further injury; an older adult with no history of falls may demonstrate better balance and control; and a middle-aged client with stable medical conditions is less likely to be affected by the factors that typically lead to falls. Therefore, the combination of an elderly individual's increased susceptibility with the added complications of confusion and urinary frequency significantly heightens their fall risk.

5. Which client is at the highest risk for aspiration?

- A. A client who is receiving oral medication**
- B. A client with dysphagia**
- C. A client receiving a continuous enteral feeding through NG tube**
- D. A client who is positioned upright**

Considering the risk factors associated with aspiration, a client receiving continuous enteral feeding through a nasogastric (NG) tube is indeed at a higher risk for aspiration. This is because the continuous flow of liquid nutrition can easily lead to the risk of material entering the airway if not managed carefully. In this situation, the position of the client is critically important. If they are not adequately positioned (ideally at an elevation of 30 to 45 degrees), there is a significant likelihood that the feeding could backflow and cause aspiration. Additionally, any potential regurgitation of the formula can increase the risk of aspiration, especially if the swallowing reflex is impaired. While clients with dysphagia also face risks related to aspiration, feeding through an NG tube presents a continuous potential for aspiration, especially if protocols for safe administration are not strictly followed. In contrast, a client receiving oral medication or one positioned upright typically has lower risks of aspiration, provided they are able to swallow safely and maintain an appropriate posture during intake. Thus, among the options, the client receiving continuous enteral feeding has the highest associated risk for aspiration.

6. What is a key intervention for patients at high risk of infection?

- A. Administering antibiotics before procedures**
- B. Maintaining strict sterile techniques during procedures**
- C. Increasing visitors to the patient's room**
- D. Reducing the use of personal protective equipment**

Maintaining strict sterile techniques during procedures is a crucial intervention for patients at high risk of infection. This approach minimizes the potential for introducing pathogens into sterile areas of the body, which is especially important for individuals whose immune systems may be compromised, such as those with chronic illnesses, recent surgeries, or undergoing chemotherapy. By adhering to strict sterile protocols, healthcare providers can effectively reduce the risk of hospital-acquired infections and enhance patient safety. Other options, while they may seem relevant, do not provide the same level of direct protection against infection as maintaining sterile techniques. Administering antibiotics before procedures may be appropriate in certain circumstances but does not compensate for potential lapses in infection control practices. Increasing visitors to the patient's room does not address infection control and could actually increase exposure to pathogens. Reducing the use of personal protective equipment would significantly increase the risk of transmitting infections, especially in high-risk patients. Hence, strict adherence to sterile techniques is paramount in protecting these vulnerable individuals.

7. When identifying an infiltration at the IV catheter site, what is the first action the nurse should take?

- A. Apply warm or cold compress**
- B. Remove IV catheter**
- C. Stop the infusion**
- D. Elevate the extremity**

The first action a nurse should take upon identifying an infiltration at the IV catheter site is to stop the infusion. When infiltration occurs, the intravenous fluid and medications leak into the surrounding tissue instead of administering them into the bloodstream. Continuing the infusion can exacerbate the situation, potentially leading to further swelling, discomfort, and damage to the tissue. Stopping the infusion promptly is crucial to minimize these risks and allows the nurse to assess the situation better and decide on the appropriate interventions, such as removing the catheter, applying compresses, or elevating the extremity, based on the extent of infiltration and the patient's condition. This timely action prioritizes patient safety and helps prevent complications associated with infiltration.

8. Which assessment tool is used for identifying a patient's risk of developing a deep vein thrombosis (DVT)?

- A. The Timed Up and Go Test**
- B. The Wells criteria**
- C. The Berg Balance Scale**
- D. The Braden Scale**

The Wells criteria is a validated assessment tool specifically designed to evaluate a patient's risk for developing a deep vein thrombosis (DVT). This tool incorporates clinical findings such as the presence of active cancer, previous DVT, and the patient's mobility status, among other factors, to assign a score that helps determine the likelihood of DVT. By using the Wells criteria, healthcare providers can systematically assess risk and make informed decisions regarding further diagnostic testing or prophylactic measures. For instance, a higher score indicates a greater risk of DVT, which may prompt further investigation such as ultrasound or the initiation of anticoagulant therapy. The other assessment tools mentioned serve different purposes: The Timed Up and Go Test primarily evaluates mobility and balance, the Berg Balance Scale assesses static and dynamic balance in older adults, and the Braden Scale evaluates a patient's risk for pressure ulcers. None of these tools are designed specifically for DVT risk assessment, which underscores why the Wells criteria is the most appropriate choice for identifying a patient's risk of DVT.

9. What is the correct sequence of actions for suctioning a client with a tracheostomy?
- A. Adjust suction, don sterile gloves, check catheter function, hyperoxygenate, insert catheter with suction
 - B. Don gloves, insert catheter, adjust suction, hyperoxygenate, apply suction
 - C. Check suction function, don sterile gloves, hyperoxygenate, adjust suction, apply suction
 - D. Adjust suction, don sterile gloves, check catheter function, hyperoxygenate, insert catheter without suction**

The correct sequence of actions for suctioning a client with a tracheostomy focuses on ensuring both safety and efficacy in the procedure. The process should begin by adjusting the suction apparatus to the appropriate level, which is typically between 80 to 120 mmHg for adult patients. This step is crucial as it prevents excessive suction pressures that could harm the airway. Following the adjustment, donning sterile gloves is essential for infection control, as it minimizes the risk of introducing pathogens into the tracheostomy site or the airway. Once gloved, checking catheter function is next; this step ensures that the suction catheter is clear and functioning properly before inserting it into the tracheostomy. Hyperoxygenation of the client is a critical step as well, typically done prior to suctioning to prevent hypoxia. This is accomplished by providing supplemental oxygen for a few breaths to the patient, which helps maintain oxygen levels during the suctioning process. Then, the catheter is inserted without suction initially, allowing for a clear pathway to reach secretions in the airway. Suctioning is typically applied only when necessary, as prolonged suctioning can lead to airway trauma and hypoxia. This methodical sequence is important to safely manage the airway and minimize the risk of complications.

10. Which of the following actions should a nurse include in demonstrating diaphragmatic breathing to a preoperative client?
- A. Exhale quickly through the mouth
 - B. Inhale slowly and evenly through her nose**
 - C. Take shallow breaths through the chest
 - D. Breathe rapidly and loudly

The action of inhaling slowly and evenly through the nose is crucial in demonstrating diaphragmatic breathing to a preoperative client because it encourages deep, abdominal-based breaths that fully engage the diaphragm. This method promotes optimal lung expansion and efficient oxygen exchange, which is beneficial for relaxation and reducing anxiety prior to surgery. Inhalation through the nose also helps to filter, warm, and humidify the air, enhancing respiratory function. Diaphragmatic breathing is beneficial in preparing the body for surgery by improving oxygenation, reducing tension, and fostering a sense of calm. This technique contrasts with behaviors such as exhaling quickly through the mouth or taking shallow breaths, which may lead to inadequate ventilation and can contribute to feelings of panic or anxiety. Moreover, breathing rapidly and loudly would be counterproductive, as it could increase stress and reduce relaxation, failing to support the objectives of effective preoperative breathing techniques.