Targeted Instruction and Passing Strategies
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Now that you’ve graduated and worked hard preparing for a career in nursing, the time has come. You may be asking yourself:

“I’ve prepared for so long, now what?”

“Am I really ready to take the test?”

“How can I be assured of a strong finish in this final stretch?”

You’ve learned the bulk of your knowledge in your nursing program, and your instructors have given you a lot of useful information. Now, the National Council Licensure Exam (NCLEX-PN®) will ask you to demonstrate how well you understand that knowledge and how well you can apply it to situations you may encounter in your nursing career. This module will offer several strategies that can be used to increase your chances of passing the NCLEX-PN®.

NCLEX-PN® Essentials

To become a licensed nurse in any U.S. state or territory, you must pass first the NCLEX-PN® exam. Preparation for the NCLEX-PN® should include familiarizing yourself with how the exam is constructed and administered.

The NCLEX-PN® exam is prepared by the National Council of State Boards of Nursing (NCSBN). The exam is the same regardless of the state or territory where you test. In other words, a graduate nurse seeking licensure in Ohio will take the same test as would a graduate nurse seeking licensure in Illinois.

The requirement for receiving authorization to test does vary from state to state. To find specific requirements for your state or territory, go to http://www.ncsbn.org and click on the “Boards of Nursing” tab. To find testing centers in your state, go to http://www.pearsonvue.com/NCLEX. Some states have compacts that allow mobility of their licensure status, which means if you are licensed to practice within a particular state, other states may offer reciprocity that allows you to practice in those states as well. Information about state compacts can also be found on the NCSBN website at http://www.ncsbn.org/nlc.htm.

You may wonder why you have to take the NCLEX-PN® licensure exam. Simply stated, the mission of the NCSBN is to ensure that our society has safe and effective nursing care. Essentially, the licensure exam is a means of providing professional regulation for competence at the entry level and ensuring public safety.

It is important to understand that the NCLEX-PN® is not a test of intelligence. It is not a test for nurses who have practice experience to show their level of achievement. It does not ask questions about highly specialized nursing practices, cutting-edge technologies, vendor-specific equipment, or drug therapies not approved by the Food and Drug Administration (FDA). The NCSBN uses the following criteria to ensure fairness. The exam must be:

- Psychometrically sound
- Legally defensible
- Objective
- Empirical
- Reliable
To identify the current nature of entry-level professional practice, NCSBN conducts a job analysis study every 3 years. Using the data collected, the NCSBN determines the competency level needed for nurses to deliver safe and effective care. The questions you'll encounter on the NCLEX-PN® are consistent with what entry-level nurses actually do in clinical practice.

The NCLEX-PN® exam uses a computer-adaptive testing approach. This means that, as the test-taker, you are given questions via the computer that are based on the level of difficulty of questions you answer correctly or incorrectly. Every exam is individualized, although every test-taker begins with relatively easy questions. Each time you answer a question, the computer technology estimates your ability within a content area. With every answer, the computer’s estimate of your knowledge level gets more precise. If all goes well, you’ll reach a certain point in the testing process where you will have demonstrated a minimal competency. This occurs when you answer questions of a certain difficulty—not when you’ve answered a certain percentage of items. At this point, the computer compares your ability level with the national passing mark. One of three things will happen:

1. If you are above the passing standard at question 85, your exam will end and you will pass.
2. If you are below the passing standard at question 85, your exam will end and you will fail.
3. If your ability estimate is close to the passing mark, either nearly below or nearly above, then you will continue to receive more questions until a more precise judgment can be made about your knowledge of the content presented on the exam. You will either pass or fail depending on your performance to that point. A pass will not be awarded if you score at the passing mark. You will need to achieve above it to receive a nursing license.

Listed below are other important facts about the NCLEX-PN® exam.

<table>
<thead>
<tr>
<th><strong>NCLEX-PN® Facts</strong></th>
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<tbody>
<tr>
<td>The exam includes a minimum of 85 questions and a maximum of 205 questions.</td>
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<tr>
<td>The maximum time allowed is five (5) hours.</td>
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<tr>
<td>There is an optional 10-minute break after the first two (2) hours.</td>
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<tr>
<td>There is an optional break after an additional 90 minutes of testing.</td>
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<tr>
<td>Every test-taker receives 25 experimental questions.</td>
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<tr>
<td>You will not be able to identify which items are experimental.</td>
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<tr>
<td>Answers to experimental questions do not count in your score.</td>
</tr>
<tr>
<td>The full 205 question set is never randomly administered. The test will end when a minimal competency is demonstrated (anywhere from 85 to 205 questions).</td>
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</table>
On April 1, 2008, the NCSBN implemented a new test plan and a revised passing standard. To help determine the passing standard, the NCSBN conducted a practice analysis study to determine the minimum amount of knowledge, skills, and ability required for safe and effective entry-level nursing.

The emphasis areas from the practice analysis study are reflected by the distribution of test items in the NCLEX-PN® Detailed Test Plan. Listed below is the 2008 test plan. Examples of common content areas are listed to the right of each Client Needs category and subcategory, while the percentages listed below demonstrate the distribution for each category within the test as a whole. As you prepare for the NCLEX-PN®, familiarity with the emphasis areas in the current test plan as well as how this emphasis has changed from the previous plan (published in 2005) will help you focus your study efforts. Increased areas of emphasis on the 2008 test plan include a) Coordinated Care (up 1% from 2005) and b) Physiological Adaptation (down 1% from 2005).

### 2008 NCLEX-PN® Detailed Test Plan

<table>
<thead>
<tr>
<th>NCLEX-PN® Client Needs Category</th>
<th>Common Content Areas</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safe and Effective Care Environment</td>
<td></td>
</tr>
</tbody>
</table>
| • Coordinated Care 12%-18% | Advance Directives  
Advocacy  
Client Care Assignments  
Client Rights  
Collaboration with Interdisciplinary Team  
Concepts of Management and Supervision  
Confidentiality/Information Security  
Continuity of Care  
Establishing Priorities  
Ethical Practice  
Informed Consent  
Information Technology  
Legal Responsibilities  
Performance Improvement  
Referral Process  
Resource Management  
Staff Education  
--- |
| • Safety and Infection Control 8%-14% | Accident/Error/Injury Prevention  
Ergonomic Principles  
Handling Hazardous and Infectious Materials  
Home Safety  
Internal and External Disaster Plans  
Medical and Surgical Asepsis  
Reporting of Incident  
Restraints and Safety Devices  
Safe Use of Equipment  
Security Plan  
Standard/Other Precautions  
--- |
| Health Promotion and Maintenance 7%-13% | Aging Process  
Ante/Intra/Postpartum and Newborn Care  
Data Collection Techniques  
Developmental Stages and Transitions  
Disease Prevention  
Expected Body Image Changes  
Family Planning  
Health Promotion Programs  
High Risk Behaviors  
Human Sexuality  
Immunizations  
Lifestyle Choices  
Self-Care  
--- |
### Psychosocial Integrity

<table>
<thead>
<tr>
<th>Category</th>
<th>Topics</th>
</tr>
</thead>
<tbody>
<tr>
<td>8%-14%</td>
<td>Abuse or Neglect, Behavioral Management, Coping Mechanisms, Crisis Intervention, Cultural Awareness, End of Life Concepts, Grief and Loss, Mental Health/Illness Concepts, Spiritual Influences on Health</td>
</tr>
<tr>
<td></td>
<td>Sensory/Perceptual Alterations, Situational Role Changes, Stress Management, Substance-Related Disorders, Suicide/Violence Precautions, Support Systems, Therapeutic Communication, Therapeutic Environment, Unexpected Body Image Changes</td>
</tr>
</tbody>
</table>

### Physiological Integrity

#### Basic Care and Comfort

<table>
<thead>
<tr>
<th>Category</th>
<th>Topics</th>
</tr>
</thead>
<tbody>
<tr>
<td>11%-17%</td>
<td>Assistive Devices, Elimination, Mobility/Immobility, Nonpharmacological Comfort Interventions</td>
</tr>
<tr>
<td></td>
<td>Nutrition and Oral Hydration, Palliative/Comfort Care, Personal Hygiene, Rest and Sleep</td>
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</tbody>
</table>

#### Pharmacological and Parenteral Therapies

<table>
<thead>
<tr>
<th>Category</th>
<th>Topics</th>
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</thead>
<tbody>
<tr>
<td>9%-15%</td>
<td>Adverse Effects, Contraindications and Compatibilities, Dosage Calculations, Expected Effects</td>
</tr>
<tr>
<td></td>
<td>Medication Administration, Pharmacological Actions, Pharmacological Agents, Side Effects</td>
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#### Reduction of Risk Potential

<table>
<thead>
<tr>
<th>Category</th>
<th>Topics</th>
</tr>
</thead>
<tbody>
<tr>
<td>10%-16%</td>
<td>Diagnostic Tests, Laboratory Values, Potential for Alterations in Body Systems, Potential for Complications of Diagnostic Tests/Treatments/Procedures or Health Alterations, Therapeutic Procedures, Vital Signs</td>
</tr>
</tbody>
</table>

#### Physiological Adaptation

<table>
<thead>
<tr>
<th>Category</th>
<th>Topics</th>
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</thead>
<tbody>
<tr>
<td>11%-17%</td>
<td>Alterations in Body Systems, Basic Pathophysiology, Fluid and Electrolyte Imbalances, Medical Emergencies, Radiation therapy, Unexpected Response to Therapies</td>
</tr>
</tbody>
</table>

The majority of NCLEX-PN® items are written at the **application** and **analysis** level, although there are some lower-level **knowledge** and **comprehension** items on the test. Make certain you have broad knowledge in all Client Needs categories so that you can demonstrate at least a minimal level of competency when asked to **apply** your knowledge to the care of the clients in the scenarios presented on the exam.
Understand What is Being Asked

Next, you will learn how to clearly determine what information needs to be addressed by eliminating information that is irrelevant. This simple process clears a pathway to the correct answer and will help you answer quite a few of the most difficult questions correctly and achieve a passing score on the exam.

Types of exam items

Taking the NCLEX-PN® examination is a different type of testing experience than taking a unit exam in nursing school. All test items are written and coded based on Bloom’s Taxonomy (Bloom, et al, 1956), which is the progressive hierarchy for classifying a person’s thinking skills. Most items are written at the application and analysis levels of the taxonomy. The highest two levels are synthesis and evaluation, which are present but less common with standard four-option multiple choice questions.

Even though you won’t see many knowledge-based or comprehension questions on the NCLEX-PN®, you should at least be able to identify them as you prepare for your exam. That way, you won’t spend too much of your valuable study time on these questions – and you won’t be surprised when you don’t see more of these types of questions on test day. Here’s a quick review:

Knowledge-based questions test recall and recognition. Consider the example below (correct answer is bolded and underlined):

Which of the following is considered an adverse effect of bronchodilator therapy?
A. Limited routes of administration
B. Diuretic and electrolyte imbalances
C. Increased myocardial oxygen use
D. CNS depression and somnolence

Comprehension questions test the ability to translate and interpret. Consider the example below:

A 91-year-old female client has been on bed rest for 10 days. An indication related to immobility is:
A. soreness of the gums.
B. abdominal distention.
C. long-term memory loss.
D. decreased urine output.

As previously mentioned, you will see mostly application and analysis level questions on the NCLEX-PN®. These questions require you to use your knowledge to solve client problems. It’s really about how to decide what is most important in the context of multiple client conditions. Before attempting to choose an answer, you should consciously identify key words in the stem that are relevant to what is being asked and dismiss irrelevant information.
A common pitfall

Graduate nurses commonly choose answers that relate to what is being asked rather than answer what is being asked. For example:

A female client with cardiac monitoring has a rhythm that looks like ventricular fibrillation. Which of the following actions should the nurse take first?

A. Palpate for a carotid pulse.
B. Have the client intubated.
C. Start rescue breathing.
D. Defibrillate the client.

The question assumes the test-taker is knowledgeable about ventricular fibrillation. All test-takers should know ventricular fibrillation is always a pulseless rhythm. They should also know ventricular fibrillation is treated by performing defibrillation.

What is the question asking?

• What is the treatment for ventricular fibrillation? No!
• What is the priority nursing action when ventricular fibrillation is suspected? Yes!

The words “looks like” change what the question is asking. You should recognize that although the monitor shows ventricular fibrillation, a rescue intervention should not be initiated until absence of pulse has been established.

Although you may have the knowledge to answer the question correctly, you must also be careful to choose the correct order of interventions. This can be accomplished by giving key words in the stem appropriate attention. Failure to do so may lead you to choose an answer to a question that was not asked.

What information is relevant?

Let’s examine the examples below and practice identifying issues that are important or irrelevant to what is being asked.

Example 1:

A 44-year-old client who is obese and has a history of chronic obstructive pulmonary disease (COPD) had a ventral hernia repair 4 days ago. During this morning’s assessment, the nurse notes that the client’s dressing is saturated with purulent drainage. The client states that she was nauseated all night and vomited about an hour ago. Based on this information, which of the following should the nurse do first?

A. Call the provider to get an order for an antiemetic.
B. Assess the client’s incision line.
C. Reinforce the abdominal dressing.
D. Increase the client’s supplemental oxygen.
What factors are relevant in the question?
- Obese client
- Abdominal surgery 4 days ago
- Purulent drainage
- Vomited an hour ago

What factors should be dismissed?
- 44-year-old client
- Ventral hernia repair
- History of COPD
- Morning assessment

What is the question asking?
The question is asking for the priority nursing action for a client who has had abdominal surgery, an abdominal infection, and vomited 1 hour ago. **Answer B is correct**, because the nurse should assess the incision for wound dehiscence.

**Example 2:**
An 18-year-old male client was admitted 12 hours ago following a motor-vehicle crash in which he sustained multiple skeletal fractures. The client has been placed in balanced-suspension traction. Which of the following assessment findings requires immediate intervention?
- A. Chest pain with positioning
- B. Dyspnea
- C. Disorientation
- D. Bloody drainage around the pin site

What factors are relevant in the question?
- Admitted 12 hours ago
- Multiple skeletal fractures

What factors should be dismissed?
- 18-year-old client
- Balanced-suspension traction

What is this question asking?
The question is asking for the most clinically significant assessment data for a client who sustained multiple skeletal fractures 12 hours ago. **Answer B is correct**, because development of a fat embolus typically manifests as dyspnea and hypoxia.
Example 3:

A nurse in the emergency department is caring for an older adult client with a history of rheumatoid arthritis. The client reports recurring left calf pain after walking one to two blocks at the local mall. He reports that the pain decreases in intensity with rest. The client also states that he has nocturia. Further examination reveals that the left foot is shiny, taut, and slightly cooler than the right. Which of the following nursing interventions is most appropriate?

A. Place the client in Trendelenburg position.
B. Assess dorsiflexion and extension of the foot.
C. Elevate the leg above the heart.
D. Position the leg dependently.

What factors are relevant in the question?
- Recurring calf pain with activity
- Onset of calf pain after a short distance
- Pain relieved by rest
- Left extremity taut and shiny
- Left extremity slightly cooler

What factors should be dismissed?
- Rheumatoid arthritis
- Older adult client
- Nocturia

What is the question asking?
The question is asking for the most appropriate intervention for a client with peripheral arterial disease. Answer D is correct; placing the leg in a dependent position will increase blood flow to the extremity.

Example 4:

A nurse is caring for an immobilized client admitted 10 days ago after a large intracerebral hemorrhage. The client has just started total parenteral nutrition (TPN) and has a gastrostomy tube. Which of the following nursing interventions is most likely to prevent the development of fluid volume deficit?

A. Give boluses of water into the gastrostomy tube.
B. Assess urine output every hour.
C. Monitor intake and output every shift.
D. Perform blood glucose monitoring q.i.d.

What factors are relevant in the question?
- TPN is being administered.
- TPN has just been started.

What factors should be dismissed?
- Immobilized client
- Intracerebral hemorrhage
- Admitted 10 days ago
- Gastrostomy tube
What is the question asking?
The question is asking for the intervention that is most important to prevent the development of fluid volume deficit in a client who has just been started on TPN. **Answer D is correct**, because timely blood glucose monitoring will alert the nurse to hyperglycemia, which can induce an osmotic diuresis.

*Example 5:*
An 18-year-old primipara is preparing for discharge 12 hours after giving birth to a 7-lb infant at 39 weeks’ gestation. A follow-up home visit is scheduled 24 hours after discharge. Which of the following is most important to include in the discharge teaching?

A. Identify normal psychological responses to childbirth.
B. Review normal physiological changes related to childbirth.
C. Demonstrate postpartum self-care activities.
D. Explain nutritional needs necessary to facilitate weight loss.

What factors are relevant in the question?
- Primipara
- Discharge after 12 hours
- Home visit scheduled for 24 hours

What factors should be dismissed?
- 7-lb infant
- 39 weeks’ gestation
- 18-year-old client

What is the question asking?
The question is asking for the most important content to teach prior to discharging a primipara. **Answer C is correct.** Since a home visit is scheduled in 24 hours, the priority would be education related to promotion of comfort, rest, and prevention of complications.

*Example 6:*
A client has depression related to an impending divorce. She asks the nurse, “Do you think I should divorce my husband or just separate from him?” Which of the following responses by the nurse is most therapeutic?

A. “The best thing for you to do is to divorce him, since he is the cause of your depression.”
B. “If you are divorced, how will you support yourself? Do you have specific job skills?”
C. “How do you think a divorce will affect your children now and in the future?”
D. “What do you think would be the best thing for you to do in your situation?”

What factors are relevant in the question?
- Depressed client
What factors should be dismissed?
- The topic of the decision

What is the question asking?
The question is asking for a therapeutic response to a client with depression. **Answer D is correct**, because a statement that is open-ended and information-seeking is most appropriate for this client in this situation.

*Example 7:*
A nurse at a local elementary school should recognize which of the following children as requiring immediate intervention?
- A. A child stumbling after riding the merry-go-round
- B. A child breathing heavily after a dodge ball game
- C. A child squatting after a game of tether ball
- D. A child playing four-square on the concrete

What factors are relevant in the question?
- School-age children
- Engaged in play

What factors should be dismissed?
- School location
- Where the children are playing

What is the question asking?
The question is asking to identify the child demonstrating post-play behavior that could indicate distress or injury. **Answer C is correct**, because a squatting stance after activity is a clinical manifestation of cyanotic heart disease.

**Summary**
In this unit, we have reviewed *Bloom’s Taxonomy* and practiced questions written at the application and analysis level. As you move toward NCLEX-PN® success, “answering what is being asked” is the starting point toward getting the questions correct. Eliminating irrelevant information will help you to clearly identify the issues of importance, guiding you to the correct answer. Practice this strategy while taking each of the ATI practice assessments. Read each question carefully and purposely dismiss irrelevant content in the stem. Draw your attention to the relevant details as you consider and eliminate possible answer choices.

**Use What You Know**
Now that you know how to determine what the question is asking, you should turn your energy toward “using what you know.” The following strategies described will teach you to choose answers wisely even if you are doubtful about your knowledge of the topic. They will help you to stay in control of the test, minimize guessing, and reduce anxiety.
Stay in charge

Graduate nurses taking the NCLEX-PN® have a tendency to focus on what they don’t know rather than on what they do know. The ramifications of this mental approach are devastating.

When you focus on your lack of knowledge about a particular topic, you are likely to become anxious and start guessing or changing answers. There is also a carryover effect that can reduce your ability to answer subsequent items. You might start losing confidence. When that happens, suddenly the test begins controlling you. You should pause, take a deep breath, try to relax, and move on. Stay focused.

One of the most important factors in achieving NCLEX-PN® success is feeling in control of the test. This comes from understanding the test construction and administration and systematically managing the test items.

When you aren’t sure or don’t know

How should you manage an item when you don’t think you know anything about the topic? It is natural to become anxious if you don’t remember much about the topic. Don’t panic. Simply use your “default testing strategy.” Default strategies promote “using what you know.” This puts you back in the driver’s seat and keeps you in control of the test. The next section describes three important strategies.

Strategy 1: Use time to your advantage

Early verses late. What do you know about questions asking you to identify early and late signs and symptoms? You should know they all have something in common. Early clinical manifestations are generalized and nonspecific, whereas late signs are specific and serious. Eliminate incorrect answer choices using this strategy.

Pre, post, and intra. You may be asked about complications associated with certain procedures. What should you do if you know little or nothing about the procedure? Pay attention to whether the question is asking about “pre-procedural,” “intraprocedural,” or “postprocedural” concerns. Eliminate the options that do not correspond to what is being asked. The correct answer may be quite obvious when viewing the question from this perspective.

Time elapsed. The priority nursing action will change based on the time interval stipulated. Obviously the closer the client is to the origination of risk, the higher the risk for complications. Sometimes the time issue will be stated in terms of hours or days. In other instances the physical location of the client will tell you how long it has been since the origination of risk. Watch closely for whether the client is in the “recovery room,” “postsurgical unit,” or somewhere else. The time issue buried in those words should help you eliminate incorrect answers that don’t match what is being asked.

Strategy 2: Let Maslow’s hierarchy of needs be your guide

When taking the NCLEX-PN®, keep in mind that physiological safety will always be more important than anything psychological. You can eliminate
answers based on the premise that physiologic safety must be established prior to initiating therapeutic psychologic nursing actions. If you lack knowledge about what do to in a certain situation, let Maslow's hierarchy guide you toward the correct answer. Remember, the hierarchy starts with physiological needs and proceeds to safety and security, then love and belonging, self-esteem and, finally, self-actualization.

**Strategy 3: Remember: most complete = least room for error**

You’ll encounter items on the NCLEX-PN® that will ask you to choose the instruction or documentation that is most accurate. What should you do if you don’t remember much about the subject matter? Choosing an answer that is most complete will typically result in the least room for error and subsequent delivery of safe and effective care. To help you determine which answer is most complete, evaluate answers based on how much objectivity (fact) versus subjectivity (opinion) there is in the answer choices. A specific value, like a blood pressure, is factual, whereas a client’s report of past incidences of “high” blood pressure is subjective. Responses that are subjective are generally not correct.

**Additional default strategies**

- The answer to the question can often be discovered by looking closely at how words or actions are grouped. Scan the stem and the answer choices for cues. Identifying these cues often leads to a correlation that connects the stem to a particular answer choice.

- Read the question and options closely for words asking about direction or magnitude. For instance, stop and concentrate on the terms *intra-* versus *inter-*; *hyper-* versus *hypo-*; *increase* versus *decrease*; *lesser* versus *greater*; and *gain* versus *lose*. It is common to misread these terms by simply skimming over them too quickly.

- When in doubt, always choose a nursing action that could prevent harm to the client. Even if you don’t know whether it is related to the stem, it is still a life-saving maneuver that, in all likelihood, is correct.

- Seldom will a correct answer have the nurse physically leave the client. Choose an answer that keeps the nurse with the client.

- In some instances, rule out an option if you know it is associated with something else. For example, you may not know about the labs for warfarin therapy, but you do know the labs for heparin and aspirin. Those labs can be eliminated because you are “using what you know.”

- Graduate nurses taking the NCLEX-PN® have a tendency to use the same communication skills regardless of whether the client has anxiety, depression, schizophrenia, bipolar disorder or obsessive-compulsive disorder. Everyone wants to use empathetic listening and everyone wants to be caring. Unfortunately these are not therapeutic responses for all disorders and every situation. Keep it very simple and apply it correctly. Use what you know.

  - Responses that are open-ended acknowledge the client’s feelings and seek more information. This approach is appropriate for the client with anxiety, a knowledge deficit, or depression.
- Reality orientation is important for the client with paranoia and delusions.
- Distraction is more appropriate for the client with obsessive-compulsive disorder.

- Use of the nursing process can be helpful. Always remember to “assess” first. Even if your knowledge of the topic is gray, you can still recognize that an answer choice is an “assessment” rather than an “intervention.”

**Example 1:**

Which of the following medications interacts with isocarboxazid (Marplan)?

A. Nifedipine (Procardia)
B. Warfarin (Coumadin)
C. Acetaminophen (Tylenol)
D. Acetylsalicylic acid (Aspirin)

**Default strategy:** If you do not know much about isocarboxazid, choose the option that is most different from the others. Warfarin is an anticoagulant. Acetaminophen is a medication associated with the development of antiplatelet antibodies, resulting in thrombocytopenia, and aspirin is an NSAID, which has antiplatelet aggregation properties. As these three are somewhat similar, the correct answer is likely to be nifedipine.

**Example 2:**

An infant has a sickle cell crisis and needs pain medication. Which of the following medications should the infant receive?

A. Oxycodone (Percodan)
B. Acetaminophen with codeine (Tylenol 3)
C. Acetylsalicylic acid (Aspirin)
D. Ibuprofen (Motrin)

**Default strategy:** If you do not know much about pain medication for infants, use what you do know. You probably know that an infant can’t have aspirin and combination products because of the risk of Reye syndrome, so acetylsalicylic acid is incorrect. Acetaminophen can safely be administered to children, and acetaminophen with codeine also addresses severe pain. Stay away from oxycodone entirely, because it contains acetylsalicylic acid. Ibuprofen is not recommended for infants less than 6 months of age, because it may cause serious bleeding from the stomach or intestine. Answer the question keeping this in mind.

**Example 3:**

After being diagnosed with rheumatoid arthritis, a client is prescribed 3 months of methotrexate therapy. Which of the following findings is the most likely indication for this prescription?

A. A weight gain of 5 lbs
B. A temperature of 100° F
C. Urine specific gravity of 1.043
D. WBC 1,200/mm³; platelets 5,000/mm³
**Default strategy:** Since the therapy has been prescribed for 3 months, it could be a form of immunosuppressive therapy. Rheumatoid arthritis is an autoimmune disorder. Look for signs of immunosuppression. Doing so would lead you to the correct answer, which is D.

**Example 4:**

Which of the following is the most appropriate action to take when a client dies?

A. Give the family time alone.
B. Notify the on-call chaplain.
C. Provide the family with privacy.
D. Stay with the family at the client's bedside.

**Default strategy:** Items like this are commonly missed. Graduate nurses think families want to be left alone to grieve. Remember the default strategy: Seldom will a correct answer have the nurse physically leave the client. Stay with your client to provide support and comfort.

**Some essential NCLEX-PN® knowledge**

Certain conditions tend to have more complex issues, and thus will be represented within test items more often. As you prepare for the NCLEX-PN®, take note of the topics listed on the next page. It is much easier to “use what you know” when you have the appropriate knowledge going into the test.

- Knowledge of normal laboratory values
  - Serum sodium, potassium, calcium, creatinine, magnesium, BUN, phosphorus
  - WBCs, platelets, ESR, hematocrit, hemoglobin
  - ABGs – pH, PaCO₂, HCO₃⁻, SaO₂
- Differentiation of normal laboratory values to **clinically significant** client care issues versus **clinically insignificant** or **clinically impossible** scenarios
- Review of drug categories
- Normal 24-hour intake and urine output
- Peritoneal dialysis
- Hemodialysis
- Complications (acute and chronic) of spinal cord transection – autonomic dysreflexia
- Complications of hepatic failure – hepatic encephalopathy
- Pregnancy-induced hypertension
- Premature rupture of membranes – clinical management
- Late decelerations – management
- Pitocin administration
- Sepsis – newborn and adult
- Meningitis
- Increased intracranial pressure – clinical manifestations
- All types of traction
• Compartment syndrome
• Pulmonary embolus
• Fat embolus
• Hemophilia (A)
• Sickle cell crisis
• Gastric bypass – dumping syndrome
• Diets: diabetic, healthy heart, high fiber, renal, celiac, and regional enteritis
• Emergency burn care
• Procedures: nursing care (look for complications!)
• Growth and development

Getting the Most Difficult Questions Correct

We’ve discussed essential information about NCLEX-PN® exam construction, administration, and general preparation. You’ve learned how to “answer what is being asked” and strategies for answering items when you have little or no knowledge about a topic. Now let’s focus on “getting the most difficult questions correct.” These questions are called “priority items.” Often, these items will ask you to recognize life and death issues and execute the nursing process in a fashion that will provide clients with the highest level of safe and effective care.

It would be nice if these priority items and choices were labeled so you’d know exactly which questions were priority items. Unfortunately, there is no obvious coding of the test items. Instead, you must learn to identify the items by how they are written. Let’s discuss some of the textual formatting that will help you to recognize when you are being asked a priority item.

The table below lists statements commonly found in priority items. Note that many of them are asking you to recognize issues of life and death and to make decisions that will keep clients safe.

<table>
<thead>
<tr>
<th>Statements commonly found in priority items</th>
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<tr>
<td>Who should the nurse see first?</td>
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<td>Which phone call should the nurse return first?</td>
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<td>Who should the nurse transfer first?</td>
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<td>Who should the nurse discharge first?</td>
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<tr>
<td>Which option requires an immediate intervention?</td>
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<td>Which option requires no intervention?</td>
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<td>Which nursing action is most important?</td>
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<td>Which client should be assigned to the care of an LPN/LVN?</td>
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<td>Which client should be assigned to the care of a float nurse?</td>
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<td>Which client should be assigned to the care of an RN?</td>
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<tr>
<td>Which assessment pattern is unexpected for this client?</td>
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<tr>
<td>Which assessment pattern is expected for this client?</td>
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</table>
Look for the layers

It would seem that life and death issues would be very easy to recognize in the text of a question. Unfortunately, they are usually not obvious. Instead they are buried beneath words that, at first glance, seem to bear no clinical significance. To prevent glancing over these words and missing the most critical or impending symptom, you will need to ask yourself: “What could be the possible clinical significance of each answer choice?” Let’s look at a few items together and practice this strategy.

Example 1:
A nurse is caring for a 49-year-old client who has a radium implant in her cervix. Which of the following would require an immediate intervention by the nurse?

A. The client is observed performing her own perineal care.
B. An assistive personnel is observed removing linen from the room.
C. An assistive personnel is observed flushing urine down the toilet.
D. The client asks that visitors be kept to a minimum.

The first option would not require immediate attention because the client is already exposed to the sealed radium implant. Performing her own perineal care is appropriate. Health care providers should never be close enough to do perineal care for a client with a radium implant due to the risk of exposure.

The second option has a life and death implication that requires immediate attention. If you aren’t careful, you could easily glance over it. To answer the question correctly, you need to consciously ask yourself, “What is the potential safety risk of removing linen from this client’s room?” In other words, you need to look beneath the words to find what may be a life and death issue.

If the radium implant became displaced from the cervix into the bed linens and circulated within the central laundry supply, everyone would be exposed. Consequently, B is correct. Never remove the bed linens until the radium implant has been removed from the client.

On the surface, the third option seems to contain a life and death layer, but in reality, it is not an issue at all. Radium implants are sealed, thus the urine is not contaminated. Flushing the urine down the toilet is safe. Flushing the urine does not require immediate attention.

The fourth option is similar to the first in that exposure to the radium implant is minimal for all people in the client’s immediate surroundings. This measure provides safety and therefore does not require immediate attention.

Example 2:
An 18-year-old male client has just been admitted to intermediate care following a minor car accident. Which of the following assessment findings should the nurse consider a priority finding?

A. Vital signs: BP 150/80 mm Hg, HR 92/min, RR 22/min
B. Capillary refill of 3 seconds
C. Hypoactive bowel sounds
D. Pelvic bruising
In the first option, the blood pressure and respiratory rate are slightly elevated. On the surface this may seem clinically significant, but it should not be investigated first. A client admitted to the hospital following a car accident would likely be anxious and in pain, so slight elevations in blood pressure and respiratory rate should be expected.

In the second option the capillary refill is normal. A normal finding should not be investigated first.

In the third option the client’s bowel sound are hypoactive. On the surface, this finding may seem clinically significant, but it should be expected since the client has undergone physiologic and psychologic stress. This finding should not be investigated first.

The fourth option describes a condition that may be very serious. As you consider your options, remember to ask yourself: “What is the clinical significance of the pelvic bruising?” If the trauma to the pelvis was significant enough to cause bruising, it may have been significant enough to cause a pelvic fracture or bleeding in the abdominal cavity. Consequently, D is correct. Abdominal bruising is an external finding indicating potential internal injury. The nurse should assess for complications of pelvic and/or abdominal trauma.

**Airway, breathing, and circulation (ABC)**

Priority items commonly address issues central to survival, specifically airway, breathing, and circulation. They ask you to recognize and intervene to preserve the respiratory and cardiovascular systems. Failure to protect these systems will lead to client deterioration and death.

As you answer priority items, you should consider each answer as it relates to protection of the client’s airway, breathing, and circulation. It is also important to consider ABC checks with the perspective of trying to save the client’s life.

To avoid some common pitfalls when answering priority questions, be aware of the following:

- It is not unusual to want to care for the client who, in your mind, is the sickest. This, however, may be an inappropriate choice in triage situations. Clients who are so sick that they cannot be saved should not be treated first.
- Many times you may feel empathy for innocent victims of injury and want to console them and check them quickly before moving on to learned strategies. An example of this might be a rape victim or a neglected child. Psychological issues are always secondary and never take priority over facilitation of physiologic safety.
- Never perform ABC checks blindly without considering whether airway, breathing, or circulation issues are acute versus chronic or stable versus unstable. For example, a client who is quadriplegic and on a ventilator has chronic airway/breathing problems. However, if there is not an acute consideration such as pneumonia, the client should be considered chronic and stable. This client would not be the nurse’s first priority.
You may want to answer questions based on the way you saw procedures done while you were in a clinical setting at school, during summer employment, or working as an intern. **NCLEX-PN® items must be answered to be consistent with nationwide practice standards, not necessarily with what may have been done within your particular institution or geographic area.**

Let’s take a look at the following question:

Four clients are admitted to the emergency department following a work-site explosion. Which of the following clients should the nurse see first?

A. A client with a fractured hip: BP 110/60 mm Hg, HR 86/min, RR 20/min, T 99.2° F

B. A client with dilated and fixed pupils: BP 60/46 mm Hg, HR 56/min, RR 8/min, T 104.4° F

C. A client with burns to the nose, mouth, and hands: BP 120/80 mm Hg, HR 100/min, RR 28/min, T 98° F

D. A client with type 2 diabetes mellitus: BP 100/60 mm Hg, HR 100/min, RR 26/min, T 99.4° F, blood glucose 110 mg/dL

The client in the first option has a fractured hip and stable vital signs. The client is clearly **acute but stable** and can be treated at a later time. The client **does not need to be seen first**.

The client in the second option is profoundly hypotensive and becoming bradycardic with a slowing respiratory rate and elevated temperature. The client is **acute and unstable** and has **pupils that are fixed and dilated**. This indicates probable brain death. The client also has obvious breathing and circulation issues. He is clearly the sickest; however, this client **cannot be saved**. Consequently, this client is not your priority because it is unlikely that anything can be done to improve his clinical condition. This client **does not need to be seen first**.

The client in the third option has burns to the face. Burns to the face, especially near the mouth and nose, commonly result in damage to the airway. Here lies that **life and death layer** that must be acknowledged. This client is **acute and unstable**. Although he has no obvious airway or breathing issues, there is **great risk**. Early assessment and intervention optimizes protection of the respiratory system, thus this client **should be seen first**.

The client in fourth option has borderline blood pressure and tachypnea, which indicates evolving diabetic ketoacidosis. Tachypnea is compensatory and favorable for reduction of pH. The blood pressure is dropping because of the hyperglycemic-induced diuresis. Tachycardia is likely a compensatory phenomenon from the fluid volume deficit. Breathing and circulation issues are present, but the client is technically **acute and stable** and **should not be seen first**.
**Safe and effective delegation**

Safe and effective delegation of tasks and client care assignments is extremely important when setting priorities for client care. The rules listed below do not allow for opinion and preference. Follow them exactly so that the appropriate health care personnel are performing activities that are safely within their scope of practice.

- The delivery of safe and effective care is always the driving force behind delegation of tasks and client care assignments. Any other option will be incorrect.
- RNs perform all client teaching. No matter how simple the teaching, it still must be done by the RN. The LPN/LVN may reinforce teaching performed by the RN.
- RNs should perform all admission assessments so that an accurate baseline is established. This includes the first set of vital signs, all aspects of the first physical assessment, and a health history.
- Client care assignments are made by the RN, not by support staff. Client care assignments should remain unchanged unless there is an authentic issue of client care safety or a health care provider safety is endangered.
- An assistive personnel (AP) can perform tasks such as taking vital signs, range-of-motion exercises, bathing, bedmaking, obtaining urine specimens, enemas, and blood glucose monitoring. An AP cannot interpret results or perform any task beyond the skill level of any certification already attained.
- All communication between the RN and support staff should be direct, objective, and complete to ensure the highest level of safe and effective care delivery.
- The LPN/LVN is managed under the supervision of the RN. Certain higher level skills can be delegated after competency has been established by the RN (e.g., dressing changes or suctioning).

Let's take a look at the following question:

A charge nurse is managing three RNs and one LPN/LVN. Which of the following clients should the charge nurse assign to the LPN/LVN?

A. A client with type 1 diabetes mellitus scheduled for discharge today  
B. A client in Thomas-Pearson traction who is 2 days postoperative  
C. A client with scant, tenacious tracheotomy secretions  
D. A client having a colonoscopy this afternoon

The first option includes a teaching requirement, and the LPN/LVN cannot legally teach.

The second option describes a client in traction, which is within the scope of LPN/LVN practice guidelines if competency is verified by the RN.

Normally, an LPN/LVN could care for the client in the third option. However, in this case, there is a possible life and death issue. The word “tenacious” implies that the client has a possible fluid volume deficit that needs to be addressed. An RN needs to deal with the ineffective airway clearance from the tenacious secretions so that the client can breathe more easily.
The client discussed in the fourth option is having a diagnostic test and therefore requires teaching. An LPN/LVN cannot legally care for this client. The correct answer is B. The LPN/LVN can care for the client with traction only after competency is verified by the RN.

**Conclusion**

We have discussed some very simple and straightforward strategies that you can use to: a) answer the question being asked by eliminating information that is irrelevant, b) use what you know in situations where you doubt your understanding of the topic, and c) get the most difficult questions correct through identification of priority situations and life and death issues.

Understanding these strategies is a great beginning, but don’t stop here. As you prepare for the NCLEX-PN®, use these strategies on practice tests and refer to this module often to reinforce what you’ve learned. The more you practice, the sooner these strategies will become second nature to you. By the time you take the exam, your approach to the test items will have become systematic and objective. Remember, wherever you work or whatever position you hold, the nursing profession is wonderfully challenging and rewarding. Your future begins now, with you!
Bibliography


