NurseAdemy
ESTUDIA ONLINE

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 A client being measured for crutches asks the nurse why the crutches cannot rest up underneath the arm for extra support. The nurse responds, knowing that which would **most likely** result from this improper crutch measurement?

1. A fall and further injury
2. Injury to the brachial plexus nerves
3. Skin breakdown in the area of the axilla
4. Impaired range of motion while the client ambulates

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

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

NOTES:

Q3 A primary health care provider's prescription reads nitroglycerin grains 1/150 sublingually stat. The label on the bottle reads nitroglycerin 0.4 mg/tablet. The nurse prepares how many tablet(s) to administer the correct dose? Fill in the blank.

Q4 A primary health care provider prescribes phenytoin 0.1 g orally 3 times a day. The nurse determines that the prescribed dosage is being administered if the client will be receiving a total of **how many milligrams in a 24-hour period?** Fill in the blank.

NOTES:

REMEMBER

FÓRMULA
DESEO SOBRE TENGO

$$\frac{\text{DOSIS ORDENADA}}{\text{DOSIS DISPONIBLE}} \times \text{VOLUMEN} = \text{RESULTADO}$$

FÓRMULA
Mililitros x Hora

$$\frac{\text{ML (Cantidad de Infusion)}}{\text{H (Tiempo Ordenado)}} = \text{RESULTADO}$$

FÓRMULA
Factor Goteo

$$\frac{\text{ML (Cantidad de Infusion)}}{\text{H (Horas Ordenadas)}} \times \frac{\text{Factor Goteo}}{\text{60 mins}} = \frac{\text{Resultado}}{\text{Horas en Min}} = \text{RESULTADO}$$

$$\frac{\text{ML (Cantidad de Infusion)}}{\text{Tiempo en Minutos}} \times \text{Factor Goteo} = \text{RESULTADO}$$

Q7 The nurse is assisting a client to collect a midstream urine specimen. How would the nurse implement **aseptic technique**?

1. Cleansing the meatus with antiseptic pads using upward strokes
2. Letting go of the labia once this tissue is cleansed to allow the client to urinate
3. Making sure that the fingers avoid touching the inside of the collection container
4. Instructing the client to urinate in the container after the labia have been cleansed

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Q8 The nurse educator is orienting a new nurse to the pediatric unit and is including tips for medication administration. Which statement by the new nurse indicates that the **teaching has been effective**?

1. "It helps to use magical thinking with the infant-age group."
2. "It helps to use magical thinking with the school-age group."
3. "It helps to use magical thinking with the toddler-age group."
4. "It helps to use magical thinking with the preschool-age group."

NOTES:

PIAGET'S THEORY OF COGNITIVE

Stage	Age Range	Characteristics	Teaching Approach
Sensorimotor	0 to 2 years	- Focuses on immediate sensory experiences. **- Lives in the present moment.** - Unable to understand abstract concepts or future/past events. - Doesn't understand play; responds to direct instructions.	Teach in the present moment. Use simple and direct instructions.
Preoperational (Preschooler)	3 to 6 years	**- Fantasy-oriented, imaginative, and illogical thinking.** - Understands the future and the past. - Lacks rule-based thinking. - More open to imaginative play.	Incorporate imaginative and creative elements into teaching. Keep instructions simple and future/past-oriented.
Concrete Operations	7 to 11 years	- Rule-oriented thinking. - Difficulty with abstract concepts. - Believes there is only one correct way to do things. **- Learning is based on rules and concrete experiences.**	Teach with clear rules and concrete examples. Introduce topics a day or two in advance. Use age-appropriate reading and practical demonstrations.
Formal Operations	12 to 15 years	**- Capable of abstract thinking and understanding cause and effect.** - Can think like an adult. - Able to make decisions that require abstract thinking.	Treat them more like adults in terms of teaching and expectations. Address complex and abstract concepts.

NOTES:

Q9 The nurse is providing dietary instructions to a client about food items that are high in niacin. Which food item would **the nurse recommend** as highest in niacin?

1. Poultry
2. Potatoes
3. Tomatoes
4. Strawberries

Q10 The nurse receives an order to obtain a 24-hour urine collection for a patient with a renal infection. Which **actions** should the nurse perform when collecting this specimen? **Select all that apply.**

1. Educate the patient about the procedure.
2. Collect all urine voids, except the initial void, during the 24-hour period.
3. Keep the primary collection container on ice or refrigerated during the collection period.
4. Have the patient void at the end of the collection period and add this sample to the main container.
5. Discard the first void at the start of the collection period.

NOTES:

Q11 The nurse is reviewing the ventilator settings on a client with an endotracheal tube attached to mechanical ventilation. The nurse notes that the tidal volume is set at 500 mL. How does the nurse **interpret this setting?**

1. It is the amount of air delivered with each set breath.
2. It is a breath that has a greater volume than the preset tidal volume.
3. It is the number of breaths that the client will receive per minute by the ventilator.
4. It is the fraction of inspired oxygen (FiO2) that is delivered to the client through the ventilator.

Q12 **Select the correct sequence number for each item:**

1. Hyperoxygenate the client.
2. Place the client in a semi-Fowler's position.
3. Attach the suction tubing to the suction catheter.
4. Turn on the suction device and set the regulator at 80 mm Hg.
5. Insert the catheter into the tracheostomy until resistance is met, and then pull it back 1 cm.
6. Apply intermittent suction and slowly withdraw the catheter while rotating it back and forth.

NOTES:

Q13 The nurse is assessing the status of pain in an alert older client who was recently admitted to the hospital with a diagnosis of ruptured lumbar disc. What are some of the beliefs and **concerns older adults have about pain? Select all that apply.**

1. Pain is something that must be lived with.
2. Nurses are too busy to listen to reports of pain.
3. Pain signifies a serious illness or impending death.
4. Reporting pain will result in being labeled as a "bad" client.
5. Expressing pain is only done by people who want attention.
6. Nurses and other caregivers often give too much medication to older clients.

Q14 The home health care nurse makes a home visit to a client who has an ulcer on the medial aspect of the left ankle. The wound is being treated with a hydrocolloid dressing. The nurse removes the hydrocolloid dressing, cleanses the wound as prescribed, and reapplies the hydrocolloid dressing. The nurse schedules the next visit for wound care and changing the hydrocolloid dressing in how many days, **which is the maximum number of days? Fill in the blank.**

NOTES:

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STUDENT WORKBOOK

CLINICAL CASES

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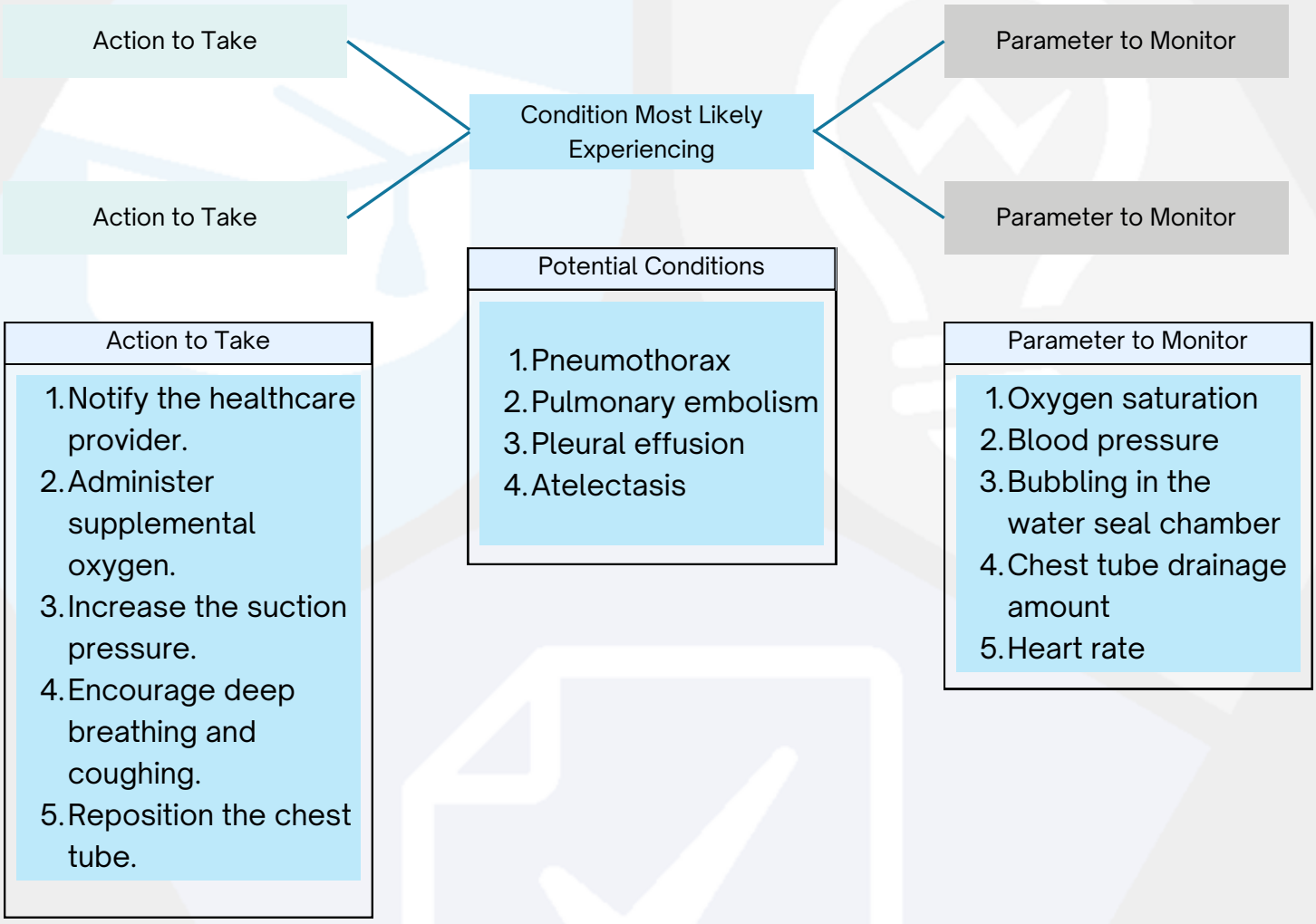
A 58-year-old client undergoes a right lung lobectomy to remove a suspected tumor. Biopsy results are pending, but the tumor has caused moderate pain in the right lung area. The client has no history of cancer and reports no history of cancer in the family. The client reports being a physical therapist and works at a rehabilitation center. The medical history includes hypertension and taking lisinopril 20 mg daily. No other medical or surgical history reported.

10:00 Client was admitted to medical-surgical unit from the recovery unit following right lung lobectomy 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. 40 mL serosanguinous drainage in the collection chamber, intermittent bubbling in the water seal chamber, gentle bubbling in the suction control chamber. Alert and oriented, oxygen via NC at 2 L/min, HOB at 30 degrees.

Vital Signs: Temp = 98.4°F (36.9°C) HR = 85 BPM RR = 18 bpm BP = 122/76 mm/Hg SpO2 = 94% on 2 L oxygen. Pain 2/10 right chest tube insertion site, increases with deep breathing and coughing.

11:00 The nurse notes that the client has mild dyspnea and reports an increase in pain to 4/10. Drainage in the collection control chamber is at 75 mL serosanguinous drainage; there is continuous moderate bubbling in the water seal chamber and gentle bubbling in the suction control chamber.

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.



NOTES:

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NEXT GENERATION
NCLEX®
Bilingual Review





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