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Next Generation
NCLEX-RN®

STUDENT WORKBOOK

SKILLS

NCLEX® EXAM TIPS

- Ensure that you have a strong foundation in the fundamental nursing skills. Master the basic techniques and procedures, such as hand hygiene, vital sign assessment, and medication administration. These skills form the building blocks for more complex nursing tasks.
- Familiarize yourself with the step-by-step process for each nursing skill. Pay attention to the order and sequence of actions required. Practice the skills repeatedly until you are confident in your ability to perform them accurately and efficiently.
- Time management is crucial during the exam. The NCLEX has a time limit, so it's important to allocate your time wisely. During your practice sessions, aim to complete each skill within the recommended time frame. This will help you develop a sense of how long each skill should take, allowing you to pace yourself effectively during the actual exam.
- Infection control is a critical aspect of nursing skills. Ensure that you are well-versed in standard precautions, including hand hygiene, personal protective equipment (PPE) usage, and proper disposal of contaminated materials. Adhere to these precautions consistently during both practice sessions and the actual exam.
- Patient safety is of utmost importance. Prioritize safety measures such as correct body mechanics, proper use of restraints (if applicable), and fall prevention strategies. Remember to consider patient-specific factors, such as allergies or contraindications, before implementing any interventions.
- The NCLEX assesses your ability to think critically and make sound nursing judgments. Apply critical thinking skills when approaching nursing skills. Consider the patient's condition, potential complications, and appropriate interventions. Understand the rationale behind each step and be prepared to explain why you are performing certain actions.
- Instead of passively reading or observing, actively engage with the material. Practice recalling the steps and key information for each skill from memory. This will strengthen your ability to recall and apply the information during the exam.
- Take advantage of practice resources, such as nursing skill workbooks, online tutorials, or videos that provide demonstrations and explanations. Use these resources to reinforce your understanding and fine-tune your technique.
- If possible, practice your skills with a study partner or seek feedback from experienced nursing professionals or educators. They can provide valuable insights, correct any mistakes, and offer suggestions for improvement.
- Test anxiety can impact your performance. Develop strategies to manage stress and anxiety, such as deep breathing exercises, positive self-talk, and visualization techniques. Stay calm and focused during the exam, and trust in your preparation.

NCLEX® MNEMONICS

- "ABCDE" - Assessment and Management of Acute Events: This mnemonic helps nurses remember the key components of assessing and managing acute events, such as a patient experiencing a medical emergency or deterioration in their condition.
  - Airway: Ensure the patient has a clear airway and is able to breathe adequately.
  - Breathing: Assess the patient's breathing and provide any necessary interventions to maintain respiratory function.
  - Circulation: Evaluate the patient's circulation, including pulse, blood pressure, and perfusion.
  - Disability: Assess the patient's neurological status, including level of consciousness, pupillary response, and motor function.
  - Exposure: Ensure the patient is adequately exposed for a thorough assessment and appropriate interventions.

- "SOAP" - Documentation Format: This mnemonic assists nurses in organizing their documentation according to the SOAP format, which is commonly used in healthcare settings.
  - Subjective: Document the patient's subjective information, including their symptoms, concerns, and reported history.
  - Objective: Record the objective findings from assessments, vital signs, physical examinations, and diagnostic tests.
  - Assessment: Provide a professional assessment of the patient's condition based on the subjective and objective information.
  - Plan: Outline the plan of care, including interventions, treatments, medications, and follow-up actions.

- "BRAT" - Dietary Interventions for Gastrointestinal Upset: This mnemonic helps nurses remember appropriate dietary recommendations for patients experiencing gastrointestinal upset, such as diarrhea or nausea.
  - Bananas: Offer bananas, which are easy to digest and provide potassium and fiber.
  - Rice: Suggest plain rice, which is bland and helps to bind loose stools.
  - Applesauce: Provide applesauce, which is gentle on the stomach and contains pectin, aiding in digestion.
  - Toast: Recommend plain toast, which is light and can help absorb excess stomach acid.

Q1 The nurse is teaching a client with right-sided weakness related to a **stroke** about how to properly ambulate with a cane. Which client action would indicate a **need for further teaching?**

1. The client holds the cane on the right side of the body.
2. The client moves the weaker leg toward the cane first.
3. The client holds the cane 6 inches laterally from the foot.
4. The client keeps two points of support on the floor at all times.

Q2 The nurse is providing medication instructions to a parent. Which statement by the parent indicates a **need for further instruction?**

1. "I need to cuddle my child after giving the medication."
2. "I can give my child a frozen juice bar after my child swallows the medication."
3. "I need to mix the medication in the baby food and give it when I feed my child."
4. "If my child does not like the taste of the medicine, I need to encourage my child to pinch the nose and drink the medication through a straw."

NOTES:

Q3 The primary health care provider's prescription reads levothyroxine, 150 mcg orally daily. The medication label reads levothyroxine, 0.1 mg per tablet. The nurse would plan to administer how **many tablet(s)** to the client? **Fill in the blank.**

Q4 A primary health care provider's prescription reads 1000 mL of normal saline (NS) to infuse over 12 hours. The drop factor is 15 drops (gtt)/1 mL. The nurse plans to set the flow rate at how many drops per minute? Fill in the blank. **Record your answer to the nearest whole** number.

NOTES:

Q5 Before enema administration, the nurse positions the client in a left lateral position. What is **the rationale for using this position**?

1. It is more comfortable.
2. It facilitates the passage of stool.
3. It prevents a vasovagal response from occurring.
4. It facilitates instillation of the enema solution into the colon.

Q6 The nurse is preparing to give a full bed bath to a client. Which question is **most important** for the nurse to ask the client before beginning the bed bath?

1. "Do you have any allergies?"
2. "Will you be able to wash your own hair?"
3. "Are there any areas you want us to spend more time bathing?"
4. "Do you have any preferences regarding how we help you bathe?"

NOTES:

Q7 Two nurses are leaving the room of a client whose care required them to wear a gown, mask, and gloves. Which **action** by these nurses could **lead to the spread of infection**?

1. Taking off the gloves first before removing the gown
2. Removing the gown without rolling it from inside out
3. Washing the hands after the entire procedure has been completed
4. Removing the gloves and then removing the gown using the neck ties

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Q8 The **nurse is preparing to administer medication using a client's** nasogastric tube. Which **actions** would the nurse take **before administering the medication**? Select all that apply.

1. Check the residual volume.
2. Aspirate the stomach contents.
3. Turn off the suction to the nasogastric tube.
4. Remove the tube and place it in the other nostril.
5. Test the stomach contents for a pH indicating acidity.

NOTES:

Q9 The nurse is reviewing the instillation technique for both eye ointment and eye drops with the parent of a pediatric client diagnosed with **bacterial conjunctivitis.** Which statement made by the parent would indicate that **learning has taken place**?

1. "I will be careful not to touch the eye or eyelid during administration."
2. "I will place my child on the left side to administer drops in the right eye."
3. "I will administer the eye ointment and then wait 5 minutes and administer the eye drops."
4. "I will have my child blink after the instillation to encourage thorough distribution of the eye drops."

Q10 The nurse is providing discharge dietary teaching to a client with a history of irritable bowel syndrome (IBS). What comment made by the client tells the nurse that **further instruction** is needed?

1. "I'll eat more beans and peas."
2. "I need to eliminate caffeine and alcohol."
3. "I'm afraid my child will get this disease."
4. "I know I need to take vitamins and mineral supplements."

NOTES:

Q11 An oxygen delivery system is prescribed for a client with chronic obstructive pulmonary disease to deliver a precise oxygen concentration. Which **oxygen delivery** system **would the nurse prepare** for the client?

1. Face tent
2. Venturi mask
3. Aerosol mask
4. Tracheostomy collar

Q12 The nurse has a prescription to obtain a 24-hour urine collection in a client with a renal infection. Which **actions** would the nurse take when collecting this specimen? Select all that apply.

1. Explain the procedure to the client.
2. Save all subsequent voidings after the first void during the 24-hour period.
3. During the collection period, place the main container on ice or in a refrigerator.
4. Have the client void at the end time, and place this specimen in the main container.
5. Have the client void at the start time, and place this specimen in the main container.

NOTES:

Q13 The nurse is preparing to suction a client via a tracheostomy tube. The nurse would plan to limit the **suctioning time to a maximum** of which time period?

1. 5 seconds
2. 10 seconds
3. 30 seconds
4. 60 secondd

Q14 The nurse works in a long-term care facility, caring for older clients. The nurse would make **which interpretation** when an older client complains of **pain**?

1. Pain is a natural and expected outcome of aging.
2. Something is wrong, and an assessment needs to be made.
3. Nonpharmacological relief measures are ineffective in older clients.
4. It is best to treat the symptom of pain immediately **rather than** focus on identifying the cause.

Q15 A client has a wound with a moderate amount of drainage and is scheduled for a dressing change. **Which dressing,** if selected by the student nurse, **requires further intervention** by the nursing instructor?

1. Foam
2. Alginate dressing
3. Hydrocolloid dressing
4. Semipermeable transparent film

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STUDENT WORKBOOK

CLINICAL CASE

ITEM 1

HEALTH HISTORY

A 53-year-old client undergoes a right lung wedge resection to remove a tumor. Biopsy results are pending but the tumor has caused moderate to severe pain in the right lung area. The client has no history of cancer and reports no history of cancer in the family.

The client reports being a nurse and works at a home health agency as a visiting nurse. The medical history includes hyperlipidemia and taking atorvastatin 40 mg daily. No other medical or surgical history reported.

VITAL SIGNS

Temp = 98.6°F (37.0°C)
HR = 80 BPM
RR = 20 bpm
BP = 118/70 mm/Hg
SpO2 = 95% on 2 L oxygen.
Pain 3/10 right chest tube insertion site, increases with deep breathing and coughing.

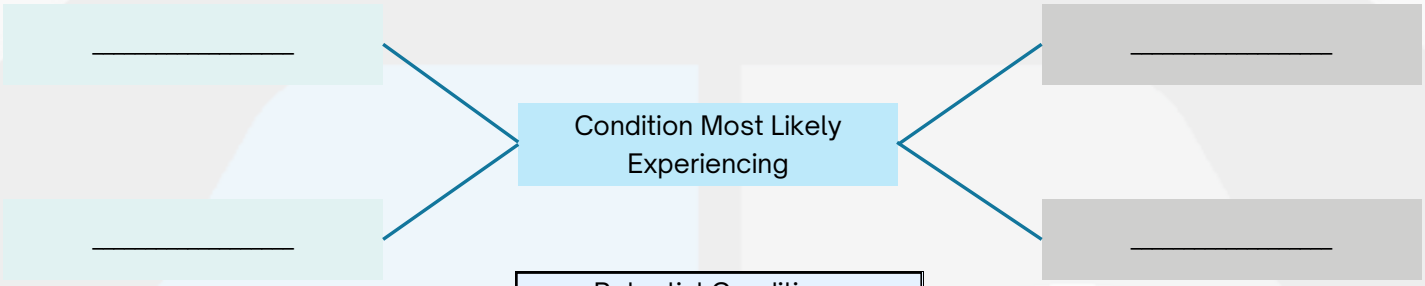
ITEM 1

NURSE'S NOTES

1100: Client was admitted to medical-surgical unit from the recovery unit following right wedge resection with one chest tube attached to a 3-chamber closed chest tube drainage system. Dressing covering the chest tube insertion site is occlusive, dry, and intact. 50 mL bloody drainage in the collection chamber, intermittent bubbling in the water seal chamber, gentle bubbling in the suction control chamber. Arousable and oriented, oxygen via NC at 2 L/ min, HOB at 30 degrees

1200: The nurse notes that the client has dyspnea and reports an increase in pain to 5/10. Drainage in the collection control chamber is at 100 mL bloody drainage; there is continuous vigorous bubbling in the water seal chamber and gentle bubbling in the suction control chamber.

Complete the diagram by dragging from the choices below to specify what condition the client is most likely experiencing, 2 actions the nurse should take to address that condition, and 2 parameters the nurse should monitor to assess the client's progress.



Potential Conditions

1. Bleeding
2. Air leak in the drainage system
3. Displacement of the chest tube in the pleural space
4. Lung has reexpanded

Action to Take

1. Clamp the tubing and determine location of the problem.
2. Apply pressure to the chest tube insertion site.
3. Check for subcutaneous emphysema.
4. Disconnect and submerge the chest tube in a bottle of sterile water.
5. Notify the surgeon.

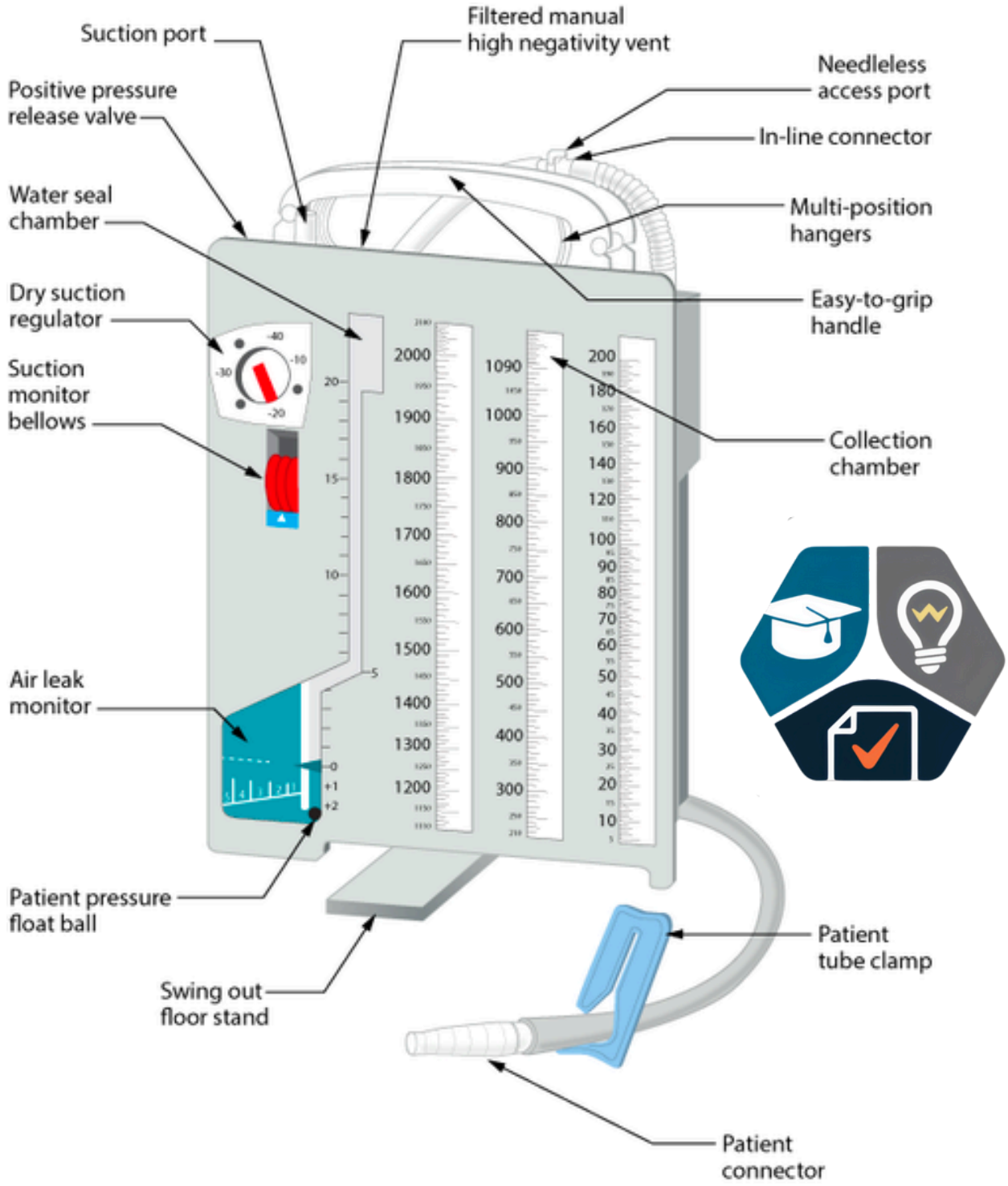
Parameter to Monitor

1. Chest x-ray
2. Hemoglobin, hematocrit, platelets, red blood cells
3. Respiratory status, HR, BP, RR, SpO2
4. Fluctuation and bubbling in the water seal chamber
5. Drainage amount in the collection chamber

MY NOTES

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Complete the diagram by selecting from the choices below to specify which condition the client is most likely experiencing, 2 actions the nurse would take to address that condition, and 2 parameters the nurse would monitor to assess the client's progress.



The VS are within normal limits and therefore are not related to any of the potential conditions. The dyspnea could be related to bleeding, an air leak in the drainage system, or displacement of the chest tube in the pleural space.

MY NOTES

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Bilingual Review





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