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## Conclusion
Overview

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-RN®) 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 document will offer several strategies that can be used to increase your chances of passing the NCLEX-RN®.

Test Strategies and Essentials

- To become a licensed nurse in the United States or its territories, you must pass the NCLEX-RN exam. Preparation for the NCLEX-RN should include familiarizing yourself with how the exam is constructed and administered.

- The NCLEX-RN 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. However, 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 Web site http://www.ncsbn.org/nlc.htm.

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

- It is important to understand that the NCLEX-RN 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 medication therapies not approved by the U.S. Food and Drug Administration. The NCSBN uses specific criteria to ensure fairness, thus the exam must be:
  - Psychometrically sound.
  - Legally defensible.
  - Objective.
  - Empirical.
  - Reliable.

- To identify the current nature of entry-level professional practice, NCSBN conducts a practice 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-RN are consistent with what entry-level nurses actually do in clinical practice.
The NCLEX-RN 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 the client need categories. 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:

- If you are above the passing standard at question 75, your exam will end and you will pass.
- If you are below the passing standard at question 75, your exam will end and you will fail.
- 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-RN exam.

- The exam includes a minimum of 75 questions and a maximum of 265 questions.
- The maximum time allowed is 6 hr.
- There is an optional 10-min break after the first 2 hr.
- Every test-taker receives 15 experimental questions.
- You will not be able to identify which items are experimental.
- Answers to experimental questions do not count in your score.
- The full 265-question set is never randomly administered. The test will end when a minimal competency is demonstrated (anywhere from 75 to 265 questions).
Overview

- On April 1, 2010, 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-RN Detailed Test Plan. Listed below are the related activity statements from the 2008 RN Practice Analysis of Newly Licensed RNs in the United States and Member Board Jurisdictions, which are included in the 2010 NCLEX-RN detailed test plan. Topic areas are listed with each Client Need category and subcategory, while the percentages are listed to demonstrate the distribution for each category within the test as a whole. As you prepare for the NCLEX-RN, familiarity with the emphasis areas in the current test plan as well as how this emphasis has changed from the previous plan (published in 2007) will help you focus your study efforts.

### SAFE AND EFFECTIVE CARE ENVIRONMENT

**Management of Care (16%-22%)**

**Definition:**
- Providing and directing nursing care that enhances the care-delivery setting to protect clients, family/significant others, and health care personnel

**Topic areas**
- Integrate advance directives into the client’s plan of care.
- Act as a client advocate.
- Initiate, evaluate, and update the plan of care, care map, and clinical pathway used to guide and evaluate client care.
- Incorporate evidence-based practice/research results when providing care.
- Educate the client and staff about client rights and responsibilities (ethical/legal issues).
- Collaborate with health care members in other disciplines when providing client care.
- Manage conflict among clients and health care staff.
- Maintain client confidentiality/privacy.
- Provide and receive report on assigned clients.
- Use approved abbreviations and standard terminology when documenting care.
- Maintain continuity of care between/among health care agencies.
- Assess/ triage client(s) to prioritize the order of care delivery.
- Prioritize workload to manage time effectively.
- Recognize ethical dilemmas and take appropriate action.
- Follow practices in a manner consistent with a code of ethics for RNs.
- Verify that the client comprehends and consents to care/procedures, including procedures requiring informed consent.
- Receive and/or transcribe primary care provider orders.
- Use information technology (computer, video, books) to enhance the care provided to a client.
- Use emerging technology in managing client health care (telehealth, electronic records).
- Recognize limitations of self/others and seek assistance and/or begin corrective measures at the earliest opportunity.
- Comply with state and/or federal regulations for reporting client conditions (abuse/neglect, communicable disease, gunshot wound, dog bite).
- Report unsafe practice of health care personnel to internal/external entities and intervene as appropriate (substance abuse, improper care, staffing practices).
- Provide care within the legal scope of practice.
- Participate in performance improvement/quality assurance process (collect data or participate on a team).
- Recognize the need for referrals and obtain necessary orders.
- Supervise care provided by others (licensed practical nurse, assistive personnel, other RNs).
### SAFE AND EFFECTIVE CARE ENVIRONMENT

**Definition:** Protecting clients, family/significant others, and health care personnel from health and environmental hazards

<table>
<thead>
<tr>
<th>Topic areas – related topics include, but is not limited to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Protect the client from injury (falls, electrical hazards).</td>
</tr>
<tr>
<td>- Implement emergency response plans (internal/external disaster).</td>
</tr>
<tr>
<td>- Use ergonomic principles when providing care (assistive devices, proper lifting).</td>
</tr>
<tr>
<td>- Assess the client’s allergies/sensitivities and intervene as needed (food, latex, environmental allergies).</td>
</tr>
<tr>
<td>- Ensure proper identification of client when providing care.</td>
</tr>
<tr>
<td>- Verify appropriateness and/or accuracy of a treatment order.</td>
</tr>
<tr>
<td>- Follow procedures for handling biohazardous materials.</td>
</tr>
<tr>
<td>- Educate the client about home safety issues.</td>
</tr>
<tr>
<td>- Acknowledge and document practice error (incident report for medication error).</td>
</tr>
<tr>
<td>- Facilitate appropriate and safe use of equipment.</td>
</tr>
<tr>
<td>- Participate in the institution security plan (newborn nursery security, bomb threats).</td>
</tr>
<tr>
<td>- Apply principles of infection control (hand hygiene, room assignment, isolation, aseptic/sterile technique, universal/standard precautions).</td>
</tr>
<tr>
<td>- Educate the client and staff regarding infection-control measures.</td>
</tr>
<tr>
<td>- Comply with federal/state/institutional requirements regarding the use of client restraints and/or safety devices.</td>
</tr>
</tbody>
</table>

### HEALTH PROMOTION AND MAINTENANCE (6%-12%)

**Definition:** Providing and directing nursing care of the client and family/significant others that incorporates the knowledge of expected growth and development principles, prevention and/or early detection of health problems, and strategies to achieve optimal health

<table>
<thead>
<tr>
<th>Topic areas – related topics include, but is not limited to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Provide care and education that meets the special needs of the following clients: infant (1 month to 1 year), preschooler (ages 1 to 4 years), the school-age child (ages 5 to 12 years), adolescent (ages 13 to 18 years) adult (ages 19 to 64 years), older adult client (ages 65 to 85 years, over 85 years).</td>
</tr>
<tr>
<td>- Provide prenatal care and education.</td>
</tr>
<tr>
<td>- Provide postpartum care and education.</td>
</tr>
<tr>
<td>- Provide newborn care and education.</td>
</tr>
<tr>
<td>- Assess and teach the client about health risks based on known population or community characteristics.</td>
</tr>
<tr>
<td>- Plan and/or participate in the education of individuals in the community (health fairs, school education).</td>
</tr>
<tr>
<td>- Provide information about healthy behaviors and health promotion/maintenance recommendations (provider visits, immunizations).</td>
</tr>
<tr>
<td>- Perform targeted screening examination (scoliosis, vision and hearing assessments).</td>
</tr>
<tr>
<td>- Provide information for prevention of high risk health behaviors (smoking cessation, safe sexual practices, drug education).</td>
</tr>
<tr>
<td>- Assess the client’s readiness to learn, learning preferences, and barriers to learning.</td>
</tr>
<tr>
<td>- Assess the client’s understanding of and ability to manage self-care in the home environment (community resources).</td>
</tr>
<tr>
<td>- Perform a comprehensive health assessment.</td>
</tr>
</tbody>
</table>
## Psychosocial Integrity (6%-12%)

**Definition:**
- Providing and directing nursing care that promotes and supports the emotional, mental, and social well-being of the client and family/significant others experiencing stressful events, as well as clients who have acute and chronic mental illness.

**Topic areas - related topics include, but is not limited to:**
- Assess the client for potential or actual abuse/neglect, and intervene when appropriate.
- Incorporate behavioral management techniques when caring for a client (positive reinforcement, setting limits).
- Assess the client for drug/alcohol-related dependencies, withdrawal, or toxicities, and intervene when appropriate.
- Provide support to the client in coping with life changes (loss, new diagnosis, role change, stress).
- Assess the potential for violence and initiate/maintain safety precautions (suicide, homicide, self-destructive behavior).
- Incorporate client cultural practice and beliefs when planning and providing care.
- Provide end-of-life care and education to clients (hospice).
- Recognize the impact of illness/disease on individual/family lifestyle.
- Assess family dynamics to determine plan of care (structure, bonding, communication, boundaries, coping mechanisms).
- Provide care and education for acute and chronic behavioral health issues (anxiety, depression, dementia, eating disorders).
- Assess psychosocial, spiritual, and occupational factors affecting care, and plan interventions as appropriate.
- Address the client’s needs based on visual, auditory, or cognitive distortions (hallucinations).
- Recognize nonverbal cues to physical and/or psychological stressors.
- Establish and maintain a therapeutic relationship with the client.
- Use therapeutic communication techniques to provide support to the client.

## Physiological Integrity

### Basic Care and Comfort (6%-12%)

**Definition:**
- Providing comfort and assistance in the performance of activities of daily living

**Topic areas - related topics include, but is not limited to:**
- Assist the client to compensate for a physical or sensory impairment (assistive devices, positioning, compensatory techniques).
- Assess and manage the client who has an alteration in elimination (bowel, urinary).
- Perform irrigations (of bladder, ear, eye).
- Perform a skin assessment and implement measures to maintain skin integrity and prevent breakdown (turning, repositioning, pressure-relieving support surfaces).
- Apply, maintain, or remove orthopedic devices (traction, splints, braces, casts).
- Apply and maintain devices used to promote venous return (antiembolic stockings, sequential compression devices).
- Promote circulation (active or passive range of motion, positioning, and mobilization).
- Assess the client’s need for pain management and intervene as needed using nonpharmacological comfort measures.
- Provide therapies for comfort and treatment of inflammation and swelling (apply heat and cold treatments, elevate limb).
- Calculate the client’s I&O.
- Provide the client with nutrition through continuous or intermittent tube feedings.
- Manage the client who has an alteration in nutritional intake (adjust diet, monitor height and weight, change delivery to include method, time and food preferences).
- Assess and intervene in client performance of activities of ADLs and instrumental activities of daily living.
- Perform postmortem care.
- Assess the client’s need for sleep/rest, and intervene as needed.
### PHYSIOLOGICAL INTEGRITY

**Pharmacological and Parenteral Therapies (13%-19%)**

<table>
<thead>
<tr>
<th>Definition:</th>
<th>Providing comfort related to the administration of medications and parenteral therapies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Topic Areas – related topics include but is not limited to:</td>
<td>Manage the client who is experiencing side effects and adverse reactions to a medication.</td>
</tr>
</tbody>
</table>

### Reduction of Risk Potential (10%-16%)

<table>
<thead>
<tr>
<th>Definition:</th>
<th>Reducing the likelihood that clients will develop complications or health problems related to existing conditions, treatment or procedures.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Topic Areas – related topics include but is not limited to:</td>
<td>Assess and respond to changes in the client’s vital signs.</td>
</tr>
</tbody>
</table>
## PHYSIOLOGICAL INTEGRITY

### Physiological Adaptation (11%-17%)

**Definition:** Managing and providing care for clients who have acute, chronic, or life-threatening physical-health conditions

<table>
<thead>
<tr>
<th>Topic areas related topics include, but is not limited to:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Assist with invasive procedures (central line placement).</td>
<td>Monitor and care for clients who are on a ventilator.</td>
</tr>
<tr>
<td>Implement and monitor phototherapy.</td>
<td>Monitor and maintain devices and equipment used for drainage (surgical wound drains, chest tube suction, negative pressure wound therapy).</td>
</tr>
<tr>
<td>Maintain the desired temperature of a client (cooling and/or warming blanket).</td>
<td>Perform and manage care of a client who is receiving peritoneal dialysis.</td>
</tr>
<tr>
<td>Monitor and care for clients who are on a ventilator.</td>
<td>Perform suctioning (oral, nasopharyngeal, endotracheal, tracheal).</td>
</tr>
<tr>
<td>Monitor and maintain devices and equipment used for drainage (surgical wound drains, chest tube suction, negative pressure wound therapy).</td>
<td>Provide wound care and/or assist with dressing change.</td>
</tr>
<tr>
<td>Assist with invasive procedures (central line placement).</td>
<td>Provide ostomy care and education (tracheal, enteral).</td>
</tr>
<tr>
<td>Monitor and care for clients who are on a ventilator.</td>
<td>Provide pulmonary hygiene (chest physiotherapy, incentive spirometry).</td>
</tr>
<tr>
<td>Monitor and maintain devices and equipment used for drainage (surgical wound drains, chest tube suction, negative pressure wound therapy).</td>
<td>Provide postoperative care.</td>
</tr>
<tr>
<td>Assist with invasive procedures (central line placement).</td>
<td>Manage the care of the client who has a fluid and electrolyte imbalance.</td>
</tr>
<tr>
<td>Implement and monitor phototherapy.</td>
<td>Monitor and maintain arterial lines.</td>
</tr>
<tr>
<td>Maintain the desired temperature of a client (cooling and/or warming blanket).</td>
<td>Manage the care of a client who has a pacing device (pacemaker, biventricular pacemaker, implantable cardioverter defibrillator).</td>
</tr>
<tr>
<td>Monitor and care for clients who are on a ventilator.</td>
<td>Manage the care of the client who is on telemetry.</td>
</tr>
<tr>
<td>Monitor and maintain devices and equipment used for drainage (surgical wound drains, chest tube suction, negative pressure wound therapy).</td>
<td>Manage the care of a client who has alteration in hemodynamics, tissue perfusion, and hemostasis (cerebral, cardiac, peripheral).</td>
</tr>
<tr>
<td>Assist with invasive procedures (central line placement).</td>
<td>Manage the care of a client who has impaired ventilation/oxygenation.</td>
</tr>
<tr>
<td>Implement and monitor phototherapy.</td>
<td>Evaluate the effectiveness of the treatment regimen for a client who has an acute or chronic diagnosis.</td>
</tr>
<tr>
<td>Maintain the desired temperature of a client (cooling and/or warming blanket).</td>
<td>Perform emergency care procedures (cardiopulmonary resuscitation, abdominal thrust maneuver, respiratory support, automated external defibrillator).</td>
</tr>
<tr>
<td>Monitor and care for clients who are on a ventilator.</td>
<td>Identify pathophysiology related to an acute or chronic condition (signs and symptoms).</td>
</tr>
<tr>
<td>Monitor and maintain devices and equipment used for drainage (surgical wound drains, chest tube suction, negative pressure wound therapy).</td>
<td>Recognize signs and symptoms of complications and intervene appropriately when providing client care.</td>
</tr>
</tbody>
</table>

- The majority of NCLEX-RN items are written at the application and analysis level, although there are some lower-level knowledge and comprehension items on the test. Make certain that you have broad knowledge in all Client Need categories so that you can demonstrate a minimal level of competency when asked to apply your knowledge to the care of the clients in the scenarios presented on the exam.
Overview

- 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-RN 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-RN, you should be able to identify them as you prepare for your exam. That way, you won’t spend too much of your 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 examples below (correct answers are bolded).

A nurse is preparing to administer medications to a client who has asthma. Which of the following should the nurse recognize as an adverse effect related to bronchodilator therapy?

A. Limited routes of administration
B. Diuresis and electrolyte imbalances
C. Increased myocardial oxygen use
D. Postural hypotension and somnolence

- Comprehension questions test the ability to translate and interpret.

An older adult client has been on bed rest for 10 days. The nurse recognizes that which of the following may represent a physical finding related to this client’s immobility?

A. Gingival sensitivity
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-RN. 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.

Common Pitfalls and Relevant Information

- Graduate nurses commonly choose answers that relate to what is being asked rather than answer what is being asked.
A nurse is standing at the bedside of a client when the monitor pattern changes and appears to show ventricular fibrillation. Which of the following actions should the nurse take first?

A. Start rescue breathing.
B. Palpate the client’s carotid pulse.
C. Defibrillate the client.
D. Print a copy of the rhythm.

- The question assumes that 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 word “appears” changes 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 a pulse has been established. Therefore, B is the correct option.
    - 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.

An adult client who is obese and has a history of COPD had a ventral hernia repair 4 days ago. The client vomited 1 hr ago and now reports severe abdominal pain. Which of the following actions should the nurse take first?

A. Administer an antiemetic.
B. Start supplemental oxygen.
C. Assess the client’s incision line.
D. Reinforce the client’s dressing.

- What factors are relevant in the question?
  - The client is obese
  - Client underwent abdominal surgery 4 days ago
  - The client is experiencing severe abdominal pain
  - The client vomited 1 hr ago
- What factors should be dismissed?
  - The client is an adult
  - The client has a ventral hernia repair
  - The client has a history of COPD
- What is the question asking?
  - The question is asking for the priority nursing action for a client who has had abdominal surgery and vomited 1 hr ago. Option C is correct because the nurse should assess the incision for wound dehiscence.
An adolescent client was admitted 12 hr ago following a motor vehicle crash. Multiple skeletal fractures were sustained. The client has been placed in balanced-suspension traction. Which of the following assessment findings requires immediate intervention by the nurse?

A. Disorientation
B. Shallow respirations
C. Chest pain with positioning
D. Bloody drainage at the pin site

- What factors are relevant in the question?
  - The client was admitted 12 hr ago
  - The client has multiple skeletal fractures

- What factors should be dismissed?
  - The client is an adolescent
  - The client is in balanced-suspension traction

- What is the question asking?
  - The question is asking for the most clinically significant assessment data for a client who sustained multiple skeletal fractures 12 hr ago. Option A is correct because development of a fat embolus can cause disorientation or other central nervous system involvement.

An older adult client reports recurring calf pain after walking 1 to 2 blocks at the local mall. He tells the nurse that the pain disappears after sitting down. The nurse notes that the skin on his feet is shiny and cool. Which of the following nursing interventions is most appropriate at this time?

A. Position the leg dependently.
B. Elevate the leg above the heart.
C. Immobilize the leg to prevent further injury.
D. Assess dorsiflexion and extension of the foot.

- What factors are relevant in the question?
  - Recurring calf pain with activity
  - Onset of calf pain after a short distance
  - Pain relieved by rest
  - Feet that are shiny and cool

- What factors should be dismissed?
  - Older adult client

- What is the question asking?
  - The question is asking for the most appropriate intervention for a client who has peripheral arterial disease. Option A is correct, because placing the leg in a dependent position will increase blood flow to the extremity.

A nurse is caring for a client who is semi-comatose 10 days after a postintracerebral hemorrhage. The client has an NG tube in place and was started on total parenteral nutrition today. The nurse should complete which of the following actions to prevent the development of fluid volume deficit?

A. Monitor the client’s fluid I&O every shift.
B. Give boluses of water through the NG tube.
C. Perform blood glucose monitoring every 6 hr.
D. Increase the client’s oral fluid intake to 3 L per day.

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

- What factors should be dismissed?
  - The client is semi-comatose
  - The client had an intracerebral hemorrhage
UNDERSTANDING THE NCLEX-RN® TEST PLAN

- 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 total parenteral nutrition. Option C is correct, because timely blood glucose monitoring will alert the nurse to hyperglycemia, which can induce an osmotic diuresis.

A nurse is preparing to discharge an adolescent client who is primipara 12 hr after vaginal delivery of a term newborn. A follow-up home visit is scheduled for 24 hr after discharge. Which of the following is most important for the nurse to include in the client’s discharge teaching?

A. Demonstrate postpartum self-care skills.
B. Explain nutritional approaches for weight loss.
C. Review physiological changes after childbirth.
D. Discuss psychological responses to childbirth.

- What factors are relevant in the question?
  - The client is primipara
  - The client is being discharged after 12 hr
  - The client’s first home visit is scheduled in 24 hr

- What factors should be dismissed?
  - The newborn was born at term
  - The client is an adolescent

- What is the question asking?
  - The question is asking for the most important content to teach prior to discharging a client who is primipara. Option A is correct. Since a home visit is scheduled in 24 hr, the nurse’s priority would be education related to promotion of comfort, rest, and prevention of complications.

A client who has been diagnosed with depression related to marital conflict asks the nurse, “Do you think I should divorce my spouse or just separate?” Which of the following responses by the nurse is most appropriate?

A. “You should divorce since marital conflict is the source of your depression.”
B. “If you do divorce, do you have sufficient income to support yourself?”
C. “How do you think divorce will affect your children now and in the future?”
D. “What do you think would be the best thing for you to do at this point?”

- What factors are relevant in the question?
  - The client is depressed

- What factors should be dismissed?
  - The topic of the client’s decision

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

A school nurse observes several children playing on the playground at the local elementary school. Which of the following children would require immediate intervention by the nurse?

A. Two children arguing with each other
B. A child breathing heavily after running
C. A child climbing on the swing-set supports
D. A child squatting after playing catch with a ball

- What factors are relevant in the question?
  - The children are school age
  - The children are playing

- What factors should be dismissed?
  - The location of the school
  - Where the children are playing
UNDERSTANDING THE NCLEX-RN® TEST PLAN

What is the question asking?

○ The question is asking to identify the child that is demonstrating postplay behavior that may indicate distress or injury. Option D 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 succeeding on the NCLEX-RN, “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.
Overview

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 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.

Staying Focused

- Graduate nurses taking the NCLEX 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 success on the NCLEX is maintaining control of the test. This comes from understanding the construction of the test and its administration as well as systematically managing its items.

Managing Test Items

- 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; however, 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.

Strategies

- 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 “preprocedural,” “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.
- Let Maslow’s hierarchy of needs be your guide.
  - When taking the NCLEX, 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.

Remember: most complete = least room for error
You’ll encounter items on the NCLEX 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 laboratory values for warfarin therapy, but you do know the laboratory values for heparin and aspirin. Those values can be eliminated because you are “using what you know.”
- Graduate nurses taking the NCLEX 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. Again, 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 who has 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.”

### A nurse is caring for a client who is receiving isocarboxazid (Marplan). Which of the following prescriptions should the nurse question?

A. Acetaminophen (Tylenol)
B. Acetylsalicylic acid (Aspirin)
C. Nifedipine (Procardia)
D. Ibuprofen (Motrin)

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

### A nurse is caring for an infant who is experiencing sickle-cell crisis and requires pain medication. Which of the following medications should the nurse expect the infant to receive?

A. Meperidine hydrochloride (Demerol)
B. Acetaminophen with codeine (Tylenol 3)
C. Acetylsalicylic acid (Aspirin)
D. Morphine sulfate (Morphine)

**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; therefore, acetylsalicylic acid is incorrect. Acetaminophen can safely be administered to children, and acetaminophen with codeine also addresses severe pain. Meperidine hydrochloride causes metabolites to form in the central nervous system, and for an infant, morphine is a powerful medication that may possibly be used after the acetaminophen with codeine. The best answer for this question is B.
A client who has just been diagnosed with rheumatoid arthritis is required to receive 3 months of methotrexate therapy. The nurse recognizes that which of the following are associated with the therapy? (Select all that apply.)

A. WBC count of 1,200 mm$^3$
B. Weight gain of 2.27 kg (5 lb)
C. Oral temperature of 37.8° C (100° F)
D. Urine-specific gravity of 1.043
E. Platelets of 5,000 mm$^3$

**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 should lead you to the correct answer, which is A and E.

When an older adult client dies from complications of a stroke, the client’s spouse is present at the bedside. Which of the following nursing actions should the nurse take to support the client’s spouse?

A. Escort the spouse to the hallway outside the room.
B. Ask the chaplain to come be with the spouse.
C. Stay with the spouse at the client’s bedside.
D. Give the spouse time alone with the client.

**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. The best response for this question is C.

**Essential NCLEX-RN 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, take note of the topics listed. It is much easier to “use what you know” when you have the appropriate knowledge going into the test.
  - Laboratory values (clinically significant care issues verses clinically insignificant or clinically impossible)
  - Identify laboratory values for ABGs (pH, PO$_2$, PCO$_2$, SaO$_2$, HCO$_3^-$), BUN, cholesterol (total) glucose, Hct, Hgb, glycosylated hemoglobin (HbA1c), platelets, potassium, sodium, WBC count, creatinine, PT, and aPTT
  - Recognize deviations from normal for values of albumin (blood), alanine aminotransferase (ALT), aspartate aminotransferase (AST), ammonia, bilirubin, bleeding time, calcium (total), cholesterol (HDL and LDL), digoxin, erythrocyte sedimentation rate, lithium, magnesium, phosphorous/phosphate, protein (total), urine (specific gravity, albumin, pH, WBC count)
  - ABGs, and compensatory mechanisms
  - Respiratory failure (assessment and interventions – chest tube management)
  - Pharmacological classifications (side effects verses adverse reactions – monitoring and treatment)
  - Fluid balance (normal I&O: 24-hr totals)
  - Dialysis (hemodialysis and peritoneal complications or reactions)
  - Acute and chronic spinal-cord injuries (spinal shock verses autonomic dysreflexia)
  - Head Injuries (closed verse open – monitoring for increased intracranial pressure)
  - Hepatic failure (complications and reactions)
  - Obstetrical complications (pregnancy-induced hypertension, abruptio placenta, placenta previa)
  - Complications of labor (premature rupture of membranes, FHR monitoring: late verses variable decelerations, oxytocin (Pitocin) administration and management)
  - Infectious diseases: sepsis (adult and newborn) and meningitis (bacterial, viral, and fungal)
  - Musculoskeletal complications (traction, alterations in perfusion, compartment syndrome)
  - Cardiovascular compromise (heart failure, angina, MI)
  - Arrhythmias (lethal verses nonlethal rhythms and treatment)
  - Nutritional requirements (diets, gastric bypass, dumping syndrome)
  - Hematologic issues (hemophilia, sickle-cell crisis, and leukemia/neutropenia)
  - Emergency management (pulmonary embolism, burns, trauma: initial actions)
  - Growth and development (recognizing deviations from stages throughout the lifespan)
  - Nursing procedures (pre, intra and postprocedure interventions and responsibilities: prevention of complications)
Overview

- We’ve discussed essential information about the construction of the NCLEX exam, its administration, and general preparation techniques. 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.” 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 priority items and choices were labeled so you’d know exactly which questions were priority. 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.

    - Statements commonly found in priority items
      - Who should the nurse see first?
      - Which phone call should the nurse return first?
      - Who should the nurse transfer first?
      - Who should the nurse discharge first?
      - Which option requires an immediate intervention?
      - Which option requires no intervention?
      - Which nursing action is most important?
      - Which client should be assigned to the care of a licensed practical nurse (LPN)?
      - Which client should be assigned to the care of a float nurse?
      - Which client should be assigned to the care of an RN?
      - Which assessment pattern is unexpected for this client?
      - Which assessment pattern is expected for this client?

Examine Question 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.

A nurse is caring for a client who has a cervical radium implant. Which of the following requires an immediate intervention by the nurse?

A. The client is observed performing her own perineal care.
B. The client asks that visitors be restricted to immediate family.
C. A staff member flushes the client’s urine down the toilet.
D. A staff member removes dirty linens from the client’s room

- The first option would not require immediate attention because the client is already exposed to the sealed radium implant. The client is able to perform her own perineal care. Health care providers should never be close enough to do perineal care for a client who has a radium implant due to the risk of exposure.
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 can be exposed. 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 second 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. Therefore, D is correct. Never remove the bed linens until the radium implant has been removed from the client.

A nurse is caring for an adolescent client who was admitted after an automobile crash. Which of the following should the nurse consider as a priority assessment finding?

A. Blood pressure 150/80 mm Hg
B. Capillary refill 3 seconds
C. Hypoactive bowel sounds
D. Unilateral 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 crash 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 sounds 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. Therefore, 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 (ABC). 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 a client’s ABC. 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. However, this 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 child who has been neglected. Psychological issues are always secondary and never take priority over facilitation of physiologic safety.
- Never perform ABC checks blindly without considering whether ABC issues are acute versus chronic or stable versus unstable. For example, a client who is quadriplegic and receiving ventilation 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 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 brought to the emergency department following a work-site explosion. The nurse should first triage the client who

A. has a fractured hip, is alert and oriented, and is reporting moderate hip pain.
B. is unresponsive, has dilated and fixed pupils, and has agonal respirations.
C. has burns to the nose, mouth, and hands, and has minimal respiratory stridor.
D. has type 2 diabetes mellitus and has disorientation to time and place.

- 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 unresponsive and has agonal respirations. 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 the life and death layer that you must acknowledge. This client is acute and unstable. Although he has no obvious airway or breathing issues there is a great risk. Early assessment and intervention optimizes protection of the respiratory system; thus, this client should be seen first.
- The client in the fourth option has borderline blood pressure and tachypnea, which indicates evolving diabetic ketoacidosis. Tachypnea is compensatory and favorable for reduction of pH. The client’s 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 are 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 licensed practical nurse (LPN) 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 the safety of a health care provider is in danger.
  - An assistive personnel (AP) can perform tasks such as taking vital signs, range-of-motion exercises, bathing, bed making, 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 is managed and supervised by the RN. Certain higher-level skills can be delegated after competency has been established by the RN (dressing changes or suctioning).
A charge nurse is making assignments for three RNs and one licensed practical nurse (LPN). The charge nurse plans to assign the LPN to the client who

A. has type 1 diabetes mellitus and is scheduled for discharge today.
B. is in balanced traction and had a surgery 2 days ago.
C. has thick secretions from a tracheostomy that was performed yesterday.
D. is scheduled for a routine colonoscopy this afternoon.

- The first option includes a teaching requirement, and the LPN cannot legally teach.
- The second option describes a client in traction, which is within the scope of LPN practice guidelines if competency is verified by the RN.
- Normally, an LPN could care for the client in the third option. However, in this case, there is a possible life and death issue. The word “thick” 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 cannot legally care for this client.
- The correct answer is B. The LPN can care for the client who is in traction only after competency is verified by the RN.
CONCLUSION

- We have discussed some very simple and straightforward strategies that you can use to:
  - Answer the question being asked by eliminating information that is irrelevant.
  - Use what you know in situations where you doubt your understanding of the topic.
  - 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, 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. You may begin.


