Welcome to Caring 4 You . Net
Dream .... Believe .... Achieve ....

RN & LPN 2 DAY NCLEX SEMINAR REVIEW

"healing the community by caring 4 you"

OUTLINE AND WORK BOOKLET

CARING 4 YOU . NET AND ANNELIESE GARRISON, RN ALL RIGHTS RESERVED 2012
Welcome to the  
Caring 4 You NCLEX 2 Day Review  
Delegation and Prioritization Seminar

THIS SERIES NOW COMES WITH A 50 PAGE WORK BOOKLET AND RELAXATION CD! All CD's are audio CD's and can play in any CD player with the exception of the quiz CD that is of printable format. This is not your mother's NCLEX Review. The NCLEX has changed focusing on delegation, prioritization, infection control, triage, etc. You can learn a 9 System Review or a specialty anywhere on the 'Net or a review course. But if you want to get "inside the nclex", the buck stops here.

Description of items:

WORK BOOKLET: What's New On The NCLEX? Is brought to you exclusively by Caring 4 You. It is now only available in this Welcome To The RN & LPN Caring 4 You 2 Day NCLEX Seminar Outline and Work Booklet. Yes, that's right! This entire seminar has just been updated for you. The 7 CD's now come with a 50 page work booklet with plenty of room for you to take your own notes as you follow along on the CD's. This was done over a one-year period with thousands of students sharing their NCLEX experiences. It must be noted here that Caring 4 You will in no way compromise the NCLEX by knowingly sharing actual NCLEX questions.

PART 1: Understand Delegation. What is Delegation? Know the different levels of nursing so that you can understand who to delegate what to. The 4 A's of delegation helps you to understand what delegation is and much more!

PART 2: Delegating and Prioritizing in a Disaster. Understand how to prioritize using safety and Maslow. The NCLEX test plan is broken down here. Know the difference between internal, external and natural disasters and how to delegate and prioritize should such an event occur. The NCLEX is heavy on this.

PART 3: Test Taking Tips and Strategies. Upon doing some practice questions, people usual have 3-5 weaknesses in the way they answer questions. I will explain this and much more as to what you can do to help you study more effectively and time efficiently.

PART 4: Concept Behind The Nclex. Test Day Preparation. This is a great CD to put your NCLEX myth worries to rest! I explain the concept behind the NCLEX that even your instructors and other NCLEX reviewers do not understand. I go over what to expect the day of the test and after.

PART 5: Prioritization and delegation Quizzes. These quizzes are used throughout the seminar. I use these quizzes to help you learn how to answer the questions correctly by figuring out your weakness while you
take your exams. You will need this CD to refer to the quizzes used in the seminar. Or you can use this CD on its own. This CD covers:
Prioritizing Care of a Cardiac Client; Critical Thinking NCLEX Questions; Critical Thinking Delegation Questions; Delegation and Prioritization Questions; More Prioritization Questions; [ Updated ] New Format Questions; [ New ] Triage in a Disaster;[ New ] 120 NCLEX Format Questions.

PART 6: Learning Meditation for the NCLEX. Anxiety is a big part in taking any test, exam or quiz. Please use this CD each time you study. You may use it before you study or after you study. This CD is only 15 minutes in length. I made it that way so that you can repeat it, as you like.

PART 7: When you are done, have a little fun and play ‘This is NCLEX JEAPORDY”

This series is updated each month or more.

There are so many testimonials; they can't ALL be mentioned here!

Dear Anneliese,
I took your seminar and I wanted to thank you so very much for all your help and support through this difficult time. I'm so happy to say that I PASSED my exam with all 265 questions. I'm now officially and RN!!!! So so happy and wanted to thank u again for being so kind and helpful! – MBG

Thanks Anneliese
I passed. I had 75 questions...and over 10 of them were the choose all that apply questions. And tons and tons of who do you see first. That delegation info you gave was fabulous. Thanks again! – Kristina

I honestly think your program is excellent. You go into great detail how to answer and what to look for in a question. Don't change anything in the teaching style! – Carolyn

UPDATE

Please be sure to know your EKG strips.

Also, be sure to know some legal terms like “Intentional Tort”; “Liable”; “Slander”; “Assault and Battery” “Malpractice” etc.

Also, be sure to know about how to work with a multidisciplinary team

Also, know about “Continuos Quality Improvement”.

( These topics are best taught through one – on one tutoring ]
How to Get Your NCLEX Results

NCLEX® Quick Results Service

Candidates in the following jurisdictions may access their "unofficial" results via the NCLEX® Candidate Web site or through the NCLEX® Quick Results Line:


Via the web ($7.95) - Go to www.pearsonvue.com/nclex, sign in with your user name and password. After logging in, you will see your Current Activity. Under Recent Appointments, find the row with your current test, go to "Status" and double click on "Quick Results" link. If your results are available, a credit card payment page will display. Fill in the payment information, click on the Continue button, and a confirmation page will display. Click ONLY ONCE on the Confirm Order button and your exam results will appear. In order to receive your results, you must provide a credit card number to which the $7.95 charge can be billed. (Please note: Your credit card will only be charged if your results are available.)

Via the phone ($9.95) - Call the NCLEX Quick Results line at 1.900.776.2539 (1.900.77.NCLEX). Please note that this is a 900 number and NOT an 800 number. This service will be available 24 hours a day. The $9.95 fee will appear on your local telephone bill under "NCLEX Test."

(Please be aware: When you use the NCLEX Quick Results line, you will not be charged if your results are not yet available. However, once your results are available, if you call more than once, you will be charged for each call.)

Only the board of nursing to which you applied can release your official results. The NCLEX examination results in the Quick Results Service are unofficial, and do not authorize you to practice as a licensed nurse.

Be sure to wait two business days after your test before you request your results.
What’s New On The NCLEX

This will only be available through this OUTLINE AND WORK BOOKLET. I use to have this on one of the 6 CD’s in the Caring 4 You NCLEX Series but I thought it beneficial to put a relaxation tape in the series.

This will not specifically go over in depth what is new and how to study but rather, what subjects were touched upon the most on the NCLEX exam. Right now, in light of 9/11 and terrorism the NCLEX is heavy on delegation and prioritization. I take it a step further and teach you how to delegate and prioritize in a disaster which, as I understand, may be on the NCLEX exam as well. If there is a subject that you feel may be on the NCLEX, feel free to add it to the list I have provided spaces for you to do so:

Diet:
Know the normal values for:

Magnesium

Potassium

Sodium

Calcium

Vit. K

What foods are high in Vitamin K

How Vitamin K interacts with Heparin and Coumodin

Why is Vitamin K given to newborns?

NOTES:

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_________________________________________________________________
Fluid/Electrolytes
Metabolic Alkalosis

Respiratory Alkalosis

NOTES:

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_________________________________________________________________
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Cardiovascular
How a Stress Test is administered

Why Nitro is administered and the side effects

S/S of Arterial Sclerosis

S/S of CHF

NOTES:

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Respiratory
S/S of TB

How is the Allen Test Administered?

Have a clear understanding of normal breath sounds

Have a clear understanding of the use of a mist tent

Have a clear understanding of how a mechanical ventilator works
1. What to do when a high pressure alarm sounds
2. What to do when a low pressure alarm sounds

NOTES:
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Pediatrics
Know a general overview of the stages of development
Example: A 4-year-old toddler runs into the door as they are playing. You as the nurse want to be able to explain to the mother that this is normal, as they are considered hyperactive and have trouble with spatial recognition.

Know age appropriate toys
Ex: What would be appropriate for a 2-year-old?

Age appropriate foods
Ex: What is the food choice for a 1-year-old?

NOTES:
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Muscular-Skeletal
Know Bryant’s Traction

Know Buck’s Traction

Know Halo Traction

Be aware of the proper weight bearing and transferring procedures

Know the proper use of a cane, walker or crutches
S/S of osteoporosis and how to treat it

S/S and over all disease of Multiple Sclerosis

NOTES:

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_________________________________________________________________
_________________________________________________________________

Endocrine:

Have an understanding of Addison’s Disease [S/S and TX]

Diabetes and your pts understanding of it as well [Pt teaching]

What assessment is taken by the nurse when you give NPH?

Know the disease process and the S/S of hyperthyroidism

Know the disease process and the S/S of hypothyroidism

NOTES:

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_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

Neurovascular:

Know how to assess ALL cranial nerves
   When there is an injury, what cranial nerve is involved?
      Ex: A pt has a C6 injury, what is the damage?

S/S of increased cranial pressure

NOTES:

_________________________________________________________________
_________________________________________________________________
Cancer/Burns/Poisoning/Immunizations
Know immunizations for a child

Know overview of colon, breast, cervical and testicular cancer

Who is at high risk for best cancer?

Frontal lobe tumor
  What kinds of problems are associated with it?
  What are the S/S and how to treat it?

Know the interventions for the pt., nurse, and visitors when dealing with external and internal radiation

NOTES:

Gastrointestinal:
Know celiac disease
  What kind of diet would you put a pt on that had celiac disease?

Dumping syndrome
  How would you prevent it?

NOTES:

Genitourinary:
Understand who is at highest risk for bladder Cancer
Women’s Health:
Know each stage of labor and what to expect at each stage
   How would you intervene for the pt. in specific stages of labor?

Know about Disseminated Intravascular Coagulation [DIC]

Psychiatric:
Alzheimer’s
Alcohol Withdraw
Suicide
Schizophrenia
Delusions of grandeur
Bipolar
Depression
Cultural Issues:
What is specific about the diet of a Mormon?
   They fast one Sunday out of every month

Know how different cultures may express or relate to pain

Herbs on the NCLEX:
Herbs: Toxicity’s and drug interactions

Please go to my web site for further in depth information
http://caring4you.net/herbs.html
Understanding Delegation. What is Delegation?

Know the different levels of nursing so that you can understand who to delegate what to. The 4 A’s of delegations helps you to understand what delegation is and much more!

A lot of people who have trouble with the NCLEX have difficulty because they have specific weaknesses in the way they pick out the questions. I start each seminar by letting you take a short quiz. [Stop the series now and take this quiz.]

Time for RN: 13 min and 50 sec
Time for LPN: 11 min and 30 sec

Prioritizing Care of a Cardiac Client

This can also be found on CD Part 5. In this 10-question quiz of a cardiac client, focus will be on prioritizing and administration of medications.

1. A 60-year-old male is admitted to the ER with chest pain that radiates to the shoulder, jaw and left arm. Following MD orders, the nurse should FIRST....
   - Administer the morphine
   - Obtain a 12 lead EKG
   - Obtain blood work

2. The purpose of administering a thrombolytic drug to a pt with an MI is to
   - Help keep them hydrated
   - Dissolve clots they may have
   - Prevent kidney failure

3. A PRIORITY nursing diagnosis for the first 24 hours of a MI is
   - Impaired Gas Exchange
   - High Risk for Infection
   - Fluid Volume Deficit

4. A PRIORITY nursing diagnosis related to the administering of TPA is
   - Observe for chest pain
   - Monitor for increased atrial dysrhythmias
   - Monitor the 12 lead EKG

5. A 69-year-old male is admitted to the ER with heart failure complicated by pulmonary edema. A PRIORITY assessment at admission would be
   - Blood Pressure
Skin breakdown
Serum Potassium

6. Which of the following would be a PRIORITY nursing diagnosis for this heart failure pt?
High risk for infection related to stasis of secretion in alveoli.
Impaired skin integrity related to pressure.
Activity Intolerance related to imbalance between oxygen supply and demand.

7. Digoxin is administered intravenously to this client primary because the drugs acts to
Dilate coronary arteries.
Increase myocardial contractility
Decrease cardiac dysrhythmias

8. Metroprolol tartrate, may be administered the a client with heart failure because it acts to
reduce peripheral vascular resistance
increase peripheral vascular resistance
reduce fluid volume

9. Furosemide is administered intravenously. How soon after should the nurse begin to see the desired effect?
5 to 10 minutes
30 minutes to 1 hour
2 to 4 hours

10. The nurse teaches the client to take oral furosemide in the morning. The primary reason for this is to help
decrease gastointestinal irritation
retard rapid drug absorption
excrete fluids accumulated during the night

[ANSWERS ARE ON CD PART 5 ENTITLED PRIORITIZING CARE OF A CARDIAC CLIENT ANSWERS]

Please turn the CD on to go over rationale and answers.

Weaknesses you may have encountered...

1. Too fast or too slow? [Time management problem]
2. Did you read too much into the question?
3. Did you read the question wrong?
4. You simply did not know the material?

Take a moment to right down your weaknesses. Most people have between 2-5 ways they find themselves answering questions incorrectly.
1. In order to understand delegation, you have to understand the different levels of nursing.

   A. Licensed Practical Nurse or Licensed Vocational Nurse [LPN/LVN]

   B. Registered Nurse [RN]

   C. Registered Nurse [BSN]

   D. Registered Nurse [MSN]

   E. Certified Midwife
II. What is Delegation?

The 4 A’s of delegation

1. Assessment

2. Assignment

3. Authority

4. Accountability

III. Delegate Effectively

A. Five rights:

1. Right task

2. Right circumstances
3. Right person

4. Right direction and communication

5. Right Supervision and evaluation
Decision Making Model for Delegations of Selected Nursing Tasks

- RN assessment of patient's nursing care needs completed?
  
<table>
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<tr>
<th>YES CONTINUE</th>
<th>No</th>
<th>STOP</th>
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<td>Do Assessment then proceed with a consideration of delegation</td>
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- Is task within a licensed nurse's scope of practice?
  
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<th>YES CONTINUE</th>
<th>No</th>
<th>STOP</th>
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<td>Do not delegate</td>
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- Is the unlicensed person identified and properly trained?
  
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<th>YES CONTINUE</th>
<th>No</th>
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<td>Provide and document training then proceed with a consideration of delegation</td>
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- Can the task be performed without requiring judgement based on nursing knowledge?
  
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<th>YES CONTINUE</th>
<th>No</th>
<th>STOP</th>
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<td>Do not delegate</td>
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* Are the results of the task reasonably predictable?

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<td>Do not delegate</td>
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- Can the task be safely performed according to exact, unchanging directions?
• Can the task be performed without a need for complex observations or critical decisions?

• Can the task be performed without repeated nursing assessments?

• Can the task be performed properly without life threatening consequences?

• Is appropriate supervision available?

• There are no specific laws or rules prohibiting the delegation

Let us end this portion by taking another quiz to see if you have been able to realize your weaknesses and answer the questions correctly:

Time for RN: 27 min and 0 sec

Time for LPN: 22 min and 6 sec
20 questions on Delegation and Prioritization

1. The following clients present to a walk-in clinic at the same time. Which should the nurse schedule to be seen first?
   A. 25 year old with high fever, vomiting and diarrhea
   b. 38 year old with sore throat, fever, and swollen lymph glands
   c. 40 year old with severe headache, vomiting and stiff neck
   d. 44 year old limping on a very swollen bruised ankle

2. Of the four clients listed below, which responsibility should the nurse direct the technician to carry out first?
   a. 89 year old with COPD resting quietly on 2 liters of O2 needs morning vitals with O2 sat
   b. 77 year old with gastrointestinal bleeding needs bedside commode emptied
   c. 55 year old diabetic with fasting blood sugar of 75, at 80% of breakfast and needs morning snack
   d. 49 year old with rheumatoid arthritis needs splints reapplied to both hands.

3. The LPN is assigned to care for a client who had a total right hip two days ago. Which observation should the LPN report immediately to the nurse?
   a. incisional paid rated on 6 on a scale of 0-10
   b. reddened incision line with a temperature of 99.6 F
   c. pain and redness in the left lower leg
   d. the client is not tolerating 20lbs of weight bearing on the right leg

4. The nurse just received report on the following clients. Who should the nurse see first?
   a. 35 year old with suspected acute tubular necrosis, urine output totaled 25cc's for the last two hours.
   b. 49 year old with cancer of the breast, 2 days post mastectomy, reported to be having difficulty coping with the diagnosis.
   c. 54 year old with TB in respiratory isolation, requesting pain medication
   d. 36 year old with chest tube insertion after a spontaneous pneumothorax, respirations 16

5. After receiving report on the following clients, who should the nurse assess first?
   a. 25 year old with the hemoglobin level of 15.9
   b. 36 year old on Coumadin with a prothrombin time of 35.6 seconds
   c. 38 year old with a total calcium level of 9.4
   d. 45 year old with a BUN of 30 and creatinine of 1.1

6. After completing assessment rounds, which finding would the nurse report to the physician immediately?
   a. client who has not had a bowel movement in 4 days abdomen is firm
   b. client who had a pulse of 89 and regular now has pulse of 100 and irregular
c. client who is very depressed and has eaten 10% of meals for the last 2 days.

d. client who has developed a rash around the neck and face who has been on iv penicillin for 2 days.

7. After receiving report on four clients at 7am, what should the nurse complete first?
   a. call physician to report antiemetic for client who has been vomiting
   b. notify family of a client’s transfer to ICU for chest pain
   c. call a potassium level of 5.9 to the attention of the physician
   d. begin routine assessment rounds, starting with the sickest client

8. A 62 year old client has a history of coronary heart disease and is brought into the ER complaining of chest pain. What initial action should be taken by the nurse?
   a. give the client ntg gr 1/150 sl now
   b. call the cardiologist about the admission
   c. place the client in a high Fowlers position after loosening the shirt
   d. check blood pressure and note the location and degree of chest pain

9. As a nurse working the ER, which client needs the most immediate attention?
   a. a 3 yr old with a barking cough, oxygen sat of 93 in room air, and occasional inspiratory stridor
   b. a 10 month old with a tympanic temperature of 102, green nasal drainage, and pulling at the ears
   c. an 8 month old with a harsh paroxysmal cough, audible expiratory wheeze and mild retractions
   d. a 3 year old with complaints of a sore throat, tongue slightly protruding out his mouth, and drooling.

10. As the office nurse, you are reviewing client messages for a return call. Which client should the nurse call back first.
    a. client 36 weeks gestation complaining of facial edema
    b. a client 24 weeks gestation complaining of urinary frequency
    c. a client 12 weeks gestation whose had five episodes of vomiting in 36 hours
    d. a client 20 weeks gestation complaining of white, thick vaginal discharge.

11. Which hospital roommate assignment would be most appropriate for a 3 year old girl with nephrotic syndrome?
    a. 2 year old girl with croup
    b. 3 year old girl with impetigo
    c. 4 year old boy with tonsillitis
    d. 4 year old boy with a fractured femur

12. You are a home health nurse. Which client should you see first?
    a. 7 year old who is recovering from a pelvic fracture
    b. 5 year old who was diagnosed with type 1 diabetes and released from
the hospital 2 days ago
c. an 8 year old with cystic fibrosis who is on 1 l og oxygen via nasal cannula
d. a 4 year old who has npo received any immunizations since 15 months of age

13. The registered nurse is planning the client assignments. Which assignment is an appropriate assignment for the nursing assistant?
a. assist a 12 year old boy with Down's syndrome, who is profoundly, developmentally disabled, to eat lunch
b. obtain a temperature of a 29 year old woman receiving the final 30 minutes of a whole blood transfusion
c. complete initial vital signs on a 51 year old man who has just returned from surgery and PACU for a bowel transfusion
d. complete a sterile dressing change on a 70 year old woman admitted for skin graft

14. A physician orders MRI's for the following four clients. Select the client that the nurse would send without questioning the order.
a. 21 year old diabetic with an implanted insulin pump
b. 18 year old pregnant primigravida
c. a 72 year old client with CHF and a pacemaker
d. a 35 year old auto accident victim on life support systems

15. After receiving report, which of the following four clients should the nurse assess first?
a. client with stage 3 anxiety and disoriented
b. client with severe agoraphobia and refuses to leave her room
c. client with paranoid schizophrenia and pacing the halls
d. client with post-traumatic stress disorder and socially withdrawn

16. A client is admitted with suspected substance abuse. All of the following information was obtained upon admission. Which assessment data is of primary concern to the nurse?
a. client reports taking a prescription medicine for high blood pressure daily.
b. client exhibiting restlessness, irritability, and has tachycardia
b. client exhibiting restlessness, irritability, and has tachycardia
c. client reports taking the substance on a daily basis for six months
d. clients exhibits a cough, slightly elevated temperature and malaise

17. As the office nurse, which client should be assessed first?
a. client with history of drug abuse and diabetes, morning blood sugar 65
b. client with depression and has eaten less than 30% of meals for 24 hours
c. client with anxiety and productive cough of white sputum
d. client with borderline personality exhibiting self-damaging behaviors

18. The charge nurse is approached by a new graduate nurse who has been assigned four clients: a diabetic with a 4:00 pm blood sugar of 99, a cardiac client with a potassium of 3.3, a client with
pyelonephritis with a temperature of 100.8, and an adult client with a 20% second degree burn of the legs. Which client should the charge nurse suggest the graduate assess first?

a. the diabetic
b. the cardiac client
c. pyelonephritis client
d. burn client

19. Blood gases were drawn at 7:00 am on four clients. None of the clients were on any type of oxygen and had not received any type of breathing treatment prior to the blood gases being drawn. Which blood gas results should be of greatest concern for the nurse?

a. 24 year old pneumonia client with a ph 7.33, pco2 49, po2 90, hco3 26
b. 35 year old asthma client with a ph of 7.37, pco2 46, po2 95, hco3 29
c. 45 year old with a chest tube and with a ph 7.40, pco2 40, po2 90, hco3 24
d. 65 year old with COPD and ph 7.35, pco2 48, po2 82, hco3 28

20. Which task would be the least appropriate to delegate to a nursing assistant?

a. feed 10 month old a bottle who has crackles bilaterally, harsh, productive cough and in room air
b. help 10 year old with cystic fibrosis, diminished breath sounds in the RLL up to the bathroom
c. obtain vital signs of a 9 year old who was admitted yesterday for an acute asthma exacerbation
d. obtain the respiratory rate of a 6 week old infant who was admitted two hours ago with a respiratory rate of 64.

[ANSWERS ARE ON PART 5 ENTITLED DELEGATION AND PRIORITIZATION ANSWERS]
PRIORITIZATION USING MASLOW

One way many students forget to prioritize is because they forget to use Maslow’s Hierarchy of Needs. Remember one of these needs is safety and I will get into more of this later.

Let us start this section by taking another quiz. I like to do this for two reasons. 1). It is good practice for you and 2). It is my hope that you are getting better at your weaknesses that I mentioned earlier in the seminar. [STOP THE SERIES NOW AND TAKE THIS QUIZ]

Time for RN: 27 min and 0 sec

Time for LPN: 22 min 6 sec

Critical Thinking NCLEX Questions

1. Initial drug therapy in the management of Lyme disease includes:
   - Tetracycline
   - Steroids
   - Salicylic Acid
   - Nonsteroidal anti-inflammatory agents

2. A patient has ingested a non corrosive poison and you cannot reach a poison control center. Your first act of care is to:
   - Induce vomiting with Syrup of Ipecac
   - Dilute the ingested poison with milk or water
   - Attempt to neutralize the poison
   - Have them eat a cracker

3. A patient is suffering from chemical burns to the skin caused by dry lime. Your first step in care should be to:
   - Wash the area with running water
   - Remove the lime with phenol
   - Remove the lime with alcohol
   - Brush away the lime

4. You are caring for someone of Filipino decent. What is the important thing to remember about their diet?
   - They believe that eating rice cleanses the system
   - Spicy foods help prepare their soul for God.
   - Food is tasty but not spicy
   - They eat spicy foods because they believe it help them stay healthy.

5. A priority nursing diagnostic category for the client with hypertension would be
   - Pain
   - Fluid Volume Deficit
   - Impaired Skin Integrity
   - Health Management
6. After 12 hours of experiencing regular contractions, the nurse determines the client is still in the latent stage and should be monitored closely for signs of exhaustion, hypotension, fluid overload, and bradycardia.

7. You are the home health nurse of a family of Haitian decent, what is the most important thing to remember when caring for the elderly? As the family member becomes older, medicines are rejected and replaced by prayer. Haitian family members place great value in caring for their elderly at home. The nurse should be aware that they view her/him as a gift from the gods. The nurse should be aware that she/he will be viewed as an "outsider".

8. What are the 5 rights of medication administration?
   Right dose, right pt, right route, right time, right medicine.

9. A patient just had a seizure, all of the following are important data to collect except:
   A full set of vital signs
   Apical Pulse
   Level of consciousness in post ictal state
   a rectal check

10. Which of the following clients is at risk of developing hyponatremia?
    a client with a potassium level of 5.7 mmol/L
    The febrile client with copious watery diarrhea
    the client with massive systemic infection
    A client who is taking high doses of steroids.

11. You are the only nurse on the floor, all of the following can be delegated to unlicensed personnel except:
    You may delegate a client that is being discharged because they have a clean bill of health.
    You may delegate a task to a UAP that is frequently occurring
    You may delegate a tasks that have predictable results
    You may delegate tasks that are considered standard and unchanging

12. When delegating to other personnel, it is important to remember the 4 A's of delegation. These are all of the following except: Assessment Authority
Assigning Actions

13. You are the triage nurse at a fire scene, all of the following are considered emergent except:
Excessively high temperatures (over 1050 F or 40.50 C)
Obviously mortal wounds where death appears reasonably certain
Open chest or abdominal wounds
Obvious multiple injuries

14. When caring for an ethnic minority, you as the charge nurse need to be sensitive to needs and cultures. The most important thing to understand is:
Try to understand their diets and work with dietary in order to insure proper nutrition.
The language barrier. If present, work with a family member.
Remember that many families have basic fears about speaking out or being perceived as speaking out.
What is their illness? It may have an impact on quality of care.

15. The 5 Rights of Delegation include all of the following except:
Right work environment
Right Circumstances
Right Direction
Right Task

16. The nurse knows the specific expected and desired outcomes for clients with a particular diagnosis are:
Established by legislation as law.
Mandated by federal regulatory agencies.
Based on predetermined standards of care.
Governed by the state in which they live.

17. When a minor has the legal right to consent to medical treatment, he or she also has the right to control disclosure of information related to that treatment.
true
false

18. When caring for an ethnic minority who speaks a language unknown to you the nurse should not use
Another nurse working on the same floor
A paid professional
A member of the custodial department
A family member

19. To which document should the nurse refer when information is needed regarding issues of client's right to information and explanations regarding treatment costs?
code for nurses
hospital billing department policies
patient's bill of rights
a durable power of attorney

20. A mother expresses concern about her 4 year old being hyperactive and always bumping into things and spilling things. The most appropriate intervention at this time would be:
Determine if there has been any changes at home.
Explain that this is not unusual
Explore the possibility of abuse
Suggest he see a pediatric neurologist

[ANSWERS ARE ON PART 5 ENTITLED CRITICAL THINKING NCLEX QUESTIONS ANSWERS]
Prioritization

Another reason why it is so important to learn how to properly prioritize is because of the nursing shortage. The NCLEX is answering this shortage by focusing more and more on delegation and prioritization questions. This is especially true with the RN exam but you will find it on both tests.

A. Remember the nursing process:

1. Assessment

2. Analysis

3. Planning

4. Implementation

5. Evaluation
B. The second step in learning how to prioritize is to remember you’re A,B,C,’s:

1). Airway

2). Breathing

3). Circulation

C. The third step in prioritization is using Maslow’s Hierarchy of Needs:

1). Physiological Needs

2). Safety Needs

3). Needs of affection and belonging

4). Needs of Esteem

5). Need for Self Actualization
When using Maslow, for the med-surg questions, one would be concerned with the first two steps. For psychiatric questions, one would use all 5 steps to help choose the right answer on the exam using Maslow’s Hierarchy of Needs.

D. When prioritizing, also remember to use the safety first rule or safe effective care.

1). Physiological Integrity

2). Physiosocial Integrity

3). Health Maintenance
Prioritizing and Delegating in a Disaster

This type of question may be found on the NCLEX. In order for me to explain how to prioritize, first one must know the difference between INTERNAL disasters and EXTERNAL disasters with the advent of 9/11/2001 which will forever be etched in our minds.

A). Internal Disasters

B). External Disasters

How does one prioritize in a disaster? Remember the word T-R-I-A-G-E:

1). Trauma

2). Respiratory
3). Intracranial Pressure and Mental Status

4). An Infection

5). GI [Upper]

6). GI [Lower] Elimination

The four triage categories and a description of their meanings are:

1). Green is the lowest priority

2). Moving up the ladder is yellow

3). The highest priority is red

4). Final category is black
How do we make the determination? If you were the External triage disaster leader would you know where to start? Remember these three letters - R-P-M

1). Respiration

2). Perfusion

3). Mental Status

Let’s quickly review how START integrates with the METTAG system
♦ Anyone who gets up and walks to the designated area is given a green tag (may not even require hospital care).
♦ Anyone who is not breathing is given a black tag (dead/non-salvageable)
♦ Anyone who fails one of the RPM assessments is given a red tag (critical/immediate)
♦ Anyone who cannot walk but passes all the assessments is given a yellow tag (delayed)
Test Tips and Strategies

I. How to choose the right answer:

A. Decide which part of the nursing process NCLEX question is dealing with:
   1). Assessment
      Words in the questions associated with assessment questions:

   2). Analysis:
      Words in the questions associated with analysis questions:

   3). Planning:
      Words in the questions associated with the planning questions:
4). Implementation

Words in the questions that deal with implementation questions:

5). Evaluation

Words in the questions that may deal with evaluation questions:

B. Category of priority. I touched on this in the last CD but this is important

1). Safe and effective care environment
2). Physiological Integrity

3). Psychosocial Integrity

4). Health Maintenance

II. Helpful Strategies
   A. Can you identify the topic?

   B. Are the answers assessments or implementations?

   C. Does Maslow fit?

   D. Are all answers physical?
   E. What is the outcome of each of the remaining answers?
Points to Remember:

1. You’re always taking care of a patient.
2. This isn’t the real world, answer questions according by what you read in the textbooks. This is hard to do if you have been working as an LPN or CNA already.
3. You always have an doctors order unless it is for the pt’s. Safety then you can call the MD later.
4. Don’t pass the buck. The NCLEX wants to know what you the nurse would do unless the question is specifically dealing with delegation.
5. Always take care of the pt first then the equipment.
6. Know Lab Values [Na, K, Ca, Cl, etc.]
7. Communicate therapeutically. Never ask a “why question”.
8. Learn how to answers positioning questions by asking yourself, “What are you trying to prevent or promote”?
9. Learn to recognize expected outcomes.
10. DO NOT DELEGATE initial assessments, teaching and evaluation.
11. Pay attention to the words, “best”, “first”, “initial”, etc.

Hints

Communicate therapeutically, ELIMINATE answer choice that are authoritarian, "Yes/No" questions, "why" questions, answer choices that explore, and are Nurse centered.

With Positioning ask what are you trying to prevent or promote, think A&P and pathophysiology. Ask what position best accomplishes what you are trying to prevent or promote?

Establishing priorities: think, if you can only do one thing and then go home, what would be the outcome of your action?, Maslow, after Maslow use ABC's and ask does this make sense?

Remember "First" does not always mean assessment and "Action" does not always mean implementation.

Assessment traps commonly on NCLEX: no assessment listed then you assess first, Incomplete assessment (validation required) then continue to assess, Incorrect assessment—does not make sense to the situation.

Evaluation Strategy: determine outcome of each answer choice, ask is this a desired outcome, Use this if all your answers are assessments or if they are all implementations, BUT FIRST MASLOW and if unable to Maslow then use this Evaluation strategy.

General NCLEX test taking rules:

1) Identify the topic of the question
2) Select an answer by eliminating choices
3) Do not use background information unless absolutely necessary
4) Do not read into the question
5) Think about what the answer choices really mean

**Coma, Coma, And Rule:** All parts of the answer must be correct!
DO NOT MAKE ASSUMPTIONS!

Look for underlying concepts -- think about what each answer choice really means, don't have an emotional response ("Most" means there may be more than one correct answer choice you must choose the best)
Remember DO THE LEAST HARM when caring for the patient.

III. 14 Rules of Test taking:

**RULE 1**  -- NCLEX is test bedside nursing, remember you are taking care of pt.

**RULE 2**  -- Test isn't real world, it is based on textbook and theoretically testing.

**RULE 3**  -- The nurse is always ordered such as nursing intervention, independent judgement, and interdependent.

**RULE 4**  -- Don't pass the buck, such as notify doc, call social worker, refer to dietitian, you look at options of intervention yourself before you refer.

**RULE 5**  -- Take care pt first and then equipment.

**RULE 6**  -- Memorize lab values [norm]
RULE 7 -- Communication therapeutically; eliminate authoritarian, ask why, yes/no questions, explore, don't worry, focus on nurse instead pt.

RULE 8 -- Learn to recognize expected outcomes. When you answer ask yourself, "is this pt outcome?"

RULE 9 -- You need to be able to answer and question about positioning. Is this positioning prevent or promotion. Think before you answer,, and think anatomy.

RULE 10-- Don't delegate assessment, teaching, or evaluation.

RULE 11 -- You must be able to establish pt priority such evaluation. Use Maslow strategies,, eliminate psychosocial, NCLEX consider pain is a psychosocial,, Use ABCs [ Airway, breathing and circulation ], but use ABC's Last. Use assessment/implementation strategy first. When answering questions remember that "FIRST" --- don't always mean assessment, and "Action"-- doesn't always mean implementation.

RULE 12 -- Assessment traps-- no assessment, incomplete assessment, then you need validation required.

RULE 13 -- Use evaluation strategy---determine outcome of each answer, is outcome desirable, use if all answers assessment or all implementation... if you can't use Maslow, then you must use
evaluation. The NCLEX is mainly concerned with looking for a complication.

**RULE 14** -- Be confidence.

**CARING4YOU.net Rule** -- Don't be stressed and take you time but remember, the test has the potential of 265 questions. If you are taking the LPN exam, you will have a 5 hour period to complete the exam. 5 hours is 300 minutes. If you are taking the RN exam, you will have a 6 hour period to complete the exam. 6 hours is 360 minutes.

IV. NCLEX Strategies

1). Know yourself and how you answer questions. This is why I went over what your possible weaknesses may be.

2). Know the test plan. {Updated test plan is on my site for the RN at http://caring4you.net/nclex.html right hand side. For the LPN, it is on my site at http://caring4you.net/lpnncclex.html right hand side}

3). Think positive: “I can do this I just need to figure out how”.

4). Get organized and plan ahead.
5). Learn how to read questions.

6). Practice, practice, practice, answer many questions.

7). Arrive early for warm up.

8). You will not be able skim the whole test first.

9). Focus on what you know.

10). When in doubt, do NOT change answers.

11). List lab values, draw pictures.
12). While studying at home, write any information that you have missed during your studies down.

13). Do not forget to eat a good breakfast the morning of your test.

14). I do not recommend this often, but if you are one of the many masses that have taken the NCLEX more than 2 times, perhaps, you need to see a doctor.

15). Lastly, I would recommend a dry run to the testing center. Find out where to park and where the actual room is for the NCLEX exam.

V. Management of Care

A 7 year old boy with a compound fracture is being admitted to a pediatric unit. Which of the following actions is best for the nurse to take?

(1) Ask the nursing assistant to obtain the child's VS while the nurse obtains a history from the parents

(2) Ask the LPN/LVN to assess the peripheral pulses of the child's left leg while the nurse completes the admission forms

(3) Ask the LPN/LVN to stay with the child and his parents while the nurse obtains phone orders from the physician

(4) Ask the nursing assistant to obtain equipment for the child's care while the nurse talks with the child and his parents
Rule #1: Do not delegate the functions of assessment, evaluation and nursing judgement.

Rule #2: This is not the real world.

Rule #3: Delegate activities for stable patients with predictable outcomes.

Rule #4: Delegate activities that involve standard, unchanged procedures.

Rule #5: Remember Priorities!

Using the rules of management, the answer to the question above is:

(4). Ask the nursing assistant to obtain equipment for the child’s care while the nurse takes with the child and his parents.
The Concept Behind the NCLEX

So many students think that if the test shuts off at 75 questions they passed. Others think if it shuts off at 75 questions they failed and still others think that if they answered all 265 questions they failed. This is not true. Some students do not even answer all of the questions at all and still pass. Why did my test shut off at 192. Why did my friend’s test shut off at 75. Everyone I know, passed at 75? Let me explain:

The goal of Computerized Adaptive Testing or CAT, is to determine your competence, based on the difficulty of questions you can answer correctly, NOT how many questions you can answer correctly. This is a fundamentally different approach than is used on paper-and-pencil tests, where everyone receives the same questions. CAT examinations are individualized.

A. We know the exact difficulty of each of the approximately 3,000 questions in the pool.

B. First, the computer asks a relatively easy question, and if you answer it correctly, it asks a somewhat harder question.

C. After you have answered the minimum number of questions, the computer compares your competence level to the passing standard add makes one of three decisions:

D. Each examination is designed to meet all requirements of the NCLEX Test Plan with a certain percentage of questions in each Test Plan area.
E. You are not allowed to skip questions or go back to review or change previous answers because the heart of the CAT methodology, adaptive branching through the examination, makes skipping or revising earlier answers logically invalid.

F. Test anxiety is indeed a problem for many people.

I hope this information will assist you....
Sincerely,
Ellen Julian, Ph.D. Psychometrician

If you would like to write to the Board of Nursing Licensure the current information is as follows:

**Dorothy Green Nclex Administration Coordinator**
111 East Wacker Drive Suite 2900
Chicago, Illinois 60601
Main Phone Number: (312) 525-3600
Main Fax Number: (312) 279-1032
Toll-free service for Testing is (866) 293-9600
Test Day Preparation

What to Expect at the Testing Center

What to Expect after the Test

Caring 4 you has an updated RN test plan on my web site on the right hand side:
   http://caring4you.net/nclex.html

Caring 4 you has an updated LPN test plan on my web site on the right hand side:
   http://caring4you.net/lpnclex.html

A. What to expect the day of the actual test:

B. What type of document to expect in the mail after the test:

C. How can you find out your results:

D. Diagnostic Profile:
If you have taken the exam before, take heart this is my story:

*Our greatest glory comes, not in our inability to fall,  
but in our ability to rise each time we fall*

This Too Shall Pass

~You may or may not know, I didn't pass the NCLEX my first time~

Dear Graduate Nurse:

Hello, let me start by saying that I know you are very hurt right now and somehow taking solace in the fact that other people have failed too, is not much comfort. Now you have to wait to take your boards again. Do I have the picture right at all? If I do, let me say you must pull yourself together my friend. Truth of the matter is that a lot of nurses fail their boards. They just don't tell anyone. All you hear about is how straight to the point the boards were and how they passed the first time this is what is adding to your depression. Cheer up my friend. I too did not pass my boards. I took the boards not once, not twice, but three times. I wish someone would have given me the advice I am about to give you but I learned by trial and error. Nerves you know—excellent people person but not a good test taker. I studied my butt off. All told, I went through 7000 practice questions and took a Review Course but alas, to no avail until I finally calmed down, I passed my boards.

THERE IS NO GROWTH WITHOUT EFFORT.

You grow by responding positively to change.  
Growth means change and change involves risks when stepping from the known to the unknown.  
Your strength and growth will come only through continuous effort and struggle.  
All your growth depends on activity.  
There is no development without effort.  
Trouble is the common denominator of living.  
It is the great equalizer.  
Your trials, your sorrows and your grief's will develop you.  
Whatever good or bad fortune comes your way, you can always give it meaning and transform it into something of value.  
Wealth is nothing, position is nothing, fame is nothing.  
Who you become inside is everything.  
What happens is not as important as how you react to what happens.

Anneliese Garrison, RN  Email: caring4you_computer@yahoo.com

“healing the community by caring 4 you”
FIND OUT YOUR RESULTS FOR FREE

1. Type address http://pearsonvue.com/nclex/activity/. Login your Username and Password

2. Click ‘Register’ button.

3. Choose your Exam Type. Click ‘Next’.

4. Select Country of Test Center Location. Click ‘Next’.
   In the next items, you may answer only the required field (with *).

5. Click ‘Yes’ in first Question, then select your Country in dropdown menu. Wait for page to refresh.

6. Leave the City and Program Code fields blank if you’re in foreign country, as shown below. Click ‘Search’ and again, wait for the page to refresh.

7. Then select the Country (or your Nursing program with Program Code) that appeared after refresh, as shown below. Click ‘Next’.

8. Select your Board of Nursing, as shown. Take a deep breath, the next screen will hint you of your result. If you’re ready, click ‘Next’.

Here are the possible outcomes:

• If you passed the NCLEX, there’s a pop-up that says, “THE EXAMINEE HAS PASSED THIS EXAM CANNOT SET A NEW APPOINTMENT”

If you failed, the registration will continue and ask you for Payment, credit card details.

Disclaimer: I have been told that this Pearsonvue trick has been tried many times already, and it works. Of course, official NCLEX Results will be mailed to you by your State Board of Nursing