ATI FUNDAMENTALS PROCTORED FINAL EXAM 2025 TEST BANK - 100 MUST-KNOW QUESTIONS WITH ANSWERS & RATIONALES | HIGH-YIELD NCLEX PREP

1. A nurse is assessing a client who received morphine 30 minutes ago for pain. Which of the following findings is the priority?

A. Reports pain level of 8/10
B. Respiratory rate of 7/min
C. Last bowel movement was 3 days ago
D. Distended bladder

Answer: B. Respiratory rate of 7/min
Explanation: Respiratory depression is a life-threatening adverse effect of morphine and takes priority.

2. A nurse is preparing to suction a client's tracheostomy. Which action should the nurse take?

A. Apply intermittent suction during insertion
B. Suction airway for 20 seconds with each pass
C. Hyperoxygenate for 30-60 seconds before suctioning
D. Decrease suction pressure to 150 mm Hg if O2 sat drops

Answer: A. Apply intermittent suction during insertion
Explanation: Intermittent suction prevents trauma to the mucosa.

3. A nurse is teaching a client with Type 2 Diabetes about foot care. Which statement indicates understanding?

A. "I can apply lotion between my toes."
B. "I should trim my toenails straight across."
C. "I can soak my feet daily."
D. "I will walk barefoot at home to improve circulation."

Answer: B. "I should trim my toenails straight across."
Explanation: Trimming toenails straight across helps prevent injury and infection.

4. Which of the following requires contact precautions?

A. Measles
B. Clostridium difficile
C. Tuberculosis
D. Influenza

Answer: B. Clostridium difficile
Explanation: C. difficile requires contact precautions due to the risk of transmission through direct or indirect contact.

5. A nurse is obtaining informed consent for surgery. The client states, "I don't want the surgery anymore." What is the appropriate response?

A. Explain the risks of not having the procedure
B. Encourage the client to proceed
C. Document the client's decision
D. Discuss alternatives to surgery

Answer: C. Document the client's decision
Explanation: The nurse must respect the client's autonomy and document their choice.

6. A client has a latex allergy and is scheduled for surgery. Which action should the nurse take?

A. Schedule the surgery first in the day
B. Cleanse stoppers with iodine
C. Use powdered gloves
D. Use latex-free IV tubing only

Answer: A. Schedule the surgery first in the day
Explanation: This minimizes exposure to latex residue in the operating room.

7. A nurse is teaching a client about self-administering ophthalmic drops. Which statement indicates understanding?

A. "I will press on the inner corner of my eye after instilling drops."
B. "I will insert drops into the center of my eye."
C. "I will keep my eyes closed for 10 minutes after the drops."
D. "I will raise my eyelid while looking down and insert the drops."

Answer: A. "I will press on the inner corner of my eye after instilling drops."
Explanation: This prevents systemic absorption of the medication.

8. A nurse is teaching a client about care of an indwelling urinary catheter. Which statement is correct?

A. Secure the drainage bag to the side rails
B. Keep the drainage bag below bladder level
C. Tape the catheter to the client's abdomen
D. Empty the drainage bag when full

Answer: B. Keep the drainage bag below bladder level
Explanation: This prevents backflow of urine, reducing infection risk.

9. Which finding indicates a Stage 1 pressure injury?

A. Open wound with exposed bone
B. Blistered skin
C. Non-blanchable redness over bony prominence
D. Necrotic tissue with slough

Answer: C. Non-blanchable redness over bony prominence
Explanation: This is the hallmark of a Stage 1 pressure injury.

10. A nurse is planning care for a client with impaired mobility and incontinence. Which action reduces skin breakdown risk?

A. Apply a moisture barrier after hygiene
B. Request a urinary catheter

C. Limit fluid intake
D. Apply talcum powder to perineal area

Answer: A. Apply a moisture barrier after hygiene
Explanation: Moisture barriers protect the skin from breakdown.

11. Which action by a nurse demonstrates correct aseptic technique for a sterile field?

A. Pour sterile solution with bottle label facing palm
B. Hold bottle of solution 2 cm above sterile field
C. Reach over sterile field to grab supplies
D. Wear sterile gloves to open solution bottle

Answer: A. Pour sterile solution with bottle label facing palm
Explanation: This prevents contamination of the label.

12. A nurse is teaching about preventing urinary tract infections. Which statement by the client indicates understanding?

A. "I will wipe from back to front."
B. "I will drink at least 2 liters of fluid daily."
C. "I will hold urine to strengthen my bladder."
D. "I will use douches after intercourse."

Answer: B. "I will drink at least 2 liters of fluid daily."
Explanation: Increased fluid intake helps flush the urinary tract.

13. A nurse is caring for a client with Clostridium difficile infection. Which PPE is required?

A. Surgical mask
B. Gloves and gown