One of the first steps to be successful on the NCLEX® (National Council Licensure Examination) 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 to reduce stress and anxiety. During each of your nursing classes, you were given a syllabus with course objectives and provided with presentations to guide you through the information that would be included on the next test. In most academic settings, the faculty member who teaches the course is also responsible for the development and construction of examinations—thus you are being taught by the same person who prepares the tests, which can be a great advantage. As you begin to prepare for the NCLEX, it is important to consider who determines the content of the test plan and constructs the questions based on the test plan.

The National Council of State Boards of Nursing (NCSBN) is responsible for the development of the content and the construction of questions or items for the NCLEX examination. A practice analysis is conducted by the NCSBN every 3 years to validate the test plan and to determine currency of nursing practice. Content experts are 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, as well as importance of the nursing activity. The percentage of test items on the test plan does not specifically address specialty areas. However, on review of the nursing activities, many of the test plan areas address specialty areas of nursing practice. 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 all geographic areas and are selected according to their area of practice; therefore all areas of nursing practice are addressed in the development of the test plan. Item writers are selected to create questions based on the content identified in the test plan. All new test items or questions are reviewed by item reviewers who are also nurses in current practice and who have been directly involved with supervision of new graduate nurses. Not only do content experts and item reviewers create new items, they are also involved in the continual review of items in the NCLEX test pool to ensure all items reflect current practice.

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

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

**TEST PLAN**

The test plan is based on research conducted by the NCSBN every 3 years. The purpose of this research is to determine the most important and frequent activities of nurses who were successful on the NCLEX and who have been working after successful completion of the NCLEX. The research indicates that the majority of graduate nurses are working in an acute care environment and are responsible for caring for adult and elderly adult clients. 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 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. Assessment data are obtained, analysis of those data occurs, a plan is formulated, nursing actions are implemented, and the results of that intervention are evaluated. It is important to keep the steps of the nursing process in mind when you are critically evaluating an NCLEX question.

**Caring**
The interaction of the 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. Identifying critical learning needs for clients and their significant others and providing information in a manner that promotes the health and safety of clients are important across all levels of nursing practice.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, obstetric).

Table 1-1 lists the areas of client needs, along with the subcategories and the specific percentages associated with each subcategory. The range of percentages for each

<table>
<thead>
<tr>
<th>Table 1-1</th>
<th>NCLEX-RN® TEST PLAN—EFFECTIVE APRIL 2010 TO APRIL 2013*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Safe and Effective Care Environment</strong></td>
<td></td>
</tr>
<tr>
<td>Management of Care (16%-22%)</td>
<td>Concepts of management of nursing care—supervision, delegation, establishing priorities in client care; legal and ethical responsibilities; client rights; confidentiality</td>
</tr>
<tr>
<td>Safety and Infection Control (8%-14%)</td>
<td>Prevention of errors and accidents, implementation of standard precautions, asepsis, use of restraints, disaster planning, handling hazardous materials</td>
</tr>
<tr>
<td><strong>Health Promotion and Maintenance (6%-12%)</strong></td>
<td>Aging process and developmental stages, lifestyle choices, high-risk behaviors; principles of learning and teaching; ante/intra/postpartum and newborn; health promotion and disease prevention, techniques of physical assessment</td>
</tr>
<tr>
<td>Mental health concepts and interventions, end-of-life care, grief and loss, sensory and perceptual alterations, religious and spiritual influences; behavioral intervention/crisis intervention, chemical dependency, abuse and neglect, therapeutic communication</td>
<td></td>
</tr>
<tr>
<td><strong>Psychosocial Integrity (6%-12%)</strong></td>
<td></td>
</tr>
<tr>
<td>Basic Care and Comfort (6%-12%)</td>
<td>Assistive devices, mobility, nutrition, personal hygiene, elimination, nonpharmacologic comfort measures</td>
</tr>
<tr>
<td>Pharmacologic and Parenteral Therapies (13%-19%)</td>
<td>Medication administration; expected medication actions, adverse effects/contraindication; nursing implications; dosage calculation; blood administration, parenteral/IV therapy, central venous access devices, pain control, parenteral nutrition</td>
</tr>
<tr>
<td>Reduction of Risk Potential (10%-16%)</td>
<td>Pathophysiology, nursing implications for and nursing care to minimize potential complications of diagnostic tests/procedures/surgery; potential for alterations in body systems (tubes, pacemakers, hyper/hypoglycemia, specimens, bleeding, immobility, wounds, positions); laboratory values; changes in and/or abnormal vital signs; system specific assessments</td>
</tr>
<tr>
<td>Physiologic Adaptation (11%-17%)</td>
<td>Pathophysiology/alterations in body systems: fluid and electrolyte imbalances, hemodynamics, medical emergencies (CPR, airway, hemorrhage), unexpected response to therapies (seizures, changes in vital signs); nursing management of illness</td>
</tr>
</tbody>
</table>

Adapted from the *NCLEX-RN® Test Plan for the National Council Licensure Examination for Registered Nurses*, Chicago, 2009, National Council of State Boards of Nursing.

*Test plan information is presented as examples only and is not intended to be a complete or thorough representation of information included in any specific category.
category reflects how important that area is on the test plan. Management of care, pharmacologic and parenteral therapies, and reduction of risk potential are the subcategories with the highest emphasis on the test plan. 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’s Detailed Test Plan for the NCLEX-RN may be obtained from the NCSBN, Inc. (www.ncsbn.org). What was great new information in last month’s nursing journals will not be immediately reflected on the NCLEX. New information or new practices must be established as a standard of practice across the nation before being included on the NCLEX. Throughout this book are 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.

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

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 based on critical thinking concepts that demonstrate a candidate’s ability to make decisions and solve problems. NCLEX questions are not fact, recall, or memory-level questions. Nurses who have taken the NCLEX 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 have been developed according to the test plan and the integrated processes fundamental to nursing practice and have been categorized according to their level of difficulty. The questions have been researched and documented as pertaining to entry-level nursing behaviors.

**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 identified level of difficulty and provides an opportunity for each candidate to demonstrate competency. The NCLEX-RN 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 (Figure 1-1).

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 in labor; someone else, a situation with implications for a client with a respiratory problem; and still someone else, a situation involving a newborn. All the questions are different, but they are all based on the test plan’s critical element of standard precautions.

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

![Computer Adaptive Testing](#)

**FIGURE 1-1** Competency level.
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 (listed in the ATT) or by regular mail or by telephone (also 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 you have been declared eligible to take the NCLEX and have received an ATT, you may schedule an examination date. You must have an ATT before you can schedule your 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 you 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.

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.pearsonvue.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. Beginning in 2009, a new type of identity verification will be used in some testing locations. A Palm Vein Reader may be used at some testing sites, in addition to the digital fingerprinting, to validate identity on reentering the testing area.

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 are not 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 6 hours to complete the examination. After 2 hours of testing, you have an optional 10-minute break; another optional break occurs after 3 1/2 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

FIGURE 1-2 Plateau to establish pass or fail.

Decision: Fail

Passing level of difficulty

# of questions

0 10 20 30 40 50 60 70 75

Decision: Pass

Passing level of difficulty

# of questions

0 10 20 30 40 50 60 70 75
of the break times and the tutorial are considered part of the total 6 hours of testing time.

The examination will stop when one of the following occurs:

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

Each candidate will receive between 75 and 265 questions. The number of questions on the NCLEX is not indicative of the level of competency. The majority of candidates who complete all 265 questions will have demonstrated a level of minimum competency and therefore pass the NCLEX. A mouse will be used for selecting answers, so candidates 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 15 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.pearsonvue.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.3

SUCCESSFUL TEST TAKING ON THE NCLEX® EXAM

The NCLEX questions are different from those used in nursing schools. One of the biggest problems candidates encounter is that two or more answers may appear to be correct. Sometimes a candidate believes that more information is necessary to answer the question. However, the answer must be determined from the information provided; no one is going to clarify or provide additional information regarding a specific question or content. The strategies described below are critical in evaluating and successfully answering NCLEX questions.

- The NCLEX Hospital: What a great place to work! Remember, on the NCLEX, all clients are being cared for in an ideal environment—the NCLEX Hospital. Questions ask for nursing care and decisions based on situations in which everything is available for client care.

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

Being able to effectively 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-RN is designed to evaluate minimum levels of competency. The exam does not test total knowledge, knowledge of specialty areas, or any degree of professionalism. 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. 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 analysis of client data, an understanding of the client’s condition or disease, and the ability to determine the best action or nursing judgment 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

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 analysis of client data, an understanding of the client’s condition or disease, and the ability to determine the best action or nursing judgment that will most effectively meet the client’s needs.

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- The NCLEX Hospital: What a great place to work! Remember, on the NCLEX, all clients are being cared for in an ideal environment—the NCLEX Hospital. Questions ask for nursing care and decisions based on situations in which everything is available for client care.
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 will have 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 always 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 social worker, respiratory therapist, and hospital chaplain, as well as the physician. 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. Frequently, there is a nursing action to be taken before contacting someone for assistance. A specific item on the test plan states that the nurse will identify client data that must be reported immediately.²

- **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 ask what would be an independent nursing action to provide pain relief for a specific 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, 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. Be able to identify lab values and/or diagnostic procedures that indicate a client’s progress or lack of progress or indicate whether or not a client’s status is getting better or worse. 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:** Positioning a client may be an option to consider in the implementation of care. 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 after surgery. Determine why a client is placed in a specific position and then determine whether this is a priority in planning or intervention. See Appendix 3-1 for a further description of positions.

- **Mathematic Computations:** Mathematic computations may include calculations of intravenous (IV) rate and drip factors, 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 onscreen calculator; find the “calculator” button when you do the NCLEX Tutorial. The mathematic 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 into the box provided. The unit of measurement will be provided in the box.

**Management of Client Care**

As the role of the RN has expanded, management of client care has become increasingly important. Nursing care assignments should take into consideration the nurse 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. Licensed practical nurses (LPNs
or licensed vocational nurses (LVNs) have more independence in providing nursing care. They may direct the care of the nursing assistants. However, LPNs are ultimately under the supervision of a registered nurse. Don't panic and pull out all your management textbooks to review. Evaluate such questions in terms of general guidelines for delegation and supervision. Pay close attention to the person to whom the nurse is assigning the care or nursing activity: Is it to another RN, is it to a less qualified person (LVN or LPN), or is a specific activity (bathing, ambulating, etc.) being delegated to an unlicensed nursing assistant?

• **Don't assign steps of the nursing process or nursing judgment to anyone except an RN.** The implementation of the nursing process and the judgments based on the nursing process must be performed by an RN.

• **Don't delegate teaching assignments to anyone except another RN.** This is another area that is the primary responsibility of the RN.

• **Keep in mind the NCLEX Hospital.** Adequate staff is available to provide client care; don't worry about staff shortages. Focus on the needs of the client in the question; what is happening in the rest of the unit is not a consideration unless it is part of the actual question. The only client to consider in each question is the one involved in that question, not the other clients the 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. For stable clients, some nursing care activities can be delegated to a nursing assistant or assigned to an LPN. When determining the stability of clients, Maslow’s hierarchy of needs must be considered (see Chapter 3, Figure 3-1). Very carefully assess and identify clients who are in a changing unstable situation, especially those clients with a potential for respiratory compromise. These are clients for whom an RN should provide the care.

• **Delegate tasks that have specific guidelines.** Those tasks that have specific guidelines that are unchanging and are used in the care of a stable client can often be delegated. Bathing, collecting urine samples, feeding, providing personal hygiene, and assisting with ambulation are just a few examples of these activities. Remember you are in the NCLEX Hospital, so carefully evaluate the question and select an answer that has the RN delegating tasks to the assistive personnel and making appropriate assignments for other licensed health care personnel.

• **Identify your priority client.** The priority client is the one who is most likely to experience problems or ill effects if not taken care of first. Priority clients include those with respiratory compromise, those whose conditions are unstable and changing, and those who are at high 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 to determine what is necessary to do first for this client.

### Establishing Nursing Priorities

Almost all nurses will agree that the NCLEX is full 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 best nursing action?”

In other words, the NCLEX wants to know whether the nurse can identify the most important nursing action to be taken in order to provide safe care for the client in the situation presented. In such cases, three or four of the options are frequently correct actions; however, one of the 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.* When evaluating options, identify client needs that are physiologic and those that are psychosocial. Physiologic needs are a higher priority than psychosocial or teaching needs. A client’s physical needs must be met before his or her psychosocial or teaching needs are considered. Also remember that the ABCs (airway, breathing, and circulation) are the critical physiologic 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! Maslow’s hierarchy of needs also applies to psychosocial questions (see the section in this chapter regarding answering psychosocial questions).

• **Nursing Process:** The first step in the nursing process is *assessment.* However, do not automatically select an option that includes the word *assess* or an option that involves assessment. Assessment must be done to analyze and construct a nursing diagnosis, to develop a plan of care, and to determine the priority of nursing care implementation. If the assessment data are provided in the stem of the question, then 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.

• **Safety Issues:** These issues may include situations in the hospital or in the client’s home environment. The first
issue to consider is meeting basic needs of survival: oxygen, hydration, 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 handwashing. 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**

**Question 1**

An RN who has been working in the labor and delivery area has been reassigned to a step-down telemetry unit for the afternoon shift. Which clients would reflect the most appropriate assignment for this nurse?

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

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

**Question 2**

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

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

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

**Question 3**

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

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

**Answer:** 1. When a client complains of chest pain, oxygen should be started immediately and then vital signs should be further assessed. In the stem of the question, a cardiac client with chest pain is presented; that is enough critical assessment information for a nursing action. It is assumed that the nurse has an order for the oxygen. Further assessment will determine the status of the vital signs, and options 2 and 4 can be completed. Listening for ectopic beats and determining breath sounds are assessment activities; however, this does not provide further definitive information for determining immediate nursing care. In option 4, whether physical exertion was a factor in the occurrence of the chest pain can be determined later, but this is not an immediate concern. Option 3 gives this client airway problems, and there is no indication in the stem that the airway is an issue at this time.

**Question 4**

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

1. Remove the dressing and place a sterile dressing soaked in saline on the wound with dry reinforcement dressings on top.
2. Remove the dressing and with sterile gloves apply very gentle pressure to replace the exposed bowel.
3. Leave the dressing in place and apply an abdominal pressure dressing to prevent further exposure of the bowel.
4. Immediately notify the health care provider and then cleanse the wound area with sterile saline solution and replace the dressing.
CHAPTER 1 Testing Strategies for the NCLEX-RN® Examination

Answer: 1. The best nursing action is to cover the exposed bowel with a sterile dressing soaked in saline to prevent drying and tissue damage to the exposed bowel; then the surgeon or health care provider should be notified. Option 2 should not be done, because there may be vascular impairment to the bowel below the surface. In option 3, the dressing needs to be replaced with a moist one to protect the bowel. In option 4, the wound needs to be covered with the moist dressing before notifying the doctor. The wound should not be cleansed, because it is not a dirty wound.

Strategies for Evaluating Multiple-Choice Questions

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Question Characteristics

The majority of questions on the NCLEX, as well as on nursing school exams, are 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 1-3)

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.

Check Out the Question!

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

Now Go for the Options …

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

Box 1-1 APPLYING TESTING STRATEGIES

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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.

   It is important to understand the question and not formulate an opinion about the answer before you 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 speculating about the future (“maybe the client will . . .”). 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: Clients with arteriosclerotic heart disease (ASHD) go through several stages before becoming severely compromised. In considering the pathophysiology of heart disease, the nurse would identify what physical response that does not occur in the early stages of ASHD?
1. Decreased urine output
2. Dyspnea on exercise
3. Anginal pain relieved by rest
4. Increased serum triglyceride levels

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

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

Example: A 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 to 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 punc-
Example: A woman who gave birth 3 days ago returns to the clinic with complaints of soreness and fullness in her breasts and states that she wants to stop breastfeeding 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 breastfeeding 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 breastfeeding 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 breastfeeding.
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 breastfeeding permanently.

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

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

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

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

The correct answer is 4. The Nix solution needs to remain on the scalp for 10 minutes before the hair is rinsed. Option 1 is too frequent for the medication to be used. Option 2 is incorrect, because the child’s clothing and toys, as well as clothing and toys of the siblings, will need to be treated. Option 3 is not correct because medication should be reapplied in 7 days.
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 x 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 actions do I need to do first?

1. Administer ceftriaxone (Rocephin), 1 g, intravenously every 4 hours.
2. Perform blood cultures x2, 20 minutes apart and drawn from different sites.
3. Apply polysporin (Bacitracin) ointment topically to leg ulcer three times a day.
4. Administer acetaminophen (Tylenol), 650-mg suppository, every 4 hours for temperature above 101.8° F.

Rank the options:

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 and is in stable condition. 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 this is a common problem 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: A client is in her third trimester of pregnancy and she is scheduled for an abdominal ultrasonogram. The nurse explains to the client that results of this exam will reveal what information regarding the fetus?

1. Maturity of the fetus’s lungs (No, this is false; the ultrasound does not show any evidence of surfactant or maturational level of the lungs.)
2. Presence of congenital heart defect (No, this is false; the ultrasound is not specific enough to reveal congenital heart defects, but will show fetal cardiac movement.)
3. Gestational age (Yes, this is true; ultrasonography gives an overall picture of bone formation [biparietal diameter (BPD)], thereby indicating gestational age.)

4. Rh factor antibody level (No, this is false; this level must be determined by a blood test to evaluate for isoimmunization or hemolytic disease of the newborn.)

After a systematic evaluation of the options, option 3 is the correct answer.

11. Identify similarities in the options. Frequently, the options will contain similar information, and 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." Ever, none, all, always, never, and only are words that have no exceptions. Options containing these words are frequently incorrect. Seldom in health care is anything absolute with no exceptions; thus you can often eliminate these options. In some situations the qualifiers are 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 listed in the option must be correct if that option is to be the correct answer to the question.

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

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

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

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 of age 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 neurologic 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 an older adult client is a significant physiologic change, often an infection (commonly in the urinary tract) or dehydration. Options 1 and 3 relate more to the gradual behavior changes seen in the progression of dementia and do 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 15 pretest or unscored items in the first 75 questions on every candidate’s examination. Within those 15 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.

The alternate format questions should not have any impact on what you study 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](image-url)
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 and make a decision whether it is to be included in the correct answer. The options are preceded by square boxes, and you can check more than one box. 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 1-4. 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, IV drip calculations, or intake and output calculations—just to name a few (Figure 1-5). 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 grams to milligrams? from liters 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.3

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 1-6. Find the requested 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 your job is to place them in a correct sequence (Figure 1-7). 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
CHAPTER 1  Testing Strategies for the NCLEX-RN® Examination

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

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

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

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

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

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

Need to know: Review each of the items in the list. Determine what is the most important action to take first, then second, etc.

This question is asking you to provide care for a client who is experiencing difficulty breathing and has chest pain. The dyspnea and chest pain are most likely a result of the client’s pneumonia. Position is the first thing that you can do that will benefit the client the most, then begin the oxygen, administer the antipyretic medication, encourage clear liquids, and teaching is last. Remember Maslow when setting priorities.

The 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 1-8 through 1-12). To begin, click on the tab on the bottom of the screen to see the exhibit; then click on the tabs within the exhibit to find the information 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.

Interpretation of information: 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.

Audio Questions

Beginning in 2010, "audio" questions will be included on the NCLEX. 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 therapeutic communication questions, do not assume...
A postoperative client complains of pain, the nurse assesses the client and determines the pain is in the abdomen around the area of the incision, pain level is 6. It is 8 p.m. in the evening and the nurse is determining what can be done regarding the client’s pain. Select the best answer based on the information in the chart.

1. Give morphine sulfate 15 mg IM now.
2. Medication cannot be administered.
3. Give morphine sulfate 10 mg IM now.
4. Give hydrocodone (Vicodan) 10 mg PO.

**FIGURE 1-8** Alternate format question—exhibit item.

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

1. Give morphine sulfate 15 mg IM now.
2. Medication cannot be administered.
3. Give morphine sulfate 10 mg IM now.
4. Give hydrocodone (Vicodan) 10 mg PO.

**FIGURE 1-9** Alternate format question—first tab on exhibit item.

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

1. Give morphine sulfate 15 mg IM now.
2. Medication cannot be administered.
3. Give morphine sulfate 10 mg IM now.
4. Give hydrocodone (Vicodan) 10 mg PO.

**FIGURE 1-10** Alternate format question—second tab on exhibit item.
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.

**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 physiologic 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 be wrong answers.

• **Look for responses that indicate an acceptance of the client.** Regardless of whether the client’s views or moral values are in agreement with yours, it is important to respect his or her views and beliefs. Responses that involve telling clients what they should or should not be doing 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).

• **Do not select options or responses that block further interaction.** These options are frequently presented as closed statements or questions that encourage a yes-or-no answer from the client. Better responses are those that indicate an expectation of a more revealing verbal response from the client. **Examples:** “Are you feeling better today?” The client can just answer no to this question. It is better to ask, “How are you feeling today as compared to yesterday?” Likewise, it is better to ask, “How did you feel when your family visited today?” rather than “Did your family visit today?”

• **Look for responses that reflect, restate, or paraphrase feelings the client expressed.** 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” is bound to be a wrong answer. It is better to ask, “How did that make you feel?”

• **Do not ask “why” a client feels the way he or she does.** Most of the time, if a client understood why he or she felt a certain way, the client would 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 not help anyone.

• **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 9** (Table 9-3).

### 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 is that you cannot go back to previously answered questions on the NCLEX. At the point at which the examination asks you to confirm your answer, review the strategies used to answer the question, confirm your answer, and move on to the next question.

• **Watch your timing. Do not spend too much time on one question.** It is very important to track your timing on practice exams. This will help you be more comfortable with timing on computer testing. The NCLEX will allow you a total of 6 hours to complete the examination. 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.) Plan for an hour of practice testing; select 60 questions, and answer the questions using testing strategies. After answering the questions, review the correct answers and focus on what and why you missed questions. Practice your timing and application of test strategies so you will be comfortable with timing and the progression of questions on the NCLEX.

• **The NCLEX is a nursing competency examination, and the correct answer will focus on nursing knowledge and the provision of nursing care.** The examination does not focus on medical management or making a medical diagnosis.

• **Eliminate distracters that include the assumption that the client would not understand or would be ignorant of the situation and those distracters that protect clients from worry.** For example, “The client should not be told she has cancer because it would upset her too much” would almost certainly be an incorrect answer.

• **There is no pattern of correct answers.** The exam is compiled by a computer, and the position of the correct answer is selected at random. So, do not believe those who say to pick option 3 when you are guessing.

### STUDY HABITS

**Study Effectively**

1. **Use memory aids, mind mapping, and mnemonics.** Memory aids and mind mapping are tools that assist you in drawing associations from other ideas with the use of visual images (Figure 1-13). 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 very effective.

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. By reviewing the information after the class presentation, you more effectively and positively reinforce the learning process.

4. **Plan your study time when you are most receptive to learning.** 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 realize at 10:30 PM 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 before leaving school than it may 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 examination, will help you to identify areas in which you need additional review. Review this information in an NCLEX Review book, and then if it is not clear or if you need further explanation and information, consult your nursing textbooks.
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 to study 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:
   • Plan to answer one question per minute. Set aside 10 questions and answer them in 10 minutes; then review the answer and rationale for the question. 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.
   • 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 on the CD that accompanies this book.
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.
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 CD with additional practice questions can be found in the back of this book. The more questions you practice answering, the more effectively you will implement test-taking strategies.

**DECREASE ANXIETY**
Your activities on the day of the examination will strongly 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. This same tutorial 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 space!
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 the other person finishes before you do, will it put increased pressure on you to hurry up and finish? You don't need any additional pressures on the day of the exam or while you are taking it.
7. Make sure your meal before the test is a light, healthy one. 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 an RN working in the area you desire. Create that mental picture of where you want to be and who you want to be—an RN. Use your past successes to bring positive energy and "vibes" to your NCLEX exam. WE KNOW YOU CAN DO IT!

REFERENCES


