LUCENT NCLEX REVIEWS

TIPS for TEST TAKING

Dr. Daniel Ampomah

The NCLEX Test Plan

- The **content** of the NCLEX-RN test plan is organized into **four major Client Needs categories.**
- **Two of the four categories are further divided into subcategories.**
- **All content categories and subcategories** reflect client needs across the life span in a variety of settings.

NCLEX Test Plan Framework

- **Client Needs** categories include the following:
- Safe and Effective Care Environment
- Health Promotion and Maintenance
- Psychosocial Integrity
- Physiological Integrity.

NCLEX Test Plan Framework

- Woven within the client needs categories are four Integrated Processes.
- Nursing process
- Caring
- Communication and Documentation
- Teaching and Learning

CLIENT NEEDS

Safe Effective Care Environment

- These questions test the concepts that the nurse provides nursing care, collaborates with others and protects clients and others from hazards.

- **FOCUS on Safety**. Remember the importance of hand-washing, call lights, bed positions and the use of side rails.

Client Need #1
Safe and Effective Care Environment
Subcategory: Management of Care: 13-19%

- **Advance Directive**
- **Advocacy**
- **Case Management**
- **Client rights**
- **Collaboration with Interdisciplinary team**
- **Concept of Management**
- **Confidentiality/Information Security**
- **Consultation**
- **Continuity of Care**
- **Delegation**

Client Need #1
Safe and Effective Care Environment
Subcategory: Management of Care: 13-19%

- Establishing Priorities
- Ethical Practice
- Informed Consent
- Legal Rights and Responsibilities
- Performance Improvement (Quality Assurance)
- Referrals
- Resource management
- Staff Education
- Supervision

Client Needs
Sample Question

A client scheduled for surgery tells the nurse that she signed an informed consent but was never told about the risks of the surgery.

The nurse serves as the client's advocate by performing which of the following actions?

Client Needs (cont'd)

1. Writing a note on the front of the client's record so that the surgeon will see it when the client arrives in the operating room.

2. Documenting in the client's record that the client was not told about the risks of the surgery.

3. Contacting the surgeon and asking the surgeon to explain the surgical risks to the client.

4. Reassuring the client that the risks are minimal and unlikely to occur.

Client Need #1
Safe and Effective Care Environment
Subcategory: Safety and Infection Control: 8 –14%

- Accident prevention
- Disaster planning
- Emergency Response Plan
- Ergonomic Principles
- Error prevention
- Handling hazardous and infectious materials
- Home Safety
- Injury Prevention

Client Need #1
Safe and Effective Care Environment
Subcategory: Safety and Infection Control: 8 –14%

- Medical and Surgical Asepsis
- Reporting of Incident/Event/Irregular Occurrence/Variance
- Safe Use of Equipment
- Security Plan
- Standard/Transmission-Based/Other Precautions
- Use of Restraints/Safety Devices

Safety and Infection Control Sample Question

The physician orders tobramycin sulfate (Nebcin) 3mg/kg IV every 8 hours for a 3-year-old boy. The nurse enters the patient's room to administer the medication and discovers that the boy does not have an identification bracelet. What should the nurse do?

A. Ask the parents at the child's bedside to state their child's name.

B. Ask the child to say his first and last name.

C. Have a co-worker identify the child before giving the medication.

D. Hold the medication until an identification bracelet can be obtained.

Health Promotion and Maintenance

- Tests the concepts that the nurse provides to assist in directing nursing care to promote and maintain health

- Relates to assisting the client during the normal expected stages of growth and development from conception through old-age.

- Providing care related to the prevention and early detection of health problems

Client Need #2:
Health Promotion and Maintenance:
6 – 12%

- The Aging Process
- Ante/Intra/Postpartum and Newborn Care
- Developmental Stages and Transitions
- Disease Prevention
- Expected Body Image Changes
- Family Planning
- Family Systems
- Growth and Development

Client Need #2:
Health Promotion and Maintenance:
6 – 12%

- Health and Wellness
- Health Promotion Programs
- Health Screening
- High Risk Behaviors
- Human Sexuality
- Immunizations
- Life Style Choices
- Principles of Teaching and Learning
- Self-Care
- Techniques of Physical Assessment

Client Needs Sample Question

A nurse is preparing to care for a hospitalized female teenager in skeletal traction. The nurse plans patient care, knowing that the most likely primary concern of the teenager is:

a. Body image
b. Keeping up with school work
c. Obtaining adequate nutrition
d. Obtaining adequate rest and sleep

Psychosocial Integrity

- These test the concepts that the nurse provides nursing care that promotes and supports the emotional, mental and social well-being of the client and family.

- Content in these questions relates to promoting the ability to cope, adapt or problem solve in situations such as illnesses, disabilities or stressful events such as abuse, neglect or violence.

Client Need #3
Psychosocial Integrity: 6-12%

- Abuse/Neglect
- Behavioral Interventions
- Chemical Dependency
- Coping Mechanisms
- Crisis Intervention
- Cultural Diversity
- End of Life
- Family Dynamics
- Grief and Loss
- Mental Health Concepts

Client Need #3
Psychosocial Integrity: 6-12%

- Psychopathology
- Religious and Spiritual Influences on Health
- Sensory/Perceptual Alterations
- Situational Role Changes
- Stress management
- Support Systems
- Therapeutic Communication
- Therapeutic Environment
- Unexpected body image

Client Needs Sample Question

A boy is brought to the school nurse's office with reports of abdominal pain. On assessment, the nurse notes the presence of several bruises on the child's abdomen and back and several cigarette burn marks. The nurse suspects child abuse and plans for which priority action?

a. Documents the bruises noted on the child's body.
b. Calls the parents to ask them how the child's bruises and burn marks occurred.
c. Notifies Child Protective Services to facilitate the removal of the child from the abusive situation in order to prevent further injury.
d. Asks the child how long his parents have been abusing him.

Client Needs Sample Question

A 50-year-old male patient comes to the nurses' station and asks the nurse if he could go to the cafeteria to get something to eat. When told that his privileges do not include visiting the cafeteria, the patient became verbally abusive. Which of the following approaches by the nurse would be most effective?

a. Tell the patient to lower his voice because he is disturbing the other patients.
b. Ask the patient what he wants from the cafeteria and have it delivered to his room.
c. Calmly but firmly escort the patient back to his room.
d. Assign a nursing assistant to accompany the patient to the cafeteria.

Physiological Integrity

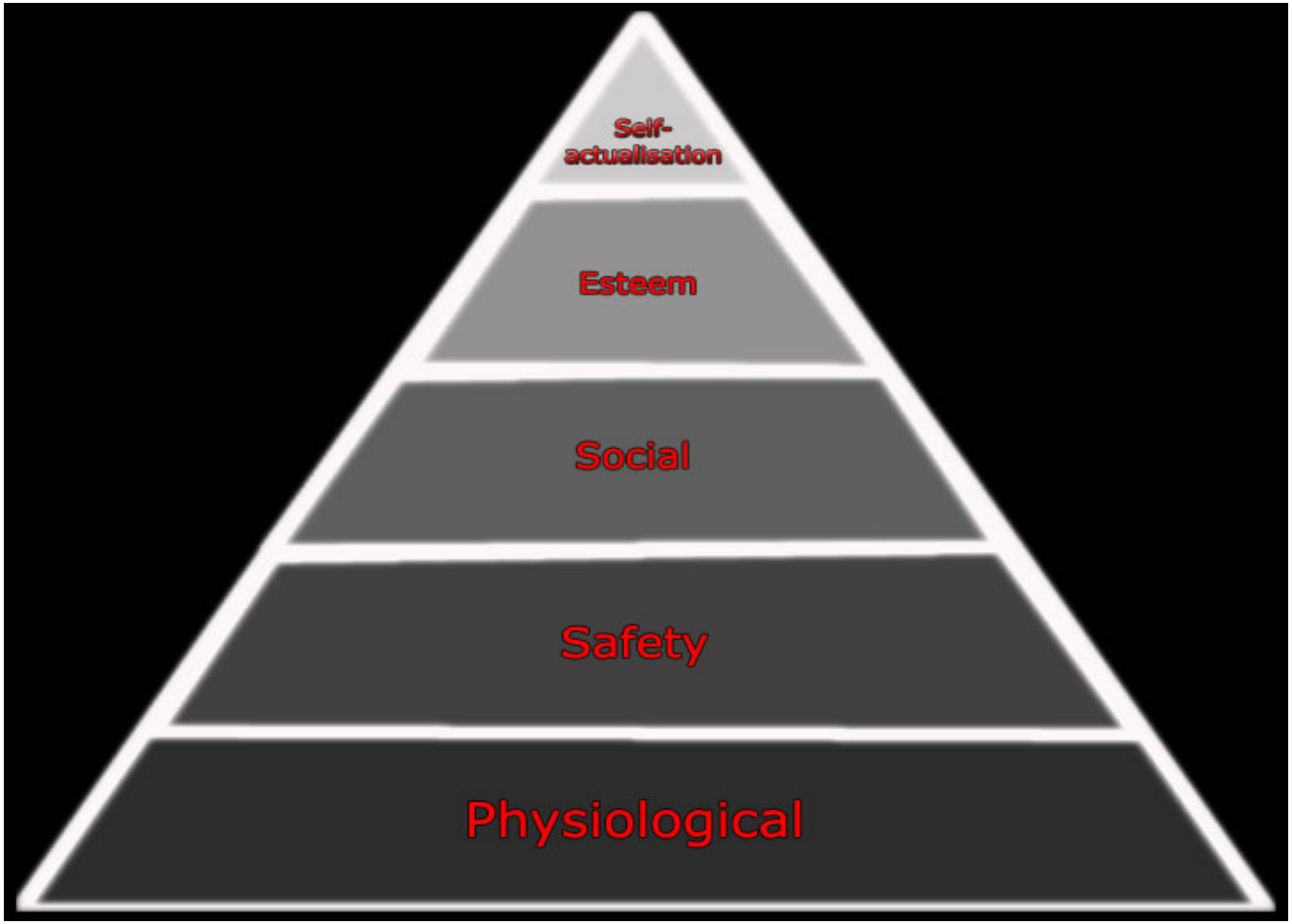
- These questions test the concepts that the nurse provides **COMFORT** and **ASSISTANCE** with the ADL's, and care related to the administration of medication.

  - **REDUCING potential for complications related to treatments, procedures or existing conditions**
  - **Remember MASLOW – the PHYSIOLOGICAL NEEDS take priority and are addressed first.**

Maslow's Hierarchy of Needs Theory

- What is Maslow's Hierarchy of Needs Theory?
- How will understanding the needs theory help with prioritizing nursing interventions?
- How does the hierarchy apply to a NCLEX candidate's life?

Maslow's Hierarchy of Needs



Maslow's Hierarchy of Needs in Descending Order

5th. Self-Actualization

4th. Self-Esteem

3rd. Love & Belonging

2nd Safety & Security

1st. Physiological Needs

Physiological Needs

- According to Maslow, physiologic needs are the **highest priority** and **must be met first.**

- **Physiologic needs are necessary for survival.**

Oxygen	Elimination
Fluid	Shelter
Nutrition	Rest
Temperature	Sex

Safety and Security
Physical and Psychosocial

- Physical safety includes decreasing what is threatening to the patient.
- The threat could be an illness, accidents, or environmental threats.
- Psychological safety states that the client must have adequate knowledge and an understanding about what to expect from others in his environment.

Love & Belonging

- Client needs to feel loved by family and accepted by others.
- When a client feels self-confident and useful, he will achieve the need of esteem as described by Maslow.

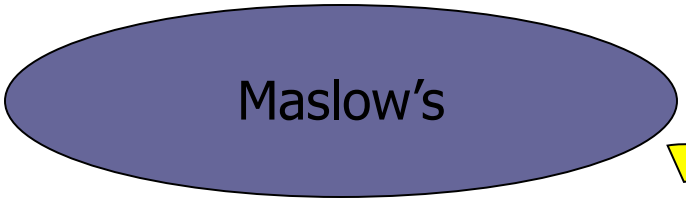
Self Esteem

- How one feels about himself/herself
- Feelings of adequacy or inadequacy

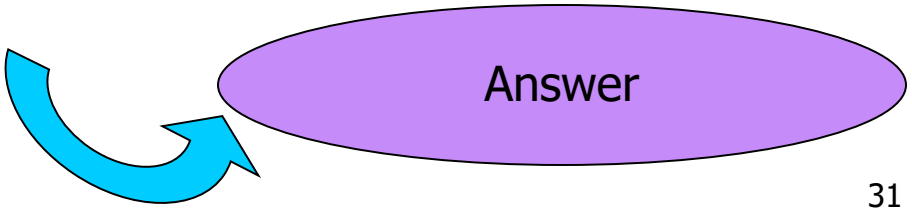
Self-Actualization

- This is the highest level of Maslow's hierarchy of needs.
- To achieve this level, the client must experience fulfilment and recognize his or her potential.
- In order for self-actualization to occur, all of the lower level needs starting with physiologic must first be met.

How to Apply Maslow's Needs to Establish Priorities of Care



- First recognize that answer options include both physical and psychosocial needs.
- Next eliminate the psychosocial answer.
- Ask yourself "Does this make sense in this case?"
- Finally apply the "ABCs" of care. **A**irway, **B**reathing, **C**irculation



Application of Maslow's Hierarchy

A woman is admitted to the hospital with a ruptured ectopic pregnancy. A laparotomy is scheduled. Which preoperative nursing intervention is most important for the nurse to consider in this patient's plan of care?

a. Fluid Replacement
b. Pain Relief
c. Emotional Support
d. Respiratory Therapy

Physical Needs First

The nurse obtains a diet history from a pregnant 16-year-old girl. The girl tells the nurse that her typical daily diet includes cereal and milk for breakfast, pizza and soda for lunch, and cheeseburger, milkshake, fries and salad for dinner. Which of the following is the most accurate nursing diagnosis based on this data provided?

Highest Priority Need

1. Altered nutrition: more than body requirements related to high-fat intake.
2. Knowledge deficit: nutrition in pregnancy.
3. Altered nutrition: less than body requirements related to increased nutritional demands of pregnancy.
4. Risk for injury: fetal malnutrition related to poor maternal diet.

Prioritizing Care

The nurse plans care for a 14-year-old girl admitted with an eating disorder. On admission, the girl weighs 82 lbs. and is 5’4” tall. Lab test indicate severe hypokalemia, anemia and dehydration. The nurse should give which of the following nursing diagnoses the highest priority?

Physiological needs are most important. Remember the “ABCs”!

1. Body image disturbance related to weight loss.
2. Self-esteem disturbance related to feelings of inadequacy.
3. Altered nutrition: less than body requirements related to decreased intake.
4. Decreased cardiac output related to the potential for dysrhythmias.

Client Need #4
Physiological Integrity
Basic Care and Comfort: 6-12%

- Alternative and Complementary Therapies
- Assistive Devices
- Elimination
- Mobility and Immobility
- Non-Pharmacological Comfort Interventions
- Nutrition and Oral Hydration
- Palliative and Comfort Care
- Personal Hygiene
- Rest and Sleep

Client Needs Sample Question

A nurse has provided information to a client about measures that will promote normal urination patterns and prevent urinary tract infections. Which statement by the client indicates a need for further information?

a. “I should take my furosemide (Lasix) in the morning.”
b. “I should drink plenty of fluids during the day.”
c. “I should try and hold my urine as long as I can rather
than expelling it when I feel the urge.”
d. “I should eat foods that will make my urine acidic.”

Client Need #4
Physiological Integrity
Pharmacological and Parenteral Therapies:
13 – 19%

- Adverse effects/Contraindications
- Blood and Blood Products
- Central Venous Access Devices
- Dosage Calculations
- Expected Outcomes/Effects
- Intravenous Therapy
- Medication Administration
- Parenteral Fluids
- Pharmacological Agents/Actions
- Pharmacological Interactions
- Pharmacological Pain Management
- Total Parenteral Nutrition

Client Needs Sample Question

Cyclosporine (Sandimmune) oral solution is prescribed for a patient who had a kidney transplant. The nurse provides information to the patient about the medication and tells the patient that which of the following is most important to monitor?

a. Temperature
b. Peripheral pulses
c. Platelet count
d. Apical heart rate

Client Need #4
Physiological Integrity
Reduction of Risk Potential: 13 –19%

- Diagnostic Tests
- Laboratory Values
- Monitoring Conscious Sedation
- Potential for Alterations in Body Systems
- Potential Complications of Diagnostic Tests/ Treatments/Procedures
- Potential for Complications from Surgical Procedures and Health Alterations
- System Specific Assessments
- Therapeutic Procedures
- Vital Signs

Client Needs Sample Question

A 7-year-old girl with type I insulin dependent diabetes mellitus (IDDM) has been home sick for several days and is brought to the ER by her parents. If the child is experiencing ketoacidosis, the nurse would expect to see which of the following lab results?

a. Serum glucose 140 mg./dl
b. Serum creatine 5.2 mg./dl
c. Blood pH 7.28
d. Hematocrit 38%

Client Need #4
Physiological Integrity
Physiological Adaptation: 11 – 17%

- Alteration in Body Systems
- Fluid and Electrolyte Imbalances
- Hemodynamics
- Illness Management
- Infectious Diseases
- Medical Emergencies
- Pathophysiology
- Radiation Therapy
- Respiratory Care
- Unexpected Response to Therapies

Integrated Processes

These "threads" of knowledge are fundamental to the practice of nursing and are integrated throughout the Patient Needs categories and subcategories.

Four Integrated Processes Categories

1. ***Nursing Process*** *is a scientific problem solving approach to client care that includes assessment, analysis, planning, implementation and evaluation.*

Four Integrated Processes Categories

2. Caring *is the interaction of the nurse and patientin an atmosphere of mutual respect and trust. In this collaborative environment, the nurse provides encouragement, hope, support and compassion to help achieve desired outcomes.*

Four Integrated Processes Categories

3. Communication/Documentation

Communication *is the verbal and nonverbal interaction between the nurse and the client, the client's significant others and the other members of the health care team.*

Documentation *relates to events and activities associated with client care which are validated in written and/or electronic records that reflect standards of practice and accountability in the provision of care.*

Four Integrated Processes Categories

4. ***Teaching/Learning*** *is the facilitation of the acquisition of knowledge, skills and attitudes promoting a change in behavior. It is the distribution of content.*

6 Types of Questions on the NCLEX Exam

- **Multiple choice -** one correct answer
- **Fill-in-the-Blank -** type in the answer
- **Hot Spot -** select a specific area on a diagram or illustration
- **Exhibit -** information needed for the answer is in the form of an exhibit or spreadsheet.
- **Ordered response -** select choice in the proper sequence (prioritize)
- **Multiple response -** more than one answer is correct; select all that apply

The Multiple-Response Items (SATA)

- A multiple-response item presents a stem that asks a question.
- It presents five or six options as potential answers.
- The test-taker must identify all (one or more) correct answers to the question posed in the stem.

The RACE Model: A Critical-Thinking Strategy to Answer Multiple-Choice Questions

The RACE model has four steps to answering a test question:

R

- Recognize what information is in the stem.
- Recognize the key words in the stem.
- Recognize who the client is in the stem.

A

- Ask what is the question asking?
- Ask specifically what the question is asking you to do.

The RACE Model: A Critical-Thinking Strategy to Answer Multiple-Choice Questions

C

- Critically analyze the options in relation to the question asked in the stem.
- Critically scrutinize each option in relation to the information in the stem.
- Critically identify a rationale for each option.
- Critically compare and contrast the options in relation to the information in the stem and their relationships to one another.

E

- Eliminate as many options as possible.
- Eliminate one option at a time.

EXAMPLES

How does the medication docusate sodium (Colace) facilitate defecation?

1. Dilates the intestinal lumen
2. Forms a bulk residue
3. Irritates the intestinal wall
4. Stool Softener

A frail, malnourished older adult has been experiencing constipation. Which medication does the nurse anticipate that the practitioner will most likely prescribe?

1. Bisacodyl (Dulcolax)
2. Docusate sodium (Colace)
3. Mineral oil (Haley's M-O)
4. Magnesium hydroxide
   (milk of magnesia [MOM])

The mother of a terminally ill child says, "I never thought that I would have such a sick child." What is the best initial response by the nurse?

1. "How do you feel right now?"
2. "What do you mean by sick child?"
3. "Life is not fair to do this to a child."
4. "It's hard to believe that your child is so sick."

Which patient has the greatest risk for developing a pressure ulcer?

1. An older adult on bed rest
2. A toddler learning to walk
3. A thin young woman in a coma
4. An emotionally unstable middle-aged man

Signs and symptoms of postthyroidectomy respiratory obstruction vary with the degree of severity. Which early sign(s) and symptoms (s) would the nurse expect with pending respiratory distress? *Select all that apply*

1. Hoarseness of voice
2. Stridor
3. Difficulty swallowing
4. Cyanosis
5. Choking sensation

A patient is to receive a 250 mL unit of packed red blood cells to infuse over two hours. The blood administration set has a drip factor of 10gtt/ml. What is the flow rate in drops per minute?

The nurse is preparing a staff education program about the stages of childhood development. Place the stages listed below in ascending chronological order. Use all the options.

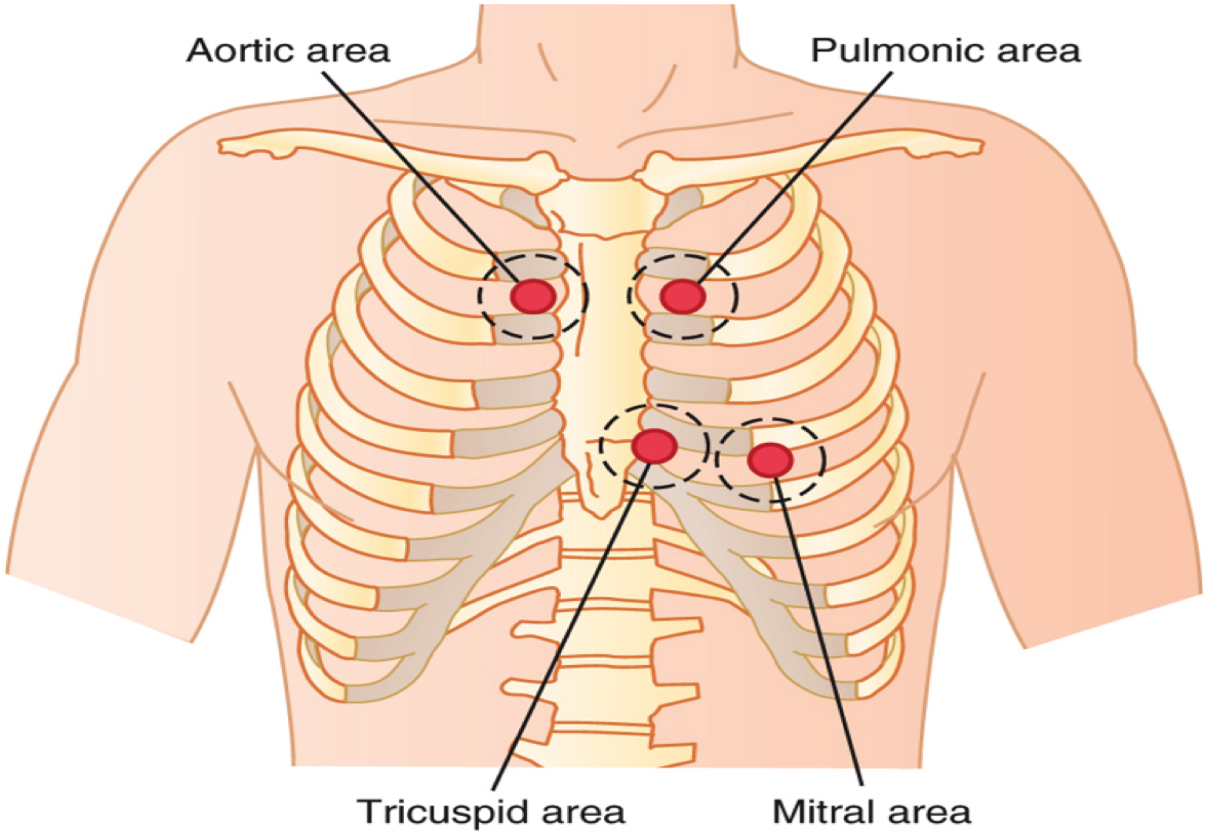
Unordered Options

- Toddlers
- Adolescence
- Infancy
- School Age
- Preschooler

Source: www.ncsbn.org

A heparin drip is being administered at a rate of 18 ml/hour. The bag of fluid has 25,000 units of heparin in 500 ml of saline. How many units of heparin is the client receiving per hour?

The nurse is performing a cardiac assessment on a client. Identify the area where the nurse should place the stethoscope to best auscultate the mitral valve.



You enter your patient's room and discover a fire. Place your actions in the appropriate order.

Unordered Options

A. Contain the fire
B. Remove the patient from the room
C. Activate the alarm
D. Extinguish the flame

Ordered Response

Test Taking Strategies

- Critical Thinking
  - Creativity
  - Problem solving
  - Decision making
- Never one right answer that is always correct in every situation.
- Select the safest nursing judgment among the listed options.

General Test-taking Rules

- Identify the topic of the question
- Select an answer by eliminating choices
- Do not use background information unless absolutely necessary.
- Do not read into the question.
- Remember this is **TEXTBOOK NURSING**.

A monoamine oxidase inhibitor is prescribed for the client. The nurse instructs the client that which of the following is a sign/symptom of toxicity related to the use of this medication?

1. Restlessness
2. Feeling of fatigue
3. Lack of energy
4. Lethargy

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

1. Begin oxygen administration
2. Listen to heart sounds for ectopic beats
3. Auscultate breath sounds and maintain airway.
4. Determine what the client was doing before onset of pain.

Don’t read into the question

- The information provided in the question is all you need.
- If you ask yourself, “What if….” you are reading into the question.
- Read the stem carefully ***before*** you read the answer choices. Try to determine what the question is asking before you read the answer choices.
- If you can’t figure out what the question is asking – then look to the alternatives for clues.

Avoid “what if…”

- **Don’t READ INTO the question**
- **Focus only on the information in the question**
- **Read every word and decide what the question is asking.**
- **Look for strategic words**
- **Always use the process of elimination**
- **Determine if the question is a positive or negative event query.**

A woman during the transition phase of labor complains of lightheadedness and a tingling sensation in her fingers. Which of the following actions should the nurse take next?

1. Have the woman breathe into a paper bag held tightly against her mouth and nose.
2. Encourage the woman to pant and blow with the next contraction.
3. Instruct the woman to take a cleansing breath and refocus her concentration.
4. Tell the woman to pant three times and exhale against pursed lips.

The nurse prioritizes her morning schedule to assess which of the following clients first?

1. A young adult with complaints of severe back pain.
2. An adult admitted to the unit with acute pancreatitis complaining of unrelenting abdominal pain.
3. An older client who complains of foot and ankle pain.
4. A newly admitted client who complains of jaw pain and indigestion.

Psychosocial vs Physical Needs

- In general – eliminate the psychosocial choices, then prioritize the physical alternatives.

Use ABC's to prioritize physical needs

- Airway
- Breathing
- Circulation
- Safety

Pain……Pain…… Pain

- Psychosocial need…usually will address after the physical needs are met.
- The answer might be pain if
  - Sudden increase in the level of pain (acute, sudden pain)
  - Pain is not controlled by the pain med

Watch out for tricks…

- Oxygen…Respiratory
- Communication – avoid choices with "I".
- Many times there will be more than one right answer…watch out for "which action should the nurse take first…"; "Which of the following is an early sign of …" etc.

1. **Fluid replacement**… physical or psychosocial
2. **Pain relief**… physical or psychosocial?
3. **Emotional support**….physical or psychosocial?
4. **Aerosol therapy**… physical or psychosocial?

A patient is admitted with a diagnosis of ruptured abdominal aortic aneurysm. Preoperatively, which goal is MOST important for the nurse to include in the plan of care?

1. Fluid replacement
2. Pain relief
3. Emotional support
4. Aerosol Treatment

ABSOLUTES – Make Answers Wrong

- **Absolutes tend to make answers WRONG**
- **Look for: ALWAYS, NEVER, ALL, NONE, MUST, ONLY, EVERY, CAN'T, WON'T, NONE**
- **These are usually incorrect statements.**
- **QUALIFIED ANSWERS such as: USUALLY, FREQUENTLY, OFTEN, GENERALLY, MAY, POSSIBLY, are usually CORRECT.**

Examples of Absolute Words

- **Always** advise clients to eat low sodium foods.
- Drink fluids **only** if they are fat-free.
- Eat **only** foods that have less than 1% fat content
- **Never** use butter for cooking.

Examples of Tentative Words

Nursing actions are **usually** in the clients' best interest.

It is **sometimes** necessary to call for an emergency support team.

Hot liquids **may** cause skin damage if spilled.

Often times clients who break their legs need instruction in crutch walking.

"ESSENTIAL" QUESTIONS

- **When the question asks what is ESSENTIAL – THINK SAFETY!**
- **Essential means that you must do it and IT CANNOT BE LEFT UNDONE!**
- **When setting priorities remember MASLOW's HIERACHY of needs.**
- **REMEMBER – "Keep them breathing, keep them safe."**
- **Also consider which actions will prevent complications**

Look for Key Words "INITIAL"

- **Look for words that focus on the issue.**
- **Look for: *Early or Late symptoms; most or least likely to occur.***
- **These words are easy to miss unless you practice LOOKING for them**
- **Look for INITIAL nursing action. This means first – think of the FIRST STEP in the Nursing Process - assessment**

Laboratory Values Sample Question

A client with a diagnosis of sepsis is receiving antibiotics by the intravenous route. The nurse assesses for nephrotoxicity by closely monitoring which of the following laboratory values?

Laboratory Values Sample Question Possible Answers

a. Lipase level
b. Platelet count
c. White blood cell count
d. Blood urea nitrogen

Nursing Interventions

- Although sometimes appropriate, avoid jumping immediately to an answer that recommends immediate referral to the patient's M.D.
- NCLEX is examining your abilities as a nurse and doesn't **usually** want immediate referral to other members of the health care team.

Visualization as a Test-Taking Strategy

- Visualize the specific information in the case situation in order to answer the question.
- See yourself performing the procedure, assessing the client, delegating the care, etc.
- Remember that clinical practice can vary depending upon where it is practiced and who is performing the care.
- Be certain that you draw upon knowledge and skills which come from nursing textbooks.

Visualization Sample Test Question

A nurse prepares to perform a sterile dressing change on an abdominal incision. The nurse explains the procedure to the patient, washes her hands and sets up the sterile field. The nurse takes which action next?

Visualization Sample - Answer Options

a. Assesses the integrity of the abdominal incision.
b. Cleans the wound with Betadine solution as prescribed.
c. Dons clean gloves and removes the old dressing.
d. Dons sterile gloves and begins the procedure.

The Odd Man Wins

- The option that is most different in length, style or content is usually correct.
- The correct answer is often the longest or the shortest.
- If two or three answers say the same think in different words – they can't all be correct
- (poor appetite and anorexia are examples)

Opposites

When two answers are opposites, such as hypotension and hypertension – the answer is usually one of the two.

An adult is admitted in shock. Which assessment finding would you expect to find?

1. Elevate blood pressure
2. Low blood pressure
3. Slow Pulse
4. Flushed color.

Choices 1 and 2 are opposites. The answer will most likely be one of those. The answer is ?

Positive and Negative Event Queries

- **A positive event query uses strategic words that ask you to select an option that is CORRECT.**
- **A negative event query uses strategic words that ask you to select an option that is INCORRECT.**
- **A common one: "Which statement indicates a client's need for further teaching"**

Look for the Umbrella Option

- Always look for the UMBRELLA option
- The umbrella option is one that is a **BROAD or UNIVERSAL** statement and usually contains the concepts of the others options with it.
- The UMBRELLA option will often be the CORRECT Answer

Example of an Umbrella Option

A client is admitted and is diagnosed with urethritis caused by chlamydial infection. The nurse assigned to the client understands that what precautions are necessary to prevent contraction of the infection during care?

- 1. Enteric Precautions
- 2. Contact Precautions
- 3. **Standard Precautions**
- 4. Wearing gloves and a mask

Recall the this infection is sexually transmitted. Also note that 3 is the umbrella option. It is correct.

Use Guidelines for Delegating and Making Assignments

- **Always think about the job description or role of the employee**
- **Think about the needs of the client**
- ***Remember to match the client needs with the scope of practice of the health care provider. KEY***
- **Someone needing tube feedings and dressing changes would need a licensed nurse**

Delegation

- What tasks must be performed by an RN?
  - Teaching
  - Assessment
  - Most invasive interventions (irrigations…)
- What tasks are delegated to a NA, UAP, CAN, CP?
  - Routine, unchanging tasks.
- What can an LPN, LVN do?

Pyramid Points

- Do not take antacids with meds
- Do not crush enteric-coated and sustained-release meds (could have SR in the name)
- Pt should never suddenly stop a med
- Nurse never adjusts a med dose..
- Pt avoid over-the-counter meds unless approved by MD
- Avoid alcohol & smoking
- Never administer the med if order is difficult to read or unclear.
- Many patients have digestive problems associated with milk products

TEST YOUR ANSWERING SKILLS

The nurse sees smoke coming from the nurse's lounge. Sequence her actions below in the order in which they should be performed.

1. Close the door to the nurses' lounge.
2. Move the patients who are in the rooms closest to the lounge to the other end of the hallway.
3. Ask the ward secretary to call a Code Red (fire).
4. Aim the fire extinguisher at the base of the fire and sweep from side to side.

Which of the following would require a nursing intervention?

1. The client's family has brought in a blow-dryer just purchased at Wal-Mart for her to use while in the hospital.
2. A nursing student has unplugged the IMED pump as she prepares to clean the device.
3. The client has brought in a two-prong extension cord so that he can move his clock radio closer to his bed.
4. The CNA has used the unit's three-prong extension cord to plug in the intermittent pulsatile compression device for an immobilized client. The cord is running along the left side of the client's bed.
5. The client was transferred to the acute care setting for follow up treatment for chest pain. She has brought a fan with her that she used at the long term care facility.

1. The client's family has brought in a blow-dryer just purchased at Wal-Mart for her to use while in the hospital. ***Must be approved by facility…***
2. A nursing student has unplugged the IMED pump as she prepares to clean the device.
3. The client has brought in a two-prong extension cord so that he can move his clock radio closer to his bed. ***Three-prongs required on all electrical devices.***
4. The CNA has used the unit's three-prong extension cord to plug in the sequential compression device for an immobilized client. The cord is running along the left side of the client's bed. ***Must secure with electrical tape.***
5. The client was transferred to the acute care setting for follow up treatment for chest pain. She has brought a fan with her that she used at the long term care facility

Must be approved by facility

Which actions described below would be appropriate when caring for a client with a radioactive implant?

1. The RN organizes the client's care so that all tasks are done during one visit to the client's room.
2. The RN delegates all tasks related to this client's care to the nurse extern (a senior nursing student) who is working on her team.
3. The RN sits on the side of the bed as she informs the client about lab results that are not "good".
4. The RN wears a lead apron whenever she is in the client's room.

1. The RN organizes the client's care so that all tasks are done during one visit to the client's room.

Too much time in room

2. The RN delegates all tasks related to this client's care to the nurse extern (a senior nursing student) who is working on her team.

Inadequate knowledge base, experience

3. The RN sits on the side of the bed as she informs the client about lab results that are not "good".

Too close!!!

4. The RN wears a lead apron whenever she is in the client's room.

Physical restraints are being used to keep a client from climbing out of bed. Which of the following are true statements re: restraints?

1. Restraints can be ordered prn.
2. The MD order for restraints stands for the remainder of the time the client is in the hospital. No further orders are needed.
3. Skin integrity and neurovascular checks should be performed every 30 minutes while the restraint is in place.
4. Restraints should be removed every four hours as the client is assisted to perform ROM exercises.

1. Restraints can be ordered prn.

NEVER! Must include type, client behavior that mandates, time frame for use.

2. The MD order for restraints stands for the remainder of the time the client is in the hospital. No further orders are needed.

Order must be renewed within a specified time frame.

3. Skin integrity and neurovascular checks should be performed every 30 minutes while the restraint is in place.

4. Restraints should be removed every four hours as the client is assisted to perform ROM exercises.

Every two hours.

Which of the following is recommended in a case of expected poisoning?

1. Rush victim to the nearest Emergency Department.
2. Induce vomiting, then call the Poison Control Center.
3. Save all vomitus and deliver to the Poison Control Center.
4. Induce vomiting immediately if a household cleaner is the expected poison.

Which of the following clients would be placed on airborne precautions?

1. 7 year old who is neutropenic.
2. 22 year old who is HIV+.
3. 18 year old with varicella (Chickenpox).
4. 35 year old with MRSA.

Which of the following describes the proper way to maintain droplet precautions during client transport?

1. A client on droplet precautions would never be allowed to leave his room.
2. The nurse transporting the client should wear a gown, glove, mask. The client is covered with a sheet.
3. The client is required to wear a non-rebreathing mask during transport.
4. The client should wear a mask during transport.

Which client described below would be at highest risk of developing Anthrax?

1. A postal worker with impetigo opens an envelope with the Bacillus anthracis toxin inside.
2. A postman with COPD delivers a box that has the Bacillus anthracis toxin inside.
3. A public high school lunch lady serves food that has been contaminated with the Bacillus anthracis.
4. A mother hugs her child after learning that the child has Anthrax.

Which of the following is a true statement?

1. 3 ml is the maximum amount that should be administered into one IM site.
2. 2 ml is the maximum amount that should be administered into one sq site.
3. The tuberculin syringe holds 10 ml of solution.
4. Insulin may be administered using any 1 ml syringe.

Which of the following is a true statement?

1. 3 ml is the maximum amount that should be administered into one IM site.
2. 2 ml is the maximum amount that should be administered into one sq site. ***1ml***
3. The tuberculin syringe holds 10 ml of solution. ***1ml***
4. Insulin may be administered using any 1 ml syringe. ***Only insulin syringes***

The 1000ml IV solution is to infuse over an 8 hour time period. Calculate drops per minute if a minidrip (60 gtts/ml) is being used.

1. 50 gtts/minute
2. 75 gtts/minute
3. 100 gtts/minute
4. 125 gtts/minute

The MD has prescribed heparin sodium 1000 units per hour by continuous IV infusion. The pharmacy prepares the medication and delivers an IV bag with 10,000 units per 100 ml. The nurse sets the infusion pump at how many ml per hr to deliver the prescribed dose?

1. 10 ml/hr
2. 15 ml/hr
3. 20 ml/hr
4. 25 ml/hr

A nurse in the Emergency Room discovers an adult unconscious on the floor in the waiting area. What action should she take first?

1. Call a code.
2. Place the client in a supine position.
3. Use the head tilt method to open the airway.
4. Shake the client gently and shout, “Are you OK?”.

What is the proper way to check for a pulse for a victim who is 4 years old?

1. Carotid artery
2. Cardiac apex
3. Brachial artery
4. Radial artery

The Automatic External Defibrillator should not be used on which of the following clients?

1. 58 year old male with Cardiovascular disease
2. 72 year old female with a significant history of CVA.
3. 6 year old with asthma
4. 28 year old with a history of a seizure disorder.

Which of the following is a true statement about the nurse's role in obtaining informed consent?

1. The nurse who receives the client in the holding area of the OR is responsible for obtaining informed consent.
2. The nurse assigned to the client 24 hours before the surgery is responsible for obtaining informed consent for the surgical procedure.
3. The circulating nurse is responsible for obtaining informed consent only if an outpatient surgical procedure is performed.
4. The nurse is responsible for ensuring that informed consent has been obtained by the MD prior to the surgical procedure.

When should NSAIDs be discontinued if a client is scheduled for a surgical procedure?

1. 2 weeks preop
2. 48 hours preop
3. 24 hours preop
4. 6 hours preop

The client has just experienced a wound dehiscence. He tells the nurse that he felt something "pop" and then began to experience excruciating pain. Sequence the actions the nurse should take in this situation.

1. Notify the MD
2. Lower the client's head.
3. Cover the area with a sterile saline dressing
4. Administer prn antiemetics.

Which of the following nursing actions will facilitate medical therapy for a client with COPD?

1. Limiting fluid intake to prevent volume overload and heart failure.
2. Oral and endotracheal suctioning as necessary.
3. Instructing the client in deep breathing and coughing techniques and pursed-lip exhalations.
4. Maintenance of bed rest and activity restrictions to reduce acidosis.

The nurse is teaching a student nurse to insert a nasogastic tube. Which of the following describes the most appropriate method to use to verify tube placement?

1. Insert 5-10 ml of air into the tube and listen for a rush of air in the stomach.
2. Place the end of the tube in a glass of water and assess for bubbling.
3. Aspirate gastric content to check for pH.
4. Obtain an X-ray.

The nurse is supervising a student as she administers a tube feeding. The nurse would intervene if she observed which of the following:

1. The student nurse elevates the head of the bed to 90 degrees.
2. The student nurse aspirates for residuals, measures the residual, checks the pH of the residuals, then discards the residuals.
3. The students nurse assesses for the presence of bowel sounds.
4. The student nurse warms the feeding to room temperature, then begins the feeding.

An endotracheal tube has just been inserted. What action should be performed first?

1. Assess for bilateral breath sounds
2. Call for a chest x-ray
3. Obtain an arterial blood gas
4. Administer prn for pain.

The nurse is supervising a student nurse as she cares for a client with a chest tube to water seal drainage via a Pleur-Evac drainage system. Which action below would necessitate an intervention by the nurse?

1. The student nurse measures drainage by emptying the contents of the Drainage Collection Chamber.
2. The student nurse checks to ensure that the drainage tubes are free of kinks.
3. The student nurse checks the water seal chamber for bubbling.
4. The student nurse checks the fluid volume in the suction control chamber.

The nurse finds that the client's Pleur-Evac is cracked and leaking. The client's respiratory rate is 49 and he is complaining of pain and severe "nervousness". Which of the following interventions should be performed first?

1. Administer prn for anxiety/nervousness
2. Administer prn for pain
3. Place the chest tube in a bottle of sterile water.
4. Replace the damaged Pleur-Evac and reattach the chest tube.

In preparing a client for a left lung thoracentesis, how should the nurse position the client?

1. Left lateral
2. Supine with arms over head
3. Prone without a pillow
4. Sitting forward with arms on bedside stand

A unlicensed assistive personnel (UAP) is caring for a client with a nasogastric tube. Which of the following interventions cannot be delegated to the UAP?

1. Repositioning the tube
2. Recording output
3. Documenting the color of drainage
4. Emptying the nasogastric bag.

A client with a nasogastric tube to suction begins to complain of abdominal discomfort. Which intervention would the nurse implement first?

1. Reposition the nasogastric tube
2. Check the function of the suction equipment
3. Irrigate the nasogastric tube
4. Call the physician

A client presents to the emergency department with upper gastrointestinal bleeding and is in moderate distress. In planning care, which nursing action would be the first priority for this client?

1. Thorough investigation of precipitating events
2. Insertion of a nasogastric tube and hematest of emesis
3. Complete abdominal examination
4. Assessment of vital signs

A client returns from surgery after a bowel resection. Which of the nurse's interventions has the highest priority?

1. Administer intravenous fluids
2. Monitor vital signs frequently
3. Maintain the client's NPO status
4. Assess client's pain level

The nurse is preparing to administer an enema. The nurse positions the client in the

1. Left lateral position with the right leg acutely flexed
2. Right Sims' position
3. Dorsal recumbent position
4. Right lateral position with the left leg acutely flexed

The client is about to undergo a lumbar puncture. The nurse describes to the client that which of the following positions will be used during the procedure?

1. Side-lying with legs pulled up and the head bent down onto the chest
2. Side-lying with a pillow under the hip
3. Prone with a pillow under the abdomen
4. Prone in slight Trendelenburg's position

The client has had surgery to repair a fractured left hip. The nurse obtains which of the following most important items to use when repositioning the client from side to side?

1. Abductor splint
2. Adductor splint
3. Bed pillow
4. Overhead trapeze

Before administering an intermittent tube feeding through a nasogastric tube, the nurse assesses for gastric residual. The nurse understands that this procedure is important to

1. Confirm proper nasogastric tube placement
2. Observe gastric contents
3. Assess fluid and electrolyte status
4. Evaluate absorption of the last feeding

The client is brought into the emergency room in ventricular fibrillation. The advanced cardiac life support nurse prepares to defibrillate by placing conductive gel pads on which part of the chest?

1. To the upper and lower half of the sternum
2. To the right of the sternum just below the clavicle and to the left of the precordium
3. To the right shoulder and in the back of the left shoulder
4. Parallel between the umbilicus and the right nipple

NEXT

FUNDAMENTALS
FOUNDATIONS OF NURSING