CHAPTER 4

Test-Taking Strategies

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If you would like to read more about test-taking strategies after completing this chapter, *Saunders Strategies for Test Success: Passing Nursing School and the NCLEX® Exam* focuses on the test-taking strategies that will help you pass your nursing examinations while in nursing school and will prepare you for the NCLEX-RN® examination.

I. Key Test-Taking Strategies (Box 4-1)

Box 4-1

Key Test-Taking Strategies

The Question

- Focus on the data, read every word, and make a decision about what the question is asking.
- Note the subject and determine what content is being tested.
- Visualize the event; note whether an abnormality exists in the data provided.
- Look for the strategic words; strategic words make a difference in determining what the question is asking.
- Determine whether the question presents a positive or negative event query.
- Avoid asking yourself, "Well, what if…?" because this will lead you to reading into the question.

The Options

- Always use the process of elimination when choices or options are presented and read each option carefully; once you have eliminated options, reread the question before selecting your final choice or choices.
- Look for comparable or alike options and eliminate these.
- Determine whether there is an umbrella or encompassing option; if so, this could be the correct option.
- Identify any closed-ended words; if present, the option is likely incorrect.
- Use the ABCs—airway, breathing, and circulation—Maslow's Hierarchy of Needs, and the steps of the Nursing Process to answer questions that require prioritizing.
- Use therapeutic communication techniques to answer communication questions and remember to focus on the client's thoughts, feelings, concerns, anxieties, and fears.
- Use delegating and assignment-making guidelines to match the client's needs with the scope of practice of the health care provider.
- Use pharmacology guidelines to select the correct option if the question or options address a medication.

II. How to Avoid Reading into the Question (Box 4-2)

Box 4-2

Practice Question: Avoiding the "What if …?" Syndrome and Reading into the Question

The nurse is caring for a hospitalized client with a diagnosis of heart failure who suddenly complains

of shortness of breath and dyspnea during activity. After assisting the client to bed and placing the client in high-Fowler's position, the nurse should take which **immediate** action?

1. Administer high-flow oxygen to the client.
2. Call the consulting cardiologist to report the findings.
3. Prepare to administer an additional dose of furosemide.
4. Obtain a set of vital signs and perform focused respiratory and cardiovascular assessments.

Answer: 4

Test-Taking Strategy

You may immediately think that the client has developed pulmonary edema, a complication of heart failure, and needs additional diuresis. In pulmonary edema, one may see this as an emergency, and might think an action should be taken before further assessment, which may lead them to choose option 3. Although pulmonary edema is a complication of heart failure, the question does not specifically state that pulmonary edema has developed; the client could be experiencing shortness of breath or dyspnea as a symptom of heart failure exacerbation, which may be expected, particularly on exertion or during activity. This is why it is important to base your answer only on the information presented, without assuming something else could be occurring. Read the question carefully. Note the **strategic word**, *immediate,* and **focus on the data in the question**, the client's complaints. Use the **nursing process**, and note that vital signs and assessment data would be needed before administering oxygen, administering medications, or contacting the cardiologist. Although the cardiologist may need to be notified, this is not the immediate action. Because there are no data in the question that indicate the presence of pulmonary edema, option 4 is correct. Additionally, **focus on what the question is asking**. The question is asking you for a nursing action, so that is what you need to look for as you eliminate the incorrect options. Use nursing knowledge and test-taking strategies to assist in answering the question. Remember to focus on the **data in the question**, focus on **what the question is asking**, and **avoid the "What if …?" syndrome and reading into the question**.

A. Pyramid points

1. Avoid asking yourself the forbidden words, "Well, what if …?" because this will lead you to the "forbidden" area: reading into the question.
2. Focus only on the data in the question, read every word, and make a decision about what the question is asking. Reread the question more than one time; ask yourself, "What is this question asking?" and "What content is this question testing?" (see Box 4-2).
3. Look for the strategic words in the question, such as *immediate, initial, first, priority, best, need for follow-up,* or *need for further teaching*; strategic words make a difference regarding what the question is asking. Use the nursing process to guide your thinking when strategic words are noted (see VI.G).
4. In multiple-choice questions, multiple-response questions, or questions that require you to arrange nursing interventions or other data in order of priority, read every choice or option presented before answering.
5. *Always* use the process of elimination when choices or options are presented; after you have eliminated options, reread the question before selecting your final choice or choices. Focus on the data in both the question and the options to assist in the process of elimination and directing you to the correct answer (see Box 4-2).
6. With questions that require you to fill in the blank,

focus on the data in the question and determine what the question is asking; if the question requires you to calculate a medication dose, an intravenous flow rate, or intake and output amounts, recheck your work in calculating and always use the on-screen calculator to verify the answer.

B. Ingredients of a question (Box 4-3)

Box 4-3

Ingredients of a Question: Event, Event Query, and Options

Event

The nurse is caring for a client with terminal cancer.

Event Query

The nurse should consider which factor when planning pain relief?

Options

1. Not all pain is real.
2. Opioid analgesics are highly addictive.
3. Opioid analgesics can cause tachycardia.
4. Around-the-clock dosing gives better pain relief than as-needed dosing.

Answer: 4

Test-Taking Strategy

Focus on **what the question is asking**, the factor to consider when planning pain relief, and consider the client's diagnosis of terminal cancer. Around-the-clock dosing provides increased pain relief and decreases stressors associated with pain, such as anxiety and fear. Pain is what the client describes it as, and any indication of pain should be perceived as real for the client. Opioid analgesics may be addictive, but this is not a concern for a client with terminal cancer. Not all opioid analgesics cause tachycardia. Remember to focus on **what the question is asking**.

1. The ingredients of a question include the event, which is a client or clinical situation; the event query; and the options or answers.
2. The event provides you with the content about the client or clinical situation that you need to think about when answering the question.
3. The event query asks something specific about the content of the event.
4. The options are all of the answers provided with the question.
5. In a multiple-choice question, there will be 4 options and you must select one; read every option carefully and think about the event and the event query as you use the process of elimination.
6. In a multiple-response question, there will be several options and you must select all options that apply to the event in the question. Each option provided is a true or false statement; choose the true statements. Also, visualize the event and use your nursing knowledge and clinical experiences to answer the

question.

7. In an ordered-response (prioritizing) or drag-and-drop question, you will be required to arrange in order of priority nursing interventions or other data; visualize the event and use your nursing knowledge and clinical experiences to answer the question.
8. A fill-in-the-blank question will not contain options, and some figure/illustration questions and audio or video item formats may or may not contain options. A graphic option item will contain options in the form of a picture or graphic.
9. A chart/exhibit question will most likely contain options; read the question carefully and all of the information in the chart or exhibit before selecting an answer. In this question type, there will be information that is pertinent to how the question is answered, and there may also be information that is not pertinent. It is necessary to discern what information is important and what the "distractors" are.
10. A Testlet is also known as a Case Study. Information about a client or event is presented in the Testlet followed by several questions that relate to the information. These questions can be in a multiple-choice format or an alternate-item format. It is important to read all of the data in the question and look for abnormalities in the information presented before answering the accompanying questions.
11. Next Generation NCLEX (NGN)® item types include cloze items, extended drag and drop, dynamic exhibits, constructed response, enhanced hot spot, enhanced multiple response, and rich media scenarios. Examples of these item types can be found in Chapter 1. The test-taking strategies discussed in this chapter are applicable and helpful in answering NGN item types.

III. Strategic Words (Boxes 4-4 and 4-5)

Box 4-4

Common Strategic Words: Words That Indicate the Need to Prioritize and Words That Reflect Assessment

Words That Indicate the Need to Prioritize

Best
Early or late
Essential
First
Highest priority
Immediate

Initial
Most
Most appropriate
Most important
Most likely
Next
Primary
Vital

Words That Reflect Assessment

Ascertain
Assess
Check
Collect
Determine
Find out
Gather
Identify
Monitor
Observe
Obtain information
Recognize

Box 4-5

Practice Question: Strategic Words

The nurse is caring for a client who just returned from the recovery room after undergoing abdominal surgery. The nurse should monitor for which **early** sign of hypovolemic shock?

1. Sleepiness
2. Increased pulse rate
3. Increased depth of respiration
4. Increased orientation to surroundings

Answer: 2

Test-Taking Strategy

Note the **strategic word**, *early*, in the query and the word *just* in the event. Think about the pathophysiology that occurs in hypovolemic shock to direct you to the correct option. Restlessness is one of the earliest signs followed by cardiovascular changes (increased heart rate and a decrease in blood pressure). Sleepiness is expected in a client who has just returned from surgery. Although increased depth of respirations occurs in hypovolemic shock, it is not an early sign. Rather, it occurs as the shock progresses. This is why it is important to recognize the **strategic word**, *early*, when you read the question. It requires the ability to discern between early and late signs of impending shock. Increased orientation to surroundings is expected and will occur as the effects of anesthesia resolve. Remember to look for **strategic words**, in both the event and the query of the question.

A. Strategic words focus your attention on a critical point to consider when answering the question and will assist you in eliminating the incorrect options. These words can be located in either the event or the query of the question.
B. Some strategic words may indicate that all options are correct and that it will be necessary to prioritize to select the correct option; words that reflect the process of assessment are also important to note (see Box 4-4). Words that reflect assessment usually indicate the need to look for an option that is a first step, since assessment is the first step in the nursing process.
C. As you read the question, look for the strategic words; strategic words make a difference regarding the focus of the question. Throughout this book, *strategic words* presented in the question, such as those that indicate the need to prioritize, are bolded. If the

test-taking strategy is to focus on *strategic words*, then *strategic words* is highlighted in **blue** where it appears in the test-taking strategy.

IV. Subject of the Question (Box 4-6)

Box 4-6

Practice Question: Subject of the Question

The nurse is teaching a client in skeletal leg traction about measures to increase bed mobility. Which item would be **most** helpful for this client?

1. Television
2. Fracture bedpan
3. Overhead trapeze
4. Reading materials

Answer: 3

Test-Taking Strategy

Focus on the **subject**, increasing bed mobility. Also note the **strategic word**, *most*. The use of an overhead trapeze is extremely helpful in assisting a client to move about in bed and to get on and off the bedpan. Television and reading materials are helpful in reducing boredom and providing distraction, and a fracture bedpan is useful in reducing discomfort with elimination; these items are helpful for a client in traction, but they are not directly related to the subject of the question. Remember to focus on the **subject**.

A. The subject of the question is the specific topic or what the question is asking about.
B. Identifying the subject of the question will assist in eliminating the incorrect options and direct you in selecting the correct option. Throughout this book, if the *subject* of the question is a specific strategy to use in answering the question correctly, it is highlighted in **blue** in the test-taking strategy.
C. The highlighting of the strategy will provide you with guidance on what strategies to review in *Saunders Strategies for Test Success: Passing Nursing School and the NCLEX® Exam*.

V. Positive and Negative Event Queries (Boxes 4-7 and 4-8)

Box 4-7

Practice Question: Positive Event Query

The nurse provides medication instructions to a client about digoxin. Which statement by the client indicates an understanding of its adverse effects?

1. "Blurred vision is expected."
2. "If my pulse rate drops below 60 beats per minute, I should let my cardiologist know."
3. "This medication may cause headache and weakness but that is nothing to worry about."
4. "If I am nauseated or vomiting, I should stay on liquids and take some liquid antacids."

Answer: 2

Test-Taking Strategy

This question is an example of a positive event query question. Note the words *indicates an understanding*, and focus on the **subject**, adverse effects. Additionally, **focus on the data** provided in the options. Digoxin is a cardiac glycoside and works by increasing contractility of the heart. This medication has a narrow therapeutic range, and is a major concern is toxicity. Currently, it is considered second-line treatment for heart failure because of its narrow therapeutic range and potential for adverse effects. Adverse effects that indicate toxicity include gastrointestinal disturbances, neurological abnormalities, bradycardia or other cardiac irregularities, and ocular disturbances. If any of these occur, the cardiologist is notified. Additionally, the client should notify the cardiologist if the pulse rate drops below 60 beats per minute, because serious dysrhythmias are

another potential adverse effect of digoxin therapy. Remember to **focus on the data** provided and note positive event queries.

Box 4-8

Practice Question: Negative Event Query

The nurse has reinforced discharge instructions to a client who has undergone a right mastectomy with axillary lymph node dissection. Which statement by the client indicates a **need for further teaching** regarding home care measures?

1. "I should use a straight razor to shave under my arms."
2. "I need to be sure that I do not have blood pressures or blood drawn from my right arm."
3. "I should inform all of my other health care providers that I have had this surgical procedure."
4. "I need to be sure to wear thick mitt hand covers or use thick pot holders when I am cooking and touching hot pans."

Answer: 1

Test-Taking Strategy

This question is an example of a **negative event query**. Note the **strategic words**, *need for further teaching*. These strategic words indicate that you need to select an option that identifies an incorrect client statement. Recall that edema and infection are concerns with this client due to the removal of lymph nodes in the surgical area. Lymphadenopathy with associated lymphedema can result, and the client needs to be instructed in the measures that will avoid trauma to the affected arm. Recalling that trauma to the affected arm could potentially result in edema and/or infection will direct you to the correct option. Remember to watch for **negative event queries**.

A. A positive event query uses strategic words that ask you to select an option that is correct; for example, the event query may read, "Which statement by a client *indicates an understanding* of the side effects of the prescribed medication?"

B. A negative event query uses strategic words that ask you to select an option that is an incorrect item or statement; for example, the event query may read, "Which statement by a client *indicates a need for further teaching* about the side effects of the prescribed medication?"

VI. Questions That Require Prioritizing

A. Many questions on the examination will require you to use the skill of prioritizing nursing actions.

B. Look for the strategic words in the question that indicate the need to prioritize (see Box 4-4).

C. Remember that when a question requires prioritization, all options may be correct and you need to determine the correct order of action.

D. Strategies to use to prioritize include the ABCs (airway–breathing–circulation), Maslow's Hierarchy of Needs theory, and the steps of the nursing process.

E. The ABCs (Box 4-9)

Box 4-9

Practice Question: Use of the ABCs

A client with a diagnosis of cancer is receiving morphine sulfate for pain. The nurse should employ which **priority** action in the care of the client?

1. Monitor stools.
2. Monitor urine output.
3. Encourage fluid intake.

4. Encourage the client to cough and deep breathe.

Answer: 4

Test-Taking Strategy

Use the **ABCs—airway, breathing, circulation**—as a guide to direct you to the correct option and note the **strategic word**, *priority*. Recall that morphine sulfate suppresses the cough reflex and the respiratory reflex, and a common adverse effect is respiratory depression. Coughing and deep breathing can assist with ensuring adequate oxygenation, since the number of respirations per minute can potentially be decreased in a client receiving this medication. Although options 1, 2, and 3 are components of the plan of care, the correct option addresses airway and breathing. Remember to use the **ABCs—airway, breathing, circulation**—to prioritize.

1. Use the ABCs—airway–breathing–circulation—when selecting an answer or determining the order of priority.
2. Remember the order of priority: airway– breathing–circulation.
3. Airway is always the first priority. Note that an exception occurs when cardiopulmonary resuscitation is performed; in this situation, the nurse follows the CAB (compressions/circulation–airway–breathing) guidelines.

F. Maslow's Hierarchy of Needs theory (Box 4-10; Fig. 4-1)

Box 4-10

Practice Question: Maslow's Hierarchy of Needs Theory

The nurse caring for a client experiencing dystocia determines that the **priority** is which action?

1. Position changes and providing comfort measures
2. Explanations about what is happening to the client
3. Monitoring for changes in the condition of the mother and fetus
4. Reinforcement of breathing techniques learned in childbirth preparatory classes

Answer: 3

Test-Taking Strategy

All the options are correct and would be implemented during the care of this client. Note the **strategic word**, *priority,* and use **Maslow's Hierarchy of Needs theory** to prioritize, remembering that physiological needs come first. Also, the correct option is the only one that addresses both the mother and the fetus. Remember to use **Maslow's Hierarchy of Needs theory** to prioritize.

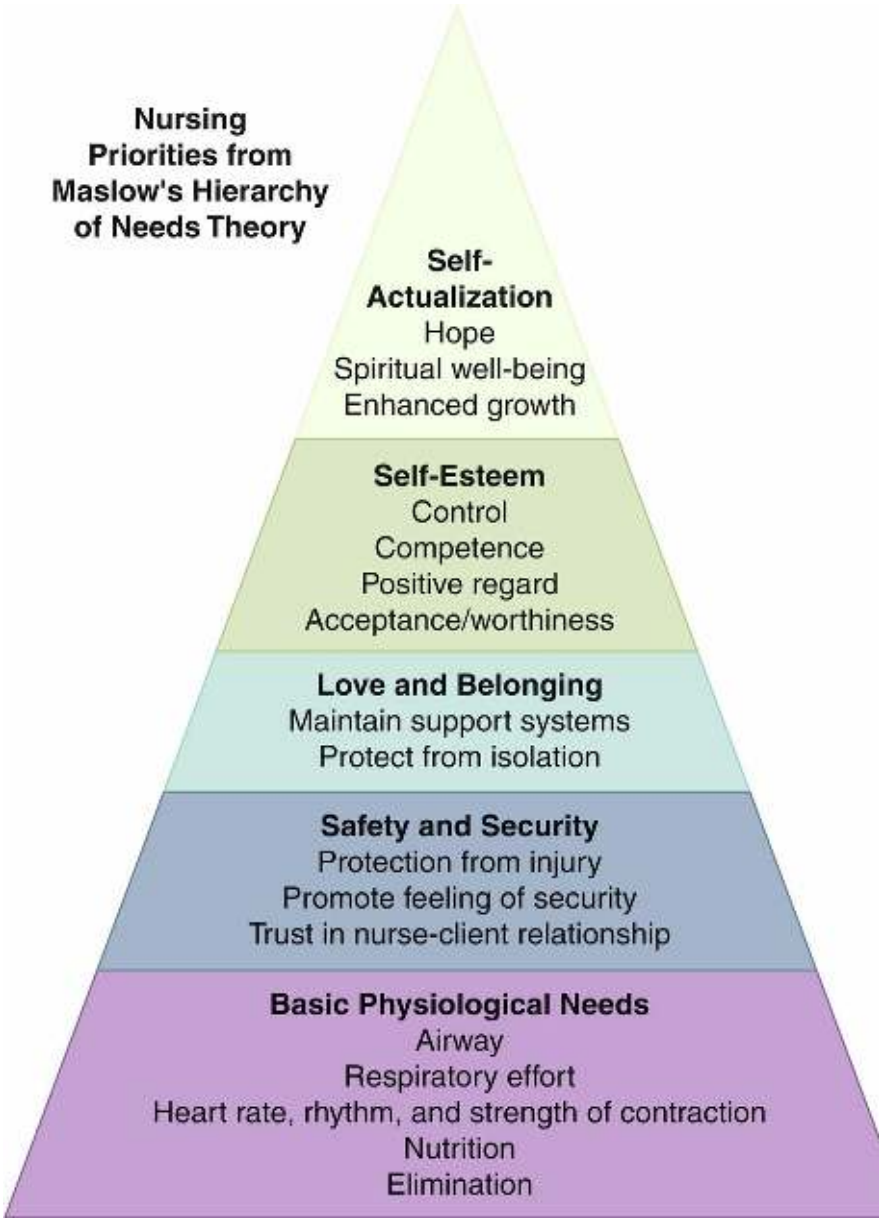

FIG. 4-1 Use Maslow's Hierarchy of Needs theory to establish priorities.

1. According to Maslow's Hierarchy of Needs theory, physiological needs are the priority, followed by safety and security needs, love and belonging needs, self-esteem needs, and, finally, self-actualization needs; select the option or determine the order of priority by addressing physiological needs first.
2. When a physiological need is not addressed in the question or noted in one of the options, continue to use Maslow's Hierarchy of Needs theory sequentially as a guide and look for the option that addresses safety.

G. Steps of the nursing process

1. Use the steps of the nursing process to prioritize.

2. The steps include assessment, analysis, planning, implementation, and evaluation (AAPIE) and are followed in this order.
3. Assessment
    a. Assessment questions address the process of gathering subjective and objective data relative to the client, confirming the data, and communicating and documenting the data.
    b. Remember that assessment is the first step in the nursing process.
    c. When you are asked to select your first, immediate, or initial nursing action, follow the steps of the nursing process to prioritize when selecting the correct option.
    d. Look for words in the options that reflect assessment (see Box 4-4).
    e. If an option contains the concept of assessment or the collection of client data, the best choice is to select that option (Box 4-11).

Box 4-11

Practice Question: The Nursing Process—Assessment

A client who had an application of a right arm cast complains of pain at the wrist when the arm is passively moved. What action should the nurse take **first?**

1. Elevate the arm.
2. Document the findings.
3. Medicate with an additional dose of an opioid.
4. Check for paresthesias and paralysis of the right arm.

Answer: 4

Test-Taking Strategy

Note the **strategic word**, *first*. Based on the **data in the question, determine whether an abnormality exists**. The question event indicates that the client complains of pain at the wrist when the arm is passively moved. This could indicate an abnormality; therefore, further assessment or intervention is required. Use the **steps of the nursing process**, remembering that assessment is the first step. The only option that addresses assessment is the correct option. Options 1, 2, and 3 address the implementation step of the nursing process. Also, these options are incorrect first actions. The arm in a cast should have already been elevated. The client may be experiencing

compartment syndrome, a complication following trauma to the extremities and application of a cast. Additional data need to be collected to determine whether this complication is present. Remember that assessment is the first step in the **nursing process**.

f. If an assessment action is not one of the options, follow the steps of the nursing process as your guide to select your next best action.
g. Possible exception to the guideline—if the question presents an emergency situation, read carefully; in an emergency situation, an intervention may be the priority rather than taking the time to assess further.

4. Analysis (Box 4-12)

Box 4-12

Practice Question: The Nursing Process—Analysis

The nurse reviews the arterial blood gas results of a client and notes the following: pH 7.45, P_{CO_2} 30 mm Hg, and HCO_3 22 mEq/L (22 mmol/L). The nurse analyzes these results as indicating which condition?

1. Metabolic acidosis, compensated
2. Respiratory alkalosis, compensated
3. Metabolic alkalosis, uncompensated
4. Respiratory acidosis, uncompensated

Answer: 2

Test-Taking Strategy

Use the **steps of the nursing process** and analyze the values. The question does not require further assessment; therefore, it is appropriate to move to the next step in the nursing process, analysis. The normal pH is 7.35 to 7.45. In a respiratory condition, an opposite effect will be seen between the pH and the P_{CO_2}. In this situation, the pH is at the high end of the normal value and the P_{CO_2} is low. So, you can eliminate options 1 and 3. In an alkalytic condition, the pH is elevated. The values identified indicate a respiratory alkalosis. Compensation occurs when the pH returns to a normal value. Because the pH is in the normal range at the high end, compensation has occurred. Remember that analysis is the second step in the **nursing process**.

a. Analysis questions are the most difficult questions because they require understanding of the principles of physiological responses and require interpretation of the assessment data.
b. Analysis questions require critical thinking and determining the rationale for therapeutic prescriptions or interventions that may be addressed in

the question.

c. Analysis questions may address the formulation of a statement that identifies a client need or problem. Analysis questions may also include the communication and documentation of the results from the process of the analysis.

d. Often, these types of questions require assimilation of more than one piece of information and application to a client scenario.

5. Planning (Box 4-13)

Box 4-13

Practice Question: The Nursing Process—Planning

The nurse developing a plan of care for a client with a cataract understands that which problem is the **priority?**

1. Concern about the loss of eyesight
2. Altered vision due to opacity of the ocular lens
3. Difficulty moving around because of the need for glasses
4. Becoming lonely because of decreased community immersion

Answer: 2

Test-Taking Strategy

Note the **strategic word**, *priority*, and use the **steps of the nursing process**. This question relates to planning nursing care and asks you to identify the priority problem. Use **Maslow's Hierarchy of Needs theory** to answer the question, remembering that physiological needs are the priority. Concern and becoming lonely are psychosocial needs and would be the last priorities. Note that the correct option directly addresses the client's problem. Remember that planning is the third step of the **nursing process**.

a. Planning questions require prioritizing client problems, determining goals and outcome criteria for goals of care, developing the plan of care, and communicating and documenting the plan of care.

b. Remember that actual client problems rather than potential client problems will most likely be the priority.

6. Implementation (Box 4-14)

Box 4-14

Practice Question: The Nursing Process—Implementation

The nurse is caring for a hospitalized client with angina pectoris who begins to experience chest pain. The nurse administers a nitroglycerin

tablet sublingually as prescribed, but the pain is unrelieved. The nurse should take which action **next?**

1. Reposition the client.
2. Call the client's family.
3. Contact the health care provider.
4. Administer another nitroglycerin tablet.

Answer: 4

Test-Taking Strategy

Note the **strategic word**, *next*, and use the **steps of the nursing process**. Implementation questions address the process of organizing and managing care. This question also requires that you prioritize nursing actions. Additionally, **focus on the data in the question** to assist in avoiding reading into the question. You may think it is necessary to check the blood pressure before administering another tablet, which is correct. However, there are no **data in the question** indicating that the blood pressure is abnormal and could not sustain if another tablet were given. In addition, checking the blood pressure is not one of the options. Recalling that the nurse would administer 3 nitroglycerin tablets 5 minutes apart from each other to relieve chest pain in a hospitalized client will assist in directing you to the correct option. Remember that implementation is the fourth step of the **nursing process**.

a. Implementation questions address the process of organizing and managing care, counseling and teaching, providing care to achieve established goals, supervising and coordinating care, and communicating and documenting nursing interventions.
b. Focus on a nursing action rather than on a medical action when you are answering a question, unless the question is asking you what prescribed medical action is anticipated.
c. On the NCLEX-RN® exam, the only client that you need to be concerned about is the client in the question that you are answering; avoid the "What if …?" syndrome and remember that the client in the question on the computer screen is your *only* assigned client.
d. Answer the question from a textbook and ideal point of view; remember that the nurse has all of the time and all of the equipment needed to care for the client readily available at the bedside; remember that you do not need to run to the supply room to obtain, for example, sterile gloves because the sterile gloves will be at the client's bedside.

7. Evaluation (Box 4-15)

Box 4-15

Practice Question: The Nursing Process—Evaluation

The nurse is evaluating the client's response to treatment of a pleural effusion with a chest tube. The nurse notes a respiratory rate of 20 breaths per minute, fluctuation of the fluid level in the water seal chamber, and a decrease in the amount of drainage by 30 mL since the previous shift. Based on this information, which interpretation should the nurse make?

1. The client is responding well to treatment.
2. Suction should be decreased to the system.
3. The system should be assessed for an air leak.
4. Water should be added to the water seal chamber.

Answer: 1

Test-Taking Strategy

Use the **steps of the nursing process** and note that the nurse needs to evaluate the client's response to treatment. Focus on the **subject** and the **data in the question**. Also, **determine whether an abnormality exists** based on these data. Remember that fluctuation in the water seal chamber is a normal and expected finding with a chest tube. Because the client is being treated for a pleural effusion, it can be determined that he or she is responding well to treatment if the amount of drainage is gradually decreasing because the fluid from the pleural effusion is being effectively removed. If the drainage were to stop suddenly, the chest tube should be assessed for a kink or blockage. There is no indication based on the **data in the question** to decrease suction to the system; in fact, it is unclear as to whether the client is on suction at all. There are also no **data in the question** indicating an air leak. Lastly, there are no **data in the question** indicating the need to add water to the water seal chamber; again, it is unclear as to whether the client has this type of chest tube versus a dry suction chest tube. Remember that evaluation is the fifth step of the **nursing process**.

a. Evaluation questions focus on comparing the actual outcomes of care with the expected outcomes and on communicating and documenting findings.
b. These questions focus on assisting in determining the client's response to care and identifying factors that may interfere with achieving expected outcomes.
c. In an evaluation question, watch for negative event queries, because they are frequently used in evaluation-type questions.

H. Determine Whether an Abnormality Exists (Box 4-16)

Box 4-16

Practice Question: Determine Whether an Abnormality Exists

The nurse is caring for a client being admitted to the emergency department with a chief

complaint of anorexia, nausea, and vomiting. The nurse asks the client about the home medications being taken. The nurse would be **most** concerned if the client stated that which medication was being taken at home?

1. Digoxin
2. Captopril
3. Losartan
4. Furosemide

Answer: 1

Test-Taking Strategy

Note the **strategic word**, *most.* The first step in approaching the answer to this question is to **determine whether an abnormality exists**. The client is complaining of anorexia, nausea, and vomiting; therefore, an abnormality does exist. This tells you that this could be an adverse or toxic effect of one of the medications listed. Although gastrointestinal distress can occur as an expected side effect of many medications, anorexia, nausea, and vomiting are hallmark signs of digoxin toxicity. Therefore, the nurse would be most concerned with this medication if taken at home by the client. Remember to first **determine whether an abnormality exists** in the event before choosing the correct option.

1. In the event, the client scenario will be described. Use your nursing knowledge to determine whether any of the information presented is indicating an abnormality.
2. If an abnormality exists, either further assessment or further intervention will be required. Therefore, continuing to monitor or documenting will not be a correct answer; don't select these options if they are presented!

VII. Client Needs

A. Safe and Effective Care Environment

1. According to the National Council of State Boards of Nursing (NCSBN), these questions test the concepts of providing safe nursing care and collaborating with other health care team members to facilitate effective client care; these questions also focus on the protection of clients, significant others, and health care personnel from environmental hazards.
2. Focus on safety with these types of questions, and remember the importance of hand washing, call lights or bells, bed positioning, appropriate use of side rails, asepsis, use of standard and other precautions, triage, and emergency response planning.

B. Physiological Integrity

1. The NCSBN indicates that these questions test the concepts that the nurse provides care as it relates to comfort and assistance in the performance of activities of daily living as well as care related to the administration of medications and parenteral therapies.
2. These questions also address the nurse's ability to reduce the client's potential for developing complications or health problems related to

treatments, procedures, or existing conditions and to provide care to clients with acute, chronic, or life-threatening physical health conditions.

3. Focus on Maslow's Hierarchy of Needs theory in these types of questions and remember that physiological needs are a priority and are addressed first.
4. Use the ABCs—airway–breathing–circulation—and the steps of the nursing process when selecting an option addressing Physiological Integrity.

C. Psychosocial Integrity

1. The NCSBN notes that these questions test the concepts of nursing care that promote and support the emotional, mental, and social well-being of the client and significant others.
2. Content addressed in these questions relates to supporting and promoting the client's or significant others' ability to cope, adapt, or problem-solve in situations such as illnesses; disabilities; or stressful events including abuse, neglect, or violence.
3. In this Client Needs category, you may be asked communication-type questions that relate to how you would respond to a client, a client's family member or significant other, or other health care team members.
4. Use therapeutic communication techniques to answer communication questions because of their effectiveness in the communication process.
5. Remember to select the option that focuses on the thoughts, feelings, concerns, anxieties, or fears of the client, client's family member, or significant other (Box 4-17).

Box 4-17

Practice Question: Communication

A client scheduled for surgery states to the nurse, "I'm not sure if I should have this surgery." Which response by the nurse is appropriate?

1. "It's your decision."
2. "Don't worry. Everything will be fine."
3. "Why don't you want to have this surgery?"
4. "Tell me what concerns you have about the surgery."

Answer: 4

Test-Taking Strategy

Use **therapeutic communication techniques** to answer communication questions and remember to focus on the client's thoughts, feelings, concerns, anxieties, and fears. The correct option is the only one that addresses the client's concern. Additionally, asking the client about what specific concerns he or she has about the surgery will allow for further decisions in the treatment process to be made. Option 1 is a blunt response and does not address the client's concern. Option 2 provides false reassurance. Option 3 can make the client feel defensive and uses the nontherapeutic communication technique of asking "why." Remember to use **therapeutic communication techniques** and

focus on the client.

D. Health Promotion and Maintenance
   1. According to the NCSBN, these questions test the concepts that the nurse provides and assists in directing nursing care to promote and maintain health.
   2. Content addressed in these questions relates to assisting the client and significant others during the normal expected stages of growth and development, and providing client care related to the prevention and early detection of health problems.
   3. Use the Teaching and Learning theory if the question addresses client teaching, remembering that the client's willingness, desire, and readiness to learn is the first priority.
   4. Watch for negative event queries, because they are frequently used in questions that address Health Promotion and Maintenance and client education.

VIII. Eliminate Comparable or Alike Options (Box 4-18)

Box 4-18

Practice Question: Eliminate Comparable or Alike Options

The nurse is caring for a group of clients. On review of the clients' medical records, the nurse determines that which client is at risk for excess fluid volume?

1. The client taking diuretics
2. The client with an ileostomy
3. The client with kidney disease
4. The client undergoing gastrointestinal suctioning

Answer: 3

Test-Taking Strategy

Focus on the **subject**, the client at risk for excess fluid volume. Think about the pathophysiology associated with each condition identified in the options. The only client who retains fluid is the client with kidney disease. The client taking diuretics, the client with an ileostomy, and the client undergoing gastrointestinal suctioning all lose fluid; these are **comparable or alike** options. Remember to eliminate **comparable or alike** options.

A. When reading the options in multiple-choice or multiple-response questions, look for options that are comparable or alike.
B. Comparable or alike options can be eliminated as possible answers, because it is not likely for both options to be correct.

IX. Eliminate Options Containing Closed-Ended Words (Box 4-19)

Box 4-19

Practice Question: Eliminate Options That Contain Closed-Ended Words

A client is to undergo a computed tomography (CT) scan of the abdomen with oral contrast, and the nurse provides preprocedure instructions. The nurse instructs the client to take which action in the preprocedure period?

1. Avoid eating or drinking for at least 3 hours before the test.
2. Limit self to only 2 cigarettes on the morning of the test.

3. Have a clear liquid breakfast only on the morning of the test.
4. Take all routine medications with a glass of water on the morning of the test.

Answer: 1

Test-Taking Strategy

Note the **closed-ended words** "only" in options 2 and 3 and "all" in option 4. Eliminate options that contain **closed-ended words**, because these options are usually incorrect. Also, note that options 2, 3, and 4 are **comparable or alike** options in that they all involve taking in something on the morning of the test. Remember to eliminate options that contain **closed-ended words**.

A. Some closed-ended words are "all," "always," "every," "must," "none," "never," and "only."
B. Eliminate options that contain closed-ended words, because these words imply a fixed or extreme meaning; these types of options are usually incorrect.
C. Options that contain open-ended words, such as "may," "usually," "normally," "commonly," or "generally," should be considered as possible correct options.

X. Look for the Umbrella Option (Box 4-20)

Box 4-20

Practice Question: Look for the Umbrella Option

A client admitted to the hospital is diagnosed with a pressure injury on the coccyx with a wound vac. The wound culture results indicate *methicillin-resistant staphylococcus aureus* is present. The wound dressing and wound vac foam is due to be changed. The nurse should employ which protective precautions to prevent contraction of the infection during care?

1. Gown and gloves
2. Gloves and a mask
3. Contact precautions
4. Airborne precautions

Answer: 3

Test-Taking Strategy

Focus on the client's diagnosis and recall that this infection is through direct contact. Recall that contact precautions involves the use of gown and gloves for routine care, and the use of gown, gloves, and face shield if splashing is anticipated during care. Note that the correct option is the **umbrella option**. Remember to look for the **umbrella option**, a broad or universal option that includes the concepts of the other options in it.

A. When answering a question, look for the umbrella option.
B. The umbrella option is one that is a broad or universal statement and that usually encompasses the concepts of the other options within it.
C. The umbrella option will be the correct answer.

XI. Use the Guidelines for Delegating and Assignment Making (Box 4-21)

Box 4-21

Practice Question: Use Guidelines for Delegating and Assignment Making

The nurse in charge of a long-term care facility is planning the client assignments for the day. Which client should be assigned to the assistive personnel (AP)?

1. A client on strict bed rest
2. A client with dyspnea who is receiving oxygen therapy
3. A client scheduled for transfer to the hospital for surgery
4. A client with a gastrostomy tube who requires tube feedings every 4 hours

Answer: 1

Test-Taking Strategy

Note the **subject** of the question, the assignment to be delegated to the AP. When asked questions about delegation, think about the role description and scope of practice of the employee and the needs of the client. A client with dyspnea who is receiving oxygen therapy, a client scheduled for transfer to the hospital for surgery, or a client with a gastrostomy tube who requires tube feedings every 4 hours has both physiological and psychosocial needs that require care by a licensed nurse. The AP has been trained to care for a client on bed rest. Remember to match the client's needs with the scope of practice of the health care provider.

A. You may be asked a question that will require you to decide how you will delegate a task or assign clients to other health care providers (HCPs).
B. Focus on the information in the question and what task or assignment is to be delegated.
C. When you have determined what task or assignment is to be delegated, consider the client's needs and match the client's needs with the scope of practice of the HCPs identified in the question.
D. The Nurse Practice Act and any practice limitations define which aspects of care can be delegated and which must be performed by a registered nurse. Use nursing scope of practice as a guide to assist in answering questions. Remember that the NCLEX is a national exam and national standards rather than agency-specific standards must be followed when delegating.
E. In general, noninvasive interventions, such as skin care, range-of-motion exercises, ambulation, grooming, and hygiene measures, can be assigned to an assistive personnel (AP).
F. A licensed practical nurse (LPN) can perform the tasks that a AP can perform and can usually perform certain invasive tasks, such as dressings, suctioning, urinary catheterization, and administering medications orally or by the subcutaneous or intramuscular route; some selected piggyback intravenous medications may also be administered.
G. A registered nurse can perform the tasks that an LPN can perform and is responsible for assessment and planning care, analyzing client data, implementing and evaluating client care, supervising care, initiating teaching, and administering medications intravenously.

XII. Answering Pharmacology Questions (Box 4-22)

Box 4-22

Practice Question: Answering Pharmacology Questions

Quinapril hydrochloride is prescribed as adjunctive therapy in the treatment of heart failure. After administering the first dose, the nurse should monitor which item as the **priority?**

1. Weight
2. Urine output
3. Lung sounds
4. Blood pressure

Answer: 4

Test-Taking Strategy

Focus on the name of the medication and note the **strategic word**, *priority*. Recall that the medication

names of most angiotensin-converting enzyme (ACE) inhibitors end with "*-pril,*" and one of the indications for use of these medications is hypertension. Excessive hypotension ("first-dose syncope") can occur in clients with heart failure or in clients who are severely sodium-depleted or volume-depleted. Although weight, urine output, and lung sounds would be monitored, monitoring the blood pressure is the priority. Remember to use pharmacology guidelines to assist in answering questions about medications and note the **strategic words**.

A. If you are familiar with the medication, use nursing knowledge to answer the question.
B. Remember that the question only will identify the generic name of the medication on most occasions.
C. If the question identifies a medical diagnosis, try to form a relationship between the medication and the diagnosis; for example, you can determine that cyclophosphamide is an antineoplastic medication if the question refers to a client with breast cancer who is taking this medication.
D. Try to determine the classification of the medication being addressed to assist in answering the question. Identifying the classification will assist in determining a medication's action or side effects or both.
E. Recognize the common side effects and adverse effects associated with each medication classification and relate the appropriate nursing interventions to each effect; for example, if a side effect is hypertension, the associated nursing intervention would be to monitor the blood pressure.
F. Focus on what the question is asking or the subject of the question; for example: intended effect, side effect, adverse effect, or toxic effect. It is helpful to learn the most common side effects, adverse effects, and toxic effects by medication classification.
G. Learn medications that belong to a classification by commonalities in their medication names; for example, medications that act as beta blockers end with "*-lol*" (e.g., ateno*lol*).
H. If the question requires a medication calculation, remember that a calculator is available on the computer; talk yourself through each step to be sure the answer makes sense, and recheck the calculation before answering the question, particularly if the answer seems like an unusual dosage.
I. Pharmacology: Pyramid Points to remember
    1. In general, the client should not take an antacid with medication, because the antacid will affect the absorption of the medication, either increasing or decreasing the absorption.
    2. Enteric-coated and sustained-release tablets should not be crushed; also, capsules should not be opened.
    3. The client should never adjust or change a medication dose or abruptly stop taking a medication.
    4. The nurse never adjusts or changes the client's medication dosage and never discontinues a medication.
    5. The client needs to avoid taking any over-the-counter

medications or any other medications, such as herbal preparations, unless they are approved for use by the primary health care provider.

6. The client needs to avoid consuming alcohol.
7. Medications are never administered if the prescription is difficult to read, is unclear, or identifies a medication dose that is not a normal one. It is safer if medications are prescribed electronically.
8. Additional strategies for answering pharmacology questions are presented in *Saunders Strategies for Test Success: Passing Nursing School and the NCLEX® Exam.*

XIII. Answering Complex Questions Using Clinical Judgment

A. You may encounter questions on the NCLEX exam that present a scenario with information or data. Included in the scenario may be demographic information such as age and gender, chief concern, admitting diagnosis, history of present illness, past medical history, surgical history, family history, social history, allergies, and medications, which provides the situation and background for the case.

B. These scenarios may also include data such as vital signs, physical assessment findings, laboratory and diagnostic test results, client prescriptions, and a medication administration record.

C. The candidate may be required to discern between important, relevant data to the clinical situation and data that, although it is important to be aware of, may not have any bearing, relevance, or effect on nursing interventions for the client and the current medical problems.

D. While reviewing the case, try to look at each piece of data in a step-by-step fashion and decide whether it has bearing, relevance, or a potential effect on nursing interventions for the client (see Box 4-23).

Box 4-23

Case Scenario: Strategies for Analyzing Data Using Clinical Judgment

Situation/Background:

Subjective

Chief Complaint (CC):

"I am not feeling any better since starting the antibiotics 4 days ago."

History of Present Illness (HPI):

Reports flu-like symptoms with congestion, throat pain, productive cough with approximately 2 tablespoons of yellow sputum daily, weakness, fatigue. Started 9 days ago, constant, started on cephalexin 4 days ago for the same symptoms with no effect. Also reports cerumen impaction for the last month and wants to know whether she can have it removed.

Past Medical History (hx) (PMH):

Medical hx includes heart failure (type and ejection fraction unknown), hyperlipidemia, hypertension, heart disease with defibrillator/pacemaker placement, type 2 diabetes, pneumonia with pleural effusions requiring thoracentesis × 2, chronic kidney disease (CKD) (stage unknown due to lack of trending labs). Surgical hx includes

defibrillator/pacemaker placement and thoracentesis on two separate occasions in 2017, hysterectomy for fibroid tumors in 2009, right-sided mastectomy for localized cancer in 2008.

Medications:

Aspirin 81 mg PO daily, atorvastatin 10 mg PO daily, carvedilol 12.5 mg PO twice daily, glipizide 5 mg PO twice daily, isosorbide mononitrate 20 mg PO twice daily, furosemide 20 mg every Wednesday, lisinopril 2.5 mg PO daily, Nitrostat 0.4 mg SL every 5 min × 3 prn chest pain, sodium bicarbonate PO twice daily (dosage unknown); cephalexin 500 mg PO twice (started 4 days ago, course to be finished today).

Allergies:

NKA (no known allergies)

Family History (FH):

Unknown.

Social History (SH):

Married, lives at home with husband, retired. Denies exposure to environmental/occupational hazards. Is active throughout the day, but does not engage in any specific exercise regimen. Sleeps approximately 7 hours per night, but sleep has been interrupted due to shortness of breath. Denies smoking, denies drinking alcohol, denies use of recreational drugs.

Review of Systems (ROS)

General Survey/Constitutional: Denies fevers, unintentional weight loss, night sweats. Reports generalized weakness and fatigue. Integumentary: Denies skin changes, sweating, rashes. Head, Eyes, Ears, Nose, Mouth & Throat: Reports intermittent headache. Denies vision changes, ear pain. Reports nasal congestion and drainage. Reports throat pain. Cardiovascular: Denies palpitations. Denies chest pain. Reports hx of defibrillator and pacemaker. Neurological: Denies incoordination, syncope, inability to concentrate. Psychiatric: Denies mood changes, depression. Reports anxiety during coughing due to shortness of breath. Hematological/Lymphatic: Denies lymph node enlargement, tenderness.	Respiratory: Reports SOB (shortness of breath) with coughing. Reports sleeping elevated and sitting on the side of the bed at night to breathe. Reports frequent productive cough (see HPI). Gastrointestinal: Denies n/v/d (nausea/vomiting/diarrhea). Reports incontinence of BM (bowel movement), loose, occurs with coughing. Genitourinary: Denies dysuria, urinary frequency, incontinence. Musculoskeletal: Reports muscle pain in the ribs with coughing. Reports generalized muscle pain and joint pain. Allergic/Immunological: Denies fever, rashes, allergy symptoms.

Physical Exam:

Objective

Weight: 87.8 kg (193.5 lb)	Temp: 37.0° C oral (98.6 F)	Blood Pressure: 140/90 mm Hg right arm
Height: 170 cm (66.9 inch)	Pulse: 89 bpm (beats per minute)	Respiration: 24 bpm (breaths per minute)
BMI: 30.3	O2Sat: 93% RA (room air) before nebulizer O2Sat: 97% RA after nebulizer and during interview	Waist Circumference: Deferred

General Appearance:

75-year-old Caucasian female, appears short of breath while coughing. During interview, client kept eyes closed and appeared fatigue. Speaking in fragmented sentences.

Skin:
Skin color white, consistent with ethnic background. Skin intact throughout. Skin uniformly warm and dry. No diaphoresis.

ENT:
Bilateral obstructing cerumen noted in both ear canals. Purulent nasal discharge noted. Oropharynx reddened, tonsillar pillars 2 + without exudates. Sputum noted, 1 tsp, yellow.

Neck:
Neck symmetrical, trachea midline. No lymphadenopathy, neck supple.

Breast:
Deferred.

Cardiovascular:
Regular rate and rhythm, S1, S2, no S3, S4. + 2 pitting edema in bilateral lower extremities. Radial pulses + 2 bilaterally. Dorsalis pedis and posterior tibial pulses 1 + bilaterally.

Respiratory:
L (left) sided rhonchi, inspiratory and expiratory. R (right) sided diminished in upper lobes. Coarse crackles in bilateral bases. Wheezing noted in bilateral upper lobes. Productive cough noted frequently throughout exam.

Gastrointestinal:
Deferred.

Genitourinary:
Deferred.

Musculoskeletal:
Full active range of motion of all joints and spine. Muscle strength testing deferred.

Neurological:
Alert and oriented to person, place, time, and situation. Gait is weak, walks with cane.

Psych:
Physical appearance and behavior appropriate.

Laboratory/Diagnostic Test Results

Recent outpatient chest x-ray (CXR) from 4 days ago shows bilateral pneumonia with small bilateral pleural effusions

Assessment (Diagnosis)

1. Bilateral pneumonia, unspecified organism
2. Bilateral pleural effusion, not elsewhere classified
3. Rule out heart failure exacerbation
4. Impacted cerumen, bilateral
5. History of heart disease with pacemaker/defibrillator placement, hypertension, heart failure, type 2 diabetes, pneumonia with thoracentesis, CKD-stage unknown

Recommendation:

Plan

1. Admit to medical-telemetry
2. Admitting dx: bilateral pneumonia with bilateral pleural effusions
3. Two-view CXR
4. Echocardiogram
5. Sputum culture
6. CBC w/ diff, CMP, BNP, A1C, ABG, U/A & C + S
7. Levofloxacin 750 mg IV every 24 hr
8. Electrolyte replacement protocol
9. Inhaled respiratory treatments every 6 hr prn SOB/wheezing
10. Titrate oxygen to maintain SpO_2 greater than 92%
11. Incentive spirometer 10 times every 1 hr while awake
12. Cardiac/renal diet
13. Continue home medications
14. Furosemide 40 mg IV every 8 hours
15. Strict I&O monitoring
16. Up ad lib with assistance

17. Sequential compression devices for prevention of venous thromboembolism
18. PT/OT evaluation
19. Further prescriptions to follow

Test-Taking Strategy:
In analyzing this case scenario, important information for the nurse to note that may have bearing, relevance, or an effect on the care provided is noted below, with an accompanying rationale.

CC:
This information is important for the nurse to note because it could indicate that the causative bacteria of the client's pneumonia is not sensitive to the prescribed antibiotic, cephalexin, which is a cephalosporin.

HPI:
The symptoms described are in alignment with the client's admitting diagnosis. Of note is that the client describes cerumen impaction. This is not of priority concern at this time and can be addressed with her primary health care provider on an outpatient basis.

PMH:
The client's medical history makes her a likely candidate for heart failure exacerbation due to her comorbid conditions and history of complicated pneumonia. Additionally, she is at risk for fluid volume overload because of the presence of pleural effusions, the likelihood of heart failure, as well as likelihood of renal failure, in particular, chronic kidney disease.

Surgical Hx:
The placement of a defibrillator/pacemaker and thoracentesis make this client a likely candidate for acute coronary syndrome and cardiorespiratory compromise. Furthermore, the fact that this client had a right-sided mastectomy in 2008 should alert the nurse to the fact that blood pressures, blood draws, and IVs should not be done on this side. Further complicating the case, is the idea that the client may have some degree of chronic kidney disease and therefore should have an arm preserved in case there was ever a need for a fistula for dialysis. Conferral with a nephrologist should be suggested at this time.

Medications:
The client is on medications to manage her comorbid conditions. She is continuing her home medications while in the hospital. Based on the medications to be administered, the nurse should be assessing pulse rate, blood pressure, potassium level, as well as for signs of fluid volume overload and cardiovascular compromise such as chest pain to determine whether medications are appropriate and safe to administer.

SH:
The client is married and has a support system. It may be important for the nurse to know the setup of the home and whether it would be conducive for a safe discharge home. Orthopnea is a very sensitive indicator of a fluid volume overload state, and the nurse should be prepared to initiate emergency measures if needed.

ROS:
Other subjective findings that are important include complaints of generalized weakness and fatigue, intermittent headache, nasal congestion, throat pain, shortness of breath with productive cough, sleeping elevated at night, sitting at the side of the bed to breathe during the night, incontinence of loose stool during coughing, and history of defibrillator/pacemaker placement. These findings should indicate to the nurse that the client likely has pneumonia secondary to an upper respiratory infection, in addition to heart failure exacerbation and fluid volume overload. The client is at risk for decreased cardiac output; problems with oxygenation and perfusion; sepsis; and compromised safety due to weakness, fatigue, and hypoxemia.

Physical Exam:
Of note is that the client is obese, afebrile, moderately hypertensive, with signs of decreased oxygenation, which is improved with a nebulizer treatment. This may suggest the airway is reacting to insult or injury by constricting. The general appearance of the client, and the fact that she is speaking in fragmented sentences, also should alert the nurse to the potential for clinical deterioration. Yellow sputum is consistent with the diagnosis of pneumonia. The nurse should collect the sputum for analysis. The client has + 2 pitting edema in the lower extremities, with diminished peripheral pulses. This may suggest heart or renal failure. The adventitious lung sounds should also be a concern for the nurse, and these findings should be closely monitored.

Laboratory and Diagnostic Test Results:

The nurse should note the previous result of the CXR and compare this result to the new one, which is particularly helpful in monitoring the resolution or worsening of the pneumonia and pleural effusion. The nurse should note that a sputum culture is very important, and a urinalysis has been prescribed, because the client has been incontinent of stool placing the client at risk for urinary tract infection. The nurse should follow-up on new results as they become available.

Assessment (Diagnosis):

The nurse should note the diagnosis of bilateral pneumonia, unspecified organism. The nurse is tasked with obtaining a sputum culture, which is important in directing the medical management of this client because it indicates the type of bacteria present, as well as its sensitivity to specific antibiotics. The nurse should also note the diagnosis of pleural effusion, which could become infected and may require thoracentesis or chest tube placement. The nurse should note that the plan is to rule out heart failure exacerbation and diagnostic results, such as, but not limited to, the BNP, CXR result, and the echocardiogram require follow-up and review.

Plan:

The nurse should ensure all prescriptions are implemented within a timely manner and report any abnormal or new findings to the primary health care provider. The nurse should ensure the plan of care for the client is logical, and that any consulting specialists are in communication with the primary health care provider. In reviewing the specific plan of care, the nurse should perform an admission assessment and place the client on telemetry. The heart rhythm should be monitored throughout the shift. The nurse should ensure the chest x-ray and echocardiogram are completed and should follow-up on the results. The nurse should collect the sputum culture and should use a suction device if needed or elicit the assistance of the respiratory therapist to ensure the sample obtained is expectorated or taken from the lower airway. A lower airway sample is not contaminated by oral mucosa. The nurse should collect a clean-catch urine sample or obtain a prescription to use a straight catheter if needed to ensure the sample is not contaminated. The nurse should also follow-up on the results of the CBC, CMP, BNP, A1C, and ABGs and report any abnormal results. The nurse will need to administer the levofloxacin IV after sputum specimen collection, and should assess the IV site prior to, during, and after administration. The nurse should ensure that the client is not administered continuous fluids through the IV at any time due to the risk of fluid volume overload. The nurse should administer any depleted electrolytes following the electrolyte protocol if needed based on lab results. The nurse should address any change in oxygenation by titrating oxygen as needed. An incentive spirometer should be given to the client to prevent atelectasis. It is important for clients with pneumonia to use an incentive spirometer to help with oxygenation. The nurse will administer the IV furosemide and should pay attention to the potassium level, blood pressure, and intake and output. The output specifically is what helps the nurse know if the medication is having the intended effect. Assisting the client to walk and applying sequential compression devices are important to prevent venous thromboembolism, which could occur as a result of immobility. Physical and occupational therapy (PT/OT) evaluation is important to evaluate for a safe discharge to home.

Analyzing complex case scenarios in a step-by-step fashion helps make important connections, which contribute to the provision of safe and effective client care.