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39	A	B	C	D	E

PRACTICE QUESTIONS

ATI Testing

VCPL

VATI Comprehensive Predictor - Test Center

EDITION

Demo

QUESTIONS

9

FORMAT

Limited Edition PDF

Before you begin

What this is

9 practice questions for ATI Testing **VCPL**, each with its answer key and an explanation. Answer a question before you read its key — the explanation is worth more once you have committed.

If something looks wrong

Send us three things and we will check it:

- the exam code, **VCPL**
- the question number
- the email address on your order

Write to **support@mometrix.net**. We reply within one business day.

QUESTION 1

MULTIPLE CHOICE

A nurse is preparing to administer a dose of digoxin to a client with heart failure. Which of the following findings should the nurse assess before administering the medication? (Choose two.)

- ☒ **A** Apical pulse rate
- ☒ **B** Serum potassium level
- ☐ **C** Respiratory rate
- ☐ **D** Blood pressure
- ☐ **E** Glasgow Coma Scale score

ANSWER A - B

WHY Before administering digoxin, the nurse must assess the apical pulse for one full minute (hold if <60 bpm in adults) and review the serum potassium level, because hypokalemia increases the risk of digoxin toxicity. Respiratory rate, blood pressure, and GCS are not specific pre-administration assessments required for digoxin.

QUESTION 2

MULTIPLE CHOICE

A nurse is caring for a client who has signed an advance directive stating that they do not want to be resuscitated if their heart stops. The client later becomes unresponsive and the spouse insists that everything be done to save the client. Which of the following actions by the nurse are appropriate? (Choose two.)

- ☒ **A** Follow the client's advance directive
- ☐ **B** Follow the spouse's wishes
- ☐ **C** Notify the provider of the advance directive
- ☐ **D** Encourage the spouse to accept the situation
- ☒ **E** Document the advance directive in the medical record

ANSWER A - E

WHY The advance directive is a legally binding document that reflects the client's autonomous decision. The nurse must honor the directive and ensure it is documented in the medical record. The spouse cannot override the client's wishes, and the nurse should not attempt to change the spouse's views but should support the client's previously expressed wishes. The provider should already be aware because the advance directive is part of the chart.

QUESTION 3

TRUE FALSE

A client with active pulmonary tuberculosis should be placed in a private room with negative-pressure airflow, and healthcare workers should wear an N95 respirator when entering the room.

- ☒ **A** True
- ☐ **B** False

ANSWER A

WHY True. Tuberculosis is transmitted by airborne droplet nuclei and requires airborne precautions, which include a private, negative-pressure (airborne infection isolation) room and use of a fit-tested N95 or higher-level respirator by staff entering the room. Standard surgical masks are insufficient for protecting the wearer from airborne particles.

QUESTION 4 SINGLE CHOICE

A nurse is performing a vaginal examination on a client in labor and notes that the umbilical cord is protruding from the vagina. Which of the following actions should the nurse take first?

- ☐ A Administer oxytocin to stimulate contractions
- ☒ B Place the client in the knee-chest position
- ☐ C Apply a fetal scalp electrode
- ☐ D Perform a manual vaginal examination to push the cord back

ANSWER B

WHY Umbilical cord prolapse is an obstetric emergency. The first action is to relieve pressure on the cord by positioning the client in the knee-chest (or Trendelenburg) position while notifying the provider for emergency delivery. Oxytocin would worsen cord compression, a fetal scalp electrode would add pressure, and manually replacing the cord is not within the nurse's scope and is not the initial intervention.

QUESTION 5 SINGLE CHOICE

A nurse is caring for a client who has dysphagia following a stroke. Which of the following actions should the nurse take when feeding the client?

- ☐ A Position the client supine with the head of the bed flat
- ☐ B Offer thin liquids to facilitate swallowing
- ☒ C Place food on the unaffected side of the mouth
- ☐ D Feed the client rapidly to reduce aspiration risk

ANSWER C

WHY Clients with dysphagia should be positioned upright at 90 degrees (high Fowler's) and have food placed on the unaffected (stronger) side of the mouth to facilitate safer swallowing. Thin liquids increase aspiration risk; thickened liquids are typically recommended. Feeding the client rapidly increases aspiration risk and should be avoided.

QUESTION 6

SINGLE CHOICE

A client who recently lost a spouse states, 'I don't know how I can go on without them.' Which of the following responses by the nurse is the best example of therapeutic communication?

- ☐ A 'You'll feel better with time; everyone grieves differently.'
- ☒ B 'Tell me more about what you are feeling right now.'
- ☐ C 'Why do you think you feel this way?'
- ☐ D 'Many people in your situation eventually feel the same way.'

ANSWER B

WHY 'Tell me more about what you are feeling right now' uses an open-ended question that invites the client to explore their feelings, demonstrating therapeutic communication. Offering false reassurance, asking 'why' questions, and generalizing the experience are non-therapeutic techniques that block further communication.

QUESTION 7

SINGLE CHOICE

A nurse is reviewing laboratory results for a client who is receiving heparin therapy for a deep vein thrombosis. Which of the following laboratory values should the nurse monitor to evaluate the effectiveness of the therapy?

- ☐ A Prothrombin time (PT)
- ☐ B International normalized ratio (INR)
- ☒ C Activated partial thromboplastin time (aPTT)
- ☐ D Platelet count

ANSWER C

WHY Heparin therapy is monitored using the activated partial thromboplastin time (aPTT), with a therapeutic range typically 1.5 to 2.5 times the control value. PT and INR are used to monitor warfarin therapy. Platelet count is monitored to detect heparin-induced thrombocytopenia but does not measure the anticoagulant effectiveness of heparin.

QUESTION 8

SINGLE CHOICE

A nurse is caring for a client who develops ventricular fibrillation on a cardiac monitor. Which of the following actions should the nurse take first?

- ☐ A Administer epinephrine 1 mg
- ☐ B Perform synchronized cardioversion at 200 joules
- ☒ C Initiate cardiopulmonary resuscitation (CPR) and defibrillation
- ☐ D Obtain a 12-lead electrocardiogram

ANSWER C

WHY Ventricular fibrillation is a pulseless, life-threatening rhythm. Immediate high-quality CPR and unsynchronized defibrillation are the first priorities, following the ACLS pulseless arrest algorithm. Epinephrine is given after the first defibrillation if the rhythm persists. Synchronized cardioversion is used for unstable tachycardias with a pulse, not for VF. Obtaining a 12-lead ECG wastes critical time during arrest.

QUESTION 9

SINGLE CHOICE

A nurse is preparing to administer 40 mEq of potassium chloride IV to a client. Which of the following actions is appropriate?

- ☐ A Administer the dose as an IV push over 1 minute
- ☐ B Dilute in 100 mL of normal saline and infuse over 1 hour
- ☐ C Administer undiluted through a central line over 4 hours
- ☒ D Dilute appropriately and administer no faster than 10 mEq per hour

ANSWER D

WHY IV potassium chloride must always be diluted (typically in at least 100 mL of IV fluid) and infused slowly—no faster than 10 mEq per hour in adults without cardiac monitoring—to prevent life-threatening hyperkalemia, cardiac arrhythmias, and phlebitis. It is never given as an IV push. The rate and dilution depend on the client's condition, but a maximum infusion rate of 10 mEq/hour is a standard safety limit.