One of the first steps to being successful on the NCLEX® (National Council Licensure Examination) for practical nursing is to understand how the test is developed. An important step in preparing for the examination is to find out as much as possible about the test; this will help reduce stress and anxiety. During school there were 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 responsible for teaching a course was also responsible for the development and construction of the course examinations. As you begin to prepare for the NCLEX-PN, 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 the construction of questions or items for the NCLEX-PN 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 consulted to assist in the creation of the practice analysis. The activity performances and knowledge identified by the content experts are analyzed with consideration given to frequency of performance, impact on client safety, and variety of client 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. These content experts represent geographical areas across the United States and are selected according to their area of practice; therefore all areas in the practice of practical nursing 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 nurses currently licensed in their jurisdiction who are responsible for supervision and teaching of practical nursing students in the clinical area, or who are currently employed in clinical nursing practice working with new graduate practical nurses. An additional panel of practicing nurses reviews all new test items or questions to ensure that each question or item reflects entry level practical nursing practice.

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 the current practice of practical nursing.

So, what does this all mean? It means that nurses in current practice and nursing faculty work together to identify the content and to develop questions for the NCLEX-PN. 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 PN.

The NCLEX-PN is used by every U.S. state to determine entry into nursing practice as a PN. 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 this research is to determine the most important and frequent activities of practical nurses who were successful on the NCLEX and who have been working after successful completion of the NCLEX. The current research indicates that the majority of graduate practical nurses are working in long term care facilities or in hospitals and are caring for clients ages 65 to over 85 years old. Each question will reflect a level of the nursing process or an area of client needs, and each question 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 practical nursing.

**Nursing Process**

The nursing process is a scientific approach to problem solving; it has been a common thread in your nursing curriculum since the beginning of school. There is nothing new about the nursing process on the NCLEX. Data collection, planning, implementation and evaluation are all integral steps in the
nursing process. It is important to keep the steps of the nursing process in mind when you are critically evaluating an NCLEX question, data must be obtained and analyzed before an action can be determined. (Box 1-1)

Caring

The interaction of the client 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 client.

Communication and Documentation

Events and activities—both verbal and nonverbal—that involve the client, the client’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 client care. Principles of documentation and provision of client 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 clients’ behavior through teaching and learning. Nurses provide education to clients and to their significant others in a variety of settings. 2

Areas of Client Needs

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

Table 1-1 lists the areas of client needs, with the subcategories and the specific weight associated with each subcategory. The range of percentages for each category reflects how important that area is on the test plan. Physiological Adaptation, Basic Care and Comfort, and Coordinated Care are the subcategories with the highest emphasis. 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-PN may be obtained from the NCSBN, Inc. (www.ncsbn.org). New information or new practices must be established as a standard of practice across the nation before being included on the NCLEX. Throughout this book are TESTING ALERT boxes that call your attention to areas of the test plan. Pay attention to these boxes and think about how each concept or principle can apply to different types of clients.

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

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 client situation presented in the question. NCLEX questions are not fact, recall, or memory-level questions. The questions are based on critical thinking concepts that demonstrate a candidate’s ability to make decisions and solve problems. Nurses who have taken the NCLEX have stated that the NCLEX questions were not like any questions they had on nursing school examinations; however, the nursing content and principles needed to determine the answer were provided in their nursing school curriculum. The questions and answers have been thoroughly researched and validated. The standardization of information is important because the NCLEX is administered nationwide to determine entry level into nursing practice. This ensures that regional differences in nursing care will not be a factor in the exam.

All questions presented to a candidate taking the NCLEX-PN have been developed according to the NCLEX-PN Test Plan. The questions have been researched and documented as pertaining to entry-level nursing behaviors.2,3
WHAT IS COMPUTER ADAPTIVE TESTING?

Computer adaptive testing provides a method for generating an examination according to each candidate’s ability. Each time a candidate answers a question, the computer then selects the next question based on the candidate’s answer to the previous question. The examination continues to present test items based on the test plan and provides an opportunity for each candidate to demonstrate competency. The NCLEX-PN is graded in a manner different from the grading of conventional school exams. A candidate’s score is not based on the number of questions answered correctly, but rather on the standard of competency as established by the NCSBN. A student’s competency level is calculated against the preestablished level of competency.

A test bank of questions is loaded into the candidate’s computer at the beginning of the examination. Different candidates receive different sets of questions, but all test 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 clients can be presented to test this concept: one candidate may have a question based on standard precautions required for a client who is postoperative, someone else, a situation with implications for a newborn, and still someone else, a situation involving an older adult client. All the questions are different, but they are all based on the test plan’s critical element of standard precautions.

The candidate will receive new questions based on the response to the previous question. When a question is answered correctly, the next question presented to the candidate may have a higher level of difficulty. A candidate cannot skip questions or go back to previously answered questions. As the examination progresses, it is interactively assembled. As 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

<table>
<thead>
<tr>
<th>TABLE 1-1</th>
<th>NCLEX-PN® TEST PLAN - APRIL, 2008 - APRIL, 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coordinated Care (12%-18%)</td>
<td>Management of nursing care—client care assignments, supervision, prioritizing nursing care, and delivery of safe care; maintaining continuity of care, legal and ethical practices; client rights</td>
</tr>
<tr>
<td>Safety and Infection Control (8%-14%)</td>
<td>Prevention of errors, accidents, and injury; proper use of restraints and safety devices; implementation of standard precautions; asepsis, ergonomics, handling hazardous materials</td>
</tr>
</tbody>
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### Safe, Effective Care and Environment

- Coordinated Care (12%-18%)
  - Management of nursing care—client care assignments, supervision, prioritizing nursing care, and delivery of safe care; maintaining continuity of care, legal and ethical practices; client rights

### Health Promotion and Maintenance (7%-13%)

- Aging process and expected body changes; growth and development and transitions; ante/intra/postpartum, and newborn care; techniques for data collection (physical assessment); disease prevention; principles of learning and teaching; immunizations

### Psychosocial Integrity (8%-14%)

- Mental health and illness concepts; crisis intervention; abuse and neglect; end-of-life care, cultural, religious and spiritual influences on health; grief and loss; therapeutic communication; changes in body image (expected and unexpected); substance abuse

### Physiological Integrity

- Basic Care and Comfort (11%-17%)
  - Assistive devices, elimination, mobility, nutrition, hygiene and oral hydration, comfort measures

- Pharmacological and Parenteral Therapies (9%-15%)
  - Medication administration; adverse effects, expected effects and contraindications for medications

- Reduction of Risk Potential (10%-16%)
  - Perform diagnostic testing; laboratory values—collect specimens, compare data to normal value, reinforce client teaching; perform therapeutic procedures; accurately monitor vital signs; monitor client for potential alteration in body systems (neuro checks, circulatory checks, prenatal complications, immobilization)

- Physiological Adaptation (11%-17%)
  - Alterations in body systems (drainage devices, alterations in blood glucose, wound care, suctioning, identify symptoms of infection, complications of pregnancy/labor/delivery/postpartum, etc); fluid and electrolyte imbalances; medical emergencies, radiation therapy; identify and intervene to unexpected response to therapies (IV, bleeding, infection, etc)

Adapted from the 2008 NCLEX-PN® Detailed Test Plan (Item writer, item reviewer, nurse educator version), Chicago, 2008, National Council of State Boards of Nursing.
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 1-1).

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 is available on the National Council website. After the candidate’s application and registration fees have been received and approved by the state, the candidate will receive an authorization to test (ATT) from the NCSBN. After the examination fee has been paid, it will not be refunded, regardless of how the candidate registered. The candidate may register for the NCLEX at the NCLEX Candidate website or by regular mail or by telephone. All the contact information is listed in the ATT. The Candidate Bulletin (CB) is available on the National Council website—be sure to print this bulletin for future reference. The CB provides critical information, including addresses and phone numbers for registration and specific details regarding the registration process.

Scheduling the Examination

After a candidate has been declared eligible to take the NCLEX and has received an ATT, the candidate may schedule an examination date. A candidate must have an ATT before they can schedule their examination. The CB lists the phone number to call to schedule the examination. Once the ATT has been issued, the state stipulates a period of time within which the candidate must take the examination. This ranges from 60 to 365 days, with the average being 90 days; this period cannot be extended. You must test within the validity dates noted on your ATT. The ATT must be presented at the testing site before you can be admitted to take the examination. You are encouraged to call and schedule the appointment to take the examination as soon as possible after receiving the ATT, even if you do not plan to take the test immediately. This will increase the probability of getting the testing date you want.

Early in the last semester, students should begin planning for when they want to take the examination. Students should plan on taking the examination within 2-6 weeks of graduation. If a review course is considered, then that should be factored into the schedule. The month after graduation is not a good time to plan a vacation or any life-changing events. Complete the NCLEX and then move on with your life. Do not procrastinate about scheduling the examination, the longer after graduation and review course that the examination is taken, the colder the knowledge. Take the examination when the nursing content is most current in your mind and you are still in the testing mode from school.

Pearson Vue is the company that provides the testing facility and computers for the examination. A tutorial on how to use the computer on NCLEX is available at www.vue.com/nclex. Go to the site and review the tutorial. It should be very familiar to you when you see it on NCLEX; this same tutorial will be presented to you at the beginning of your examination.

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 U.S. driver’s license, a passport, or a U.S. state-issued identification, or a U.S. military issued identification. At the testing site before testing, each candidate will be digitally fingerprinted, a photo will be taken, and a signature will be required.

Day of the Examination

You should plan on arriving at the center about 30 minutes before scheduled testing time. If you arrive more than 30 minutes late, the scheduled testing time will be canceled and you will have to reapply and repay the examination fee. An erasable note board will be available at your computer terminal. You will not be allowed to 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.

**Testing**

You will have a maximum of 5 hours to complete the examination. After 2 hours of testing, you have an optional 10-minute break; another optional break occurs after 31/2 hours of testing. If you need a break before that time, notify one of the attendants at the testing center. The computer will automatically signal when a scheduled break begins. All of the break times and the tutorial are considered part of the total 5 hours of testing time.

The examination will stop when one of the following occurs:

1. 85 questions have been answered, and a minimum level of competency has been established; or a lack of minimum competency has been established (see Figure 1-1).
2. The candidate has answered the maximum number of 205 questions.
3. The candidate has been testing for 5 hours, regardless of the number of questions answered.

Each candidate will receive between 85-205 questions. The number of questions on the NCLEX is not indicative of the level of competency. The majority of candidates who complete all 205 questions will have demonstrated a level of minimum competency and therefore pass the NCLEX. A mouse will be used for selecting answers, so candidates should not worry about different computer keyboard 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 25 pretest or unscored items or questions. The statistics on these items will be evaluated in order to determine whether the item is a valid test item to be included in future NCLEX test banks. All of the items that are scored, or counted, on a candidate’s examination have been pretested and validated. It is impossible to determine which questions or items are scored items and which are pretest items. It is important to treat each question as a scored item.

The CB from the NCSBN is very important; read it carefully and keep it until the results from NCLEX have been received. This bulletin will provide directions and will answer more of your questions regarding the NCLEX. The CB is available online (from the NCSBN at www.ncsbn.org or from Pearson Vue at www.vue.com/nclex).

**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, from Pearson Vue, or from the NCSBN. Check the information received from the appropriate state board of nursing to determine how and when your results will be available. Test results may be available online. In some states, 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 Pearson Professional Center, NCLEX Candidate Services, 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.

**SUCCESSFUL TEST TAKING ON THE NCLEX® EXAM**

Being able to effectively apply 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-PN is designed to evaluate a minimum level of competency. The purpose of the examination is to determine whether a candidate has the knowledge, skills, and ability required for safe and effective entry-level nursing practice as a practical nurse. Throughout the examination, 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 evaluation and interpretation of client data, an understanding of the client’s condition or disease, and the ability to determine the best action that will most effectively meet the client’s needs.

Practice testing is an excellent method of studying for the NCLEX. After taking a practice test, use the results to determine whether you need additional review in certain areas or whether you are missing questions because of poor test-taking strategies.

**NCLEX® TEST-TAKING STRATEGIES**

The NCLEX questions are different from those found on nursing school exams. One of the biggest problems candidates encounter is that there appears to be two or more correct answers. Sometimes a candidate believes that more information is necessary to answer the question. However, the answer must be determined from the information provided; no one will
clarify or provide additional information regarding a specific question or content. The strategies described in this section are critical in evaluating and successfully answering NCLEX questions.

- **The NCLEX Hospital:** What a great place to work! In the situations or questions presented on NCLEX, all clients are being cared for in an ideal environment—the NCLEX Hospital. NCLEX questions are based on textbook practices, not necessarily on the real world. It must be assumed that clients will respond just as the textbooks indicate they will. Candidates who have a lot of clinical experience may experience problems on the test if they answer questions based on the possibility that there may not be adequate staff or equipment or if they believe the option for the nursing care presented is not “realistic.” Nursing care provided on the examination is performed in the NCLEX Hospital, where the nurse has adequate staff, supplies, and anything else required to provide the safest care for the client. This approach is necessary because this is a nationally standardized examination.

- **Calling the Doctor (or anyone else):** Be cautious about passing the responsibility for care of the client to someone else. This is an exam on nursing care; evaluate the question carefully and see what nursing action should be taken before consulting or calling someone else. This includes the RN supervisor, social worker, respiratory therapist, and hospital chaplain, as well as the doctor. After you have carefully evaluated the question, if the client’s condition is such that the nurse cannot do anything to resolve the problem, then calling for assistance may be the best answer. Evaluate situations, is there a nursing action to be taken before contacting someone for assistance. A specific item on the test plan states that the nurse will identify client data that must be reported immediately. It is important to identify critical changes in a client’s condition, as well as make a nursing judgment when the client’s condition requires reporting to the RN or to the physician.

- **Doctor's Orders:** It should be assumed that 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 client’s problem, then assume that there is an order for it. If the focus of a question is to determine if a nursing action is a dependent or an independent nursing 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 client.

- **Focus on the Client:** Look for answers that focus on the client. Identify the significant or central person in the question. Most often, this is going to be the client. Wrong choices would be those that focus on maintaining hospital rules and policies, dealing with equipment, or solving the nurse’s problems. Evaluate the status of the client first, provide for client safety and then deal with the equipment problems, or concerns. Other questions may ask the nurse to respond to a client’s family or significant others. Determine the person to whom the question is directed.

- **Client's Age:** Consider a client to be an adult unless otherwise stated. If the age of a client is important to the question, it will be stated in years or in months. Descriptions such as “elderly adult” and “geriatric client” are not commonly used. These terms have been established as negative descriptors of older clients. The description of such a client may be “older adult,” or a specific age may be given.

- **Laboratory Values:** It is important to know normal values for the common laboratory tests. A question may be based on nursing activities regarding a specific lab value, knowledge of lab values or a diagnostic procedure that would indicate a client’s condition is getting better or worse. Be able to identify lab values and/or diagnostic procedures that indicate a client’s progress or lack of progress. Determine whether specific nursing actions are required based on the abnormal values or diagnostic results. For example, when a client’s blood glucose level is 50 mg/dL and he or she is awake and alert, the client will need something to eat, preferably a complex carbohydrate. If a client has a hemoglobin value of 8.5 g/dL, nursing care will involve avoidance of unnecessary physical activities, and the client will need to be kept warm.

- **Positions:** If a specific position for the client appears in the stem of 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 by placing the client in the position, and why is the position important for this client? Sometimes a client position will appear in the options. Consider whether positioning is important to the care of the client presented. For example, the semi-Fowler’s position is very important to a client who is having difficulty breathing, and the supine position or low Fowler’s position may provide the most comfort for a client postoperatively. Determine the purpose of a specific client 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 medication dosages, conversion of units of measurement, as well as calculation of intake and output. 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. There will be an on screen calculator, find the “calculator” button when you do the NCLEX Tutorial. The mathematical calculations may be presented in a multiple-choice format or in an alternate format question in which you are asked to fill in the blank. For fill in the blank questions, calculate your answer and then type the answer number into the box provided. The unit of measurement will be provided in the box.
Management of Client Care

As the role of the licensed practical nurse (LPN) has expanded, management of client care has become increasingly important. A large percentage of graduates surveyed on the last job analysis reported they had “charge nurse” responsibilities. The majority of the management responsibilities were in the long-term care facilities. LPN’s may direct the care of the nursing assistants as well as other LPN’s. However, LPNs are under the supervision of a registered nurse. There is a director of nurses, or an administrator that is an RN and is ultimately responsible for nursing care delivered in that facility. Do not panic: pay close attention to what nursing action the question is focusing on and to whom the nurse is assigning the care or nursing activity – is it to another LPN, or is it to a less qualified person?

- **Keep in mind the NCLEX Hospital.** Adequate staff is available to provide safe client care; don’t worry about staff shortages. Focus on the needs of the client in the question – the activities on the rest of the unit are not pertinent to answering the question. The only client to consider in each question is the one involved in that question, not the other clients the practical nurse may have been assigned.

- **Identify the most stable client.** The most stable client 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. When determining the stability of clients, Maslow’s hierarchy of needs should be considered (see Chapter 2, Figure 2-1). The most stable client is often the one for which nursing activities can be delegated to a nursing assistant.

- **Assign tasks that have specific guidelines.** Those tasks that have specific guidelines that are unchanging and are used in the care of a stable client can often be assigned to the nursing assistant. Bathing, collecting urine samples, feeding, providing personal hygiene, and assisting with ambulation are just a few examples of these activities.

- **Identify your priority client.** The priority client is the one who is most likely to experience problems or ill effects if they are not taken care of first. Priority clients include those with conditions that are unstable and changing, and those who are at an increased risk for developing complications. NCLEX questions may present a typical nursing care assignment and ask which client the nurse would care for first; or a situation with a client 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 client, to see him or her first, and then to determine what is necessary to do first for this client.

- **Carefully read the question and determine which clients are in a changing unstable situation, these are clients that may require contacting the RN or the physician. This judgment could be tested in a question where the LPN cannot meet the client needs and needs to obtain further assistance and or direction.

- **Client Care Assignments:** Nursing care assignments should take into consideration the caregiver who is educationally prepared, experienced, and most capable of caring for the client. Unlicensed assistive personnel (UAP), patient care attendants (PCA), and/or nursing assistants must be directly supervised in the provision of safe nursing care. Pay close attention to the person to whom the nurse is assigning the care or nursing activity: Is it to another LPN, or is a specific activity (bathing, ambulating, etc.) being delegated to an unlicensed nursing assistant?

Establishing Nursing Priorities

Almost all nurses will agree that the NCLEX has a lot of priority questions. These questions may be worded in a variety of ways:

- “What is the priority nursing action?”
- “What should the nurse do first?”
- “What is the initial nursing action?”

In other words, the NCLEX wants to know if the PN can identify the most important nursing action to be taken in order to provide safe care for the client in the situation presented. This may be found in questions where three of four of the options are correct; however, one of the options or actions needs to be performed before the others. This is where critical thinking is necessary—*think like a nurse!* There are three areas to consider when determining priority nursing actions: Maslow’s hierarchy of needs, the nursing process, and client 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 must come first.* (Figure 3-1) When evaluating options, identify client needs that are physiological and those that are psychosocial. Physiological needs are a higher priority than psychosocial needs. A client’s physical needs must be met before considering his or her psychosocial needs. Also remember that the ABCs (airway, breathing, and circulation) are the critical physiological needs because these are at the base of Maslow’s pyramid. However, be cautious—don’t always select “airway” as the best answer. Sometimes the client does not have an airway problem, so don’t read that into the question and give the client an airway problem! If a client is in pain, it is difficult to determine what is contributing to his/her psychosocial problem. Maslow’s hierarchy of needs also applies to the client with psychosocial problems – take care of the physiological needs, then focus on the psychosocial needs. (see the section in this chapter regarding answering psychosocial questions).

- **Nursing Process:** The first step in the nursing process for
the practical nurse is data collection. When evaluating a question, it is important to determine if the question provides adequate data for the nurse to make a decision regarding nursing interventions. Obtaining more information (data collection) may be the first nursing action. However, do not automatically select an option that involves data collection. If client data are provided in the stem of the question, then it will be important to consider Maslow’s hierarchy of needs when planning or selecting the best nursing action or implementation. If a nursing action has been implemented, then the question may focus on evaluating the effectiveness of the nursing action. Read the question carefully and determine what is being asked. (Box 1-1).

- Safety Issues: This may include situations in the hospital, in a long term care facility, or in the client’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 hygiene. When you are critically evaluating questions that involve a client’s safety and multiple options appear to be correct, determine what activity will be of most benefit to the client.

**Example Questions for Management and Priority Setting**

The LPN is making assignments on a nursing care unit. What tasks could be assigned to the experienced nursing assistant?

1. Evaluate the skin in the sacral area for a client on bed rest.
2. Report on the quantity and characteristics of a client’s urine output.
3. Assist a client to obtain a clean-catch urine specimen.
4. Evaluate the tolerance of client on tube feedings.

**Answer: Option 3**

The nursing assistant can be assigned activities that involve standard, unchanging procedures such as helping to obtain a clean-catch urine specimen from a client. The LPN should evaluate the skin on the sacral area for any evidence of a break in skin integrity. The characteristics of the urine should be evaluated by the LPN, however the nursing assistance can empty and measure the amount of urinary output. Dietary intake for client’s who do not have a problem with nutrition can be reported by the nursing assistant, however the LPN needs to determine the tolerance of the tube feedings.

The LPN is in charge of the nursing unit on the afternoon shift in an ambulatory care center. After receiving a hand off report on the clients, who would the nurse evaluate first?

1. A client who had a laparoscopic cholecystectomy, has been in the unit for 4 hours, and is complaining of left shoulder pain.
2. A client who had a prostate biopsy about 6 hours ago and is beginning to complain of perineal discomfort, chills, and feeling flushed.
3. A young adult who complains of being nauseated and refuses to take his first dose of the oral postoperative antibiotic.

**Answer: Option 2**

The client who is post-biopsy of the prostate should be evaluated first, because he could be developing a sepsis secondary to the biopsy. The client who is postcholecystectomy is experiencing referred shoulder pain, which is common after this procedure. The young adult client and the older adult client can be evaluated after the cholecystectomy client.

The practical nurse is working on a step down nursing telemetry unit. A client tells the nurse he is beginning to have mid-sternum chest pain. What is the first nursing action?

1. Begin oxygen at 4L/min per nasal cannula.
2. Request the charge nurse evaluate the cardiac rhythm.
3. Auscultate breath sounds and maintain airway.
4. Determine client activities prior to onset of chest pain.

**Answer: Option 1**

When a client complains of chest pain, oxygen should be started immediately, and then the status of the vital signs should be determined. The client is on a telemetry unit and is experiencing chest pain – this is enough information for a nursing action. Data collection will determine the status of the vital signs and further action can be evaluated. If the vital signs are unstable or if the client is experiencing an untoward dysrhythmia, then oxygen administration would still be the most important first nursing action. Activity prior to the chest pain can be evaluated after the current physical status is determined. Option 3 assumes the client has airway problems, there is no indication in the question stem that airway is a problem.

The LPN received a shift handoff report for a group of assigned clients. Which client should the practical nurse see first?

1. A client who underwent a thoracotomy 3 days ago, his vital signs are stable and he is complaining of chest pain when he coughs.
2. An 85-year-old client who has a fractured hip, she is in Buck’s traction and is complaining of pain; she is scheduled for surgery in 4 hours.
3. An adult male client admitted 3 hours ago for dehydration; the vital signs are temperature 99°F, pulse 100 beats/min and irregular, and BP 118/80 mm Hg.
4 A cardiac client whose was admitted 24 hours ago who is beginning to complain of increased chest pain.

Answer: Option 4

The client with cardiac disease is the most unstable and is beginning to exhibit symptoms that could be warning signs of cardiac ischemia. This client needs to be assessed immediately, and the nurse should anticipate administration of sublingual nitroglycerin. After assessment of vital signs, this client’s change in condition may need to be reported to the charge nurse and or to the doctor. The client with a thoracotomy may be developing pneumonia secondary to surgery and immobility, but the situation does not require immediate attention. The client with a fractured hip is also not in an unstable situation, even though she is uncomfortable. The client with dehydration is exhibiting symptoms related his dehydration but is not unstable at this time.

A client has returned from abdominal surgery and the nurse is assessing the incisional site. The dressing has some bright red blood on it, and on closer observation the nurse determines a small area of evisceration. What is the best nursing action?

1. Remove the dressing and place a sterile saline soaked dressing on the wound and reinforcement dressing on top.
2. Remove the dressing and with sterile gloves apply very gently pressure to replace 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 stained dressing, cleanse the wound area using sterile antiseptic solution and replace the dressing.

Answer: Option 1

The best nursing action is to cover the exposed bowel with sterile saline soaked dressing to prevent drying and tissue damage to the exposed bowel and then the physician should be notified. Option 2 should not be performed, there may be vascular impairment to the bowel below the surface. In option 3 the dressing needs to be replaced with a moist dressing to protect the bowel. In option 4, the wound should not be cleansed as 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. Implementing testing strategies now will help to increase test scores in school, in addition to being one more step toward success on the NCLEX.

Question Characteristics

The majority of questions on the NCLEX, as well as on nursing school exams, are in a multiple-choice format. 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 client situation. The part of the stem that asks the question will present a problem or situation. The question may be presented as complete or an incomplete sentence. One of the options presented will most correctly answer the question or complete the sentence. (Figure 1-2)
Options

There are four options from which to choose an answer.

- Three options are distracters; 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.

Specific Strategies and Examples of Multiple-Choice Questions

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

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 the client might...” Don’t make the client any sicker then he or she already is!

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

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

**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 (true) or negative (false) format.

Watch for words that provide direction to the question. A positive or true stem may include the following: “indicates the client understands,” “the best nursing action is,” “the preoperative teaching would include,” or “the best nursing assignment is.” Also watch for words in the stem that have a negative meaning so that the question is asking for a response that is not accurate or is false. Phrases such as “is contraindicated,” “the client should avoid,” “indicate the client does not understand,” “does not occur,” and “indicates [medication, 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:** The nurse is discussing body mechanics with a client who has had back surgery. What nursing observations would indicate the client did not understand the principles discussed? The client:

1. Bends at the knees to pick up an object from the floor.
2. Carries the object close to his body.
3. Places his feet apart when bending or picking up an object.
4. Bends from the waist to pick up an object from the floor.

**The correct answer is #4.** Rephrase the question: I need to identify what the client is doing wrong regarding body mechanics. Bending from the waist does not represent good body mechanics; the client should bend with the knees (squatting), not from the waist. All other options represent good body mechanics.

4. **Pay attention to where the client is in their disease process or condition.** Examples of this are terms such as “immediately postoperatively,” “the first postoperative day,” and “experienced a myocardial infarction this morning.” Also watch for words in the stem that have a negative meaning so that the question is asking for a response that is not accurate or is false. Phrases such as “is contraindicated,” “the client should avoid,” “indicate the client does not understand,” “does not occur,” and “indicates [medication, 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:** A client had a cardiac catheterization through the left femoral artery. 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 and monitor catheter insertion site for inflammation.
2. Elevate the head of his bed 90 degrees and keep affected extremity straight.
3. Evaluate his blood pressure and respiratory status every 15 minutes for 4-6 hours.
4. Check his pedal and femoral pulses every 15 minutes for first hour, and then every 30 minutes.

**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, it is important to evaluate vital signs, but does not require them to be done every 15 minutes for 4-6 hours if client is stable. Option 4 is critical in the first few hours following a cardiac catheterization.

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 client with this condition/procedure/medication/problem?

Example: A woman who is 3 days postpartum returns to the clinic with complaints 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 answer will be a true statement. Think about breast-feeding and the common discomforts and problems the client encounters. Don’t look at the options yet. 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 client how to apply a breast binder to decrease the discomfort and the production of milk.
2. Tell the client that breast fullness may be a sign of infection and she will not be able to continue breast-feeding.
3. Suggest to the client that she decrease her fluid intake for the next 24 hours to temporarily suppress lactation.
4. Explain to the client 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 permanently.

6. Identify the step in the nursing process being tested.

Remember, you must have adequate client 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? Is the correct nursing action to obtain further assessment data? Look for key words that can assist you in determining what type of information is being requested.

Example: An 85-year-old client is a resident in a long-term care facility. The nurse assigned to the client for morning care observes numerous bruises and abrasions in various stages of healing on the client’s back and torso. The nurse from the previous shift explains that the client fell down. What is the best nursing action?

1. Review the chart for details regarding the client’s fall.
2. Cover the abrasions with a protective dressing.
3. Notify the supervisor regarding the possibility of an abusive situation.
4. Further evaluate the client to determine presence of other 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 client’s physiological needs are the priority. Option 1 does not immediately alleviate any client problem or provide any assistance to the client. Options 2 and 3 relate to nursing actions that may be done after the immediate injuries and needs have been assessed. Focus on the client; priority setting and physiological needs must be addressed first.

7. Confused at this point? What if, after reading the question, you do not know what the question is even asking? Take a deep breath, reread the question, and ask yourself, “What is the main topic of the question?” 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: The nurse is caring for a client who is scheduled for a thoracotomy at noon. The nurse is evaluating the client at 10am. Which client finding would be most important for the practical nurse to report to the nursing supervisor?

Is the question asking for problems regarding the surgical preparation, or the current status of the client’s conditions, or maybe even preoperative teaching? Check out the options.

1. Vital signs are: pulse rate 100 beats/min, respirations 20 breaths/minute, oral temperature 99°F.
2. Surgical consent form is not signed and on the chart.
3. The client states that he is anxious about the surgery.
4. Lab reports indicate the hemoglobin level is 12.5g/dl and the hematocrit level is 36%.

After checking the options, it appears the question is asking for the preoperative or surgical preparation of the client. 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 option is #2. The surgical consent should be on the chart and the client should not be given any preoperative narcotics before the consent form is signed. This needs to be taken care of immediately. The vital signs are within acceptable limits (option 1), anxiety is normal before surgery (option 3), and the hemoglobin and hematocrit levels are within normal lim-
its (option 4). This is a preoperative question that could be asked in any surgical client situation.

8. **Don’t focus on predicting a right answer!** Frequently, the answer you anticipate is not going to be an option! Keep in mind the characteristics and concepts of nursing care for a client 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 client 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 client 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. Of the orders listed here, what nursing action will I need to do first?

1. Penicillin V potassium (Pen Vee K) 500mg, PO, every 6 hours.
2. Blood cultures × 2, 20 minutes apart and drawn from different venipuncture sites.
3. Polysporin (Bacitracin) ointment topically to leg ulcer three times a day.
4. Acetaminophen (Tylenol), 650mg suppository, every 4 hours for temperature above 101.8°F.

Rank the options:

1st—Option 2; blood cultures must be obtained prior to antibiotic.

2nd—Option 1 needs to done after the blood cultures have been drawn.

3rd—Option 4 will not produce any immediate response or assistance in treating the problem, although it will make the client more comfortable.

4th—Option 3 will help to reduce the infection, but the priority is to obtain the culture and then for the antibiotic to be started.

Here is another approach to the options:

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 surface bacteria, but the blood cultures are still a priority. Eliminate this option because both options 1 and 2 are more important.

Consider option 4—This is treating the symptoms rather than 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 client; 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 options carefully. Remember, distracters are designed to be plausible to the situation and thus to “distract” you from the correct answer. All the options may be correct, but only one will be the best answer.

Example: A client has just returned to his room from the recovery room after a lumbar laminectomy with a spinal fusion. The client’s vital signs are stable. In considering possible complications the client 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.

All of these options are plausible for the situation. However, consider that this is the client’s operative day, he is currently stable, 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—eliminate these from consideration. Option 2 would be appropriate if respiratory problems were anticipated; however, there is no indication of respiratory compromise. (Remember, don’t always select airway-related answers.) **The correct answer is #3**, because urinary retention is a common problem related to restrictions on mobility, pain medication as well as anesthesia in the immediate postoperative period after a lumbar laminectomy.

10. **As you read the options, eliminate those that you know are not correct.** Consider each option as true or false. 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. Correctly eliminating options will increase your chances of selecting the correct answer.

Example: The nurse is performing a urinary catheterization on a female client. When cleansing the labia, the nurse should:

1. Cleanse the inner labia and then cleans the outer labia.
2. Cleanse the perineum from back to front with a cotton ball.
3. Use each cotton ball only one time.
4. Inspect the vaginal opening for blood.
Systematically evaluate the options:

Option 1 – no, the outer labia should be cleansed before the inner labia.

Option 2 – no, cleansing should be performed from front to back.

Option 3 – yes, each cotton ball should only be used one time, and then discarded.

Option 4 – no, it does not affect the procedure even if the client is menstruating.

After a systematic evaluation of the options, option #3 is the correct answer. Always evaluate every option; do not stop with what you think is the first correct answer.

11. Identify similarities in the options. Frequently, the options will contain similar information, and sometimes you can eliminate similar options. If three options are similar, the different one may be the correct answer. When two of the options are very similar and one of those options is not any better than the other, 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: The nurse is assisting a client to identify foods that would meet the requirements for a high-protein, low-residue diet. Which foods would represent correct choices for this diet?

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

Options 1, 2, and 3 all contain a meat or fish 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 skin, making these high-residue choices. The correct answer is option #1, for both high-protein and low-residue qualities. Note that the NCLEX will not focus on dishes that contain a mixture of foods in which you would need to know the recipe to answer correctly. Also, unless specified, do not attribute special characteristics to a food; if a food has a special characteristic, it will be stated (e.g., “low sodium” soup or “low fat” yogurt).

12. Identify words in the options that are “qualifiers.” Every, none, all, always, never, and only are examples of words that have no exceptions. Options containing these words are frequently incorrect. Seldom in health care is anything absolute with no exceptions; thus you can often eliminate these options. In some situations the qualifiers can be correct, especially when a principle or policy is described. For example, the nurse always establishes positive client identification before administering medications. This would be a correct statement. Carefully evaluate qualifiers; they are clues to the correct answer.

Example: The nurse is obtaining a specimen from a client’s incisional area for a wound culture and sensitivity. What client information will the sensitivity part of the procedure reflect?

1. Presence and characteristics of all bacteria present in the client’s wound
2. Which antibiotics will effectively treat the bacteria present
3. Differentiation of the bacteria and viruses present in the wound
4. All the treatments to which 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. Identifying all the bacteria and all the treatments is not feasible from a culture and sensitivity. 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 option may include the other three options or need to be considered first.

Example: The nurse is planning to teach a client with diabetes about his condition. Before the nurse provides instruction, what is most important to evaluate? The client’s:

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

Options 1, 2, and 3 are certainly important considerations in diabetic education. However, they cannot be initiated until the nurse evaluates the client’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 client’s understanding of nutrition.

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

Example: The practical nurse is preparing a client’s 8am medications. The client has the following medications ordered: digoxin (Lanoxin) 0.125mg, PO; furosemide (Lasix) 20mg, PO, captopril (Capoten) 25mg, PO. The client’s current vital signs are: blood pressure 110/86, pulse 78, respi- rations 18, and temperature 99°F orally. What would be the best nursing action?

1. Administer all of the medications, chart them as given, and document the client’s apical heart rate.
2. Hold the digoxin and the captopril; recheck the heart rate and blood pressure in 30 minutes.
3. Hold the captopril, administer the other medications and notify the nursing supervisor.

4. Hold the furosemide until the intake and output can be evaluated, administer all other medications.

In the methodical evaluation of the items in the options, you can eliminate items. Option 2: there is no reason to hold the digoxin or the captopril. Option 3, there is not reason to hold the captopril or to notify the nursing supervisor. Option 4, there is no reason to hold the furosemide. 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 answer the question.

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

**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 client is a significant physiological change, often an infection (commonly in the urinary tract), dehydration, or hypoxia. Options 1 and 3 relate more to the gradual behavior changes seen in the progression of dementia and do nothing “to determine the possible cause.” Option 2 also 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. 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 test item pools and are randomly selected to meet the items on the test plan and the established level of difficulty. The NCSBN has not specified a number of alternate format questions that will be included in a candidate’s test bank. A candidate should expect several alternate format questions. It is important to consider that there will be 25 pretest or unscored items in the first 85 questions on every candidate’s examination. Within those 25 items, there may be several 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 unscored items.

**Figure 1-3 Alternate format question—multiple response.**
The alternate format questions should not have any impact on what or how you 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 minor modifications. 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 require you 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, you will select each item to be included in the answer—consider each item, make a decision if it is to be included in the correct answer or not. You must select all the answers that are correct to the question, if you do not select all of the correct options that apply to the question, the answer will be considered wrong.

**Testing Strategy:** Think about the question presented in Figure 1-3. Standard plus droplet precautions will be used for this client. What is added to standard precautions when 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 client.

*Answer:* Options 1, 4, and 5. In option 1, yes (true), the nurse is going to provide morning care and have direct contact with the client; therefore gloves should be worn. Option 2, no (false), the suctioning supplies should be left in the room. Option 3, no (false), the gown and mask are disposed of in the client’s room. Option 4, yes (true), a mask is necessary if the nurse is to come within 3 feet of the client, which the nurse can expect to do when providing or assisting with morning care. Option 5, yes, (true), a gown should be worn because the nurse is going to be close to and have direct contact with the client. Option 6, no (false), the stethoscope should not be taken into the client’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 are frequently presented for medication dosage calculations, or intake and output calculations—just to name a few (Figure 1-4). A drop-down calculator is provided on the computer screen. With calculation questions, the final unit of measurement will always be provided. Only the number will be placed in the answer box. Check the items necessary to make this calculation. For example, is it necessary to make conversions from cups to ounces or to milliliters? Make sure all of the units of measure needed in the final answer are in the same system of measurement.

Memorize the formulas necessary to calculate the drug dosages and conversions. The number of decimal places to be included in the answer will be indicated in the question. 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. To calculate the correct answer on the question in Figure 1-5: ½ cup broth is 120mL, 1 cup gelatin is 240mL, 200mL of water and 950mL of IV fluid for a total intake of 1510mL.
**Hot Spot Questions**

In a hot spot question, you will be presented with a graphic and asked to identify a specific item, area, or location on the graphic. Look at Figure 1-5. Identify the area on the graphic and then you would click on it with the mouse.

*Answer: The “hot spot” (in this case, the 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, several steps or actions are listed, and you will need to place them in a correct sequence (Figure 1-6). All of the options will be used, but you must place them in the correct order. The first thing to do is to decide in what order you want to place the options or rank the actions. After you have determined your answer, click on the option you want to place first, “drag” that option over, and place it in the first box. Then select the option you want to place second, drag that option over, and place it in the next box. Continue this process until you have used all of the options present. Practice by considering how you would answer the question in Figure 1-6.
Answer: The client 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. Next, encourage intake of clear liquids to decrease viscosity of secretions. Finally, provide instruction regarding risk factors (psychosocial need).

Chart or Exhibit Items

In this type of question, a client situation or problem and client information are provided in a chart or an exhibit (Figures 1-7 through 1-10). First, read the information presented and understand what information the question is asking for. Then click on the tabs within the exhibit to find the information needed to answer the question. There may be several tabs to click on, check the information included within each tab and determine if it is pertinent to the situation.

The question is asking you to identify what would be the best pain medication to administer to this client. On reviewing the information, you will find that all answers are feasible. Check the tabs or exhibit information. Check the nurses notes, the medication administration record (MAR) and the doctor’s orders. What you should find within these tabs is that the client received morphine 10 mg IM at 11:00 am; became lethargic and slept for the next 5 hours. He received hydrocodone PO at 4:00 pm and was comfortable for 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 is preferable to give a client a PO pain medication than a parenteral pain medication. The hydrocodone provided effective pain relief for 4 hours when it was administered the last time, and the doctor’s order is current.

Figure 1-7  Alternate format question—exhibit item.

Figure 1-8  Alternate format question—first tab on exhibit item.
Audio Questions

Beginning in April, 2010, “audio” questions will be included in the test banks for the NCLEX-PN. The screen will tell the candidate to place the head phones on to listen to the information. The information may be replayed if necessary. After listening to the information, the candidate will select an answer from the options presented.

Therapeutic Nursing Process: Principles of Communication

Throughout the examination there will be questions requiring use of the principles of therapeutic communication. In thera-

peutic communication questions, do not assume the client 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 client.

TESTING ALERT: Use therapeutic communication techniques to provide support to client and the family; establish a trusting nurse-client relationship; assess psychosocial, spiritual, cultural and occupational factors affecting care; allow time to communicate with client/family and significant others; provide therapeutic environment.
Situations requiring use of therapeutic communication are not always centered around a psychiatric client. Frequently, these questions are centered on the client experiencing stress and anxiety. There may be questions relating to therapeutic communication in the care of clients experiencing stress, anxiety related to a specific client situation, or a change in body image as a result of physiological problems.

Look for responses that focus on the concerns of the client. Do not focus on the concerns of the nurse, hospital, or physician. Determine whether the client 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 client to express how he or she feels. Clients frequently experience difficulty in expressing their feelings. Focus on responses that encourage a client 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. In order to build trust and promote a positive relationship, it is important to be honest with the client. Options that include telling the client "don't worry," or "everything is going to be all right," or "your doctor knows best" will most likely be wrong answers.

Look for responses that indicate an acceptance of the client. Regardless of whether you agree with the client’s views or moral values, it is important to respect his or her views and beliefs. Carefully evaluate responses that involve telling clients what they should or should not be doing, these are often wrong answers (e.g., telling an alcoholic that she should quit drinking or telling a depressed client that he should not feel that way).

Be careful about responses that give opinions or advice on the client's situation. Do not assume an authoritarian position. You should not insist that the client follow your advice (e.g., quit drinking, exercise more, quit smoking).

Look for responses that reflect, restate, or paraphrase feelings the client expressed. Do not tell the client how he or she should or should not feel. Look for responses that encourage the client to describe how he or she feels—responses that reflect, restate, or paraphrase feelings the client expresses. An option such as “You should not feel that way” would be a wrong answer; it would be better to ask “How did that make you feel?”

Do not ask “why” a client feels the way he or she does. If a client understood why he or she felt a certain way, the client would most likely be able to do something about it. The most common answer when a nurse asks a client why he or she feels a certain way is “I don’t know,” which does provide any information.

Do not use coercion to achieve a desired response. Do not tell clients 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 6 (Table 6-1).

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, students often “talk themselves out” of the correct answer and change it to the incorrect one. The good news - you cannot go back to previously answered questions on the NCLEX. Before leaving the question, review the strategies you used to answer the question. When you press the enter bar, or select Next, another question will be presented and you cannot go back to the previous question.

Watch your timing. Do not spend too much time on one question. It is very important to evaluate 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 5 hours to complete the examination. When you are taking a practice test, plan to spend about a minute on each question. Some questions you will answer quickly; others may take some time. Do not spend more than 2 minutes deliberating the answer to a question. If you do not 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. Medical management or identifying a diagnosis based on symptoms are not the focus of the examination.

Eliminate distracters that assume the client “would not understand” or would be ignorant of the situation and those distracters that indicate the nurse needs to protect clients from worry. For example, “The client should not be told she has cancer because it would upset her too much” would most likely be an incorrect answer.

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. There is no validity in the rumor to select option 3 when you are guessing.
STUDY HABITS

Study Effectively

1. **Use memory aids, mindmapping, 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 1-11). Mnemonics are words, phrases, or other techniques that help you remember information. Images, pictures, and mnemonics will stay with you longer than written text information.

2. **Develop 3 × 5 cards with critical information.** Do not overload the card; put a statement or question on one side and answers or follow-up information on the other side. For example, on one side you might write “low potassium,” and on the other side you would list the relevant values. Another card might say “nursing care for hypokalemia” on the front, 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 and studied your set of cards with priority information, trade them with friends, and see what they have put on their cards. Sets of cards 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 a very effective way to study.

3. **Review class notes the next day.** A very effective study habit to develop during school is to review your 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.

4. **Plan your study time when you are most receptive to learning.** Do not wait until the end of the day when you have finished everything else. It is difficult to get up at 6:00 am, work all day, deal with family activities, and finally decide at 10:30pm that you are just too tired to study. You may feel guilty that you were not able to study for the intended 2 hours that evening. Schedule your study time – it may be easier for you to study for 2 hours prior to leaving school than it will be to study for 2 hours when you get home.

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. Do not expect your family to leave you alone while you study; this is frequently too much to ask, especially of children or a spouse. Go to the library, nursing school, or someone’s house where there are no disturbances.

6. **Start planning your NCLEX preparation 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 preparing. 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. Practice testing, or an end of the semester assessment exam will assist you to identify areas in which you need additional review.
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. Let everyone know when you are planning on studying and how important it is for you to study.
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.
   - Select a group of questions, plan for about 1 minute per question for practicing testing. After answering the questions, review the correct answers and focus on what and why you missed questions. Set aside 10 questions and answer them in 10 minutes; then review the answer and rationale for the questions. This will allow you to focus on testing strategies and not break your train of thought by checking the right answers.
   - Evaluate your comfortable pace for answering questions; this will keep you on target with your timing as you practice answering test questions. Initially, it may take you longer to answer questions when you have to think about testing strategies. Practicing testing strategies will help you improve your testing time.
   - Do not answer a question and then stop to look up the correct answer. Answer all of the questions in the section you have set aside; 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 at the end of each chapter in the book and with the online questions.

5. Evaluate your 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 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. Refer to an NCLEX Review book for further information, if you still do not understand the concept or information, go to your nursing textbooks.

6. Evaluate the questions you answered incorrectly. Review the rationale for the right answer and understand why you missed it.

7. Reuse the questions at a later point to review the information again.

8. A test bank of questions is available online, check your book for the code to access these questions. The more questions you practice answering, the more effectively you will be able to implement test-taking strategies.

**DECREASE ANXIETY**

Your activities on the day of the examination can influence your level of anxiety. By carefully planning ahead, you can eliminate some anxiety-provoking situations.

1. Review the NCLEX tutorial at the Pearson Vue website -www.vue.com/nclex/ or at the National Council website – www.NCSBN.org. The same tutorial is on both sites and will be your orientation to the computer and the testing process. It should seem like an old friend when you see it.

2. Visit the examination site before the day of the exam. Consider 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.

3. 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!

4. Do something pleasant the evening before the examination. This is not the time to cram.

5. Anxiety is contagious. If those around you are extremely anxious, avoid contact with them before the examination.

6. Carefully consider whether you want to go to the testing site with anyone else. If your companion 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.

7. Your meal before the test should be a light, healthy one. Do not go into NCLEX on an empty stomach. Avoid eating highly spiced or different foods. This is not the time for a gastrointestinal upset.

8. Wear comfortable clothes. This is not a good time to wear tight clothing or new shoes.

9. 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.

10. Wear soft-soled shoes; this decreases the noise in the testing area.

11. Make sure you have the ATT papers and photo ID that are required to gain admission to the examination site.
12. Do not take study material to the examination site. You are not allowed to take it into the testing area, and it is too late to study.

13. 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 and then return to the question. You may have gained a different perspective. Use good test-taking strategies, select an answer, and move on.

14. Reaffirm to yourself that you know the material. This is not the time for self-defeating behavior or negative self-talk. YOU WILL PASS!! Build your confidence by visualizing yourself in 6 months as a PN working in the area you desire. Create that mental picture of where you want to be and who you want to be—an LPN or LVN. Use your past successes to bring positive energy and “vibes” to your NCLEX exam. WE KNOW YOU CAN DO IT!

REFERENCES


