

ATI RN Comprehensive Predictor Practice Test (Sample)

Study Guide



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SAMPLE

Questions

- 1. What is a common side effect of clozapine that should be monitored?**
 - A. Increased appetite**
 - B. Dry mouth**
 - C. Excessive sweating**
 - D. Constipation**
- 2. What indicates a risk for aspiration in a client receiving intermittent tube feeding?**
 - A. A history of obesity.**
 - B. A history of gastroesophageal reflux disease.**
 - C. A history of diabetes.**
 - D. A history of hypertension.**
- 3. What medication is commonly used for acute episodes of Raynaud's disease?**
 - A. Epinephrine**
 - B. Nitroglycerin**
 - C. Beta-blockers**
 - D. Calcium channel blockers**
- 4. What is the appropriate IV solution to prime tubing for a transfusion of packed RBCs?**
 - A. 5% dextrose in water**
 - B. 0.9% sodium chloride**
 - C. Lactated Ringer's solution**
 - D. Half-strength saline solution**
- 5. What should be done if a newly licensed nurse is suctioning a client's tracheostomy incorrectly?**
 - A. A supervisor should step in immediately**
 - B. Intervention is required if the nurse inserts the catheter without applying suction**
 - C. Assessment should be conducted before intervention**
 - D. The nurse should continue until finished**

- 6. What should a nurse do if a client experiences fetal bradycardia during labor?**
- A. Administer oxygen to the mother**
 - B. Assess maternal and fetal status immediately**
 - C. Notify the operating room for a possible cesarean**
 - D. Increase the intravenous fluids**
- 7. What should a nurse include when assessing a client's risk for food aspiration?**
- A. The client's ability to chew and swallow safely**
 - B. The types of foods the client enjoys**
 - C. The client's body mass index (BMI)**
 - D. The client's level of physical activity**
- 8. What is the appropriate action by a nurse if a client shows signs of dehydration?**
- A. Restrict fluid intake**
 - B. Administer IV fluids as prescribed**
 - C. Increase solid food intake**
 - D. Encourage heavy exercise**
- 9. What nursing action is appropriate for a client with thrombocytopenia?**
- A. Encourage regular exercise**
 - B. Serve the client raw vegetables**
 - C. Avoid invasive procedures**
 - D. Increase fluid intake**
- 10. What is the first action a nurse should take if they observe welts on a child's legs during a home visit?**
- A. Apply a cold compress**
 - B. Document clinical findings**
 - C. Contact the physician immediately**
 - D. Perform a skin assessment**

Answers

SAMPLE

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

SAMPLE

Explanations

SAMPLE

1. What is a common side effect of clozapine that should be monitored?

- A. Increased appetite**
- B. Dry mouth**
- C. Excessive sweating**
- D. Constipation**

While dry mouth is a known side effect of various antipsychotic medications, including clozapine, the side effect that is particularly significant and requires careful monitoring is actually constipation. Clozapine has a well-documented association with gastrointestinal effects, including constipation, which can be severe and lead to complications such as bowel obstruction or even death if not managed appropriately. The risk of constipation with clozapine is heightened because it can cause reduced gastrointestinal motility. Monitoring bowel habits and advising patients on preventative measures, like dietary modifications or use of laxatives when necessary, are essential practices in nursing care for patients receiving this medication. Although increased appetite, excessive sweating, and dry mouth can occur with clozapine, they are typically not as dangerous or as critical to monitor compared to the potential complications arising from constipation.

2. What indicates a risk for aspiration in a client receiving intermittent tube feeding?

- A. A history of obesity.**
- B. A history of gastroesophageal reflux disease.**
- C. A history of diabetes.**
- D. A history of hypertension.**

A history of gastroesophageal reflux disease (GERD) is a significant risk factor for aspiration in clients receiving intermittent tube feeding. GERD involves the backward flow of stomach contents into the esophagus, which can lead to increased risk of aspiration if those contents enter the airway. Clients with GERD may have compromised esophageal motility or sphincter function, making them more susceptible to reflux episodes. When these individuals receive tube feeding, the contents can easily flow back into the throat and potentially be aspirated into the lungs, leading to aspiration pneumonia and other complications. In contrast, a history of obesity, diabetes, or hypertension does not intrinsically increase the risk of aspiration during tube feeding. While obesity may contribute to various health issues, it does not directly impact the mechanisms of swallowing or reflux as GERD does. Similarly, diabetes and hypertension broadly affect systemic health but are not primary considerations related to the mechanics of aspiration risk in the context of tube feedings. Thus, having a history of GERD highlights a specific physiological concern that directly correlates to the aspiration risk during tube feedings.

3. What medication is commonly used for acute episodes of Raynaud's disease?

- A. Epinephrine**
- B. Nitroglycerin**
- C. Beta-blockers**
- D. Calcium channel blockers**

In the context of Raynaud's disease, the correct medication commonly used for acute episodes is calcium channel blockers. These medications, such as nifedipine and amlodipine, are effective in relaxing the smooth muscle of blood vessels, which helps to improve blood flow to the extremities during episodes of vasospasm. By inhibiting calcium ions from entering the cells, calcium channel blockers lead to vasodilation, alleviating the symptoms associated with Raynaud's attacks. While certain medications from the list may have therapeutic effects in other conditions or contexts, they are not the primary treatment for acute episodes of Raynaud's disease. For example, epinephrine and beta-blockers are generally associated with other cardiovascular functionalities and are not specific to the management of Raynaud's symptoms. Nitroglycerin is primarily used for angina or heart-related conditions and does not directly address the underlying mechanisms of Raynaud's episodes. Therefore, calcium channel blockers are the preferred choice, particularly for their role in reducing the frequency and severity of vascular responses during episodes.

4. What is the appropriate IV solution to prime tubing for a transfusion of packed RBCs?

- A. 5% dextrose in water**
- B. 0.9% sodium chloride**
- C. Lactated Ringer's solution**
- D. Half-strength saline solution**

The appropriate IV solution to prime tubing for a transfusion of packed RBCs is 0.9% sodium chloride. This solution is an isotonic saline solution that closely matches the osmolarity of the blood, making it safe for use with blood products. When preparing for a transfusion, it is essential to maintain the integrity of the RBCs and ensure that the infusion does not cause hemolysis or other adverse reactions. 0.9% sodium chloride provides the right environment for the packed RBCs without introducing additional substances that could potentially interact negatively with the blood components. It hydrates the fluid without causing shifts in fluid balances or leading to hemolysis, which could happen with solutions containing dextrose or other electrolytes. Using an isotonic solution is a standard practice to ensure that the transfusion proceeds smoothly and safely, thus protecting the patient and the integrity of the blood products.

5. What should be done if a newly licensed nurse is suctioning a client's tracheostomy incorrectly?

- A. A supervisor should step in immediately**
- B. Intervention is required if the nurse inserts the catheter without applying suction**
- C. Assessment should be conducted before intervention**
- D. The nurse should continue until finished**

When a newly licensed nurse is suctioning a client's tracheostomy incorrectly, immediate intervention is crucial to ensure the client's safety and well-being. If the nurse inserts the suction catheter without applying suction, it can lead to complications such as injury to the airway, ineffective clearance of secretions, and distress for the patient. In this situation, the priority is to modify the technique being used to prevent harm and to ensure effective suctioning. Correct suctioning involves inserting the catheter and then applying suction while withdrawing the catheter with a rotating motion, which helps clear secretions without causing additional trauma. Failing to apply suction during insertion of the catheter indicates a significant misunderstanding of the suctioning procedure, requiring prompt corrective action to protect the client's respiratory status. This intervention is vital, as it directly addresses the inappropriate technique being used. Therefore, emphasizing correct practice is essential for patient safety and effective nursing care, making this the appropriate response to the situation.

6. What should a nurse do if a client experiences fetal bradycardia during labor?

- A. Administer oxygen to the mother**
- B. Assess maternal and fetal status immediately**
- C. Notify the operating room for a possible cesarean**
- D. Increase the intravenous fluids**

In the case of fetal bradycardia during labor, the priority is to assess both maternal and fetal status immediately. This assessment is crucial because it provides vital information regarding the well-being of both the mother and the fetus, which can guide further interventions. Evaluating the fetal heart rate pattern and any associated symptoms in the mother can help determine the cause of the bradycardia and the urgency of the situation. Upon assessing the situation, the nurse can then take appropriate actions based on the findings. For instance, if the bradycardia is persistent and concerning, subsequent steps may include administering oxygen to the mother to improve fetal oxygenation, increasing intravenous fluids if the mother is dehydrated, or preparing for possible surgical intervention if there is evidence of fetal distress. While other options such as administering oxygen or increasing intravenous fluids may be appropriate interventions later on, they should follow the initial assessment to ensure that the most urgent needs are addressed based on the current status of both the mother and fetus.

7. What should a nurse include when assessing a client's risk for food aspiration?

- A. The client's ability to chew and swallow safely**
- B. The types of foods the client enjoys**
- C. The client's body mass index (BMI)**
- D. The client's level of physical activity**

When assessing a client's risk for food aspiration, it's essential to focus on the client's ability to chew and swallow safely. This is a direct indicator of their swallowing function, which is critical in preventing aspiration. Clients who have difficulty swallowing (dysphagia) are at a higher risk for aspiration, as they may not be able to manage food or liquids properly, leading to the possibility of these substances entering the airway instead of the esophagus. Assessing swallowing abilities, including the strength and coordination of the muscles used in chewing and swallowing, helps identify individuals who may need dietary modifications or swallowing therapy to reduce their aspiration risk. Other factors such as the types of foods the client enjoys, body mass index, and level of physical activity may provide some context about the client's overall health and habits but do not directly address the mechanics of swallowing and the risk of aspiration. Thus, they are not as crucial in this specific assessment.

8. What is the appropriate action by a nurse if a client shows signs of dehydration?

- A. Restrict fluid intake**
- B. Administer IV fluids as prescribed**
- C. Increase solid food intake**
- D. Encourage heavy exercise**

Administering IV fluids as prescribed is the most appropriate action when a client exhibits signs of dehydration. This intervention directly addresses the deficiency of fluids and electrolytes in the body, which is crucial for restoring normal physiological function. IV fluids are often used in a clinical setting because they can quickly rehydrate the client and ensure that the necessary volume is delivered more efficiently than through oral intake, especially if the client is unable to take sufficient fluids orally due to severity of dehydration or other underlying conditions. Providing IV fluids helps to maintain or restore circulation, support kidney function, and improve overall fluid balance, which is essential for optimal health. This action aligns with best practice in nursing care, particularly for clients who are more severely dehydrated or unable to maintain hydration through oral means. Other options do not appropriately address the needs of a dehydrated client. Restricting fluid intake would exacerbate the problem, while simply increasing solid food intake may not provide the immediate hydration necessary. Encouraging heavy exercise could lead to further fluid loss and worsen the dehydration status. Thus, administering IV fluids as prescribed is the most effective and immediate strategy for managing dehydration effectively.

9. What nursing action is appropriate for a client with thrombocytopenia?

- A. Encourage regular exercise**
- B. Serve the client raw vegetables**
- C. Avoid invasive procedures**
- D. Increase fluid intake**

For a client with thrombocytopenia, avoiding invasive procedures is critical because this condition is characterized by a significantly reduced platelet count, which increases the risk of bleeding. Platelets play a crucial role in blood clotting, and when their numbers are low, any invasive procedure—such as venipuncture, surgery, or even dental work—can lead to excessive bleeding and complications. In this context, ensuring that the client is not subjected to unnecessary risks is paramount to their safety. Implementing measures such as using gentle techniques for blood draws, avoiding injections, and ensuring careful monitoring can help prevent adverse outcomes related to their low platelet levels. While other options may promote health or comfort in different scenarios, they do not directly address the increased risk of bleeding associated with thrombocytopenia as effectively as avoiding invasive procedures. For instance, although increasing fluid intake can support overall health, it does not mitigate the bleeding risks posed by the condition.

10. What is the first action a nurse should take if they observe welts on a child's legs during a home visit?

- A. Apply a cold compress**
- B. Document clinical findings**
- C. Contact the physician immediately**
- D. Perform a skin assessment**

In the scenario where a nurse observes welts on a child's legs during a home visit, the appropriate first action is to document clinical findings. Accurate documentation provides a detailed record of the child's condition at that specific moment, including the appearance of the welts, any accompanying symptoms, and the child's overall demeanor. This information is crucial for continuity of care and can be essential for any further assessments or interventions required. Documenting clinical findings also serves multiple purposes: it allows for communication between healthcare providers, aids in identifying trends over time, and supports medical decision-making. In a home visit context, this step is vital because the child's condition can change, and having thorough notes helps ensure that all observations are communicated effectively to other members of the healthcare team. While other actions might be necessary afterward—such as performing a skin assessment to gather more specific data or applying a cold compress if the welts are itchy or swollen—documentation is ongoing and critical as the first step in addressing any medical concerns. This practice aligns with nursing standards and ensures the safety and quality of care provided to the child.