

VATI Greenlight Practice Exam (Sample)

Study Guide



Everything you need from our exam experts!

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Table of Contents

| | |
|------------------------------------|-----------|
| Copyright | 1 |
| Table of Contents | 2 |
| Introduction | 3 |
| How to Use This Guide | 4 |
| Questions | 5 |
| Answers | 8 |
| Explanations | 10 |
| Next Steps | 16 |

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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 is an example of appropriate documentation for medication administration?**
 - A. Carafate 1g PO 1hx AC**
 - B. Carafate 1g IM 1hr AC**
 - C. Carafate 1g PO 1hr PC**
 - D. Carafate 1g IV 30min AC**

- 2. During enteral nutrition, what lab level should a nurse report?**
 - A. Serum calcium of 9.5**
 - B. Serum sodium of 128**
 - C. Serum potassium of 4.5**
 - D. Serum glucose of 150**

- 3. What action should a nurse take for a client with an MRSA infection?**
 - A. Wear gloves but no gown**
 - B. Use hand sanitizer before care**
 - C. Don a gown and gloves when providing perineal care**
 - D. Isolate the client in a single room**

- 4. What instruction should a nurse give about bathing a newborn?**
 - A. "Use soap and water on the entire body."**
 - B. "Wash your newborn's head under a stream of running water."**
 - C. "Avoid using any water during the first week."**
 - D. "Use a sponge bath for the first month."**

- 5. In performing wound irrigation, how should the nurse hold the bottle while pouring?**
 - A. With the cap facing up**
 - B. With the palm over the label**
 - C. With the bottle upright**
 - D. With the nozzle pointing down**

- 6. What is the nurse's priority action when a client shows signs of confusion postoperatively?**
- A. Notify the surgeon immediately**
 - B. Assess the client's neurological status**
 - C. Provide reassurance to the client**
 - D. Check the client's medications**
- 7. Which task is appropriate to delegate to an assistive personnel on a medical-surgical unit?**
- A. Administer medication to a client**
 - B. Change a wound dressing for a postoperative client**
 - C. Administer a large-volume enema to a client**
 - D. Perform a head-to-toe assessment on a client**
- 8. What dietary advice should be given to a client taking lithium carbonate?**
- A. Take medication with water only**
 - B. Take medication with milk**
 - C. Take medication with a high-protein snack**
 - D. Take medication on an empty stomach**
- 9. What initial assessment is crucial for clients with suspected pelvic and femur fractures?**
- A. Pain assessment**
 - B. Mobility evaluation**
 - C. Swelling measurement**
 - D. Age assessment**
- 10. After a femoral cardiac catheterization, what action should a nurse take during the first 30 minutes?**
- A. Assess the client's pain level.**
 - B. Monitor the incision for bleeding.**
 - C. Compare the bilateral peripheral pulses.**
 - D. Document vital signs every 15 minutes.**

Answers

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

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Explanations

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1. What is an example of appropriate documentation for medication administration?

- A. Carafate 1g PO 1hx AC**
- B. Carafate 1g IM 1hr AC**
- C. Carafate 1g PO 1hr PC**
- D. Carafate 1g IV 30min AC**

The correct answer reflects a commonly accepted format for documenting medication administration. In this case, the documentation notes the medication "Carafate," the dosage of "1g," the route of administration as "PO" (which stands for per os, or orally), and the timing of administration as "1hx AC," which indicates that the medication was given one hour before meals (AC stands for ante cibum, or before meals). This type of documentation is appropriate because it provides clear and accurate information about the medication given, how it was administered, and when it was given in relation to meals. This ensures that the healthcare team members can easily understand the medication schedule and any necessary dietary guidelines that accompany the administration of the drug, especially since Carafate is often used to coat the stomach and is influenced by food intake. Other options include routes and timings that do not align with the standard practice for administering Carafate or suggest inaccuracies such as incorrect routes (IM or IV) or timings (PC instead of AC). Therefore, the first option offers the most accurate and conventional approach to medication documentation.

2. During enteral nutrition, what lab level should a nurse report?

- A. Serum calcium of 9.5**
- B. Serum sodium of 128**
- C. Serum potassium of 4.5**
- D. Serum glucose of 150**

In the context of enteral nutrition, monitoring laboratory values is crucial to ensure patient safety and optimal nutritional support. A serum sodium level of 128 is indicative of hyponatremia, which is a low sodium concentration in the blood. This condition can lead to serious complications, including neurological issues such as confusion, seizures, or even coma. Hyponatremia can occur in patients receiving enteral nutrition due to several factors, including excessive free water intake, inappropriate formula composition, or underlying medical conditions that may affect fluid balance. Given that sodium plays a vital role in maintaining fluid balance, nerve function, and muscle contraction, any abnormality, particularly one that reflects significant derangement, must be reported promptly. The other options present different lab values that may not indicate immediate risk. A serum calcium level of 9.5 is within the normal range, serum potassium of 4.5 is typically normal, and although a serum glucose level of 150 is elevated, it is not as urgent as the significantly low sodium level, which poses an immediate threat to the patient. Therefore, reporting the serum sodium level of 128 is critical to ensure timely intervention and management of the patient's nutritional and hydration status.

3. What action should a nurse take for a client with an MRSA infection?

- A. Wear gloves but no gown**
- B. Use hand sanitizer before care**
- C. Don a gown and gloves when providing perineal care**
- D. Isolate the client in a single room**

When caring for a client with an MRSA (Methicillin-resistant Staphylococcus aureus) infection, the most appropriate action involves donning a gown and gloves when providing perineal care. This practice is rooted in the guidelines for preventing the spread of this highly resistant bacterium, which can cause serious infections. Wearing gloves protects the nurse from direct contact with potentially infectious materials, such as bodily fluids, while the gown serves as an additional barrier to prevent contamination of clothing and to decrease the risk of spreading MRSA to other patients or areas within the healthcare environment. This level of personal protective equipment (PPE) is particularly critical during procedures that have a higher risk of exposure to infectious materials, such as perineal care. Adhering to these infection control measures is essential in managing MRSA cases, ensuring the safety of both the healthcare worker and other individuals in the facility. Other options may not provide the same level of protection or adhere to the recommended precautions for managing MRSA infections.

4. What instruction should a nurse give about bathing a newborn?

- A. "Use soap and water on the entire body."**
- B. "Wash your newborn's head under a stream of running water."**
- C. "Avoid using any water during the first week."**
- D. "Use a sponge bath for the first month."**

The instruction regarding washing a newborn's head under a stream of running water is appropriate as it highlights a method that minimizes the baby's exposure to direct water flow and allows for gentle cleansing. In practice, it's important to support the baby's safety and comfort during bathing. When bathing a newborn, care should be taken to avoid using harsh soaps which can irritate their sensitive skin, hence the choice stating to use soap and water on the entire body is not advisable for a newborn's delicate skin. Recommendations generally suggest sponge baths until the umbilical cord stump falls off, rather than a full bath with running water. Therefore, while gently washing the head might not involve direct soaking of the infant, it's an effective means to keep the newborn clean without overwhelming them with water. In terms of bathing practices during the initial period, avoiding any water completely in the first week is not necessary as gentle cleansing is acceptable and beneficial for hygiene. Sponge baths are usually recommended until the umbilical cord is healed, but this typically lasts for only about a week or until the cord stump falls off, rather than an entire month, making the concept of sponge bathing for the first month less accurate. This information also emphasizes the appropriateness of using careful techniques for keeping a newborn clean

5. In performing wound irrigation, how should the nurse hold the bottle while pouring?

- A. With the cap facing up**
- B. With the palm over the label**
- C. With the bottle upright**
- D. With the nozzle pointing down**

Holding the bottle with the palm over the label while pouring wound irrigation fluid is important for several reasons. This technique ensures that the nurse maintains a clear view of the nozzle and directs the irrigation fluid precisely where needed. Additionally, positioning the palm over the label helps to prevent any contamination from the label getting into the wound or the solution itself, which is crucial for maintaining a sterile environment. By obscuring the label, the nurse can also avoid potential distraction from any information or markings that may be present, allowing for better focus on the task at hand. This method enhances control and reduces the risk of spillage, ultimately ensuring the patient receives safe and effective wound care.

6. What is the nurse's priority action when a client shows signs of confusion postoperatively?

- A. Notify the surgeon immediately**
- B. Assess the client's neurological status**
- C. Provide reassurance to the client**
- D. Check the client's medications**

When a client shows signs of confusion postoperatively, the priority action for the nurse is to assess the client's neurological status. This assessment is critical in determining the underlying cause of the confusion, which can range from transient effects of anesthesia to more serious complications such as hypoxia, electrolyte imbalances, or stroke. Thoroughly assessing the neurological status involves evaluating the client's level of consciousness, orientation, motor responses, and any other neurological signs that may indicate an emerging problem. Understanding the severity and nature of the confusion enables timely intervention and appropriate care. While informing the surgeon is an important action in cases of significant concern, it should follow an initial assessment to provide the surgeon with accurate information regarding the client's condition. Providing reassurance can help to reduce anxiety, but it does not address the potential underlying issues that could cause confusion. Checking medications is also relevant, particularly to rule out sedative effects or adverse reactions, but it comes after the essential step of assessing the client's neurological condition. Thus, prioritizing the assessment allows for a systematic approach to identifying the cause of confusion and determining the necessary interventions, ensuring the client's safety and wellbeing.

7. Which task is appropriate to delegate to an assistive personnel on a medical-surgical unit?

- A. Administer medication to a client**
- B. Change a wound dressing for a postoperative client**
- C. Administer a large-volume enema to a client**
- D. Perform a head-to-toe assessment on a client**

The task of administering a large-volume enema is appropriate to delegate to assistive personnel on a medical-surgical unit because it falls within the scope of practice for trained nursing assistants or other assistive staff, provided that they have received the necessary training to perform this task. This procedure is typically a routine care measure and does not require the critical assessment skills of a registered nurse or licensed practical nurse. In contrast, administering medication, changing a wound dressing, and performing a head-to-toe assessment all involve complex clinical judgment, monitoring of the client's condition, and potential implications on the client's safety and health. These tasks require the specialized knowledge and decision-making capabilities of a licensed nurse, making them inappropriate for delegation to assistive personnel.

8. What dietary advice should be given to a client taking lithium carbonate?

- A. Take medication with water only**
- B. Take medication with milk**
- C. Take medication with a high-protein snack**
- D. Take medication on an empty stomach**

Giving dietary advice to a client taking lithium carbonate requires an understanding of how food can impact the absorption of the medication and the overall management of lithium levels in the body. Taking the medication with milk can help buffer the stomach and may reduce gastrointestinal irritation, which some patients experience when taking lithium. Additionally, milk provides calcium and protein, which can be beneficial overall. It's important to note that while the other options might appear viable, they do not provide the same balancing effect. For instance, taking lithium on an empty stomach can lead to increased absorption and potentially higher plasma levels, raising the risk of toxicity. Drinking water alone may not provide any protective benefit against gastrointestinal upset. A high-protein snack may not directly assist with the absorption of lithium in the same way that milk does, and the protein content could vary depending on the type of snack, possibly affecting how the medication is absorbed or metabolized. Thus, taking lithium carbonate with milk is the most supportive option for both comfort and safety in medication management.

9. What initial assessment is crucial for clients with suspected pelvic and femur fractures?

- A. Pain assessment**
- B. Mobility evaluation**
- C. Swelling measurement**
- D. Age assessment**

The initial assessment that is crucial for clients with suspected pelvic and femur fractures is the pain assessment. In cases of fractures, clients often experience significant pain which can provide important insights into the nature and severity of the injury. Pain assessment helps in identifying the location, intensity, and type of pain, which can influence immediate treatment decisions. Understanding the level of pain can also indicate the need for urgent interventions, such as pain management or stabilization of the affected area, and helps inform healthcare providers about potential complications associated with fractures, such as shock or internal bleeding due to pelvic fractures. While mobility evaluation, swelling measurement, and age assessment are also important in the broader context of injury assessment, they do not provide as immediate and critical information about the condition of the patient as a pain assessment does during the initial evaluation phase.

10. After a femoral cardiac catheterization, what action should a nurse take during the first 30 minutes?

- A. Assess the client's pain level.**
- B. Monitor the incision for bleeding.**
- C. Compare the bilateral peripheral pulses.**
- D. Document vital signs every 15 minutes.**

After a femoral cardiac catheterization, monitoring the bilateral peripheral pulses is crucial during the first 30 minutes. This assessment is essential to ensure that there is adequate circulation and that no complications, such as hematoma or occlusion, are occurring in the affected limb. The femoral artery is accessed during the procedure, and the risk of complications such as thrombosis or bleeding can impact blood flow. By comparing the peripheral pulses, the nurse can identify any discrepancies between the two legs, which could indicate potential issues with blood flow resulting from complications of the catheterization. If one pulse is weaker or absent compared to the other, it could signal a problem that requires immediate intervention. While assessing pain levels, monitoring for bleeding, and documenting vital signs are all important nursing responsibilities, the immediate focus following cardiac catheterization is on circulatory assessments, making the evaluation of peripheral pulses a priority during those critical first moments post-procedure.

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://vatigreenlight.examzify.com>

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

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