

# VATI Greenlight Practice Exam (Sample)

## Study Guide



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**SAMPLE**

## **Questions**

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- 1. What might a nurse assess for in a client with fractured ribs who develops thrombophlebitis?**
  - A. Pulmonary embolism**
  - B. Deep vein thrombosis**
  - C. Chest pain**
  - D. Hypoxia**
- 2. Which action by the nurse demonstrates the concept of veracity when caring for a client?**
  - A. A nurse explains the potential risks of treatment**
  - B. A nurse provides medication without explanation**
  - C. A nurse withholds information about side effects**
  - D. A nurse makes promises to the client without certainty**
- 3. Which of the following is NOT a sign of withdrawal in a newborn?**
  - A. Tachypnea**
  - B. Irritability**
  - C. Tremors**
  - D. High birth weight**
- 4. Which common side effect may occur with phenelzine use in clients?**
  - A. Hypertension**
  - B. Weight loss**
  - C. Severe headaches**
  - D. Dry mouth**
- 5. What should the nurse do first when obtaining a low pulse oximeter reading of 89% in a postoperative client?**
  - A. Apply supplemental oxygen**
  - B. Repeat the test on another finger**
  - C. Assess the client's respiratory status**
  - D. Notify the healthcare provider**

- 6. What is the appropriate route of administration for a client receiving heparin?**
- A. Intravenously**
  - B. Intramuscularly**
  - C. Subcutaneously**
  - D. Orally**
- 7. What does a tonic-clonic seizure typically involve?**
- A. Loss of consciousness with muscle rigidity**
  - B. Localized muscle twitching**
  - C. Absence of awareness**
  - D. Sudden emotional outbursts**
- 8. What should be checked one hour after administering chlorpromazine by IM injection?**
- A. Blood glucose levels**
  - B. Orthostatic blood pressure**
  - C. Body temperature**
  - D. Respiratory rate**
- 9. In the case of a 17-year-old client requiring an emergency appendectomy, which action is appropriate for informed consent?**
- A. Obtain verbal consent from the client while waiting for the parents**
  - B. Delay the procedure until the parents are present**
  - C. Have the client's older sibling give consent**
  - D. Witness the signature of the client's parent when they arrive**
- 10. What objective should a nurse prioritize when conducting a mental health assessment for a new client?**
- A. Gather comprehensive medical history.**
  - B. Establish rapport and trust with the client.**
  - C. Assign a psychiatric diagnosis.**
  - D. Prepare the treatment plan without client input.**

## **Answers**

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

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## **Explanations**

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**1. What might a nurse assess for in a client with fractured ribs who develops thrombophlebitis?**

- A. Pulmonary embolism**
- B. Deep vein thrombosis**
- C. Chest pain**
- D. Hypoxia**

In a client with fractured ribs who develops thrombophlebitis, it is crucial for the nurse to be vigilant about the risk of a pulmonary embolism. This condition can occur if a blood clot from the deep veins, often due to thrombophlebitis, dislodges and travels to the lungs, leading to serious respiratory complications. The risk is particularly heightened in clients with rib fractures, as the associated pain may lead to reduced mobility, increasing venous stasis and the likelihood of clot formation. Therefore, evaluating for signs and symptoms of a pulmonary embolism, such as sudden onset of shortness of breath, chest pain, or increased heart rate, is an essential part of the assessment in this situation. Identifying a potential pulmonary embolism early can significantly improve outcomes for the patient, making it a top priority for the nurse to assess in this clinical scenario.

**2. Which action by the nurse demonstrates the concept of veracity when caring for a client?**

- A. A nurse explains the potential risks of treatment**
- B. A nurse provides medication without explanation**
- C. A nurse withholds information about side effects**
- D. A nurse makes promises to the client without certainty**

The action that demonstrates the concept of veracity in nursing is when a nurse explains the potential risks of treatment. Veracity refers to the principle of truthfulness and involves being honest and transparent with clients about their care, including the benefits and risks associated with different treatment options. By openly discussing the potential risks, the nurse ensures that the client can make informed decisions about their care, fostering trust in the nurse-client relationship and respecting the client's right to autonomy. This practice aligns with ethical standards that emphasize the importance of truthfulness in healthcare.

**3. Which of the following is NOT a sign of withdrawal in a newborn?**

- A. Tachypnea**
- B. Irritability**
- C. Tremors**
- D. High birth weight**

High birth weight is not a sign of withdrawal in a newborn. Withdrawal symptoms in newborns are typically associated with the exposure to substances, such as opioids, during pregnancy. These symptoms can manifest in various physical and behavioral indicators. Tachypnea, or rapid breathing, is commonly observed in newborns experiencing withdrawal, as their bodies may react to the absence of the substance they were exposed to in utero. Irritability is also a prevalent withdrawal symptom; newborns can exhibit increased fussiness and difficulty being consoled. Tremors are another sign that may be seen in infants undergoing withdrawal, as their nervous systems respond to the sudden change in their environment and the lack of substance exposure. In contrast, high birth weight does not indicate any withdrawal symptoms. It may sometimes reflect a healthy prenatal environment or could be associated with other factors but does not relate to withdrawal status in the context of substance exposure.

**4. Which common side effect may occur with phenelzine use in clients?**

- A. Hypertension**
- B. Weight loss**
- C. Severe headaches**
- D. Dry mouth**

Phenelzine, a monoamine oxidase inhibitor (MAOI), is commonly associated with hypertension as a significant side effect. This occurs particularly when phenelzine is taken alongside tyramine-rich foods, which can cause a hypertensive crisis. Tyramine is an amino acid found in various foods, and when its levels rise in the body due to the inhibition of monoamine oxidase, it can lead to a dangerous increase in blood pressure. This interaction is a crucial consideration when prescribing phenelzine, as clinicians must educate clients on dietary restrictions to mitigate the risk of hypertension. While other side effects like weight loss, severe headaches, or dry mouth can occur, they are not as prominently linked to phenelzine nor do they pose the same level of immediate risk as hypertension does. Therefore, the association of hypertension with phenelzine use is a critical aspect of its pharmacological profile that healthcare providers and clients must acknowledge and manage carefully.

**5. What should the nurse do first when obtaining a low pulse oximeter reading of 89% in a postoperative client?**

- A. Apply supplemental oxygen**
- B. Repeat the test on another finger**
- C. Assess the client's respiratory status**
- D. Notify the healthcare provider**

In this situation, the most appropriate first action is to assess the client's respiratory status. A pulse oximeter reading of 89% indicates that the oxygen saturation in the client's blood is lower than the normal range, which typically falls between 95% and 100%. Before taking further steps, it is crucial for the nurse to evaluate the patient's breathing pattern, effort, and any other signs of respiratory distress—such as cyanosis, use of accessory muscles, or abnormal lung sounds. By assessing the respiratory status, the nurse can gather vital information to determine the cause of the low pulse oximeter reading and decide on the next appropriate interventions. While applying supplemental oxygen, repeating the test, or notifying the healthcare provider are important actions that may follow, they are contingent on understanding the patient's current respiratory condition first. This thorough assessment allows for a more tailored and effective response to the low oxygen saturation level.

**6. What is the appropriate route of administration for a client receiving heparin?**

- A. Intravenously**
- B. Intramuscularly**
- C. Subcutaneously**
- D. Orally**

The appropriate route of administration for a client receiving heparin is subcutaneously. Heparin is an anticoagulant that is commonly used to prevent and treat blood clots. When administering heparin, the subcutaneous route is preferred for several reasons. This route allows for the medication to be absorbed slowly and steadily into the bloodstream, maintaining a therapeutic level over time without the peaks and troughs that might occur with other routes. Subcutaneous administration also minimizes the risk of complications associated with intravenous or intramuscular administration, such as bleeding or local tissue irritation. While heparin can be given intravenously, especially in acute settings for faster action, the subcutaneous route is generally suitable for prophylactic treatment and routine anticoagulation therapy. Oral administration is not an option for heparin because it is not effective when taken orally due to extensive metabolism in the gastrointestinal tract and liver. Intramuscular administration is also not recommended due to the increased risk of bleeding and hematoma formation. Therefore, subcutaneously is the most appropriate route for heparin administration in most cases.

**7. What does a tonic-clonic seizure typically involve?**

- A. Loss of consciousness with muscle rigidity**
- B. Localized muscle twitching**
- C. Absence of awareness**
- D. Sudden emotional outbursts**

A tonic-clonic seizure, also known as a grand mal seizure, typically involves a loss of consciousness accompanied by muscle rigidity followed by rhythmic jerking movements. During the initial tonic phase, the person experiences muscle stiffness as the muscles contract, leading to a loss of posture and potential falling. This is followed by the clonic phase, where the individual exhibits rhythmic jerking movements of the body. The loss of consciousness during this type of seizure means that the person is not aware of their surroundings or what is happening to them. While other options do describe different types of seizure activities, they do not correctly represent the combination of features that characterize a tonic-clonic seizure. Localized muscle twitching is more indicative of partial seizures, absence of awareness aligns with absence seizures, and sudden emotional outbursts could be seen in other contexts but are not a defining feature of tonic-clonic seizures.

**8. What should be checked one hour after administering chlorpromazine by IM injection?**

- A. Blood glucose levels**
- B. Orthostatic blood pressure**
- C. Body temperature**
- D. Respiratory rate**

After administering chlorpromazine via intramuscular injection, it is crucial to monitor the patient's orthostatic blood pressure one hour later due to the potential side effects associated with this medication. Chlorpromazine, an antipsychotic medication, can cause sedation and fluctuations in blood pressure. Monitoring orthostatic blood pressure specifically helps identify any significant drops in blood pressure that may occur when the patient changes position, which can lead to dizziness or falls. The significance of checking orthostatic blood pressure lies in the fact that chlorpromazine can have a hypotensive effect, particularly during the initial hours after administration when the body is still adjusting to the medication. This monitoring ensures patient safety and helps inform further medical decisions regarding continued treatment or adjustments in dosage. While blood glucose, body temperature, and respiratory rate are also important vital signs to monitor in a clinical setting, they are not as directly impacted by the pharmacological effects of chlorpromazine as orthostatic blood pressure, making the latter the most relevant choice shortly after the medication is given.

**9. In the case of a 17-year-old client requiring an emergency appendectomy, which action is appropriate for informed consent?**

**A. Obtain verbal consent from the client while waiting for the parents**

**B. Delay the procedure until the parents are present**

**C. Have the client's older sibling give consent**

**D. Witness the signature of the client's parent when they arrive**

Informed consent in medical situations involving minors can be complex due to legal and ethical considerations. For a 17-year-old client who requires an emergency appendectomy, it is important to understand the legal framework regarding consent for medical treatments. Obtaining verbal consent from the client while waiting for the parents is appropriate in this scenario because many jurisdictions allow mature minors—typically defined as individuals aged 16 and older—to provide consent for their own medical care, especially in emergency situations. When the situation is urgent, as with an appendectomy, delaying the procedure for parental consent could put the patient at risk. Therefore, seeking the teenager's consent, given their age and ability to understand the implications of the procedure, aligns with the principles of autonomy and timely medical intervention. In this context, options that involve delaying care for parental consent or having siblings provide consent are not suitable as they do not adhere to the established guidelines for situations involving mature minors. Witnessing a parental signature may be necessary once the parents arrive, but it does not address the immediate need for consent to proceed with urgent medical treatment.

**10. What objective should a nurse prioritize when conducting a mental health assessment for a new client?**

**A. Gather comprehensive medical history.**

**B. Establish rapport and trust with the client.**

**C. Assign a psychiatric diagnosis.**

**D. Prepare the treatment plan without client input.**

Establishing rapport and trust with the client is a crucial objective during a mental health assessment. Building a trusting relationship allows the client to feel safe and secure in sharing their thoughts, feelings, and experiences, which is essential for obtaining accurate and meaningful information. Trust can significantly influence the client's willingness to engage in the assessment process candidly, thus enabling the nurse to gather more relevant data that can inform future care. When clients feel respected and understood, they are more likely to participate actively in their assessment and treatment, leading to more effective outcomes. This foundation of trust not only facilitates open communication but also enhances the therapeutic relationship, which is vital in mental health settings. While gathering a comprehensive medical history, assigning diagnoses, and preparing treatment plans are important components of care, they should follow after initial trust and rapport are established. This ensures that the client feels valued and involved in their own care from the outset.