Unique Approach to Success on the NCLEX-RN©

Test Strategies, Embedded Linking, Conceptualization and Practice

LOIS S. MARSHALL, PHD, RN
NURSE EDUCATION CONSULTANT
NCLEX-RN/PN EXPERT
AUTHOR, TAKE CHARGE OF YOUR NURSING CAREER
To open and close your control panel click the orange arrow.

Submit questions and comments via the Questions panel. To test out this feature enter the state or country you are joining us from.

**Note:** Today’s presentation is being recorded and will be available on the Sigma Repository in 48 hours.
Myths re: NCLEX-RN® Exam

- Number of questions=Success or Failure
- Length of time=Success or Failure
- Types of questions=Success or Failure
- State you take exam in=Success or Failure
- NCLEX is easier now because of changes due to pandemic=True or False
- Best studying is done by reading review book=True or False
- Focus on what your friends/faculty tell you about exam=True or False
Preparing for NCLEX-RN®

- Know yourself as a test taker/studier

- Best methods for preparation towards your success
  - What to use for study preparation
  - How much should you study
  - Know about the test plan
  - Controllable circumstances...maximize
  - Uncontrolled variables
Marshall’s© Linking and Conceptualization Strategies For NCLEX-RN®

Test Taking Strategies for Success

- What are linking and conceptualization?

- How can these strategies assist me on NCLEX-RN®
Practice Questions

(Some original (Marshall) or modified, and/or adapted from work done initially for Silvestri (Saunders, 2011))
Oxygen through nasal cannula at 2L/min is prescribed for a client. The nurse avoids which of the following actions in the care of the client?

a. Applying water soluble lubricant to the nares
b. Instructing the client and family about the purpose of the oxygen
c. Humidifying the oxygen
d. Instructing the client to breathe through the nose only
Question 2

A nurse is assessing a client with a diagnosis of bulimia nervosa who has problems with her nutrition. The nurse would obtain information from the client about which of the following first?

a. Feelings about self and body weight
b. Eating patterns and food preferences
c. Feelings about lack of control
d. Previous and current coping skills
A nurse is caring for a client after an allogenic liver transplant and is receiving tacrolimus (Prograf). The nurse monitors the client for which adverse effect of the medication?

a. Decreased urine output
b. Hypotension
c. Profuse diaphoresis
d. Photophobia
A nurse answers the call bell of a client who has an internal cervical radiation implant. The client states that she thinks the implant fell out. The nurse checks the client and sees the implant lying in the bed sheets. The nurse immediately takes what action?

a. Picks up the implant and disposes it in a red bag to be picked up by radiation therapy
b. Asks another nurse to assist in reinserting the implant
c. Calls the physician stat
d. Uses the long-handed forceps to pick up the implant and places it in a lead lined container
A postoperative client who underwent pelvic surgery suddenly experiences dyspnea and tachypnea. The nurse suspects that the client has a pulmonary embolism and takes which action first?

a. Obtains an intravenous infusion pump to administer heparin sodium
b. Increases the rate of intravenous fluids infusing to prevent hypotension
c. Administers low-flow oxygen through the nasal cannula
d. Obtains an ampule of bicarbonate to treat acidosis
Question 6

The nurse notes documentation that a client’s peripheral pulses are +3. The nurse determines that the pulses are:

a. Full and brisk
b. Bounding
c. Normal
d. Palpable
A CD4+ T-cell count is performed on a client who is human immunodeficiency virus (HIV) positive. The results of the test indicate a CD4+ count of 700mm³. The nurse interprets this test result to indicate:

a. That an infection is likely to develop
b. That the count is dangerously low
c. There is improvement in the client’s condition
d. There is a need for aggressive therapy with intravenous antibiotics
A client scheduled for a coronary artery bypass graft states to the nurse, “I’m not sure if I should have this surgery.” Which of the following responses by the nurse is most appropriate?

a. “Don’t worry. Everything should be fine.”

b. “It is ultimately your decision so whatever you think is best for you.”

c. “Why don’t you want to have this surgery?”

d. “Let’s discuss what your concerns are about having the surgery.”
Gentamicin sulfate (Garamycin), 80mg in 100mL normal saline is to be administered over 30 minutes. 
he drop factor is 10 drops/mL. A nurse sets up the flow rate at how many drops per minute?

Answer:______________________________
Nitroprusside sodium (Nipride) is being administered to a client. The nurse monitors for which intended effect of the medication?

a. Headache
b. Relief of chest pain
c. Flushing of the skin
d. Hypotension
A nurse is caring for a client with a brainstem injury. The nurse monitors which of the following as the priority?

a. Radial pulse rate
b. Respiratory rate and rhythm
c. Urine output
d. Temperature
A 4-year old child is admitted to the hospital for surgery. The nurse asks the parents which priority question to identify the adequacy of support for the child’s psychosocial needs?

a. “What signs and symptoms has your child been having?”
b. “Will a family member be able to stay with the child most of the time?”
c. “How much do you know about the surgery and its expected outcome?”
d. “What are your child’s favorite toys?”
An emergency room nurse is caring for a client with a suspected myocardial infarction who is experiencing chest pain unrelieved by nitroglycerin. The nurse administers 5mg morphine sulfate intravenously as prescribed. After administration of morphine sulfate, the nurse takes which priority action?

a. Places the call bell at the client’s side and instructs the client to call the nurse if the chest pain is not relieved
b. Monitors the client’s urinary output hourly
c. Places the client in a supine position
d. Monitors the client’s blood pressure and respirations
A nurse is monitoring an infant diagnosed with congenital hypothyroidism. The nurse would expect to note which of the following assessment findings?

a. Excessive sleepiness
b. Hypertonic reflexes
c. Frequent, loose stools
d. Hyperactivity
A nurse is planning the client assignments for the day. Which of the following clients would the nurse assign to the nursing assistant?

a. A client scheduled for discharge home
b. A client on strict bed rest
c. A postoperative client who had an emergency appendectomy yesterday
d. A client scheduled for a cardiac catheterization
Question 16

A nurse is providing instructions to a client about quinapril hydrochloride (Accupril). The nurse tells the client:

a. To take the medication with food only
b. To rise slowly from lying to sitting position
c. To discontinue the medication if nausea and vomiting occurs
d. To expect a therapeutic effect will be seen immediately
A nurse is caring for a client admitted to the hospital with a musculoskeletal injury. The nurse monitors for the major symptom associated with neurovascular compromise by:

a. Counting the client’s apical pulse for one full minute
b. Observing for drainage on the dressing of the affected extremity
c. Taking the client’s blood pressure on the unaffected side
d. Determining whether pain is experienced with passive range of motion of the affected extremity
Question 18*

A nurse administers a fatal dose of morphine sulfate to a client. During the subsequent investigation of the error, it is determined that the nurse did not assess the client’s respiratory rate prior to administering the medication. Failure to adequately assess the client is addressed under which function of the Nurse Practice Act?

a. Defining specific educational requirements for licensure in the state
b. Describing the scope of practice of licensed and unlicensed care providers
c. Recommending specific terms of incarceration for nurses who violate the law
d. Identifying the process for disciplinary action if standards of care are not met
A nurse provides dietary instructions to a client with cholecystitis. The nurse determines that the client understands the instructions if the client states that which of the following food items is acceptable in the diet?

a. Angel food cake
b. Ice cream
c. Barbeque chicken
d. Baked potato with broccoli and cheese
A nurse has instructed a nursing assistant in the procedure for collection of a 24-hour urine specimen from a client. The nurse determines that the nursing assistant understands the directions if the nursing assistant states to:

a. Save the first urine specimen collected at the start time
b. Keep the specimen at room temperature
c. Discard the last voided specimen at the end of the collection time
d. Ask the client to void, discard the specimen, and note the start time
Contact Information

- Via the Sigma Circle (For Sigma members)...Lois Marshall
- Email... LSM4556@aol.com
- Twitter... @NCLEXprof
- FB...Lois Marshall
- IG... @NCLEXprof
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