

Testing Strategies for the NCLEX-RN® Examination



One of the first steps to being successful on the NCLEX® (National Council Licensure Examination) is to understand how it is developed. An important step in preparing for the examination is to find out as much as possible about the test; this will help to reduce stress and anxiety. During school, you had syllabi with course objectives and faculty class presentations to guide you through the information that would be included on the next examination. In most academic settings, the nursing faculty member responsible for teaching the course was also responsible for the development and construction of examinations. As you begin to prepare for the NCLEX, it is important to consider who determines the content of the test plan and constructs the questions based on the test plan.

The National Council of State Boards of Nursing (NCSBN) is responsible for the development of the content and question or item construction for the NCLEX examination. A practice analysis is conducted by the NCSBN every 3 years to validate the test plan and to determine currency of nursing practice. Content experts are employed to assist in the creation of the practice analysis. The data from the practice analysis are used to determine the knowledge necessary for activity performance of graduate nurses within the first 6 months of practice. The activity performances and knowledge identified by the content experts are analyzed with consideration of frequency of performance, impact on patient safety, and variety of patient care settings. This analysis provides the basis for development of the content to be included in the NCLEX Test Plan.

The content experts are practicing nurses who work with or supervise new graduates in the practice setting. The content experts represent all geographical areas and are selected according to their area of practice; therefore all areas of nursing practice are addressed in the development of the test plan. Item writers are selected to create questions based on the content identified in the test plan. Item writers are registered nurses (RNs) currently licensed in their jurisdiction who are responsible for teaching students in the clinical arena or who are currently employed in clinical nursing practice. All new test items or questions are reviewed by item reviewers who are also nurses in current practice and who have been directly involved with supervision of new graduate nurses. Not only do content experts and item reviewers create new items, they are also involved in the continual review of items in the NCLEX test pool to ensure all items reflect current practice.¹

So, what does this all mean? It means that nurses in current practice and nursing faculty members work together to

identify the content and develop questions for the NCLEX-RN. All geographical areas, as well as all areas of nursing practice, are included. The purpose of the examination is to assure the public that each candidate who passes the examination can practice safely and effectively as a newly licensed, entry-level RN.

The NCLEX-RN is used by all of the states to determine entry into nursing practice as an RN. Each state is responsible for the testing requirements, retesting procedures, and entry into practice within that state. Each state requires the same competency level or passing standard on the NCLEX; there is no variation in the passing standard from state to state.

TEST PLAN

The test plan is based on research conducted by the NCSBN every 3 years. The purpose of the research is to determine the most important and frequent activities of nurses who were successful on the NCLEX and who have been working after successful completion of the NCLEX. This research indicates that the majority of graduate nurses are working in an acute care environment and are responsible for caring for adult and older adult patients. Each question will reflect a level of the nursing process or an area of patient needs, and each will be categorized according to a validated level of difficulty. The exam consists of questions that are designed to test the candidate's ability to apply the nursing process and to determine appropriate nursing responses and interventions to provide safe nursing care.

Integrated Processes

Integrated throughout the test plan are principles that are fundamental to the practice of nursing.

Nursing Process

The nursing process has been a common thread since the beginning of nursing school; there is nothing new about the nursing process on the NCLEX. The process must go in order: assessment, analysis/nursing diagnosis, planning, implementation, and evaluation. Adequate assessment data must be obtained before a nurse proceeds to the next step. Frequently, questions on the NCLEX will be based on obtaining essential assessment data; other questions will present the assessment data in the stem of the question. It is

important to keep the steps of the nursing process in mind when you are critically evaluating an NCLEX question.

Caring

The interaction of the patient and the nurse occurs in an atmosphere of mutual respect and trust. To achieve the desired outcome, the nurse provides hope, support, and compassion to the patient.

Communication and Documentation

Events and activities, both verbal and nonverbal, that involve the patient, the patient's significant others, and the health care team are documented in handwritten or electronic records. These records reflect quality and accountability in the provision of patient care. Principles of documentation and provision of patient confidentiality are important considerations in any area of nursing practice.

Teaching and Learning

Nurses provide or facilitate knowledge, skills, and attitudes that promote a change in patients' behavior through teaching

and learning. Nurses provide education to patients and to their significant others in a variety of settings. Identifying critical learning needs for patients and their significant others and providing information in a manner that promotes the health and safety of patients are important across all levels of nursing practice.²

Areas of Patient Needs

The National Council Examination Committee has identified four primary areas of patient needs, which provide a structure to define nursing actions and competencies across all practice settings and for all patients. These areas reflect an integrated approach to the testing content; there is no predetermined number of questions or percentage of questions that pertain to a particular area of practice (e.g., medical-surgical, pediatric, obstetrical).

In Table 1-1, the areas of patient needs are listed with the subcategories and specific weights for each subcategory. The percentages on the categories reflect how important that area is on the test plan. Management of care, pharmacological and

TABLE 1-1 NCLEX® TEST PLAN

Safe, Effective Care and Environment	
Management of Care (13%-19%)	Management of nursing care—supervision, delegation, prioritizing, and delivery of safe care; legal and ethical practices; documentation; patient rights.
Safety and Infection Control (8%-14%)	Prevention of errors and accidents, implementation of standard precautions, asepsis, use of restraints, disaster planning, handling hazardous materials.
Health Promotion and Maintenance (6%-12%)	
Aging process and expected body changes; growth and development and transitions; ante/intra/post partum, and newborn; family characteristics; lifestyle choices; principles of learning and teaching; health promotion programs, disease prevention, immunizations, techniques of physical assessment.	
Psychosocial Integrity (6%-12%)	
Coping and Adaptation—mental health concepts and interventions, end-of-life care, coping mechanisms related to change in body image, sensory and perceptual alterations, spiritual influences.	
Psychosocial Integrity—Nursing care for acute or chronic mental illness, behavioral interventions/crisis intervention, chemical dependency, domestic violence/abuse.	
Physiological Integrity	
Basic Care and Comfort (6%-12%)	Assistive devices, mobility, nutrition, elimination, hygiene, comfort care.
Pharmacological and Parenteral Therapies (13%-19%)	Medication administration—actions, adverse effects/contraindications, nursing implications; blood administration, IV therapy, central venous access devices, chemotherapy, pain control, parenteral nutrition.
Reduction of Risk Potential (13%-19%)	Pathophysiology, nursing implications for and nursing care to minimize potential complications of diagnostic tests/procedures/surgery, laboratory values, and health alterations (tubes, pacemakers, hyper/hypoglycemia, specimens, bleeding, immobility, wounds, positions).
Physiological Adaptation (11%-17%)	Pathophysiology/alterations in body systems—signs and symptoms of conditions, traction devices, seizures, vascular access for dialysis, assess tube drainage, signs and symptoms of infections, complications of pregnancy, medical emergencies, hemodynamics, respiratory care, infections, fluid and electrolytes, radiation therapy.

Adapted from the National Council Detailed Test Plan for the NCLEX-RN® Examination, National Council of State Boards of Nursing, 2003.

parenteral therapies, and reduction of risk potential are the subcategories with the highest emphasis on the test plan. With each of the categories or subcategories are *examples* of content to be tested in that area.² When you are studying for the NCLEX, these are concepts that should be identified across the scope of nursing practice. This table has been adapted and summarized; it does not reflect the entire test plan content. The National Council Detailed Test Plan for the NCLEX-RN may be obtained from the NCSBN, Inc. (<http://www.ncsbn.org>). What was great new information in last month's nursing journals will not be immediately reflected on the NCLEX. New information or new practices must be established as a standard of practice across the nation to be included on the NCLEX. Throughout this book are ALERT boxes that call your attention to areas of the test plan. Pay attention to this information and think about how this concept or principle can apply to different types of patients.



ALERT: *The NCLEX-RN is a test that requires application of nursing concepts and principles across the life span.*

As conditions or principles are discussed, the NURSING PRIORITY boxes call your attention to critical information regarding a patient with a specific condition or situation being presented.



NURSING PRIORITY: *This is critical information to consider in providing care for a specific patient safely.*

Classification of Questions

The majority of questions on the NCLEX are written at the level of application or higher level of cognitive ability. This means a candidate must have the knowledge and understand concepts to be able to apply the nursing process to the patient situation presented in the question. NCLEX questions are based on critical thinking concepts that will demonstrate a candidate's ability to make decisions and solve problems. NCLEX questions are not fact, recall, or memory-level questions. Nurses who have taken the NCLEX will be the first to say that the questions are not like anything they had on nursing school examinations, but the nursing content and principles to determine the answer were provided in the nursing school curriculum. The questions and answers have been thoroughly researched and validated. This is what is called a "standardized exam." The standardization is important because the NCLEX is used nationwide to determine entry level into practice. This ensures that regional differences in nursing care will not be a component of the exam.

All of the questions that are presented to a candidate taking the NCLEX have been developed according to the test plan and the integrated processes fundamental to nursing

practice and have been categorized according to the level of difficulty. The questions have been researched and documented as pertaining to entry-level nursing behaviors.^{2,3}

What Is Computer-Adaptive Testing?

Computer-adaptive testing allows for a test to be generated according to each candidate's ability. As a candidate progresses through questions, the computer will select the next question to be presented to provide an opportunity to demonstrate competence. The NCLEX-RN is graded in a manner different from the grading of conventional school exams. It is not based on the number of questions answered correctly, but rather on the standard of competency as established by the NCSBN (Figure 1-1).

A test pool bank of questions will be loaded into the computer at the beginning of the examination. Different candidates will receive different sets of questions, but all the test pool banks contain questions that are developed according to the same test plan. For example, standard precautions are a critical element of the test plan. Many situations and patients can be used to test this concept: one candidate may be presented with a situation in which a patient requires obstetrical care; someone else, a situation with implications for a patient with a respiratory problem; and still someone else, a situation involving a newborn. All of the questions are different, but all of the questions are based on the test plan critical element of standard precautions.

The questions presented to the candidate are determined by the response to the previous question. When a question is answered correctly, a question with a higher level of difficulty may be presented next. The more higher level questions a candidate answers correctly, the closer he or she is to passing (Figure 1-2). A candidate cannot skip questions or go back to previously answered questions. As the examination progresses, it is interactively assembled. As long as the questions are answered correctly, the next question is selected to test another area of the test plan, and it may be at a higher level of difficulty. When a question is answered incorrectly, the computer will select an easier question. This helps to prevent a candidate from being bombarded with very difficult questions and becoming increasingly frustrated. The computer will continue to present questions that are based on the test plan and on the level of ability of the candidate until a level of competency has been established (see Figure 1-2).³

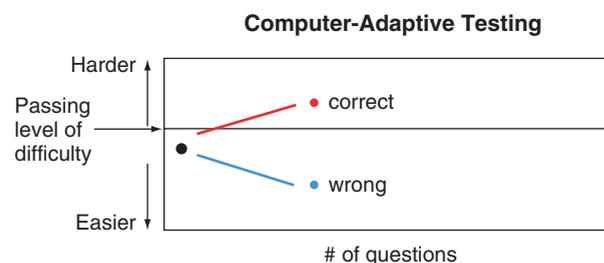


FIGURE 1-1 Competency Level.

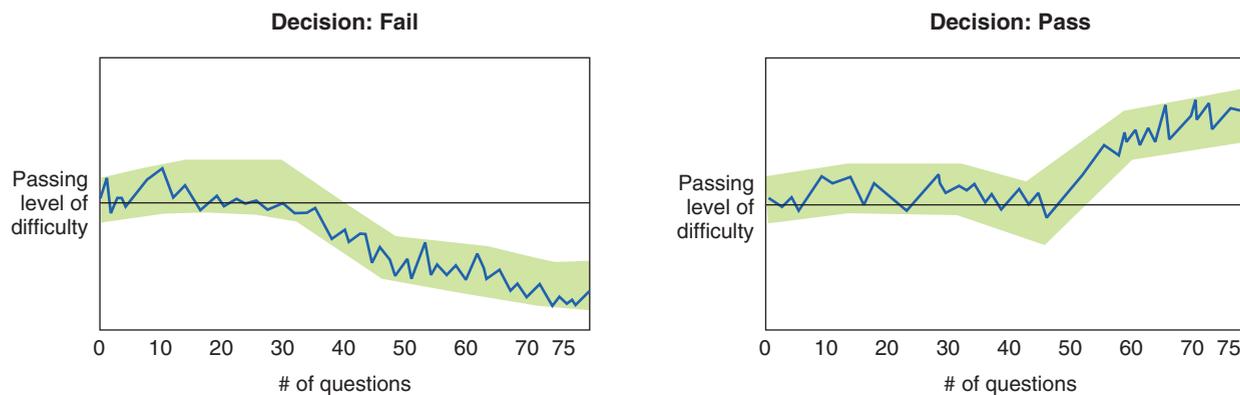


FIGURE 1-2 Plateau to Establish Pass or Fail.

Taking the NCLEX® Examination

Application

An application must be submitted to the state board of nursing in the state in which the candidate wants to be licensed. The contact information for the state boards of nursing may be found on the National Council website and in Appendix B of this book. After the candidate has been approved as eligible by the state, the candidate will receive an authorization to test (ATT) along with the candidate bulletin, either by mail or e-mail if registration was submitted to the state via e-mail. The candidate may register for the NCLEX at the NCLEX Candidate website listed in the ATT or may complete registration by regular mail or telephone. Both the website and the telephone numbers are listed in the ATT. Please consult the *Candidate Bulletin* regarding addresses and phone numbers for registration and specific information regarding the registration process. After the examination fee has been paid, it will not be refunded.³

Scheduling the Examination

After the candidate has been declared eligible to take the NCLEX and has received an ATT, he or she may schedule an examination date. A candidate must have an ATT before scheduling the examination. The *Candidate Bulletin* lists the phone number to call to schedule the examination. Once the ATT has been issued, a specific period of time in which the candidate must take the test is stipulated by the state. This ranges from 90 to 365 days, with the average being 90 days; this time frame may not be extended. The ATT must be presented at the testing site for the candidate to be admitted to take the examination. Each candidate is encouraged to call and schedule the appointment to take the examination soon after receiving the ATT, even if he or she does not plan on taking the test immediately.

Testing Center Identification

Photo identification with a signature and the ATT will be required at the testing site. The name printed on the ATT must match the identification presented at the course site.

Identification must be in English and cannot be expired. Acceptable forms of identification are a driver's license, passport, state-issued identification, U.S. military identification, and a national identity card. At the testing site before testing, each candidate will be fingerprinted, a photo will be taken, and a signature will be required.

Day of the Examination

Candidates should plan on arriving at the center about 30 minutes before scheduled testing time. An erasable note board will be provided at the computer terminal. Candidates may not take any type of books, personal belongings, hats, coats, blank tablets, or scratch paper into the testing area. A fingerprint scan will be required to reenter the testing area after each break. A tutorial and orientation to the computer will be available to help candidates get started and to make sure they understand how to use the computer.

Testing

Candidates will have a maximum of 6 hours to complete the examination. After 2 hours of testing, candidates have an optional 10-minute break; another optional break occurs after 3½ hours of testing. If a break is needed before that time, a candidate should notify one of the attendants at the testing center. The computer will automatically signal when a break begins. All of the break times and the tutorial are considered part of the total 6 hours of testing time.

The examination will stop when one of the following occurs:

1. Seventy-five questions have been presented and answered, and a minimum level of competency has been established; or a lack of minimum competency has been established (see Figure 1-2).
2. The candidate has completed the maximum number of 265 questions.
3. The candidate has been testing for 6 hours.

Each candidate will receive between 75 and 265 questions. The number of questions on the NCLEX is not indicative of the level of competency. The majority of candidates

who complete all 265 questions will have demonstrated a level of minimum competency and therefore pass the NCLEX. A mouse will be used for selecting answers, so candidates don't need to worry about different computer function keys. An onscreen calculator will also be available to use for math problems. If any problems occur with the environment or with the equipment, someone will be available to provide assistance.

In each candidate's examination, there will be 15 pretest or unscored items or questions. The statistics are evaluated on these items to determine whether the item is a valid test item for the NCLEX. All of the items that are scored on a candidate's examination have been pretested and validated. It is impossible to determine which questions or items are to be scored and which are pretest items. It is important to treat each question as a scored item.

The *Candidate Bulletin* from the NCSBN is very important; read it carefully and keep it until the results from NCLEX have been received. This will provide directions and answer more of the candidate's questions regarding the NCLEX. The *Candidate Bulletin* is available online from the NCSBN (www.ncsbn.org), and it will be available during the NCLEX registration process at the school of nursing.

Test Results

Each examination is scored twice, once at the testing center and again at the testing service. The test results are electronically transferred to the state boards of nursing. Test results are not available at the testing center. Check the information received from the appropriate board of nursing to determine how and when the results are available; test results may be available online. In some states, the results may be available within 2 to 3 days; in others, the results will be mailed, which will require a longer notification period. Do not call the testing center, the National Council, or the individual state board of nursing for test results. Follow the procedure found in the information from the state board of nursing where the license will be issued.³

SUCCESSFUL TEST TAKING ON THE NCLEX®



ALERT: *Practicing test-taking skills is critical if a candidate is going to be able to effectively use them on the NCLEX. Practice test taking should be a component of NCLEX preparation.*

Being able to effectively use test-taking strategies on an examination is almost as important as having the basic knowledge required to answer the questions correctly. Everyone has taken an examination only to find, on review of the exam, that questions were missed because of poor test-taking skills. Nursing education provides the graduate with a comprehensive base of knowledge; how effectively the

graduate can demonstrate the use of this knowledge will be a major factor in the successful completion of the examination.

The NCLEX-RN is designed to evaluate minimum levels of competency. The exam does not test total knowledge, knowledge of specialty areas, or any degree of professionalism. It is designed to determine whether a candidate has the knowledge, skills, and ability required for safe and effective entry-level nursing practice. On the NCLEX, the questions are described as being based on clinical situations common in nursing; uncommon situations are not emphasized. NCLEX questions are not fact, recall, or memory-level questions; they are questions that require critical thinking to determine the correct answer. Critical thinking will require an analysis of patient data, an understanding of the patient's condition or disease, and the ability to determine the best action or nursing judgment that will most effectively meet the patient's needs.

Practice testing is an excellent method of studying for the NCLEX. It is important to use the results from practice testing to determine whether there are areas in which additional review is needed or whether questions are being missed because of poor test-taking strategies.

NCLEX® TEST-TAKING STRATEGIES

The NCLEX questions are different from those used in school. One of the biggest problems graduates encounter is that two or more answers may appear to be correct. Sometimes a candidate believes that more information is necessary to answer the question. The answer must be determined from the information presented; no one is going to clarify or answer any questions regarding a specific question or content. Information presented here is critical to consider in evaluating and successfully answering NCLEX questions.

- **The NCLEX Hospital:** What a great place to work! On the NCLEX, all of the patients are being cared for in the NCLEX Hospital. Questions ask for nursing care and decisions based on situations in which everything is available for patient care. *NCLEX questions are based on textbook practices, not necessarily on the real world.* Patients are going to respond just as the books indicate they will. A candidate who has a lot of clinical experience will begin to experience problems if he or she considers that there may not be adequate staff or equipment, or if the nursing care is not "realistic." Nursing care provided on the examination is performed in the NCLEX Hospital: the nurse has adequate staff, supplies, and whatever is required to provide the safest care for the patient. This approach is necessary because this is a nationally standardized examination.
- **Calling the Doctor (or anyone else):** Don't pass the responsibility for care of the patient to someone else. This is an exam on nursing care; evaluate the question carefully and see what nursing action needs to be taken before consulting or calling someone else. This includes the social

worker, respiratory therapist, and hospital chaplain, as well as the doctor. After you have carefully evaluated the question, if the patient's condition is such that the nurse cannot do anything to resolve the problem, then calling for assistance may be the best answer. Frequently, there is a nursing action to be taken before contacting someone for assistance. A specific item on the test plan states that the nurse will identify data on one patient that must be reported immediately.²

- **Doctor's Orders:** A doctor's order is available to provide the nursing care in the options presented in the question. If the question asks for administration of a specific medication for the patient's problem, then assume that there is an order for it. If a question is asking whether the nursing action is a dependent or an independent action, then it will be stated in the stem of the question. For example, the question may request an independent nursing action to provide pain relief for a specific patient.
- **Focus on the Patient:** Look for answers that focus on the patient. Identify the significant or central person in the question. Most often, this is going to be the patient. Wrong choices would be those that focus on maintaining hospital rules and policies, dealing with equipment, or even solving the nurse's problems. Evaluate the status of the patient first, then deal with the equipment problems or concerns. There may also be questions that ask the nurse to respond to a patient's family or significant others. Determine the person to whom the question pertains.
- **Patient's Age:** Consider a patient to be an adult unless otherwise stated. If the age of a patient is important to the question, it will be stated in years or months. The terms "elderly adult" and "geriatric patient" are not frequently used. These terms have been established as negative descriptors of older patients. The description of such a patient may be "older adult," or a specific age may be given.
- **Laboratory Values:** It is important to know the normal lab values for the common laboratory tests. It is also important to know what to anticipate the lab values to indicate when a patient's condition is getting better or getting worse. Identify lab values or diagnostic procedures that indicate a patient's progress or lack of progress. Evaluate lab values and diagnostic procedures to determine whether the values or results are abnormal. Ask yourself how the results will affect the delivery of nursing care. For example, when a patient's blood sugar level is 50 mg/ml and he or she is awake and alert, the patient will need something to eat, preferably a complex carbohydrate. If a patient has hemoglobin value of 8.5 g/dl, nursing care will involve avoidance of unnecessary physical activities, and the patient will need to be kept warm.
- **Positions:** Positioning a patient tends to appear regularly on the NCLEX, both as a question and as an option to consider in the implementation of care. If the positioning appears in the stem or the question, then consider whether the position is for comfort, for treatment, or to prevent a complication. Evaluate the question: what is to be

accomplished with the position and why is it important for this patient? Sometimes the position appears in the options. Consider whether positioning is important to the care of the patient presented. For example, the semi-Fowler's position is very important to a patient who is having difficulty breathing, and the supine position or low Fowler's position may provide the most comfort for a patient after surgery. Determine why a patient is placed in a specific position and then determine whether this is a priority in planning or intervention. See Appendix 3-1 for a further description of positions.

- **Mathematical Computations:** Mathematical computations may include calculations of intravenous (IV) rate and drip factors, calculations of medication dosages, and conversion of units of measurement. You should be able to apply the appropriate formula to the situation. Some of the questions may call for two computations, as in a question in which all items must be converted to one unit of measurement before a dosage is calculated or in a situation in which the patient's weight in kilograms must be determined before the dosage is calculated. The mathematical calculations may be presented in a multiple choice format or in an alternate format question in which you're asked to fill in the blank.

Management of Patient Care

As the role of the RN has expanded, management of patient care has become increasingly important over the past few years. Nursing care assignments should take into consideration the nurse who is educationally prepared, experienced, and most capable of caring for the patient. Licensed practical nurses (LPNs), licensed vocational nurses (LVNs), and unlicensed assistive personnel or patient care attendants must be supervised and directed in the provision of safe nursing care. Don't panic and pull out all of the management textbooks to review. Evaluate the question in terms of the general considerations of delegation and supervision. Pay close attention to the person to whom the nurse is delegating the care or nursing activity: is it to another RN, or is it to a less qualified person (LVN or LPN) or unlicensed assistive personal or patient care assistant?

- **Don't delegate assessment, evaluation, or nursing judgment.** These levels of the nursing process must be performed by an RN.
- **Don't delegate teaching assignments.** This is another area that is the primary responsibility of the RN.
- **Keep in mind the NCLEX Hospital.** Adequate staff is available to provide patient care; don't worry about shortages. Focus on the needs of the patient in the question; what is happening in the rest of the unit is not a consideration. The only patient to consider in each question is the one involved in that question, not the rest of the patients the nurse has been assigned.
- **Identify the most stable patient.** The most stable patient is the one who has the *most predictable outcome* and is *least likely* to have abrupt changes in condition

that would require critical nursing judgments. These are the patients for whom some nursing care activities can be delegated to someone else. When determining the most stable patients, Maslow's hierarchy of needs should also be considered (see Chapter 3, Figure 3-1). Very carefully consider any patients with respiratory compromise or an unstable situation; they are most likely the patients for whom the nurse should not delegate nursing care.

- **Delegate tasks that have specific guidelines.** Those tasks that have specific guidelines that are unchanging and are used in the care of a stable patient can often be delegated. Bathing, collecting urine samples, feeding, providing personal hygiene, and assisting with ambulation are just a few examples of these activities. Remember you are in the NCLEX Hospital, so reword the question and select an answer that has the RN making the decisions.
- **Identify your priority patient.** The priority patient is the one who is most likely to experience problems or ill effects if he or she is not taken care of first. Priority patients include those with respiratory compromise, those whose conditions are unstable and changing, and those who are at high risk for development of complications. It is not unusual for the NCLEX to present a typical nursing care assignment and ask which patient the nurse would care for first. Or a situation with a patient may be presented, and you will be asked to select the first nursing action. Review the testing strategies regarding priority questions. It is important to identify the most unstable patient, see him or her first, and determine what is necessary to do first for this patient.

Establishing Nursing Priorities

Almost all nurses will say that the NCLEX is full of priority questions. These questions may be worded in the following ways:

- “What is the priority nursing action?”
- “What is the first nursing action?”
- “What is the best nursing action?”

In other words, the NCLEX wants to know whether the nurse can identify the most important action to be taken to provide care for the patient in the situation presented. In such cases, three or four of the options are frequently correct; however, one of the actions needs to be performed before the others. This is where critical thinking is needed. There are three areas to consider when determining priority nursing actions: Maslow's hierarchy of needs, the nursing process, and patient safety.

- **Maslow's Hierarchy of Needs:** And you thought this was just for fundamentals! *Always consider Maslow's hierarchy of needs and remember that physiological needs come first.* When evaluating options, identify those that are physiological and psychosocial. Physiological needs will be a higher

priority than psychosocial or teaching needs. A patient's physical needs must be met before his or her psychosocial or teaching needs are considered. Also remember the ABCs—airway, breathing, and circulation—as the critical physiological needs because these are at the base of Maslow's pyramid. Be cautious. Don't always select “airway” as the best answer. Sometimes the patient does not have an airway problem, so don't read into the question and give the patient a problem! Maslow's hierarchy of needs also applies to psychosocial questions: Take care of physical needs first, then focus on the psychosocial needs. (See the section in this chapter regarding answering psychosocial questions.)

- **Nursing Process:** Once again, the first step in the nursing process is *assessment*. This is frequently the first nursing action as well. Assessment must be done to analyze and construct a nursing diagnosis, to develop a plan of care, and to determine the priority of nursing care implementation. If the assessment data are provided in the stem of the question, then consider Maslow's hierarchy of needs when planning or selecting the best nursing action or implementation.
- **Safety Issues:** These may include situations in the hospital or in the patient's home environment. The first issue to consider is meeting basic needs of survival: oxygen, nutrition, elimination. Reduction of environmental hazards is also a concern and may include prevention of falls, accidents, and medication errors. Environmental safety also includes the prevention and spread of disease. This may include how to avoid contagious diseases or even activities such as hand washing. When critically evaluating questions that involve a patient's safety and multiple options appear to be correct, determine what activity will be of most benefit to the patient or what will cause the least harm to the patient.

Example Questions for Management and Priority Setting

A labor and delivery RN has been reassigned, or floated, to a step-down telemetry unit for the afternoon shift. Which pair of patients would reflect the most appropriate assignment for this nurse?

1. Patient who has undergone cardioversion and a patient who was admitted during the night for possible myocardial infarction (MI).
2. Patient who had a cardiac catheterization this morning and a patient admitted for 24-hour observation for first-degree heart block.
3. Patient who is currently in third-degree heart block and a patient who had a hypertensive crisis with congestive heart failure 48 hours ago.
4. Patient who had an MI with increasing premature ventricular contractions (PVCs) 72 hours ago and a

newly admitted patient with paroxysmal onset of atrial fibrillation.

Answer: 2. The labor and delivery RN needs to be assigned the most stable patients and the ones with the most predictable prognoses, which are the patients in option 2. Do not read into the situation and give the patient who has had cardiac catheterization more problems. In option 1, the patient who had a possible MI 16 hours ago is at risk for complications, as is the patient who underwent cardioversion. In option 3, the patient with third-degree heart block is most likely very unstable and may need a pacemaker. In option 4, the patient, who has had an MI is demonstrating signs of ventricular irritability, and the patient with atrial fibrillation will need to be evaluated.

The nurse is assigned a group of patients for care. Which patient would the nurse assess first?

1. A patient who had surgery 2 days ago who is complaining of pain.
2. An older adult patient reported to have increasing lethargy and confusion.
3. A newly admitted patient with a serum blood urea nitrogen (BUN) level of 32 mg/dl.
4. A hypertensive patient complaining of piercing midsternum pain.

Answer: 4. The patient with chest pain is at greatest risk of experiencing immediate problems. He or she needs to be evaluated immediately. Option 1, the patient who had surgery, is experiencing pain. This is expected but not alarming. Pain control needs to be addressed as soon as possible. In option 2, the patient with increased lethargy and confusion needs to be evaluated. These are psychosocial needs that need to be addressed; however, they do not represent an immediate physical problem. The newly admitted patient in option 3 has a slightly elevated BUN level. This could be related to hydration problems, but the patient is not presented as in an unstable situation.

A cardiac patient turns on his call light and tells the nurse he is experiencing chest pain. What is the first nursing action?

1. Administer oxygen to the patient at 4 L/min through a nasal cannula.
2. Listen to heart sounds for ectopic beats.
3. Auscultate breath sounds and maintain airway.
4. Determine what the patient was doing before the onset of pain.

Answer: 1. When a patient complains of chest pain, administration of oxygen should be started immediately and then vital signs should be determined. In the stem of the question,

a cardiac patient with chest pain is presented; that is enough critical information for a nursing action. It can be assumed that the nurse has an order for the oxygen. Further assessment will determine the status of the vital signs, and options 2 and 4 can be completed. Listening for ectopic beats will identify the regularity of the heart rate but will not provide definitive information for care. In option 4, whether physical exertion was a factor in the occurrence of the chest pain can be determined, but this is not an immediate concern. Option 3 gives this patient airway problems, and there is no indication in the stem that the airway is an issue at this time.

A patient has returned from abdominal surgery, and the nurse is assessing the incisional area. The dressing has some bright red blood on it, and on closer inspection, the nurse determines that there is an area of evisceration. What is the best nursing action?

1. Remove the dressing and place a sterile saline solution-soaked dressing on the wound and dry reinforcement dressings on top.
2. Remove the dressing, and with sterile gloves, apply very gentle pressure to replace the exposed bowel.
3. Leave the dressing in place and apply an abdominal pressure dressing to prevent further exposure of the bowel.
4. Remove all of the soiled dressing, cleanse the wound area with Betadine solution, and replace the dressing.

Answer: 1. The best nursing action is to cover the exposed bowel with a sterile saline solution-soaked dressing to prevent drying and tissue damage to the exposed bowel, then the physician should be notified. Option 2 should not be done, because there may be vascular impairment to the bowel below the surface. In option 3, the dressing needs to be replaced with a moist one to protect the bowel. In option 4, the wound should not be cleansed, because it is not a dirty wound.

Strategies for Evaluating Multiple-Choice Questions

Test-taking strategies are very beneficial during nursing school, as well as on the NCLEX. Start using them on current exams. This may help to increase test scores in school, in addition to being one more step toward success on the NCLEX (Box 1-1).

Question Characteristics

The majority of questions on the NCLEX, as well as on nursing school exams, are multiple choice. This is the type of test question that is the most familiar to candidates.

Stem of the Question

The stem presents information or describes a patient situation. The part of the stem that asks the question may be a complete sentence; it will present a problem or situation that

[NCLEX-RN] Time Remaining 2:25:30

Calculator

A nurse is placing a nasogastric tube for the purpose of gastric suctioning. What nursing activity is most reliable to confirm the placement of the tube?

1. Instill about 30 mL of air and listen for air over the gastric area.
 2. Hold the end of the tube in a cup of water, and observe for bubbles.
 3. Ask the client if he is having any difficulty breathing.
 4. Aspirate fluid into the syringe, and determine the pH.

Select the best response. Click the Next (N) button or the Enter key to confirm answer and proceed. ITEM 1

Next (N)

Answer - 4: The most reliable method of checking placement is to determine the pH of the aspirated fluid. In the past, the method described in option 1 was used but is not reliable. The second and third options are not reliable.

can be answered before the options are evaluated. The question may also be presented as an incomplete sentence. One of the options presented will most correctly complete the sentence.

Options

There are four options from which to choose an answer.

- Three options are distractors; they are designed to create a distraction from the correct answer.

- One option correctly answers the question asked in the stem.
- There is only one correct response; no partial credit is given for another answer.

1. **Read the question carefully before ever looking at or considering the options.** If you glance through the options before understanding the question, you may pick up key words that will affect the way you perceive the question.

This will help you to understand the question and not formulate an opinion about the answer before you have read the question. On a paper and pencil test, just cover the answers with your hand or a note card. If you practice this strategy before taking the NCLEX, when you get there, you will be able to do this without physically covering the answers.

2. **Do not read extra meaning into the question.** The question is asking for specific information; if it appears to be simple “common sense,” then assume it is simple. Do not look for a hidden meaning in a question. Avoid asking yourself “what if. . .?” or speculating about the future “maybe the patient will. . .” (Don’t make the patient any sicker than he or she already is!)

Example: A bronchoscopy was performed on a patient at 7:00 AM. The patient returns to his room, and the nurse plans to assist him with his morning care. The patient refuses the care. What is the best nursing action?

1. Perform all of his morning care to prevent him from becoming short of breath.
2. Continue to monitor vital signs and assess for gag and swallowing reflexes.
3. Postpone the morning care until patient is more comfortable and can participate.
4. Cancel all of the morning care because it is not necessary to perform it after a bronchoscopy.

BOX 1-1 APPLYING TESTING STRATEGIES

Check Out the Question!

1. Read the question from beginning to end.
2. Check for words that establish the question as asking for a priority: first action, priority nursing action, most important, or best.
3. Is the answer going to be a true or positive statement, or is the question asking for an answer that is a negative or false statement. Words such as *not working*, *contraindication*, and *avoid* indicate answers that are giving negative or false statements.
4. Rephrase the question in your own words. Do you understand what the question is asking?

Now Go for the Options . . .

- Look at option 1: true or false, does it answer what the question is asking?
- Go through every option: eliminate it if it is not a correct answer or keep it around if it is a possible right answer.
- If option 2 is a good option, but option 3 is better, then eliminate option 2!
- After all options have been evaluated, what is left? If you are left with only one option, great, that is the answer!
- If you are left with two options, go back and reread the question; decide which of the two options is best, select it, and move on.

The correct answer is 3. The question is asking for a nursing judgment regarding morning care. Do not read into the question and make it more difficult by trying to put in information relating to respiratory care, such as checking for gag and swallowing reflexes.

3. **Read the stem correctly.** Make sure you understand exactly what information the question is asking. Determine whether the question is stated in a positive or negative, true or false format.

Watch for words that provide direction to the question. A positive or true stem may include the following: “indicates the patient understands. . .,” “the best nursing action is . . .,” “the preoperative teaching would include. . .,” or “the best nursing assignment is. . .” Watch for words in the stem that have a negative meaning when the question is asking for a response that is not accurate or is false. Options that contain phrases such as “contraindicated,” “the patient should avoid,” “indicate the patient does not understand,” “does not occur,” and “indicates (mediation, equipment, nursing action) is not working” are negative indicators. The question is asking for information that is not accurate or actions the nurse would not take. The following words or phrases change the direction of the question: *except, never, avoid, least, contraindicated, would not occur.* It may help to rephrase the question in your own words to better understand what information is being requested.

Example: Patients with arteriosclerotic heart disease (ASHD) go through several stages before becoming severely compromised. In considering the pathophysiology of heart disease, the nurse would identify what physical response that does not occur in the early stages of ASHD?

1. Decreased urine output.
2. Dyspnea on exercise.
3. Anginal pain relieved by rest.
4. Increased serum triglyceride levels.

Rephrase the question: In the early stages of ASHD, what is not a characteristic finding? It is important to identify the key point “early stages of ASHD” and the key words “does not occur.” If you miss these essential points, you do not understand the question, and chances are, you will not choose the correct answer. The correct answer is option 1; a decrease in urine output occurs when cardiac disease is advanced enough to cause a severe decrease in cardiac output and renal perfusion.

4. **Watch where the patient is in the disease process or condition he or she is experiencing.** Examples of this are phrases such as “immediately postoperatively,” “the first postoperative day,” and “experienced a myocardial infarction this morning.”

Example: A patient had a cardiac catheterization in which the left femoral artery was used. During the

first few hours after the cardiac catheterization procedure, which nursing action would be most important?

Rewording: What is the most important nursing care in the first few hours after a cardiac catheterization?

1. Check his temperature every 2 hours.
2. Elevate the head of the bed 90 degrees.
3. Evaluate blood pressure and respiratory status every 15 minutes.
4. Check his pedal and femoral pulses every hour for 4 hours.

The correct answer is 4. The phrase, “during the first few hours after the procedure,” is important in answering this question correctly. The danger of hemorrhage and hematoma at the puncture site is greatest during this time. The question also asks for the most important nursing care. Option 3 is important to do, but option 4 is critical to this particular procedure.

5. **Before considering the options, think about the characteristics of the condition and critical nursing concepts.** What are the nursing priorities in caring for a patient with this condition/procedure/medication/problem?

Example: A woman who gave birth 3 days ago is complaining of soreness and fullness in her breasts and states that she wants to stop breast-feeding her infant until her breasts feel better. What is the best nursing response?

This is a positive question. The option will include a true statement. Think about breast-feeding and the common discomforts and problems the patient encounters. Don’t look at the options. Think “Is it normal to have fullness and soreness in the breasts during the first 3 days of lactation, and what happens if she stops breast-feeding the infant?” Now, evaluate the options:

1. Show the patient how to apply a breast binder to decrease the discomfort and the production of milk.
2. Tell the patient that breast fullness may be a sign of infection and to stop breast-feeding.
3. Suggest to the patient that she decrease her fluid intake for the next 24 hours to temporarily suppress lactation.
4. Explain to the patient that the breast discomfort is normal and that the infant’s sucking will promote the flow of milk.

In this question, option 4 is correct. Initially, breast soreness may occur for about 2 to 3 minutes at the beginning of each feeding until the let-down reflex is established. Options 1, 2, and 3 would decrease her milk production; the question did not state that she wanted to quit breast-feeding.

6. **Identify the step in the nursing process being tested.** Remember, you must have adequate assessment data before you move through the steps of the nursing process. Is there adequate information presented in the

stem of the question to determine appropriate nursing planning or intervention? Look for key words that can assist you in determining what type of information is being tested.

Example: An 85-year-old patient from a residential facility is brought into the emergency room. There are numerous bruises and abrasions in various stages of healing on the patient's face and arms. The attendant from the residential facility explains that the elderly patient fell down. What is the priority nursing action?

1. Call the residential facility and ask for an incident report.
2. Put ice on the bruises and cover the abrasions with protective gauze.
3. Notify the supervisor regarding the possibility of an abusive situation.
4. Perform a head-to-toe assessment and determine the extent of the injuries.

The correct answer is 4, to determine or assess the extent of injuries. The stem of the question did not present adequate information with which to make a nursing judgment, and the patient's physiological needs are the priority. Option 1 does not immediately alleviate pain or assist the patient. Options 2 and 3 relate to nursing actions that would be done after the immediate injuries and needs have been assessed. Priority setting and physiological needs must be addressed first.

7. **Confused at this point? Don't know what the question is even asking?** Take a deep breath, reread the question, and ask yourself what the main topic of the question is. Now read the option choices, not to eliminate options or select a correct answer, but to get a clue as to the direction of the question. It might be helpful to read the options from the bottom up (start with option 4, rather than option 1) to help your brain focus on the options.

Example: A mother brings in a toddler with pediculosis capitis. A prescription of 1% permethrin (Nix) is given to her. What is important for the nurse to teach the mother?

Is the question asking about prevention of pediculosis, complications, prevention of spread of the disease, or treatment? Check out the options. Is there an indication in the options as to the direction of the question?

1. Treatment should be continued daily for 1 week with an additional follow-up treatment in 7 days.
2. Clothing, toys, and personal belongings of other family members do not require any special care.
3. Solution should be applied today and should be applied again if nits are still visible in 24 hours.
4. Allow the medication to remain in contact with the scalp for 10 minutes, and then thoroughly rinse.

After checking out the options, it appears that the question is asking for teaching implications for the mother regarding the use of the medication, Nix. Now that you have determined what you need to identify, you can begin the process of elimination of the options until you have found the correct answer.

The correct answer is 4. The Nix solution needs to remain on the scalp for 10 minutes before it is rinsed out. Option 1 is too frequent for the rinse to be used. Option 2 is incorrect, because the child's clothing and toys, as well as clothing and toys of the siblings, will need to be treated. Option 3 is not correct because rinse should be reapplied in 7 days.

8. **Don't focus on predicting a right answer!** Frequently, the answer you want is not going to be an option! Keep in mind the characteristics and concepts of nursing care for a patient with the condition or problem in the situation presented. Eliminate options: Every time you eliminate an option, you increase your chance of selecting a correct answer.

If all of the options are plausible, then rank the options. The first one is the highest priority, and the fourth one is the lowest priority. Which one is the first action or answers the question?

Example: A patient has an ulcer (2 in × 2 in) on the calf of his right leg. The area around the ulcer is inflamed, and the ulcer is draining purulent fluid. The vital signs are: pulse, 114 beats/min; respiration, 22 breaths/min; temperature, 101° F. Which order will the nurse implement first?

Reword the question: The patient has an infection in the ulcer on his leg. His temperature is elevated, and so is his pulse; this is a normal response to infection. With the doctor's orders that are going to be listed here, what nursing actions do I need to do first?

1. Administer ceftriaxone (Rocephin), 1 gm, intravenously every 4 hours.
2. Perform blood cultures × 2, 20 minutes apart and from different venipuncture sites.
3. Apply Polysporin (Bacitracin) ointment topically to leg ulcer three times a day.
4. Administer acetaminophen (Tylenol), 650-mg suppository, every 4 hours for temperature above 101.8° F.

Rank the options:

For Option 2, blood cultures must be obtained prior to antibiotic.

Option 1 needs to be done before administration of the antibiotic is started.

Option 4 will not produce any immediate response or assistance in treating the problem but will make the patient more comfortable.

Option 3 will help to reduce the infection, once the culture has been done and administration of the antibiotic has been started.

Another approach to the options could be:

Consider option 1: This is an antibiotic that will begin to fight the infection.

Consider option 2: This is important to do to identify the causative bacteria. This is more important now than option 1; eliminate option 1.

Consider option 3: This is treating the infection topically. It will cause a decrease in the bacteria, but the blood cultures still need to be done first; eliminate this option because both options 1 and 2 are more important.

Consider option 4: This is treating the symptoms, not the cause of the problem, which is not as important as option 1 or option 2; eliminate it.

All of these options are feasible for treating this patient; however, obtaining the blood culture is the most important (option 2). If you had approached this question with a specific answer in mind (give an antibiotic), you would have found that answer; however, it would have been wrong.

9. Evaluate all of the options in a systematic manner.

After you understand the question, read all of the options carefully. Remember, distractors are plausible to the situation and are designed to “distract” you from the correct answer. All of the options may be correct, but one will be the best answer.

Example: A patient has just returned to his room from the recovery room after a lumbar laminectomy. In considering possible complications, the patient might experience in the next few hours, what nursing action is most important?

1. Monitor vital signs every 4 hours.
2. Assess breath sounds every 2 hours.
3. Evaluate every 2 hours for urinary retention.
4. Check when he last had a bowel movement.

In evaluating the options, all are plausible for the situation. However, consider that this is his operative day, and the question is asking for complications he might encounter in the next few hours after lumbar laminectomy. Options 1 and 4 are not appropriate at this period of postoperative recovery; vital signs should be checked more often, and constipation can be more effectively addressed at a later time. Option 2 would be appropriate if respiratory problems were anticipated (don't always select respiratory answers). The correct answer is 3, because this is a common problem in the immediate postoperative period after a lumbar laminectomy.

10. **As you read the options, eliminate those you know are not correct.** This will help narrow the field of choice. When you select an answer or eliminate an option, you should have a specific reason for doing so, and it will increase your chances of selecting the correct answer.

Example: A patient is in her third trimester of pregnancy and she is scheduled for a sonogram. The nurse explains to the patient that results of this exam will reveal what information regarding the fetus?

1. Maturity of the fetus's lungs (No, the sonogram does not show any evidence of surfactant or maturational level of the lungs.)
 2. Presence of congenital heart defect (No, the sonogram is not specific enough to reveal congenital heart defects.)
 3. Gestational age (Yes, the sonogram gives an overall picture of bone formation [biparietal diameter (BPD)], thereby indicating gestational age.)
 4. Rh factor antibody level (No, this level must be determined by a blood test to evaluate for isoimmunization, hemolytic disease of the newborn.)
- After a systematic evaluation of the options, option 3 is the correct answer.

11. **Identify similarities in the options.** Frequently, the options will contain similar information, and similar options may be eliminated. If three options are similar, the different one may be the correct answer.

Two of the options may be very similar; if one option is not any better than the other option, both of them are probably wrong, so start looking for another answer. Sometimes three of the options have very similar characteristics; the option that is different may be the correct answer.

Example: Which foods would meet the requirement for a high-protein, low-residue diet?

1. Roast beef, slice of white bread.
2. Fried chicken, green peas.
3. Broiled fish, green beans.
4. Cottage cheese, tomatoes.

Options 1, 2, and 3 all contain a meat that would be needed for a high-protein diet; therefore option 4 can be eliminated. Options 2, 3, and 4 all contain a vegetable that has a peeling and is high residue. The correct answer is option 1, for both high protein and low residue. The NCLEX does not focus on recipes that contain a mixture of foods causing you to wonder just how a dish was made. There are no special characteristics to the food; if a food has a special characteristic, it will be stated (e.g., “low sodium” or “low fat”).

12. **Identify words in the options that are “qualifiers.”** Every, none, all, always, never, and only are words that

have no exceptions. Options containing these words are frequently incorrect.

Seldom in health care is anything absolute with no exceptions; often, you can eliminate these options. In some situations the qualifiers are correct, especially when a principle or policy is described. The nurse always establishes positive patient identification before administering medications. This would be a correct statement. Carefully evaluate these words; they are clues to the correct answer.

Example: The nurse is performing a wound culture and sensitivity on a patient's incisional area. What patient information will the sensitivity part of the procedure reflect?

1. Presence and characteristics of all bacteria present in the patient's wound.
2. Which antibiotics will effectively treat the infection.
3. Differentiation of the bacteria and viruses present in the wound.
4. The treatments to which all the bacteria are responsive.

Options 1 and 4 contain the word "all." If you did not know the answer, you could eliminate options 1 and 4. This would give you a 50% chance of finding the right answer, which is option 2.

13. **Select the most comprehensive answer.** All of the options may be correct, but one may include the other three options or need to be considered first.

Example: The nurse is planning to teach a diabetic patient about his condition. Before providing instruction, what is most important for the nurse to evaluate? The patient's:

1. Required dietary modifications.
2. Understanding of the exchange list.
3. Ability to administer insulin.
4. Present understanding of diabetes.

Options 1, 2, and 3 are certainly important considerations in diabetic education. However, they cannot be initiated until the nurse evaluates the patient's knowledge of his or her disease state. When two options appear to say the same thing, only in different words, then look for another answer; that is, eliminate the options that you know are incorrect. Options 1 and 2 both refer to the patient's understanding of nutrition.

14. **There may be questions in which the options contain several items to consider.** After you are sure you understand what information the question is requesting, evaluate each part of the option. Is it appropriate to what the question is asking? If an option contains one incorrect item, the entire option is incorrect. All of the items listed in the option must be correct if it is to be the answer to the question.

Example: In evaluating the lab data of a patient experiencing renal failure, the nurse would identify what findings as indicative of increasing renal failure?

1. Increased BUN level, hyperkalemia, decreased creatinine clearance.
2. Increased hemoglobin, hyponatremia, increased urine electrolytes.
3. High fasting blood glucose level, increased prothrombin time.
4. Increased platelets, increased urine specific gravity, proteinuria.

In a methodical evaluation of the items in the options, you can eliminate items. The phrase "increased hemoglobin and urine electrolytes" in option 2 and the phrase "increased urine specific gravity" in option 4 make these two options incorrect. Option 3 has nothing to do with renal failure; the blood glucose level is associated more with diabetes and endocrine problems. Therefore option 1 is correct.

15. **After you have selected an answer, reread the question.** Does the answer you chose give the information the question is asking for? Sometimes the options are correct but do not give the information the question is asking for.

Example: A patient is 88 years old and has previously been alert, oriented, and active. The nursing assistant reports that on awakening this morning, the patient was disoriented and confused. What initial action would the nurse take to determine the possible cause of this change in the patient's behavior?

1. Review the history for any previous episodes of this type of behavior.
2. Call the health care provider and discuss the changes in the patient's behavior.
3. Do a thorough neurological evaluation to evaluate the specific changes in behavior.
4. Evaluate for the presence of a urinary tract infection and for adequate hydration.

Answer: 4. Option 4 is the only answer that supplies what the question asked for ". . . determine the possible cause of this change. . . ." The most common cause of a sudden change in the behavior of a geriatric patient is a significant physiological change, often an infection (commonly in the urinary tract) or dehydration. Options 1 and 3 relate more to the gradual behavior changes seen in the progression of dementia and do not answer what the question asked "to determine the possible cause..." Option 2 does not provide any assistance in determining the cause of the behavior change; further nursing assessment needs to be conducted before calling for assistance.

Alternate Format Questions

In an effort to improve and more effectively assess the entry-level nurse, the NCSBN has introduced “alternate format questions” to the examination. Since 1999, the NCSBN has been investigating the use of questions that do not conform to the standard four-option, multiple-choice format. These questions were included on the NCLEX beginning in April 2003. There is no established percentage of alternate format items a candidate will receive. The alternate format questions that have been previously validated are placed in the item pools. It has been predicted that a candidate who answers the minimum number of questions may receive one alternate format question. However, it is important to consider that there are going to be 15 pretest items in the first 75 questions on each candidate’s test. Within those 15 items, there may be several pretest or unscored alternate format items. It is important to answer all the questions to the very best of your ability because you do not know which questions are scored items and which are pretest items.^{3,4}

The alternate format questions should not have any impact on what or how to study. The content on the alternate format questions is from the same test plan as the other questions. The test-taking strategies are essentially the same with minimum modification. In other words, there is no reason to be alarmed about the alternate format questions; they are testing the same information, just in a different type of question.

Multiple-Response Items

Multiple-response items will require the candidate to select all of the options that apply to the question. The items have more than four options from which to select and will clearly state, “Select all that apply.” Using the mouse, the candidate will select each item to be included in the answer. As with the standard multiple choice answers, the answer is either right or wrong. If the candidate does not select all of the correct options that apply to the question, the answer will be considered wrong.

Testing Strategy: Think about the situation. Standard plus respiratory precautions will be used for this patient.

What is added to standard precautions when respiratory or droplet precautions are included? Go through all of the options and decide which options are true and are something the nurse should do, then select all of the true options that apply to this patient.

Answer: Options 1, 4, and 5. In option 1, the nurse is going to be providing morning care and having direct contact with the patient; therefore gloves should be worn. Option 2, the suctioning supplies should be left in the room. Option 3, the gown and mask are disposed of in the patient’s room. Option 4, a mask is necessary if the nurse is to come within 3 feet of the patient, which the nurse can expect to do when providing or assisting with morning care. Option 5, a gown should be worn because the nurse is going to be close to and have direct contact with the patient. Option 6, the stethoscope should not be taken into the patient’s room; if it is taken into the room, it should be left in the room.

Fill in the Blank

Fill in the blank questions may be used for medication dosage calculations, IV drip calculations, or intake and output calculations—just to name a few. A drop-down calculator is provided on the computer screen. With calculation questions, determine which unit of measurement will be needed for the final answer. Check the items necessary to make this calculation. Are they all in the same unit of measurement, or do some of the items need to be converted? For example, will it be necessary to make conversions from grams to milligrams, liters to milliliters, or kilograms to pounds? Make sure all of the units of measure needed in the final answer are in the same system of measurement. Only the number will be placed in the answer box; no unit of measurement will be entered in the answer box.

Memorize the formulas necessary to calculate the drug dosages and conversions. Do not round any numbers until you have the final answer. You should not enter any other characters except those necessary to form a number. You cannot enter the unit of measurement in the answer space.

[NCLEX-RN]
⌚ Time Remaining 3:15:20

☒ Calculator

The nurse is caring for an 85-year old client who has a diagnosis of *Mycoplasma pneumoniae*. What precautions will the nurse implement in assisting the client with morning care?

Select all that apply:

- 1. Wear clean gloves.
- 2. Remove all extra suctioning supplies from the room.
- 3. Dispose of the gown and mask in container outside client’s door.
- 4. Wear face mask when working within 3 feet of the client.
- 5. Put on a gown prior to entering the room.
- 6. Remove the stethoscope from the room if it did not come in contact with the client.

Select the best response. Click the Next (N) button or the Enter key to confirm answer and proceed.
ITEM 21

Next (N)

Answer: The answer is based on standard precautions, plus respiratory precautions for the pneumonia. Nothing should be removed from the room and the gown should be removed prior to leaving the room, not outside the room.

[NCLEX-RN] Time Remaining 2:25:30

Calculator

A client is receiving IV antibiotic therapy. The order is for methicillin 750 mg IV. The nurse has a vial on hand that contains 1 g. The instructions for reconstitution say to add 1.5 mL sterile water. Reconstituted solution will contain 500 mg methicillin per milliliter. How much will the nurse give?

Answer: mL

Enter the correct answer. Click the Next (N) button or the Enter key to confirm answer and proceed. ITEM 20

Next (N)

Answer - 1.5 mL
 Rationale: 500 mg: 1 mL :: 750 mg: x
 Formula: $500 \times x = 500X$
 $1 \times 750 = 750$
 $X = 750/500 = 1.5$
 The dosage calculation cannot be made from the amount of solution added to the vial. The ratio of mg per mL after reconstitution is 500 mg per mL.

Hot Spot Questions

In a hot spot question, you will be presented with a graphic that will require identification of a specific item, area, or location on the graphic. Find the spot and click on it with the mouse.

Answer: The “hot spot” or correct area to assess the apical heart rate is at the PMI, or point of maximum impulse, which is located at the fifth intercostal space, just to the left of the sternal border. In this situation, you would place the mouse over the area and click on that area.

Drag and Drop

In a drag-and-drop question, there will be several steps or actions to place in a correct sequence. All of the options will be used, but you will be required to place them in an ordered sequence. The first thing to do is to decide in what order you want to place the options or rank the actions. Determine what is the first or priority action, then the next one. After you have determined your answer, you will click on the option you want to place first and “drag” that option over and place it in the box. You will then select the option you want to place second and “drag” that option over and place

it in the box. You will continue this process until you have used all of the options present.

Answer: The patient should be placed in a semi-Fowler’s position before oxygen administration is started; an antipyretic medication should then be given. This action addresses current needs. Encourage intake of clear liquids to decrease viscosity of secretions, then provide instruction regarding risk factors.

Chart or Exhibit Items

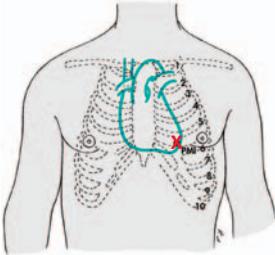
In this type of question, a patient situation or problem and patient information will be provided in a chart or an exhibit. You will need to read the information in the exhibit or the chart to answer the question. You will click on the tab on the bottom of the screen to see the exhibit, then click on the tabs within the exhibit to find the information you will need to answer the question. There may be several tabs to click on.

Interpretation of information: Patient received Demerol 50 mg IM at 11:00 AM and was lethargic and sleeping for the next 5 hours. He received hydrocodone PO at 4:00 PM and was comfortable for

[NCLEX-RN] Time Remaining 3:15:40

Calculator

The nurse is caring for a client who is receiving .25 mg Digoxin each morning. On the graphic, identify the correct location where the nurse should place the stethoscope to determine the client’s pulse.



Select the best response. Click the Next (N) button or the Enter key to confirm answer and proceed. ITEM 22

Next (N)

Answer: To evaluate the apical pulse the stethoscope should be placed on the area of the PMI - left midclavicular line, 5th intercostal space. To answer this question, you would simply click the area on the graphic. The correct location is noted in the figure.

[NCLEX-RN] Time Remaining 2:15:20

Calculator

The nurse is caring for a client with pneumonia. He is dyspneic, his temperature is 102° orally, and he is complaining of chest pain. In what order would the nurse provide care for this client?

Place all of the actions below in the order of priority for nursing care. Use all of the options.

Unordered options:

- Encourage clear fluids
- Administer humidified oxygen
- Place in Semi-Fowler's position
- Administer anti pyretic medication
- Instruct client regarding risk factors

Ordered Response:

- Place in Semi-Fowler's position
- Administer humidified oxygen
-
-
-

Select the best response. Click the Next (N) button or the Enter key to confirm answer and proceed. ITEM 23

Next (N)

Need to know: Review each of the items in the list. Determine what is the most important action to take first, then second, etc. This question is asking you to provide care for a client who is experiencing difficulty breathing and has chest pain. The dyspnea and chest pain are most likely a result of the client's pneumonia. Position is the first thing that you can do that will benefit the client the most, then begin the oxygen, administer the antipyretic medication, encourage clear liquids, and teaching is last. Remember Maslow when setting priorities.

the next 4 hours. The doctor's orders are current for both the IM and the PO medication for pain.

Answer: 4. Give the hydrocodone, PO, for pain at this time. It held him for 4 hours the last time, and the doctor's order is current.

Therapeutic Nursing Process: Principles of Communication

Throughout the examination there will be questions requiring use of the principles of therapeutic communication. In therapeutic communication questions, don't assume the

[NCLEX-RN] Time Remaining 3:20:10

Calculator

A postoperative client complains of pain, the nurse assesses the client and determines the pain is in the abdomen around the area of the incision, pain level is 6. It is 8 p.m. in the evening and the nurse is determining what can be done regarding the client's pain. Select the best answer based on the information in the chart.

Exhibit

- 1. Give 50 mg Demerol, IM now.
- 2. Medication cannot be administered.
- 3. Give 75 mg Demerol, IM now.
- 4. Give hydrocodone (Vicodan) 10 mg PO.

Select the best answer based on information in the exhibit. Click the Next (N) button or the Enter key to confirm answer and proceed. ITEM 24

Next (N)

Need to know: Click on the first exhibit and evaluate the information.

[NCLEX-RN] Time Remaining 3:20:15

Calculator

A postoperative client complains of pain, the nurse assesses the client and determines the pain is in the abdomen around the area of the incision, pain level is 6. It is 8 p.m. in the evening and the nurse is determining what can be done regarding the client's pain. Select the best answer based on the information in the chart.

Exhibit

- 1. Give 50 mg Demerol, IM now.
- 2. Medication cannot be administered.
- 3. Give 75 mg Demerol, IM now.
- 4. Give hydrocodone (Vicodan) 10 mg PO.

1. Nursing notes:

Need to know: How well did the pain medication hold the client the last time he received it?

Information:

6 a.m.	- complaining of abdominal pain around area of incision; pain level 7.
	- pain medication administered.
11 a.m.	- sleeping throughout the day, lethargic, but easily aroused.
4 p.m.	- complaining of abdominal pain around incisional area, pain level 5.
	- pain medication administered, was free of pain and resting comfortably within 30 minutes.
6 p.m.	- remains comfortable.
8 p.m.	- beginning to complain of abdominal incisional pain.

Select the best answer based on information in the exhibit. Click the Next (N) button or the Enter key to confirm answer and proceed. ITEM 24

Next (N)

[NCLEX-RN] Time Remaining 3:20:20

Calculator

A postoperative client complains of pain, the nurse assesses the client and determines the pain is in the abdomen around the area of the incision, pain level is 6. It is 8 p.m. in the evening and the nurse is determining what can be done regarding the client's pain. Select the best answer based on the information in the chart.

Exhibit

- 1. Give 50 mg Demerol, IM now.
- 2. Medication cannot be administered.
- 3. Give 75 mg Demerol, IM now.
- 4. Give hydrocodone (Vicodan) 10 mg PO.

2. Medication administration record (MAR):

Need to know: What medication did he receive last, and when was it given?

Medication Administration Record (MAR):

Demerol 50 mg IM administered at 8 a.m.

Hydrocodone 10 mg, PO administered at 4 p.m.

Select the best answer based on information in the exhibit. Click the Next (N) button or the Enter key to confirm answer and proceed. ITEM 24

Next (N)

[NCLEX-RN] Time Remaining 3:20:30

Calculator

A postoperative client complains of pain, the nurse assesses the client and determines the pain is in the abdomen around the area of the incision, pain level is 6. It is 8 p.m. in the evening and the nurse is determining what can be done regarding the client's pain. Select the best answer based on the information in the chart.

Exhibit

- 1. Give 50 mg Demerol, IM now.
- 2. Medication cannot be administered.
- 3. Give 75 mg Demerol, IM now.
- 4. Give hydrocodone (Vicodan) 10 mg PO.

3. Doctor's orders:

Need to know: What was the original order for pain control?

Orders for the last 24 hours include:

Demerol 50-75 mg, IM, every 3-4 hours for severe pain.

Hydrocodone (Vicodan) 10 mg PO, every 3-4 hours moderate pain.

Select the best answer based on information in the exhibit. Click the Next (N) button or the Enter key to confirm answer and proceed. ITEM 24

Next (N)

[NCLEX-RN] Time Remaining 3:20:40

Calculator

A postoperative client complains of pain, the nurse assesses the client and determines the pain is in the abdomen around the area of the incision, pain level is 6. It is 8 p.m. in the evening and the nurse is determining what can be done regarding the client's pain. Select the best answer based on the information in the chart.

Exhibit

- 1. Give 50 mg Demerol, IM now.
- 2. Medication cannot be administered.
- 3. Give 75 mg Demerol, IM now.
- 4. Give hydrocodone (Vicodan) 10 mg PO.

Select the best answer based on information in the exhibit. Click the Next (N) button or the Enter key to confirm answer and proceed. ITEM 24

Next (N)

Need to know: Analysis of information.
 Client received Demerol 50 mg IM at 11 a.m. and he was lethargic and sleeping for the next 5 hours. He received hydrocodone PO at 4 p.m. and he was comfortable for the next 4 hours. The doctor's orders are current for both the IM and the PO medication for pain. Give the hydrocodone, PO for pain at this time. It held him for 4 hours the last time, and the doctor's order is current.

patient is being manipulative or is in control of how he or she feels. Psychosocial problems or mental health problems are most often not under the conscious control of the patient.



ALERT: *Listening to a patient's concerns, assessing a patient's response to illness, establishing a trusting nurse-patient relationship; active listening skills are areas of the psychosocial component.*

- **Situations requiring use of therapeutic communication are not always centered around a psychiatric patient.** Frequently, these questions are centered on the patient experiencing stress and anxiety. There may be questions relating to therapeutic communication in the care of patients experiencing stress, anxiety, or a change in body image as a result of physiological problems.
- **Look for responses that focus on the concerns of the patient.** Do not focus on the concerns of the nurse, hospital, or physician. Determine whether the patient is the central focus of the question or whether the question pertains to a spouse or significant other.
- **Watch for responses that are open ended and encourage the patient to express how he or she feels.** Patients frequently experience difficulty in expressing their feelings. Focus on responses that encourage a patient to describe how he or she feels. These are frequently open-ended statements made by the nurse.
- **Eliminate responses that are not honest and direct.** To build trust and promote a positive relationship, it is important to be honest with the patient. Telling the patient, “don’t worry,” “everything is going to be all right,” or “your doctor knows best” will be wrong answers.
- **Look for responses that indicate an acceptance of the patient.** Regardless of whether the patient’s views or moral values are in agreement with yours, it is important to respect his or her views and beliefs. This is not the time to tell the patient what he or she should or should not be doing (e.g., don’t tell the alcoholic that he or she should quit drinking or the depressed patient that he or she should not feel that way).
- **Be careful about responses that give opinions or advice on the patient’s situation.** Don’t assume an authoritarian position; you should not insist that the patient follow your advice.
- **Do not select responses that block further interaction.** These are frequently presented as closed statements or questions that encourage a yes or no answer from the patient. Better responses are those that indicate an expectation of a more verbal response from the patient. **Examples:** “Are you feeling better today?” The patient can just answer no to this question. It is better to ask, “How are you feeling today as compared to yesterday?” It is better to ask, “How did you feel when your family visited today?” than “Did your family visit today?”
- **Look for responses that reflect, restate, or paraphrase feelings the patient expressed.**
- **Don’t ask “why” a patient feels the way he or she does.** Frequently, if a patient understood why he or she felt a certain way, the patient would be able to do something about it. The most common answer when a nurse asks a patient why he or she feels this way is “I don’t know,” and that does not help anyone.
- **Don’t tell the patient how he or she should or should not feel.** Look for responses that encourage the patient to describe how he or she feels; responses that reflect, restate, or paraphrase feelings expressed. A wrong answer is “You should not feel depressed.” It is better to ask, “How did that make you feel?”
- **Do not use coercion to achieve a desired response.** Don’t tell patients that they can’t have their lunch until they

get out of bed or bribe children to take their medicine with a promise of candy.

- **See examples of therapeutic and nontherapeutic communication in Chapter 9.**

TIPS FOR TEST-TAKING SUCCESS

- **Do not indiscriminately change answers.** On a paper and pencil test, if you go back and change an answer, you should have a specific reason for doing so. Sometimes you do remember information and realize you answered the question incorrectly. However, frequently students “talk themselves out” of the correct answer and change it to the incorrect one. The good news is that you cannot go back to previously answered questions on the NCLEX. At the point at which the examination asks you to confirm your answer, review the strategies used to answer the question, confirm your answer, and move on to the next question.
- **Watch your timing. Do not spend too much time on one question.** It is very important to track your timing on practice exams. This will help you be more comfortable with timing on computer testing. The NCLEX will allow you a total of 6 hours to complete the examination. You should plan to spend about a minute on each question. Some questions you will answer quickly; others may take some time. Don’t spend more than 2 minutes deliberating the answer to a question. If you don’t have a good direction for the right answer in 2 minutes, then you probably don’t know the answer. Eliminate all of the options you can, pick the best one, and move on. (Remember: You are not supposed to know all of the right answers.)
- **The NCLEX is a nursing competency examination, and the correct answer will focus on nursing knowledge and the provision of nursing care.** It does not focus on medical management or making a medical diagnosis.
- **Eliminate distractors that include the assumption that the patient would not understand or would be ignorant of the situation and those distractors that protect patients from worry.** For example, “The patient should not be told she has cancer because it would upset her too much.”
- **There is no pattern of correct answers.** The exam is compiled by a computer, and the position of the correct answers is selected at random. So, don’t believe those who say to pick answer 3 when you are guessing.

STUDY HABITS

Study Effectively

1. **Use memory aids, mind mapping, and mnemonics.** Memory aids and mind mapping are tools that assist you in drawing associations from other ideas with the use of visual images (Figure 1-3). Mnemonics are words, phrases, or other techniques that help you remember information. Images, pictures, and mnemonics will stay with you longer than information that you have read.
2. **Develop 3 × 5 cards with critical information.** Don’t overload the card; put a statement or question on one side

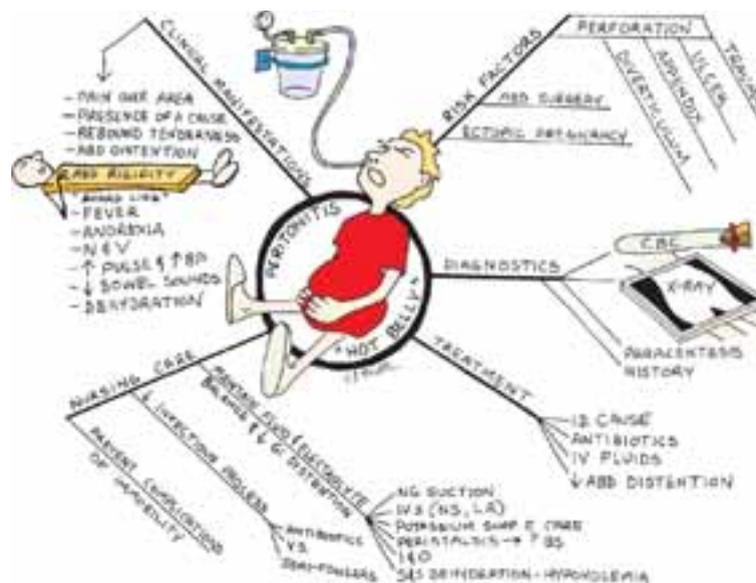


FIGURE 1-3 Peritonitis: “Hot Belly.” (From Zerwekh J, Claborn J: *Memory notebook of nursing*, vol 1, ed 3, Ingram, Texas, 2004, Nursing Education Consultants.)

and answers or follow-up information on the other side. For example, on one side you might put “low potassium,” and on the other side you would put the values. Another card might be “nursing care for hypokalemia,” and on the back, you could list the nursing care. These cards are much easier for you to carry than a load of books or class notes. When you have developed your set of cards with priority information, trade them with a friend and see what is on his or her cards. These can be used whenever you have only 15 to 20 minutes of study time. Take 20 cards with you to soccer practice, the doctor’s office, or anywhere you are going where you will have to sit and wait for a few minutes. This is quick, easy, and very effective.

3. **Review class notes the next day.** A very effective study habit to develop during school is to review the class notes the day after the class. Set aside about an hour on the day after the class and spend about 30 to 45 minutes reviewing the notes from class. Do the notes make sense to you, or are you unclear on the meaning of some of the areas? Correlate the notes and the visuals the instructor presented with the information in the textbook. It is important to take the time now to understand the information presented the previous day because it is fresher in your mind and you are more receptive to learning. By reviewing the information after the class presentation, you more effectively and positively reinforce the learning process.
4. **Plan your study time when you are most receptive to learning.** Don’t wait until the end of the day when you finish everything else. It is difficult to get up at 6:00 AM, work all day, deal with family activities, and finally study at 10:00 PM. You may feel guilty if you did not study for 2 hours that evening.
5. **Set a schedule and let everyone know the schedule.** For example, when you set aside 1 hour for review on the day after your class, make sure everyone knows this is your study time. Don’t expect your family to leave you alone while you study; this is frequently too much to ask

of children and spouse. Go to the library, nursing school, or someone’s house where there are no disturbances.

6. **Start planning your NCLEX review at the beginning of your last semester in school or 2 to 3 months before you will take the NCLEX.** Do not wait until the week before the exam to start reviewing. Even if you were an “A” student, you still need to review. Information that was presented at the beginning of school, last year, or even last semester may not be current in your knowledge base.

Set a Study Goal

1. Decide on a study method.
2. Divide the review material into segments.
3. Prioritize the segments; review first the areas in which you feel you are deficient or weak. Leave those areas you are the most comfortable with and most knowledgeable about for last.
4. Identify areas that will require additional review in a basic nursing textbook, and correlate this information in a review book.
5. Establish a realistic schedule and follow it. Planning for 8 hours of studying on your day off does not work. Instead, plan for 2 to 4 hours each day (in 20- to 30-minute chunks of time) and maybe 3 to 4 hours on your days off.
6. Plan on achieving your study goal several days before the examination.

Group Study

1. Limit the group to four or five people.
2. Group members should be mature and serious about studying.
3. The group should agree on the planned study schedule.
4. If the group makes you anxious or you do not feel it meets your study needs, do not continue to participate.
5. Group study is very effective with the right mix of participants.

Testing Practice

1. Include testing practice in your schedule.
2. Structure your practice testing.
 - Plan for answering one question per minute; if you have 45 minutes to study, then try answering about 30 questions. This will allow you time to review your answers.
 - Evaluate your comfortable pace for answering questions; this will keep you on target with your timing as you practice answering test questions.
 - Do not answer a question and then go look up the correct answer. Answer all of the questions in the section you have set aside, and then review the correct answers. This will reinforce your test-taking strategies and your test timing.
3. Try to answer the questions as if you were taking the real exam.
4. Use the testing strategies and practice on the questions included in the book and on the CD.
5. Evaluate each of the practice exams for problem areas.
 - Test-taking skills: Did you know the material but answer the question incorrectly? In this case, a test-taking strategy can be applied; go back and review the strategies. Can you identify what strategy you should have used to identify the correct answer? By becoming aware of your test-taking habits, you will become more aware of the strategies you need to implement and then you can begin to practice them more effectively.
 - Knowledge base: You did not know the material. Make a note of these areas and see whether the content begins to show trends or clusters of information in areas you need to study/review.
6. Evaluate the questions you answer incorrectly. Review the rationale for the right answer and understand why you missed it.
7. Use the questions at a later point to review the information again.
8. A computer disk with additional practice questions can be found in the back of the book. The more questions you practice answering, the more effectively you will implement test-taking strategies.
9. Do something pleasant the evening before the examination. This is not the time to “cram.”
10. Anxiety is contagious. If those around you are extremely anxious, avoid contact with them before the examination.
11. Carefully consider whether you want to go to the testing site with anyone else. If the other person finishes before you do, will it put increased pressure on you to hurry up and finish? You don’t need any additional pressures on the day of the exam or while you are taking it.
12. Make your meal before the test a light, healthy one. Avoid eating highly spiced or different foods. This is not the time for a gastrointestinal upset.
13. Wear comfortable clothes. This is not a good time to wear tight clothing or new shoes.
14. Wear clothing of moderate weight. It is difficult to control the temperature to keep everyone comfortable. Wear layers of clothes that can be removed if you get too warm.
15. Wear soft-soled shoes; this decreases the noise in the testing area.
16. Make sure you have the ATT papers that are required to gain admission to the exam site. Don’t forget your photo ID.
17. Do not take study material to the exam site. You cannot take it into the exam area, and it is too late to study.
18. Do not panic when you encounter a clinical situation you have not heard of or a situation that increases your anxiety. Take a deep breath, close your eyes, and take a “mini” vacation to one of your very favorite places. Give yourself about 30 to 45 seconds, then return to the question. You may have a different perspective on the question. Use good test-taking strategies, select an answer, and continue.
19. Reaffirm to yourself that you know the material. This is not the time for any self-defeating behavior or negative self-talk. **YOU WILL PASS!!** Build your confidence by visualizing yourself in 6 months working in the area you desire. Create that mental picture of where you want to be and who you want to be—an RN. Use your past successes to bring positive energy and “vibes” to your NCLEX Exam. **WE KNOW YOU CAN DO IT!**

DECREASE ANXIETY

Your activities the day of the examination strongly influence your level of anxiety. By carefully planning ahead, you will be able to eliminate some anxiety-provoking situations.

1. Visit the examination site before the day of the exam. Evaluate travel time, parking, and time to get to the designated area. Get an early start to allow extra time; you need to arrive at the site 30 minutes before your scheduled testing time.
2. If you have to travel some distance to the examination site, try to spend the night in the immediate vicinity. Don’t cram four or five people in one room. Everyone needs his or her own bed!

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