

ATI REDUCTION OF RISK POTENTIAL PRACTICE TEST (SAMPLE)

STUDY GUIDE



**SAMPLE STUDY GUIDE
WITH LIMITED QUESTIONS**

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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. When collecting a urine specimen for culture and sensitivity from a client with an indwelling urinary catheter, what is the correct action?**
 - A. Withdraw 3 to 5 mL of urine from the port
 - B. Collect urine from the drainage bag
 - C. Clamp the catheter prior to collection
 - D. Instruct the client to void into a sterile container
- 2. What is the first step a nurse should take when preparing to perform a capillary blood glucose test?**
 - A. Perform a quality control test
 - B. Cleanse puncture site
 - C. Check expiration date on test strips
 - D. Document results
- 3. What laboratory value indicates a client receiving bolus enteral tube feedings may need a change in formula?**
 - A. BUN 28 mg/dL
 - B. Creatinine 0.8 mg/dL
 - C. Glucose 100 mg/dL
 - D. Albumin 4.0 g/dL
- 4. Which type of consent is required for a surgical procedure?**
 - A. Verbal consent
 - B. Informed consent
 - C. Implied consent
 - D. Written consent after the procedure
- 5. What should be included in a routine safety check of a patient's room?**
 - A. Assessing comfort only
 - B. Checking for clutter and hazards
 - C. Confirming only the patient's name
 - D. None of the above

- 6. When assessing a dehydrated client, what physical sign should a nurse look for to confirm dehydration?**
- A. Elevated blood pressure
 - B. Dry mucous membranes
 - C. Increased capillary refill time
 - D. Bradycardia
- 7. Which pulse site should a nurse avoid assessing bilaterally at the same time?**
- A. Radial
 - B. Femoral
 - C. Carotid
 - D. Brachial
- 8. A nurse reviewing lab results for a client with fluid volume deficit expects to find which urine specific gravity?**
- A. 1.005
 - B. 1.020
 - C. 1.035
 - D. 1.050
- 9. What is the significance of a thorough discharge process?**
- A. It ensures patients understand their follow-up care and reduces readmission rates
 - B. It allows doctors to finalize billing procedures
 - C. It is mainly used to gather patient satisfaction scores
 - D. It provides an opportunity for healthcare providers to review their fees
- 10. A nurse is admitting a client who has influenza and reports numbness and tingling in their extremities. What acid-base imbalance should the nurse recognize this client is experiencing?**
- A. Metabolic acidosis
 - B. Respiratory alkalosis
 - C. Metabolic alkalosis
 - D. Respiratory acidosis

Answers

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

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Explanations

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1. When collecting a urine specimen for culture and sensitivity from a client with an indwelling urinary catheter, what is the correct action?

- A. Withdraw 3 to 5 mL of urine from the port**
- B. Collect urine from the drainage bag
- C. Clamp the catheter prior to collection
- D. Instruct the client to void into a sterile container

Withdrawing 3 to 5 mL of urine from the port of an indwelling urinary catheter is the appropriate action when collecting a urine specimen for culture and sensitivity. This method is essential because it ensures that the urine collected is fresh and minimizes contamination from urine that may have been stagnant in the drainage bag. Using the port on the catheter allows for a more accurate representation of the current urinary tract state, which is crucial for effective diagnosis and treatment. It is important to cleanse the port with antiseptic before withdrawing the specimen to reduce the risk of introducing external bacteria into the sample. The other options do not align with best practices for urine collection in this context. Collecting urine from the drainage bag may result in contamination, as urine can sit for extended periods, allowing for bacterial growth. Clamping the catheter before collection is unnecessary and could lead to bladder distension or discomfort for the patient, while instructing the client to void into a sterile container is not suitable when an indwelling catheter is present, as it bypasses the purpose of the catheter and does not provide a sample from the urinary tract itself.

2. What is the first step a nurse should take when preparing to perform a capillary blood glucose test?

- A. Perform a quality control test
- B. Cleanse puncture site
- C. Check expiration date on test strips**
- D. Document results

When preparing to perform a capillary blood glucose test, the first step is to check the expiration date on the test strips. This step is crucial because expired test strips can lead to inaccurate results, which may significantly affect patient care. Ensuring that the test strips are within their effective date guarantees that the readings obtained will be trustworthy and reliable. Checking the expiration date also aligns with best practices for maintaining the integrity of medical supplies and safeguarding patient safety. If the test strips are expired, they should not be used, and new ones should be obtained before proceeding with the test. This foundational step is critical in the process of performing any laboratory test, as accurate results are essential for diagnosing and managing the patient's condition effectively.

3. What laboratory value indicates a client receiving bolus enteral tube feedings may need a change in formula?

- A. BUN 28 mg/dL**
- B. Creatinine 0.8 mg/dL
- C. Glucose 100 mg/dL
- D. Albumin 4.0 g/dL

A blood urea nitrogen (BUN) level of 28 mg/dL can indicate that the client may be experiencing issues related to kidney function or protein metabolism, which could suggest a need for a change in the enteral feeding formula. Elevated BUN levels can be caused by dehydration, excessive protein intake, or renal impairment. In the context of enteral feedings, it might suggest that the current formula is too high in protein or that the client's body is not adequately processing the nutrients, possibly leading to an overload. Monitoring BUN is crucial as it helps assess the patient's nutritional status, hydration level, and kidney function. Since enteral feeding formulas can vary significantly in protein content, a BUN level that is elevated indicates a situation where adjustments to the formula may be necessary to ensure that the client receives appropriate nutrition without overloading their system, especially if renal issues are a concern. The other laboratory values indicate normal ranges or do not necessarily suggest a need for a formula change. The creatinine value is within a normal range, indicating no current renal impairment. A glucose level of 100 mg/dL is considered normal and typically indicates good blood sugar control, while an albumin level of 4.0 g/dL is also normal,

4. Which type of consent is required for a surgical procedure?

- A. Verbal consent
- B. Informed consent**
- C. Implied consent
- D. Written consent after the procedure

Informed consent is required for a surgical procedure because it ensures that the patient fully understands the nature of the surgery, the risks and benefits involved, and any potential alternatives before agreeing to proceed. This type of consent is not just a mere signature; it is a process that includes providing the patient with all relevant information in a manner they can understand, allowing them to ask questions and make an informed decision about their health care. This process is particularly important in surgical contexts because patients must be aware of the implications of undergoing a procedure that may carry significant risks. It protects the patient's autonomy, ensuring that they are actively participating in their own health care decisions. Furthermore, informed consent is a legal and ethical requirement in healthcare, safeguarding both the patient's rights and the healthcare provider's responsibilities. Other forms of consent, such as verbal or implied consent, do not provide the same level of assurance that a patient has understood and accepted the risks involved in a surgical procedure. Written consent after the procedure is also not valid since consent needs to be obtained before any surgical intervention takes place.

5. What should be included in a routine safety check of a patient's room?

- A. Assessing comfort only
- B. Checking for clutter and hazards**
- C. Confirming only the patient's name
- D. None of the above

In a routine safety check of a patient's room, checking for clutter and hazards is essential for creating a safe environment. This involves looking for any obstacles that could pose a risk to the patient, such as loose items on the floor, equipment that is not secured, or any other potential tripping hazards. Ensuring that the room is tidy helps to prevent falls and injuries, which are significant concerns in healthcare settings. Addressing comfort alone does not encompass the broader safety considerations necessary to protect the patient. Simply confirming the patient's name does not relate to the immediate physical safety environment, and neglecting safety checks could lead to preventable accidents. Therefore, evaluating the overall safety by checking for clutter and hazards is a crucial component of patient care that directly contributes to their well-being.

6. When assessing a dehydrated client, what physical sign should a nurse look for to confirm dehydration?

- A. Elevated blood pressure
- B. Dry mucous membranes**
- C. Increased capillary refill time
- D. Bradycardia

Identifying dry mucous membranes is a key physical sign in confirming dehydration. In a dehydrated state, the body's fluids are depleted, leading to less moisture in the mucous membranes. This results in a dry sensation in the mouth and throat, which can serve as an easily observable indicator of reduced hydration levels. In contrast, elevated blood pressure may not be a reliable sign of dehydration, as the relationship between fluid loss and blood pressure can vary, with some patients experiencing hypotension instead. Increased capillary refill time can occur in dehydration but can also be influenced by various other factors, such as peripheral circulation, making it less definitive as a sole sign. Bradycardia, or a slow heart rate, typically does not correlate with dehydration; instead, tachycardia is more commonly observed as a compensatory response to low intravascular volume. Thus, dry mucous membranes serve as a straightforward and effectively recognized indicator of dehydration for nurses during assessment.

7. Which pulse site should a nurse avoid assessing bilaterally at the same time?

- A. Radial
- B. Femoral
- C. Carotid**
- D. Brachial

The carotid pulse site should be assessed individually rather than bilaterally at the same time due to the risk of inducing a vagal response. When both carotid arteries are compressed simultaneously, it can lead to a significant drop in heart rate or blood pressure, potentially resulting in fainting or other cardiovascular issues. In clinical practice, it is crucial to obtain accurate and safe assessments of vital signs. By avoiding bilateral assessment of the carotid pulse, the nurse ensures that the risk of compromising the patient's hemodynamic stability is minimized. The other pulse sites, such as the radial, femoral, and brachial, do not have the same potential for adverse reactions when assessed together, making them safer for simultaneous examination.

8. A nurse reviewing lab results for a client with fluid volume deficit expects to find which urine specific gravity?

- A. 1.005
- B. 1.020
- C. 1.035**
- D. 1.050

In a client with fluid volume deficit, the concentration of their urine is expected to be higher, which is reflected in a urine specific gravity measurement. This is because, when the body is experiencing a deficit of fluids, it retains water in order to maintain homeostasis and concentrate the urine. A urine specific gravity of 1.035 indicates concentrated urine, which aligns with the body's response to dehydration. In cases of fluid volume deficit, the kidneys conserve water, leading to a smaller volume of more concentrated urine. This higher specific gravity reflects the presence of more solutes in the urine as a result of fluid retention efforts by the body. In contrast, a urine specific gravity closer to 1.005 would indicate dilute urine, which is not typical in a state of fluid volume deficit. Values around 1.020 suggest a normal concentration, while anything significantly higher than 1.035 might indicate an excessive level of concentration, potentially pointing to other issues rather than just fluid volume deficit. Thus, the choice of 1.035 as the specific gravity aligns with what would be expected in this clinical scenario.

9. What is the significance of a thorough discharge process?

- A. It ensures patients understand their follow-up care and reduces readmission rates**
- B. It allows doctors to finalize billing procedures
- C. It is mainly used to gather patient satisfaction scores
- D. It provides an opportunity for healthcare providers to review their fees

The significance of a thorough discharge process lies primarily in its ability to ensure that patients have a clear understanding of their follow-up care, which is crucial for their recovery and overall health outcomes. By effectively communicating discharge instructions, healthcare providers can help patients comprehend important aspects such as prescribed medications, follow-up appointments, and lifestyle changes necessary for recovery. This understanding is directly linked to reducing readmission rates, as patients who are well-informed are better equipped to follow their care plans and manage their conditions post-discharge. A comprehensive discharge process not only informs patients but also engages them in their own care, fostering a sense of responsibility and promoting adherence to treatment protocols. The ultimate goal is to enhance patient safety and reduce the likelihood of complications that could lead to readmission, making this aspect of patient care essential in healthcare settings.

10. A nurse is admitting a client who has influenza and reports numbness and tingling in their extremities. What acid-base imbalance should the nurse recognize this client is experiencing?

- A. Metabolic acidosis
- B. Respiratory alkalosis
- C. Metabolic alkalosis**
- D. Respiratory acidosis

The client experiencing influenza and reporting numbness and tingling in their extremities is likely experiencing respiratory alkalosis. This condition can result from hyperventilation, which may occur with respiratory illnesses like influenza. Hyperventilation leads to excessive loss of carbon dioxide (CO₂), which causes an increase in blood pH, resulting in respiratory alkalosis. Numbness and tingling, particularly in the extremities, are common neurological symptoms that arise due to the decreased levels of carbon dioxide, altering the acid-base balance and causing hypocalcemia or reduced ionized calcium levels, which contribute to these sensations. When CO₂ levels drop, the resulting shifts in blood chemistry can directly lead to sensory disturbances, making it crucial for nurses to assess these symptoms in the context of a respiratory pathophysiology. Other options like metabolic acidosis, metabolic alkalosis, and respiratory acidosis do not match the symptom profile and physiological response seen in this client scenario. These conditions have different underlying causes and manifestations. Understanding the link between the client's symptoms and the resulting acid-base imbalance is vital for proper management and interventions.

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://atireductionriskpotential.examzify.com>

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

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