Think like a nurse. Apply your knowledge.

An aspiring RN is at the test center, taking the NCLEX exam. What is the best way to approach the questions that contain several options as part of the answer?

Answer is located on page 1–6.

1.1 NCLEX 411

The National Council Licensure Examination (NCLEX-RN)

- NCLEX-RN is administered to all pre-licensure nursing candidates and measures the competencies that a newly graduated nurse is expected to perform in a safe and effective manner.
- The exam is reviewed and approved by the NCLEX examination committee every 3 years.
- The test plan for NCLEX should coincide with state nurse practice acts.

Cognitive Levels Tested in Exam

- NCLEX employs cognitive levels adapted from Bloom’s taxonomy.
- These levels include (ranked, top to bottom, from easiest to most challenging):
  - Knowledge
  - Comprehension
  - Application
  - Analysis
  - Synthesis
  - Evaluation
- For the NCLEX exam, most questions are at an application level or higher, which is the level that you have been tested at in nursing school.
- Junior nursing students are presented with knowledge- and understanding-level questions, but by the time they reach the graduation stage, these students are expected to use critical thinking that requires synthesis of concepts and application of skilled analysis to a patient need or problem, to help achieve expected patient outcomes.

Organization of Exam Categories

- NCLEX was designed around a framework of patient needs, since nursing practice is built around decisions made in regard to the needs of our patients:
  - When making clinical decisions, issues of culture, background, comorbidities, knowledge, and education level, and ability to discuss and comply with a prescribed treatment regimen must be taken into consideration
  - It is of fundamental importance to the practice of nursing to test the knowledge, skills, and abilities of the nurse in order to license a safe and competent beginner who is able to successfully care for a diverse group of patients
- NCLEX tests four major patient needs categories:
  1. Safe and effective care environment: The nurse provides and directs nursing care that enhances achievement of patient outcomes while protecting patients and health care personnel:
     - Management of care: Regulatory information (advocacy, delegation, patient rights, informed consent, and more)
     - Safety and infection control: Safety in care environments, equipment use, standard precautions, and emergency response
  2. Health promotion and maintenance: Health promotion through the lifespan; health screening, including genetics, lifestyle choices, and physical assessment techniques
  3. Psychosocial integrity: The therapeutic environment, adaptive processes, mental health, stress management across the lifespan, and alteration in sensorium
  4. Physiological integrity:
     - Basic care and comfort: Performance of activities of daily life (ADLs), assistive devices, nutrition and oral hydration, elimination, and rest and sleep
     - Pharmacological and parenteral therapies: Medication administration, parenteral therapies, adverse effects, expected outcomes of therapy, central venous access devices (CVADs), dosage calculations, and blood and blood products administration
     - Reduction of risk potential: Interpretation of changes in vital signs, laboratory and diagnostic tests and complications related to procedures, and therapeutic procedures
     - Physiological adaptation: Recognition of fluid and electrolyte imbalance, and pathophysiology and responses to unexpected emergencies

NCLEX and the Nursing Process

- On the exam, elements of the nursing process are interwoven with the categories of patient needs:
  - Caring: The philosophy of trust and mutual respect that is achieved within the therapeutic relationship
  - Communication and documentation:
     - The verbal and nonverbal items that constitute the nurse-patient relationship and the information regarding therapies, interventions, and events that require documentation
     - Documentation must adhere to regulatory standards and accountability requirements
Unit 1 • Guidelines

- **Teaching/learning**: The acquisition of knowledge skills and attitudes promotes a change in behavior
- **Culture and spirituality**: The way that the nurse involves and incorporates self-identified preferences in care and unique patient needs in order to facilitate optimization of patient recovery from illness

**Distribution of Content**
- Percentage of test questions assigned to each category is displayed in Figure 1–1.

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physiological Adaptation</td>
<td>14%</td>
</tr>
<tr>
<td>Management of Care</td>
<td>20%</td>
</tr>
<tr>
<td>Reduction of Risk Potential</td>
<td>12%</td>
</tr>
<tr>
<td>Pharmacological and Parenteral Therapies</td>
<td>15%</td>
</tr>
<tr>
<td>Basic Care and Comfort</td>
<td>9%</td>
</tr>
<tr>
<td>Safety and Infection Control</td>
<td>9%</td>
</tr>
<tr>
<td>Health Promotion and Maintenance</td>
<td>9%</td>
</tr>
<tr>
<td>Psychosocial Integrity</td>
<td>9%</td>
</tr>
</tbody>
</table>

**Figure 1–1 Distribution of Content for the 2016 NCLEX-RN® Test Plan**

**Registration for NCLEX**
- Submit application to the state where you want to be licensed.
- Register for the NCLEX exam.
- You will receive an acknowledgment of receipt.
- The Board of Nursing will decide if you are eligible to sit for the exam.
- You should receive your Authorization to Test (ATT) within 2 weeks—you cannot schedule to test until you have received your ATT form.
- There is a fee for taking the exam.
- If you need to change the date of your test, you can do so online, or by calling candidate services.
- Failing to appear on your test date means you will need to re-register, repay, and reschedule the exam.

**Study Preparation**
- In preparing for NCLEX, use a study plan that you know works best for you:
  - What type of learner are you?
  - What type of study habits did you have during nursing school?
  - Did you study in groups, or alone?
  - Did you take notes, or draw diagrams to help you to learn information and to apply it effectively?
- Strategize a plan:
  - Ensure that you obtain and use a great study guide—like this one!
  - If you can, access and work through at least 3,000 practice questions:
    - Consult online resources, bookstores, and nursing libraries to find these practice questions
  - By attempting to answer at least 3,000 questions, you vastly increase your exposure to the different types of questions that you may encounter in the test, and thereby increase your chances of success
- Remember to study well in advance of the exam.
- Remember to take care of yourself and nurture yourself holistically as you prepare to lessen stress.
- Remember that physical activity is a good distraction and promotes the release of endorphins that can facilitate concentration when you return to your studies.

**Day Before Exam**
- The night before the test (whether spent in a hotel or not):
  - Try to relax
  - Put away notes
  - Enjoy time with family and friends
  - Know that you have done all you can
  - Get a good night’s sleep

**Exam Day**
- Eat a nutritious breakfast that will give you the energy needed to focus during the exam.
- Know your destination—have your route and the time required to get there figured out before you begin your journey.
- Get to the testing center early, about 30 minutes before the test—there may be a large number of people at the location, which may slow down the entry and the processing of test takers.
- If you arrive late to the testing center, you may have to forfeit your chance to take the test, and then begin the registration process over.
- Bring the following:
  - ATT
  - Palm vein scan
  - Two forms of ID:
    - Driver’s license
    - U.S. state identification
    - Passport
    - U.S. military identification
  - Your identification MUST have the correct name and address spelled exactly as it is on your application form or you will not be allowed to take the examination.
  - Your fingerprints and photograph will be checked during your identification and processing for the exam.

**Exam**
- Palm vein scan and digital fingerprint, as well as digital signature and photo ID, will be required before entering the room.
- Do not bring anything in with you to the testing room—no notes, cell phone, gum, food, drinks, etc.
- You will be watched and recorded during the test.
- No talking with anyone.
- Note board will be provided and must be returned after the test.
- The exam is administered by computer.
- Test administrator will escort you to your assigned computer.
- There will be a tutorial prior to starting.
- If you become distracted by others typing on their computers, you may raise your hand to request ear plugs from the test administrator.

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You will be given 6 hours to complete anywhere from 75–265/275 questions.

The 15 pretest questions are not scored.

Only the true questions are scored; the rest of the questions are not scored—you will not know the difference between these questions.

Breaks are built into the exam, but are optional:
- If you go on break, your palm vein scan, digital fingerprint, digital signature, and photo ID will be required before you can re-enter the testing room and resume the test.
- Keep moving forward in the exam—there is no going back to a question to review or change your answer.
- You must answer every item.
- Do not guess in order to progress faster—this will rapidly and drastically reduce your score due to the way the test is administered.

Types of Questions
- Multiple choice
- Select all that apply/multiple response
- Prioritization
- Fill-in-the-blank: These usually involve calculations, IV flow rates, etc.
- Complete a diagram/labeling/answer a question related to an image on the screen
- Video or audio scenarios with the choice of appropriate responses to a given question
- Chart/exhibit questions: Three answer options are available to provide more information for the question scenario

Passing Standard
- NCLEX-RN is adaptive, meaning that the test adapts to your ability to apply concepts so that maximum assessment is achieved with the fewest number of questions.
- Do not overanalyze anything, simply approach each question as a unique and stand-alone item.
- You may get test items that seem similar—this does not mean that you answered the previous question incorrectly, it may mean that you are being tested on a different element of that content, or from a different perspective.
- Results are calculated by:
  - 95% confidence interval rule: This means that the computer will end the test whenever its algorithm has determined (with 95% confidence) that you are either above or below the assigned passing standard.
  - Maximum-length exam:
    - If your ability level is assessed to be very close to the passing standard, the computer will continue to administer questions until the maximum number is reached
    - In this case, the computer will calculate the percent of questions answered correctly without regard for the 95% rule
    - If the final score is below the passing standard, the candidate is unsuccessful
  - Run-out-of-time rule:
    - If the candidate runs out of time before answering the maximum number of items, and the 95% rule cannot apply, the candidate fails.

If the minimum number of questions has been answered, the computer assesses ability based on the last 60 questions—if the student has been consistently above the standard, he or she passes; if the student falls below the passing standard, he or she fails.

There is no partial credit—all answers are either correct or incorrect.

Reaching 265/275
- The computer will automatically stop when it determines whether you have passed or failed.
- Some candidates are randomly selected to complete a “full” test:
  - Just because you have to answer 230 questions does not necessarily mean that you have failed
  - You may simply be one of those randomly selected by the computer program to answer the full test
- Do not judge your performance at the end of the test.

Post Exam/Results
- Results are confidential.
- Results are sent to the Board of Nursing, which records the results and sends them to you.
- Exam results are mailed approximately 1 month after the test.
- “Unofficial” results are posted on the NCLEX website 48 business hours following the test.
- If you should happen to fail, a summary report is provided, and you must wait 45–90 days before testing again, depending on the laws in your state.

Passing the Exam!
- You receive an RN license number.
- You are a professional, with an example to set in the world.
- You have joined the most trusted family of professionals as declared by our patients in Gallup Polls for years now.
- Always do your best to advocate for your patients, give the best care to the highest possible standard, and cherish yourself as a new nurse.

1.2 Strategies for Answering NCLEX Questions

The NCLEX
- The exam sets out to assess your ability to analyze clinical scenarios, make informed clinical decisions regarding options for care (apply knowledge), and facilitate optimal patient outcomes—just as you would be required to do in the real-world clinical setting.
- The test is not about recall and memorization.
- Your nursing school should have encouraged maximum exposure to the analysis and application-type NCLEX questions during your training, including:
  - Critical thinking skills
  - Priority decisions
  - Complex health-related situations
  - Implications for nursing actions
Unit 1 • Guidelines

Live the Gold Standard of Nursing

- NCLEX world of best practices
- Ideal nursing practice
- Choose answers that reflect what your textbook or professional journals would say.
- Real-world nursing is complicated by issues that sometimes interfere in implementing what textbooks advise, but the NCLEX test is designed to assess your ability to apply knowledge and concepts within the scope of the scenario you will see on the NCLEX exam. Do not “read into” questions; if you are given information you can only apply that specific information to your response.
- Each question will provide you with the information you need to answer the question at the level of beginning application.

Identify the Topic of the Question

- Read the stem of the question carefully.
- Determine whether there is any information that you can discard once you decide exactly what is being asked in the question.
- Tease out the significant information—look for key words that indicate exactly what information is relevant to answering the question correctly.
- Discard background information—sometimes you are given information about a condition or situation that really is not useful in answering the question.

Question Example

The nurse is administering a beta-blocker to a patient with heart failure who is experiencing shortness of breath. The patient’s vital signs are T=98.2; P=96; R=32; BP=146/95 mmHg; SaO₂ 88% in O₂ at 2 L/min via N/C. What is the purpose of this medication?

This question is really testing the RN candidate’s knowledge of beta-blockers and his or her ability to apply this knowledge to the drug action in this scenario. The information about the patient’s vital signs is really meaningless in the sense that the RN candidate does not need to know the patient’s vital signs to answer the question, just how medication assists a patient with heart failure. Therefore, the vital signs can be discarded as a distractor.

Do Not Add Information to the Question

- Don’t make assumptions about the patient’s condition that are not made explicit in the question stem—only consider the information given.
- Reword the question.
- Use a few key words.
- Do not rush to find an answer that “sounds” right.
- Do not rush to discard an answer that “sounds” wrong.

Question Example

The nurse is providing discharge teaching to the parents of a newborn boy. The nurse should instruct the parents to:

a) Place the infant in a car seat, front facing on the back seat of the car.
b) Place the infant in a car seat, rear facing on the back seat of the car.
c) Have the mother sit in the back seat, holding the infant in her lap.
d) Have the mother sit in the front seat, holding the infant in her lap.

When the Topic Is Not Apparent

- Read the answers.
- Determine what question the answers could apply to.
- Determine the question.
- Choose the best answer.

Question Example

The nurse is providing care to a patient in skin traction. The most important nursing action is to:

a) Assess intake and output.
b) Assess for signs of infection around the pin site.
c) Assess for signs of skin breakdown.
d) Assess for urinary incontinence.

What if All Answers Are Correct? (Priority Type Questions)

- Determine which answer is most important—READ the question carefully until you understand what exactly it is asking.
- Sometimes all of the answers may seem to be appropriate—which is the most appropriate/best answer/first priority?
- Prioritize in order of the ABCs when appropriate.
- Would there be a negative outcome for your patient if you did not choose a particular answer?

Question Example

A 75-year-old patient had a PEG placed 2 days ago. She is now receiving an enteral feeding, Jevity 1.0, full strength at a rate of 100 mL/hr. Four hours after the first feeding, the patient started having diarrhea. The nurse should FIRST...

a) Discontinue the enteral feeding.
b) Decrease the feeding rate.
c) Request a nutritional consult.
d) Dilute the formula and administer half-strength formula.
“Worst of the Worst” Questions
◆ What are you most concerned about?
◆ What would have the greatest negative outcome for the patient?
  ● ABC priorities always come into play here
◆ What is a complication?
◆ What are you most worried about?

“Best of the Best” Questions
◆ What would have the greatest positive outcome for the patient?
◆ “ABC” question.

**Question Example**
The nurse is caring for a school-aged child following a tonsillectomy. The nurse is most concerned about which of the following findings?
- a) Dark-brown blood emesis
- b) Shallow respiration
- c) Flushed face
- d) Frequent swallowing

“Further Instruction Is Needed…”
◆ Sometimes, the question wants you to identify whether or not a patient has grasped patient-teaching concepts.
◆ Make sure you read exactly what the question is looking for:
  ● Is it that the patient understood the instruction, or that the patient needed further instruction?
◆ Look for an incorrect statement in the answer options.
◆ Which statement is wrong?

“The Patient Understands When…”
◆ Look for a correct statement.
◆ Which statement is right?

**Question Example**
A patient with a diagnosis of clinical depression has recently been placed on a monoamine oxidase inhibitor (MAOI). Which of these statements indicates the need for further patient teaching?
- a) “I usually take my medication at bedtime.”
- b) “I do not drink alcoholic beverages while I’m on the medication.”
- c) “I only eat cottage and cream cheese.”
- d) “I had my brother drive me around to do some errands.”

Delegation Questions
◆ A licensed nurse (LPN/LVN or RN) should always be aware of the scope of practice of those to whom they are delegating tasks:
  ● Licensed practical nurse (LPN) (supervised by RN):
    - Stable patients with predictable outcomes
    - No patients needing assessment, teaching
    - No patients needing complex care or procedures
    - Tube feedings—stable ostomies, NG tubes, stable post-op patients
  ● Unlicensed assistive personnel (UAP) (supervised by RN):
    - Stable patients
    - No assessment, no teaching
    - Personal care activities
    - Bathing, dressing, toileting, oral hygiene
    - Range of motion, ambulation
    - Simple lab specimens—urine, stool

**Question Example**
The RN is planning patient assignments on a medical unit. The nursing team consists of a registered nurse, a licensed practical (vocational) nurse, and two unlicensed assistive personnel (nursing assistants). Which of the following patients should the RN assign to the LPN (LVN)?
- a) A patient who requires a clean catch urine
- b) An elderly patient needing assistance with a bed bath and ambulation
- c) A patient on mechanical ventilation needing frequent assessment and suctioning
- d) A patient with an abdominal wound who needs a daily dressing change

Focus on the Patient
◆ Never leave the patient alone.
◆ In the NCLEX world, the nurse always has enough time to be with the patient.
◆ Presence of the nurse is therapeutic.

**Question Example**
When the nurse tries to take an admission history on a 3-year-old, the child’s mother bursts into tears and cannot answer any questions. Which of the following actions should the nurse take?
- a) Continue to take the history.
- b) Ask the mother if she would like some time alone to compose herself.
- c) Stay with the mother and encourage her to verbalize her fears concerning her child’s illness.
- d) Ask the mother to join her husband in the waiting room.
Unit 1 • Guidelines

When to Inform the Health Care Provider

- Some questions want to assess your knowledge of your scope of practice.
- Items such as this are testing your ability to critically think through a scenario and identify any nursing interventions that would be appropriate for you to implement prior to calling the provider.
- Don’t rush to call the provider.
- Check the answer list to see if there is any intervention you can implement before you call the provider.
- Complications occur.
- Patient’s condition is deteriorating—is one of the responses that you can call a Rapid Response?
- Patient needs medical attention.

Question Example

A patient admitted for severe nausea, vomiting, and diarrhea is receiving an IV of D51/2NS with 40 mEq KCL/L infusing at 100 mL/hr. The patient’s potassium level is 5.9. What is the initial nursing action?

a) Decrease the IV rate to 50 mL/hr and notify the provider when he or she is on rounds.
b) Stop the IV, maintain the site, notify the provider.
c) Recheck the potassium level in another 6 hours.
d) Continue with the current infusion.

Do Not Panic About the Time

- Do not dawdle but do not rush, either—you have about 1–2 minutes for each question.
- Expect 265 questions—some examinees take that many questions due to a random selection by the computer.
- The exam is a power test, not a speed test.

Think like a nurse. Apply your knowledge.

The aspiring nurse knows that there are at least two responses that are correct. It may be that all of the responses are correct. The test taker should judge each response on its own merit. Approach it from the perspective of a true/false response. For example, the aspiring nurse should ask, “Is option A true or false?” Make the decision based on each option as it relates to the question. In this way, the test taker is more likely to be successful.