

# VATI RN FUNDAMENTALS PRACTICE TEST (SAMPLE)

## STUDY GUIDE



## SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

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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. How does stress typically affect a patient's physical health?**
  - A. It has no impact on health
  - B. It can result in improved health status
  - C. It may exacerbate existing health conditions and weaken response
  - D. It alleviates chronic conditions
- 2. Which intervention should a nurse include in the care plan for a client at risk for falls?**
  - A. Have the client demonstrate how to use the call light.
  - B. Restrict the client's movement within the room.
  - C. Place the client's bed in the lowest position at all times.
  - D. Provide the client with assistive devices for mobility.
- 3. What should a nurse do when moving a client up in bed with the assistance of another nurse?**
  - A. Raise the client's arms above their head
  - B. Position the client's arms across their chest
  - C. Instruct the client to hold onto the bed rail
  - D. Keep the client's arms dangling at their sides
- 4. Why is education important in chronic illness management?**
  - A. It confuses the patient
  - B. It promotes self-management strategies
  - C. It reduces the need for follow-up care
  - D. It limits patient engagement
- 5. What does the term "scope of practice" refer to in nursing?**
  - A. The range of professional education a nurse must complete
  - B. The legal boundaries defining a nurse's permitted actions
  - C. The financial limits of patient care services
  - D. The ethical guidelines all nurses must follow

- 6. When should the nurse prepare to reassess a patient after administering a new medication?**
- A. After one day
  - B. Prior to their next dose
  - C. Within 30 minutes
  - D. Before discharge
- 7. What is the most appropriate nursing action after assessing absent bowel sounds?**
- A. Document the findings immediately
  - B. Auscultate again in 10 minutes
  - C. Notify the healthcare provider
  - D. Assess for other symptoms first
- 8. When caring for clients with traumatic brain injuries, which client requires immediate referral?**
- A. A client who has a mild headache
  - B. A client who is confused and disoriented
  - C. A client who consistently coughs after drinking liquids
  - D. A client who is experiencing fatigue and lethargy
- 9. What is the purpose of a health assessment?**
- A. To fulfill legal documentation requirements
  - B. To gather comprehensive data to guide patient care
  - C. To entertain patients during their visit
  - D. To prepare patients for surgical procedures
- 10. Which procedure is within the scope of practice for a newly licensed nurse?**
- A. Prescribing medications
  - B. Monitoring a continuous intra-arterial infusion
  - C. Performing a surgical procedure
  - D. Diagnosing medical conditions

## **Answers**

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

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## **Explanations**

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## 1. How does stress typically affect a patient's physical health?

- A. It has no impact on health
- B. It can result in improved health status
- C. It may exacerbate existing health conditions and weaken response**
- D. It alleviates chronic conditions

*Stress can significantly impact a patient's physical health, particularly by exacerbating existing health conditions and weakening the body's response to illness. When an individual experiences stress, the body undergoes a series of physiological changes, including the release of stress hormones such as cortisol and adrenaline. While these hormones can be beneficial in short bursts (for example, by providing a temporary boost in energy or focus), chronic stress leads to prolonged exposure that can adversely affect various bodily systems. Under stress, individuals may experience increased blood pressure, elevated heart rate, and a weakened immune system. This can worsen pre-existing conditions like hypertension, cardiovascular diseases, diabetes, or respiratory issues. Additionally, stress can lead to unhealthy coping mechanisms (such as poor diet, lack of exercise, or substance use), which further compromise health. In essence, managing stress is vital for maintaining physical health and preventing deterioration of existing health issues, highlighting its significant role as a health determinant.*

## 2. Which intervention should a nurse include in the care plan for a client at risk for falls?

- A. Have the client demonstrate how to use the call light.**
- B. Restrict the client's movement within the room.
- C. Place the client's bed in the lowest position at all times.
- D. Provide the client with assistive devices for mobility.

*The intervention of having the client demonstrate how to use the call light is essential for ensuring their safety and enhancing their autonomy. By teaching and assessing the client's ability to use the call light, the nurse empowers the client to communicate their needs effectively. This can be particularly important for a client at risk for falls, as it encourages them to seek assistance when they need help moving or performing activities, which can reduce the likelihood of falls. This approach also promotes the client's active participation in their own care, making them more aware of their surroundings and needs. When clients feel confident in their ability to call for help, they may be less inclined to try to move about without assistance, thereby reducing their fall risk. This practice fosters a supportive environment for recovery and safety. In contrast, restricting movement can contribute to a negative experience and may increase the client's risk of deconditioning. Keeping the bed in the lowest position is a consideration for safety, but it does not encourage independence. Providing assistive devices for mobility is certainly an important strategy as well, but it should be implemented alongside education on using available resources like the call light effectively.*

**3. What should a nurse do when moving a client up in bed with the assistance of another nurse?**

- A. Raise the client's arms above their head
- B. Position the client's arms across their chest**
- C. Instruct the client to hold onto the bed rail
- D. Keep the client's arms dangling at their sides

*When moving a client up in bed with the help of another nurse, positioning the client's arms across their chest is the best practice. This position helps stabilize the client's upper body and minimizes the risk of injury to both the client and the nurses assisting with the movement. It allows for a coordinated and secure transfer, as the arms are not flailing or in a position that could impede the movement or create discomfort. Additionally, having the arms across the chest keeps them out of the way, reducing the chance of the client's arms getting caught or injured during the repositioning. This practice is aligned with safety protocols in patient handling, ensuring that both the client's comfort and the nurses' efficiency are prioritized.*

**4. Why is education important in chronic illness management?**

- A. It confuses the patient
- B. It promotes self-management strategies**
- C. It reduces the need for follow-up care
- D. It limits patient engagement

*Education is crucial in the management of chronic illnesses because it empowers patients with the knowledge they need to take control of their health. By understanding their condition, treatment options, and necessary lifestyle adjustments, patients are better prepared to make informed decisions regarding their care. This knowledge fosters self-management strategies, which can include medication adherence, recognizing symptoms, and understanding when to seek medical help. Effective education can lead to improved health outcomes, as patients who are informed about their condition are more likely to engage in proactive behaviors that maintain and enhance their well-being. They can effectively manage their symptoms, adhere to treatment plans, and engage in healthy lifestyle changes, all of which contribute to better management of their chronic illness.*

## 5. What does the term "scope of practice" refer to in nursing?

- A. The range of professional education a nurse must complete
- B. The legal boundaries defining a nurse's permitted actions**
- C. The financial limits of patient care services
- D. The ethical guidelines all nurses must follow

The term "scope of practice" in nursing refers to the legal boundaries that define the actions and responsibilities a nurse is permitted to perform based on their education, training, and licensure. This encompasses the specific duties, functions, and role tasks that nurses are legally allowed to undertake while practicing within their profession. Understanding the scope of practice is crucial for ensuring patient safety, maintaining professional integrity, and adhering to regulatory standards. This legal framework is intended to protect both patients and healthcare providers by clearly delineating what nurses can and cannot do. It varies by state or country and often aligns with the education and clinical competencies that nurses have acquired. By operating within their defined scope, nurses can ensure that they provide safe and effective care, advocating for patients while also protecting themselves from legal repercussions. In contrast to the correct answer, the other options address different concepts. The range of professional education a nurse must complete refers to the necessary educational qualifications but does not specifically define what actions they are legally allowed to perform. Financial limits speak to the economic aspects of patient care services and do not pertain to the professional capacity of nursing practice. Ethical guidelines are important principles that guide nursing behavior and decision-making but are separate from the legal parameters of practice defined by scope.

## 6. When should the nurse prepare to reassess a patient after administering a new medication?

- A. After one day
- B. Prior to their next dose
- C. Within 30 minutes**
- D. Before discharge

Reassessing a patient after administering a new medication is crucial for monitoring its effects and identifying any adverse reactions. The recommended time frame for this reassessment is typically within 30 minutes. This period allows the nurse to evaluate the immediate response to the medication, including monitoring vital signs, assessing for side effects, and determining the effectiveness of the medication. In the context of nursing practice, newly administered medications can cause changes that may require timely intervention. Therefore, conducting the reassessment within 30 minutes helps ensure patient safety and provides an opportunity to respond quickly if any complications arise or if adjustments to the care plan are necessary. Other time frames, such as after one day or prior to the next dose, would not provide adequate monitoring for immediate reactions. Similarly, waiting until before discharge would be too late to address any potential adverse effects the patient may experience due to the new medication. Prompt and timely reassessment is essential in delivering safe and effective nursing care.

**7. What is the most appropriate nursing action after assessing absent bowel sounds?**

- A. Document the findings immediately
- B. Auscultate again in 10 minutes
- C. Notify the healthcare provider**
- D. Assess for other symptoms first

*When absent bowel sounds are assessed, it is important to recognize the potential significance of this finding, which may indicate an underlying issue such as a bowel obstruction or paralytic ileus. Promptly notifying the healthcare provider is the most appropriate action following this assessment because it ensures that the patient receives timely evaluation and intervention. The absence of bowel sounds can be a critical sign necessitating further examination and potential treatment. This action aligns with the nursing role of advocating for patient safety and coordinating care, as the healthcare provider may need to order additional diagnostic tests or initiate interventions based on this finding. The urgency of the situation often dictates the need for immediate communication rather than waiting to reassess or gather more information first.*

**8. When caring for clients with traumatic brain injuries, which client requires immediate referral?**

- A. A client who has a mild headache
- B. A client who is confused and disoriented
- C. A client who consistently coughs after drinking liquids**
- D. A client who is experiencing fatigue and lethargy

*The client who consistently coughs after drinking liquids requires immediate referral because this symptom indicates a potential swallowing dysfunction, known as dysphagia. In clients with traumatic brain injuries, dysphagia can significantly increase the risk of aspiration, where food or liquids enter the airway instead of the esophagus, leading to aspiration pneumonia and other serious complications. Timely intervention is critical; thus, a referral to a speech-language pathologist or a nurse specialized in swallowing assessment is necessary to evaluate and manage this issue. Ensuring that the client can safely swallow fluids is essential to their overall care and recovery. While confusion and disorientation, fatigue, and mild headaches are concerning symptoms in the context of a traumatic brain injury, they do not represent an immediate life-threatening risk like dysphagia does. Addressing swallowing issues promptly is crucial for maintaining respiratory health and preventing complications.*

## 9. What is the purpose of a health assessment?

- A. To fulfill legal documentation requirements
- B. To gather comprehensive data to guide patient care**
- C. To entertain patients during their visit
- D. To prepare patients for surgical procedures

*The purpose of a health assessment is fundamentally to gather comprehensive data to guide patient care. This process involves collecting information about the patient's health history, physical condition, and lifestyle, which is essential for understanding their specific needs and developing an effective plan for treatment. A thorough health assessment provides valuable insights that enable healthcare providers to identify health issues, monitor changes in a patient's condition, and create personalized care strategies. This comprehensive approach ensures that care is tailored to the individual, promoting better health outcomes and enhancing the overall quality of care. While fulfilling legal documentation requirements and preparing patients for surgical procedures may involve elements of health assessments, these are not the primary purposes. Additionally, entertaining patients does not align with the clinical and therapeutic goals of a health assessment. The primary focus remains on the collection and analysis of relevant health data to inform patient care decisions.*

## 10. Which procedure is within the scope of practice for a newly licensed nurse?

- A. Prescribing medications
- B. Monitoring a continuous intra-arterial infusion**
- C. Performing a surgical procedure
- D. Diagnosing medical conditions

*Monitoring a continuous intra-arterial infusion is a procedure that falls within the scope of practice for a newly licensed nurse. This task involves observing and managing the equipment used for the infusion, checking the patient's response, and ensuring that the infusion is functioning correctly. It requires a foundational level of nursing knowledge and skills, which new nurses are equipped with upon graduation and licensure. The other options involve responsibilities that are typically outside the scope of practice for a newly licensed nurse. For instance, prescribing medications requires a higher level of authority and is usually reserved for advanced practice nurses or physicians. Performing surgical procedures is fundamentally a task that should be done by surgeons or specialized healthcare providers. Diagnosing medical conditions also requires extensive training and is typically performed by licensed medical professionals such as physicians. Therefore, monitoring a continuous intra-arterial infusion is both an appropriate and critical responsibility for newly licensed nurses as they begin their practice.*

## 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](mailto:hello@examzify.com).

Or visit your dedicated course page for more study tools and resources:

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

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