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About the Author

Hi, I'm Chris Mulder—a full-time travel nurse anesthetist and a proud member of the nursing tribe. But I didn't always wear scrubs for a living.

Before I became a CRNA, I spent my days in a tiny cubicle, wondering why I had an English degree and no idea what I was doing with it. It didn't take long to realize I needed a major change—something meaningful, something that mattered. Much to my wife's concern (and eventual support), I went back to school to become a nurse.

It wasn't easy. Nursing school tested every part of me. But I pushed through, graduated, and started working in a busy medical ICU in Lakeland, Florida. A few years later, I was accepted into nurse anesthesia school—and, well, the rest is history.

Through it all, I noticed something: nursing education often felt overly complicated, hard to retain, and totally disconnected from real-world practice. I also met more than a few nurses who took themselves way too seriously. So I decided to take a different approach—clear, useful, and maybe even a little funny.

I get what you're going through. I've felt the anxiety before clinicals, the exhaustion after night shifts, and the dread of hitting "submit" on a tough exam. That's why I create resources that are smart, practical, and just a little more human.

At the end of the day, I'm a CRNA—but first and foremost, I'm a **nurse**. And I'm here to help you make it through, just like someone once helped me.

Preface

Read This First

If you're holding this book, you're probably in the home stretch.

The application's submitted. Your school's behind you. The countdown is real. And the only thing standing between you and your RN license… is one final exam.

Let's be clear: **the NCLEX doesn't test whether you'll be a great nurse.**

It tests whether you can recognize patterns, avoid red flags, and make safe decisions—under pressure, without second-guessing yourself.

That's what this book is built for.

You don't need 1,000 pages of fluff. You don't need to re-learn every single fact from nursing school. You need a sharp, high-yield, no-nonsense crash course to **activate the knowledge you already have** and teach you how to use it strategically.

Inside, you'll find:

- Core content boiled down by NCLEX category
- Mnemonics and memory cues that stick
- Real-world red flags that pop up on exam day
- Clinical decision strategies that help you pick the safest answer

- And a final mindset reset—so you walk in focused and confident

We've cut the filler. We've kept the gold. This is the guide for **smart students who are ready to pass now**.

So take a deep breath.
Open to Chapter 1.
And let's finish what you started.

You're closer than you think.

— *Nurse Dojo*

Chapter 1: Management of Care

Prioritization, Delegation, Legal-Ethical Scenarios, and Safe Decision-Making

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Overview

This section is the **highest-weighted category** on the NCLEX—accounting for up to **23% of your test**. It doesn't just ask *what* you know, it asks *what you do next*.

Expect questions on:

- Who you assess first
- What tasks you can delegate
- Which patient is at highest risk
- When to act vs. when to notify the provider
- Legal and ethical decisions
- Advance directives, informed consent, and scope of practice

This is about judgment, not trivia.

Mechanisms in Action: Prioritizing Under Pressure

Clinical Vignette:

You're assigned to four clients:

1. A post-op cholecystectomy with mild abdominal pain
2. A COPD patient requesting a PRN albuterol inhaler
3. A diabetic with a blood glucose of 42 mg/dL
4. A stroke patient due for discharge teaching

Question: Who do you see first?

Analysis:

- ABCs = blood glucose of 42 = immediate danger
- Discharge teaching and pain can wait
- COPD with PRN request is not life-threatening

Answer: The diabetic with BG of 42

Top 10 Testable Facts

1. **ABCs (Airway, Breathing, Circulation)** always come first—no matter how dramatic the other answers sound.
2. **New or unstable clients** take priority over stable ones.
3. **Actual problems** trump potential problems—unless the potential is deadly.
4. **Maslow's Hierarchy**: Physical > Safety > Emotional needs.
5. **The RN cannot delegate assessment, teaching, or clinical judgment**—ever.
6. **UAPs can assist with stable patients only** (basic ADLs, vitals, emptying Foley, etc.).
7. **LPNs can monitor, reinforce, and provide routine care**, but not manage unstable clients or do complex teaching.
8. **Advance directives, informed consent, and legal forms** must be verified, not assumed.
9. **The nurse's job is to protect client rights, ensure safety, and act within scope.**
10. **Never document incident reports in the patient's chart.**

Common Student Mistakes

- Delegating unstable patients to the LPN
- Picking the most dramatic option instead of the one tied to ABCs
- Forgetting that UAPs can't *assess* or *teach*
- Reporting too early instead of taking safe, independent action
- Confusing "monitor" and "assess" (only RNs assess)
- Thinking that documentation ends the problem

Key Charts & Reference Tools

Delegation Cheat Sheet

Task	**RN**	**LPN**	**UAP**
Initial assessment	Y	N	N
Medication education	Y	N	N
Tracheostomy care (stable)	Y	Y	N
Reinforce teaching	Y	Y	N
Foley insertion	Y	Y	N
Blood transfusion	Y	N	N
Feeding stable client	Y	Y	Y

Task	RN	LPN	UAP
Vitals (stable client)	Y	Y	Y
Ambulating post-op day 2	Y	Y	Y

Legal vs. Ethical Examples

Scenario	Category	NCLEX Tip
Client refuses treatment	**Ethical**	Respect autonomy
Nurse shares password	**Legal**	HIPAA violation
Not reporting abuse	**Legal/Ethical**	Mandatory reporting law
Not calling provider when condition worsens	**Legal**	Negligence

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Case-Based Judgment Scenario

You are assigned to a team of 4:

- A 68-year-old with pneumonia, RR 30, O_2 sat 89%

- A 54-year-old post-op day 2, requesting PRN pain meds
- A 45-year-old diabetic due for morning insulin
- A 76-year-old with Alzheimer's who just fell and is alert

Who do you assess first?

The pneumonia patient with hypoxia (Airway/Breathing = urgent)

Who can the LPN see?

The post-op patient needing pain meds (stable, no new issue)

Who can the UAP assist?

The diabetic patient (can obtain BG) and Alzheimer's patient (can assist with hygiene and safety)

Rapid-Fire Mnemonics

- **"Don't delegate what you can EAT":**
  - Evaluate
  - Assess

    - Teach
- **Legal Red Flags:**
    - "Always report, never document the incident report in the chart."
- **Prioritization:**
    - "New, Unstable, ABC, Actual"

Chapter 2: Safety & Infection Control

PPE, Precautions, Injury Prevention, and Creating a Culture of Safety

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Overview

Safety & infection control is a core pillar of NCLEX success. This isn't about obscure microbes—it's about whether you can **protect your patient from avoidable harm**, especially in high-risk situations.

Expect test questions on:

- Standard & transmission-based precautions
- PPE donning/doffing
- Infection control protocols
- Fall prevention and equipment safety
- Emergency prep and isolation procedures
- Restraint protocols
- Reporting and documentation

Mechanisms in Action: Infection Control Failure

Clinical Vignette:

A nurse caring for a patient with Clostridioides difficile (C. diff) uses hand sanitizer after removing gloves, then immediately enters the next room.

Outcome: The patient in the next room develops diarrhea and tests positive for C. diff.

Why it matters:
C. diff spores are alcohol-resistant. Hand sanitizer is *not enough*. **Soap and water** is required.

Top 10 Testable Facts

1. **Standard precautions = for all patients, always** (regardless of diagnosis).
2. **C. diff, norovirus, and scabies require soap and water + contact precautions.**
3. **Airborne = N95 mask + negative-pressure room (e.g., TB, measles, varicella).**
4. **Droplet = surgical mask + gloves (e.g., flu, pertussis, meningitis).**

5. **Contact = gown and gloves (e.g., MRSA, VRE, RSV).**
6. **PPE removal order: gloves → goggles → gown → mask.**
7. **Never recap used needles. Use puncture-proof sharps containers.**
8. **Restraints require provider order, ongoing documentation, and regular reassessment.**
9. **Falls are the #1 reported inpatient incident—prevention is key.**
10. **Never document that you filed an incident report in the patient's chart.**

Common Student Mistakes

- Using hand sanitizer with C. diff patients
- Choosing isolation too late in infectious cases
- Skipping protective (reverse) precautions for neutropenic clients
- Documenting incident report in the medical record
- Forgetting to reassess skin integrity under restraints

- Failing to use sterile technique with central line dressing changes

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Precaution Quick Chart

Precaution	Diseases	Room Setup	PPE
Standard	All patients	No change	Gloves (when needed), hand hygiene
Contact	MRSA, VRE, RSV, C. diff, lice	Private/cohort	Gloves, gown
Droplet	Flu, pertussis, meningitis, rubella	Private/cohort	Mask, gloves
Airborne	TB, measles, varicella	Negative-pressure room	N95 mask, door closed
Protective (reverse)	Neutropenia, chemo	Positive-pressure room	Mask, no raw food/flowers

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PPE Donning & Doffing: The Correct Sequence

Donning (put on):

1. Gown
2. Mask or respirator
3. Goggles or face shield
4. Gloves

Doffing (take off):

1. Gloves
2. Goggles or face shield
3. Gown
4. Mask

   Then hand hygiene.

Mnemonic: *"Go Me Gog Gloves" (on) and "Gl Go Gown Mask" (off)*

Injury & Fall Prevention

Fall Risk Factors:

- Age >65

- Polypharmacy (sedatives, antihypertensives, diuretics)
- Mobility issues
- Cognitive impairment
- Post-surgical status
- History of previous falls

Prevention Measures:

- Bed in lowest position
- Nonslip socks
- Bed/chair alarms
- Hourly rounding
- Clear pathways
- Toileting schedules
- Call light within reach
- Encourage use of assistive devices

Do NOT use all four side rails up—it's considered a form of restraint.

Restraints: Use With Caution

Types:

- **Physical restraints**: wrist ties, vests
- **Chemical restraints**: antipsychotics, sedatives used to control behavior

Key Rules:

- Must have **provider order** renewed every 24 hours
- Use **least restrictive** option first
- Remove every 2 hours for ROM, toileting, hydration
- Assess skin integrity and circulation
- Document every 2 hours minimum

Alternatives to restraints:

- Sitter
- Diversion
- Reorientation
- Bed alarms
- Family presence

Equipment Safety: Spot the Risk

Unsafe Setup	Why It's Dangerous
Oxygen tank unsecured	Projectile risk if knocked over
Tubing/cords on floor	Trip hazard, infection risk
Frayed electrical wires	Fire/electrical risk
Soiled linens on bed	Infection risk
Call light out of reach	Fall risk
Sharps container >¾ full	Stick hazard

Rule: If it could injure, infect, or trip someone—it's a safety risk.

Emergency Preparedness

Fire Protocol (RACE):

- **R**escue patients
- **A**larm (pull fire alarm)
- **C**ontain (close doors)
- **E**xtinguish (if safe)

Extinguisher Use (PASS):

- **P**ull the pin

- **A**im at base
- **S**queeze the handle
- **S**weep side to side

Disaster Triage (START system):

- **Red (immediate)** – breathing issues, bleeding, shock
- **Yellow (delayed)** – stable but needs care
- **Green (minor)** – walking wounded
- **Black (expectant)** – no breathing after airway reposition

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Rapid Recap & Mnemonics

- **Precaution Mnemonic: "My Chicken Hez TB"**
  → Measles, Chickenpox, Herpes Zoster, TB → Airborne
- **C. diff = Contact + Soap and Water**
- **Restraints = Last resort, not convenience**
- **Fall prevention = Routine + Environment + Communication**

- **Never write "incident report filed" in patient chart**

Chapter 3: Pharmacology & IV Therapy

High-Risk Drugs, Life-Saving Antidotes, IV Safety, and NCLEX-Favorite Meds

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Overview

Pharmacology makes up 12–18% of the NCLEX. This chapter focuses on:

- Meds that can kill if you miss a step
- Antidotes and reversal agents
- IV safety and complications
- Drug interactions and side effects
- Nursing considerations before and after administration

If the med has the power to tank a BP, crash a heart rate, or cause life-threatening toxicity, it's fair game.

Mechanisms in Action: Missed Medication Red Flags

Clinical Vignette:

You're caring for a patient on warfarin (Coumadin). They complain of black tarry stools and have a sudden drop in hemoglobin.

Missed clue: You didn't check the last INR (it was 6.2).
Outcome: The patient goes into hemorrhagic shock.
Correct move: Hold warfarin, notify provider, administer vitamin K if ordered.

Top 10 Testable Facts

1. Always check vitals and labs before giving meds that affect HR, BP, or clotting.
2. Insulin is one of the highest-risk drugs in hospitals—double check everything.
3. Potassium must be diluted and given slowly—never IV push.
4. Antibiotics require monitoring for allergies, renal toxicity, and superinfections.
5. Opioids = sedation + respiratory depression—always reassess RR.
6. Many psych drugs interact with each other—watch for serotonin syndrome, NMS, EPS.
7. Therapeutic levels matter: digoxin, lithium, phenytoin, theophylline.
8. Know your antidotes cold.
9. IV complications can kill—look for infiltration, phlebitis, air embolism.
10. Nurses must understand mechanism, monitor appropriately, and know when to hold or question.

High-Risk Drug Classes & Red Flags

Cardiac Meds

Class	Common Drugs	Nursing Considerations
Beta blockers	metoprolol, atenolol	Hold if HR < 60, can cause bronchospasm
ACE inhibitors	lisinopril, enalapril	Dry cough, angioedema, ↑ K+
Calcium channel blockers	amlodipine, diltiazem	↓ BP, avoid grapefruit
Nitrates	nitroglycerin	Headache, hypotension, contraindicated with sildenafil
Digoxin	digoxin	Therapeutic: 0.5–2.0, hold if HR < 60, monitor K+ (low = toxicity risk)

Anticoagulants

Drug	Lab	Antidote
Warfarin	INR (goal: 2–3)	Vitamin K

Drug	Lab	Antidote
Heparin	aPTT (goal: 60–80 sec)	Protamine sulfate
Enoxaparin	Platelets	Monitor for HIT (↓ platelets)

Psych Meds

Class	Key Drug	Danger
SSRIs	sertraline	Serotonin syndrome (agitation, hyperreflexia, fever)
MAOIs	phenelzine	Hypertensive crisis with tyramine foods
TCAs	amitriptyline	Cardiac toxicity, anticholinergic effects
Lithium	lithium	Therapeutic: 0.6–1.2 mEq/L, toxicity = tremors, nausea, confusion
Antipsychotics	haloperidol, risperidone	EPS, NMS, sedation, QT prolongation

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Seizure Meds

Drug	Therapeutic Range	Danger
Phenytoin	10–20 mcg/mL	Gingival hyperplasia, ataxia
Valproic acid	50–100 mcg/mL	Hepatotoxicity
Phenobarbital	15–40 mcg/mL	Sedation, respiratory depression

Insulin: Know the Onset, Peak, Duration

Type	Onset	Peak	Duration
Rapid (Lispro)	15 min	30–90 min	3–5 hrs
Short (Regular)	30–60 min	2–4 hrs	5–8 hrs
Intermediate (NPH)	1–3 hrs	6–12 hrs	12–16 hrs
Long (Glargine)	1 hr	None	24 hrs

Rules:

- Only Regular insulin can be given IV.

- Mix clear before cloudy (R → NPH).
- Watch for hypoglycemia at peak times.

Must-Know Antidotes

Toxin	Antidote
Opioids	Naloxone (Narcan)
Benzodiazepines	Flumazenil
Acetaminophen	Acetylcysteine (Mucomyst)
Heparin	Protamine sulfate
Warfarin	Vitamin K
Digoxin	Digibind
Magnesium sulfate	Calcium gluconate
Iron	Deferoxamine

IV Therapy: Safety First

IV Fluid Types

Type	Examples	Use
Isotonic	NS, LR	Volume replacement

Type	Examples	Use
Hypotonic	½ NS	Cellular hydration
Hypertonic	D5NS, D10W	Draws fluid into vessels (monitor for overload)

IV Complications

Complication	Signs	Action
Infiltration	Cool, swollen, pale	Stop infusion, elevate limb
Phlebitis	Red, warm, painful	Stop, remove IV, apply warm compress
Air embolism	SOB, chest pain, hypotension	Left side + Trendelenburg, call provider
Extravasation	Burning, blistering	Stop, leave catheter in place, call pharmacy for antidote
Speed shock	Dizziness, flushed, cardiac arrest	Stop med, maintain airway, call for help

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Common Student Mistakes

- Giving potassium IV push

- Administering insulin without checking BG
- Holding warfarin for low platelets (wrong—monitor INR)
- Forgetting to check for allergies before giving antibiotics
- Using vancomycin too fast (Red Man Syndrome = infuse over 60+ min)
- Giving beta blockers to bradycardic or asthmatic patients
- Ignoring therapeutic drug ranges or "just giving the med"

Rapid Recap & Mnemonics

- "LOL" drugs = beta blockers
- "PRIL" = ACE inhibitors
- "PINE" = calcium channel blockers
- "STATINS" = monitor liver + muscles
- "NTG = No Touching Grapefruit (CCBs)"

Insulin Rule: *Clear before cloudy, food before rapid.*

IV Push = Push Trouble → never push anything that sounds dangerous (K+, phenytoin, chemo, etc.) without checking guidelines.

Chapter 4: Physiological Adaptation

Emergencies, ABGs, Shock, Organ Failure, and Crisis Recognition

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Overview

Physiological Adaptation accounts for **11–17%** of the NCLEX and covers high-acuity situations that require **rapid clinical judgment**. These aren't subtle cases. These are the *"If you miss it, they crash"* moments.

Expect questions on:

- Acid-base imbalance
- Shock syndromes
- Neurological or cardiac emergencies
- Organ failure
- Seizures and increased ICP
- Trauma, burns, and multi-system complications

Mechanisms in Action: Recognizing the True Emergency

Clinical Vignette:

You're assigned to 4 patients:

1. A CHF patient with pitting edema
2. A diabetic patient with fruity breath and BG 422
3. A post-op patient with a blood pressure of 82/46 and 140 bpm

4. A stroke patient requesting help to the bathroom

Priority? The post-op with hypotension and tachycardia → likely hemorrhage or shock

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Top 10 Testable Facts

1. Low BP + high HR = shock until proven otherwise.
2. pH + $PaCO_2$ = respiratory status; pH + HCO_3 = metabolic status.
3. DKA = type 1, acidosis, ketones; HHS = type 2, dehydration, no ketones.
4. Signs of ↑ ICP: Cushing's triad (↑ SBP, ↓ HR, ↓ RR).
5. ABG rule of thumb: pH low = acidosis; pH high = alkalosis.
6. Renal failure = ↑ creatinine, ↓ urine, ↑ K+, acidosis.
7. Sepsis = early high temp + HR, late low BP and urine output.
8. Liver failure = jaundice, ↑ ammonia, coagulopathy, confusion.
9. Sodium, potassium, calcium imbalances = neuro and cardiac risk.
10. Trends matter more than a single lab value—watch the trajectory.

ABG Interpretation Made Simple

Normal Ranges

- pH: 7.35–7.45
- $PaCO_2$: 35–45 mmHg
- HCO_3: 22–26 mEq/L

- PaO_2: 80–100 mmHg
- SaO_2: >95%

Steps to Interpret:

1. Check pH: acid (<7.35) or alk (>7.45)?
2. Look at $PaCO_2$: respiratory (moves opposite of pH)
3. Look at HCO_3: metabolic (moves same direction as pH)
4. Is there compensation? Both CO_2 and HCO_3 abnormal = partial/full compensation

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Examples

- pH 7.30, $PaCO_2$ 50, HCO_3 24 → **Respiratory acidosis**
- pH 7.47, $PaCO_2$ 42, HCO_3 30 → **Metabolic alkalosis**
- pH 7.37, $PaCO_2$ 50, HCO_3 31 → **Compensated respiratory acidosis**

Shock Syndromes

Types of Shock

Type	Cause	Key Signs
Hypovolemic	Blood/fluid loss	↓ BP, ↑ HR, cool skin, low UO
Cardiogenic	Heart failure	Crackles, ↑ CVP, low perfusion

Type	Cause	Key Signs
Septic	Infection → vasodilation	Warm → cold, ↑ lactate, ↓ BP
Neurogenic	Spinal cord injury	↓ HR, warm skin, low BP
Anaphylactic	Allergic reaction	Airway swelling, ↓ BP, hives

Universal Signs of Shock:

- Hypotension
- Tachycardia
- Weak pulses
- Low urine output
- Cold/clammy or warm/flushed skin (depends on stage/type)

Organ Failure: Know the Patterns

Renal Failure

- ↑ BUN, ↑ creatinine
- ↓ urine output
- ↑ K+, ↓ Ca^{2+}
- Acidosis
- Fluid overload
- Risk for pulmonary edema and arrhythmias

Liver Failure

- ↑ AST/ALT
- ↑ bilirubin = jaundice
- ↑ ammonia = hepatic encephalopathy
- ↓ albumin = ascites, edema
- Coagulopathy = ↑ bleeding risk

Pancreatitis

- Severe abdominal pain, radiates to back
- ↑ amylase/lipase
- Cullen's sign (umbilical bruising), Grey-Turner (flank bruising)
- NPO, fluids, pain control (NO morphine—can cause sphincter spasm)

Neurological Emergencies

Increased ICP

- Cushing's triad: ↑ **SBP,** ↓ **HR,** ↓ **RR**
- Headache, vomiting (without nausea), decreased LOC
- Pupillary changes
- Interventions: elevate HOB 30°, avoid suctioning, maintain normothermia

Stroke (CVA)

- **Ischemic**: sudden weakness, slurred speech, facial droop
- **Hemorrhagic**: "worst headache ever," vomiting, ↓ LOC
- CT first → determine type
- Ischemic = tPA within 3–4.5 hours (after exclusion of bleed)
- NPO until swallow evaluated

Seizures

- **Tonic-clonic**: protect airway, don't restrain, side-lying
- **Postictal**: assess LOC, airway, document duration
- **Status epilepticus**: >5 minutes → **emergency** → give IV benzos

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Burns & Fluid Resuscitation

Rule of Nines (Adults)

Area	% BSA
Head	9%
Each arm	9%
Each leg	18%
Front torso	18%
Back	18%
Perineum	1%

Parkland Formula (First 24 hours):

- 4 mL × kg × %TBSA burned
- Give ½ in first 8 hours
- Remaining ½ over next 16 hours

Signs of inhalation injury:

- Soot in mouth or nose
- Singed nasal hairs
- Hoarseness, stridor
  → Prepare for early intubation

Electrolyte Imbalances & Red Flags

Electrolyte	Danger Signs
Na^+ (135–145)	Seizures, confusion (esp. if rapid shift)

Electrolyte	Danger Signs
K^+ (3.5–5.0)	Peaked T waves, arrhythmias, muscle cramps
Ca^{2+} (8.5–10.5)	Tetany, Chvostek/Trousseau, stridor
Mg^{2+} (1.5–2.5)	Torsades, reflex changes, lethargy

Common Student Mistakes

- Mixing up signs of DKA and HHS
- Not recognizing Cushing's triad as life-threatening
- Underestimating the severity of ↑ ammonia in liver failure
- Missing subtle signs of shock (early sepsis = warm skin!)
- Giving morphine in pancreatitis
- Assuming a normal BP rules out shock
- Ignoring post-seizure recovery monitoring

Rapid Recap & Mnemonics

- **"ROME" for ABGs:**
  - Respiratory = Opposite
  - Metabolic = Equal

- **Cushing's Triad = BAD ICP:**
  - Bradycardia
  - Abnormal respirations
  - (Widened) Pulse Pressure

- **"DEAD" for DKA:**
  - **D**ehydration
  - **E**lectrolytes lost
  - **A**cidosis

- **D**eath if untreated

- **Parkland Formula = 4 mL × kg × % burn**

Chapter 5: Lab Values & Diagnostics

Interpretation, Clinical Action, and High-Yield Danger Zones

Overview

Lab values are a **diagnostic compass**—and a key NCLEX focus. The test won't just ask you what the lab means; it'll ask **what to do when it's off**.

This chapter focuses on:

- Normal ranges
- What abnormal results actually indicate
- Critical thresholds you can't miss
- What action to take next
- Visual mnemonics to help you retain key labs

Top 10 Testable Facts

1. **K^+ >5.5 or <3.0 = cardiac emergency**—hook them to telemetry.
2. **Na^+ shifts = neuro risk.** Think seizures, confusion, coma.
3. **Creatinine is the best indicator of renal function.**
4. **INR >4 = bleeding risk. Hold warfarin.
5. **Troponin is the most specific marker for MI.**
6. **Hgb <7 often = transfusion consideration.
7. **Liver panel: ↑ bilirubin = jaundice; ↑ ammonia = confusion.**

8. **WBCs <4,000 = immunosuppressed. >12,000 = infection.**
9. **BNP >100 = heart failure.**
10. **Always correlate labs with signs/symptoms and act on red flags.**

Electrolytes

Lab	Normal Range	Danger Level	What It Means
Sodium (Na^+)	135–145 mEq/L	<120 or >160	Low = confusion, seizures; High = dehydration
Potassium (K^+)	3.5–5.0 mEq/L	<3.0 or >6.0	Cardiac arrhythmias, muscle cramps
Calcium (Ca^{2+})	8.5–10.5 mg/dL	<7 or >12	Tetany, seizures (low); lethargy, stones (high)
Magnesium (Mg^{2+})	1.5–2.5 mEq/L	<1.0 or >3.0	Torsades, reflex changes
Phosphorus (Phos)	2.5–4.5 mg/dL		Inverse of calcium, helps with ATP/energy

Mnemonic: *"Salt, bananas, milk, muscles, bones."*

Renal Labs

Lab	Normal	What It Means
BUN	7–20 mg/dL	↑ = dehydration or renal failure
Creatinine	0.6–1.2 mg/dL	Most reliable marker of kidney function

Lab	Normal	What It Means
GFR	>90 mL/min	<60 = chronic kidney disease; <15 = failure
Urine output	>30 mL/hr	<30 = perfusion issue or AKI

Warning Sign: ↑ K^+ + ↑ Creatinine + ↓ UO = acute renal failure

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Liver Function Panel

Lab	Normal	Meaning
AST	10–40 U/L	↑ = liver damage (alcohol, meds)
ALT	7–56 U/L	↑ = hepatitis, liver injury
Total bilirubin	0.3–1.2 mg/dL	↑ = jaundice, bile obstruction
Albumin	3.5–5.0 g/dL	↓ = fluid leaks (ascites, edema)
Ammonia	15–45 mcg/dL	↑ = encephalopathy (confusion, LOC changes)

Hematology & Coagulation

Lab	Normal	Danger	Notes
Hgb	12–18 g/dL	<7 = transfusion?	Oxygen-carrying capacity
Hct	37–52%		Often ~3× Hgb

Lab	Normal	Danger	Notes
WBC	4,000–11,000	<4k or >12k = action	Low = infection risk; high = infection/inflammation
Platelets	150k–400k	<100k = bleeding	<50k = serious risk, watch for petechiae
INR	0.8–1.2 (normal); 2–3 (warfarin)	>4 = critical	Warfarin therapy monitoring
aPTT	25–35 sec (normal); 60–80 (heparin)	>100 = bleeding	Heparin monitoring
PT	11–13 sec		Extrinsic pathway (warfarin-related)

Cardiac Enzymes & BNP

Lab	Normal	Key Use
Troponin I	<0.03 ng/mL	Rises within 3–6 hrs after MI
CK-MB	0–3 ng/mL	Less specific than troponin
BNP	<100 pg/mL	>100 = heart failure severity indicator
CRP	<3 mg/L	Inflammation marker

Note: Troponin remains elevated 7–10 days. Use this for late MI confirmation.

Blood Glucose & Diabetes Monitoring

Lab	Normal	Interpretation
Fasting BG	70–100 mg/dL	>126 = DM
Random BG	<140 mg/dL	>200 = DM with symptoms
HbA1c	<5.7% (normal)	>6.5% = diabetes
Urine ketones	Negative	Positive in DKA

Arterial Blood Gases (ABGs)

Component	Normal	Interpretation
pH	7.35–7.45	Low = acidosis; high = alkalosis
$PaCO_2$	35–45 mmHg	↑ = respiratory acidosis; ↓ = alkalosis
HCO_3	22–26 mEq/L	↑ = metabolic alkalosis; ↓ = acidosis
PaO_2	80–100 mmHg	Oxygenation status
SaO_2	>95%	Hemoglobin saturation

Diagnostic Tests You'll See on the NCLEX

Test	What It Does	Key Prep/ Nursing Notes
Chest X-ray	Lungs, heart size	Ask about pregnancy, remove metal
ECG	Heart rhythm	Monitor for ST changes, arrhythmias
CT scan	Cross-sectional imaging	With contrast? → check for iodine allergy, renal function
MRI	Detailed soft tissue	Remove metal (implants, pacemakers)
Lumbar puncture	CSF for infection/bleed	Lay flat after to avoid spinal headache
EGD	Esophagus/stomach/duodenum scope	NPO before, gag reflex after
Colonoscopy	Colon visualization	Clear liquid before, NPO after midnight, bowel prep

Test	What It Does	Key Prep/ Nursing Notes
Cardiac stress test	Cardiac perfusion under stress	NPO, no caffeine, hold beta blockers

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Common Student Mistakes

- Confusing BUN with creatinine (creatinine is more specific)
- Giving insulin without checking glucose
- Assuming all liver failure causes jaundice (ammonia levels matter more for mental status)
- Not holding metformin 48 hours before contrast CT
- Under-reacting to dangerously low sodium or high potassium
- Forgetting that low platelets = bleeding risk, not clotting

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Rapid Recap & Mnemonics

- **"BUN = Blood U Need"** → dehydration or volume issues
- **"CRIT is triple the HGB"** → ballpark hematology check
- **"Troponin = Trophy"** → #1 cardiac injury lab
- **"Hot liver labs" = AST, ALT, Ammonia, Bili**
- **"K+ = Kill zone if >6 or <3"**

Chapter 6: Psychosocial Integrity

Therapeutic Communication, Mental Health Management, and Emotional Safety

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Overview

Psychosocial Integrity makes up **6–12%** of the NCLEX—and it's often where students lose easy points by overthinking.

This section focuses on:

- Supporting emotional and psychological well-being
- Choosing the **right words** in stressful moments
- Responding to mental health crises
- Recognizing abuse and trauma
- Supporting vulnerable populations with dignity and clarity

Mechanisms in Action: Saying the Right Thing

Clinical Vignette:

A teenage patient says, *"I've been thinking a lot about how things might be better if I wasn't here anymore."*
You respond: *"Don't say that—your parents love you."*

Outcome: You've just invalidated a cry for help.
Correct response: *"Are you thinking about hurting yourself?"*

Top 10 Testable Facts

1. Therapeutic communication = open-ended, reflective, nonjudgmental
2. Never say "don't worry," "you'll be fine," or "everything will be okay"
3. Always ask directly about suicidal thoughts—never assume or avoid
4. Report abuse immediately—even if it's just suspicion
5. Psychotic clients: don't argue with delusions or hallucinations
6. In anxiety/panic: short, clear statements. Focus on safety and breathing
7. Bipolar mania = protect the client from exhaustion and injury
8. Schizophrenia = hallucinations are real to the client. Validate emotion, not the content
9. Grief, trauma, PTSD = presence > solutions
10. Prioritize clients who are unsafe to themselves or others

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Therapeutic Communication Do's and Don'ts

Do Say:

- "Tell me more about that."
- "It sounds like you're feeling overwhelmed."
- "I'm here for you."
- "That must be very difficult."
- "Can you help me understand what you're feeling?"

Don't Say:

- "Everything will be fine."

- "You just need to calm down."
- "Don't cry."
- "I know exactly how you feel."
- "Why did you do that?"

Mental Health Conditions You Need to Know

Depression

- Symptoms: flat affect, sleep/appetite changes, withdrawal
- Priority: assess for suicidal ideation, energy level, safety
- Don't leave severely depressed patients alone

Bipolar Disorder

- **Mania**: hyperactivity, no sleep, grandiosity, impulsivity
- Priorities: protect from harm, reduce stimulation, support nutrition/rest
- Avoid group therapy during mania

Schizophrenia

- **Positive symptoms**: hallucinations, delusions
- **Negative symptoms**: flat affect, apathy, withdrawal
- Interventions: clear, calm speech; avoid arguing; focus on real experiences
- **Command hallucinations = high risk**

Anxiety & Panic Attacks

- Mild: heightened focus
- Moderate–severe: restlessness, impaired thinking

- Panic: irrational, breathless, disconnected
- Interventions: remove stimuli, short sentences, focus on breathing

Obsessive-Compulsive Disorder (OCD)

- Allow rituals at first; gradually limit
- Encourage replacement coping strategies

Post-Traumatic Stress Disorder (PTSD)

- Flashbacks, nightmares, hypervigilance
- Triggers: loud noises, smells, anniversaries
- Use grounding techniques and trauma-informed care

Suicide Risk: Don't Miss These High-Risk Indicators:

- Detailed plan
- Lethal method (firearm, hanging)
- Access to means
- Recent loss or diagnosis
- Withdrawal from support system
- Giving away possessions
- Verbal hints: "You won't have to deal with me much longer."

Ask directly:
"Are you thinking about hurting yourself?"
"Do you have a plan?"
"Do you have access to the means?"

Abuse & Mandatory Reporting

Who You Must Report:

- Children
- Elderly
- Disabled or vulnerable adults

Red Flags:

- Injuries in different healing stages
- Caregiver reluctant to leave patient alone
- Inconsistent stories
- Burns, bites, spiral fractures
- Child too compliant or afraid of caregiver

Rule: You don't need proof—just reasonable suspicion.

Grief & Loss: Support Without Fixing

- Respect cultural differences in grieving
- Avoid rushing or interrupting grief
- Use presence, active listening, and silence
- Validate feelings: "This must be incredibly painful."

Defense Mechanisms: What's Healthy vs. Unhealthy

Mechanism	Description	NCLEX Tip
Denial	Refusal to accept reality	Normal in early grief; unhealthy if long-term
Projection	Attributing one's own feelings to others	Common in paranoid thinking

Mechanism	Description	NCLEX Tip
Displacement	Redirecting anger	Yelling at spouse after rough shift
Rationalization	Justifying behaviors	"I failed the test because the questions were bad"
Regression	Reverting to earlier behavior	Bedwetting in hospitalized child
Sublimation	Positive outlet for emotions	Using exercise to channel anger (healthy)

Common Student Mistakes

- Avoiding suicide questions out of discomfort
- Choosing advice-giving instead of listening
- Picking answers that minimize the patient's emotions
- Failing to report suspected abuse
- Trying to "correct" hallucinations instead of redirecting
- Believing "Why" questions are therapeutic—they're not

Rapid Recap & Mnemonics

- **"SOLER" for active listening:**
  - **S**it facing the client
  - **O**pen posture
  - **L**ean in
  - **E**ye contact
  - **R**elax
- **Signs of suicide? → Ask, Don't Assume**

- **Delusion?** → Validate **emotion**, not **belief**
- **Hallucination?** → "I don't hear it, but I understand you do.
- **Crisis = SAFETY first**, not therapy first.

Chapter 7: Basic Care & Comfort

Positioning, Nutrition, Mobility, Elimination, Skin Integrity, and Comfort Measures

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Overview

Basic care and comfort make up **6–12%** of the NCLEX. It's all about maintaining **function, dignity, safety, and comfort** in daily care tasks. Many students lose points here because they **overthink** the "simple" questions.

This chapter focuses on:

- Patient positioning
- Nutrition and special diets
- Elimination and catheter care
- Pressure injury prevention
- Hygiene, ADLs, and mobility
- Pain management and palliative care

Top 10 Testable Facts

1. High Fowler's = prevent aspiration (tube feeding, meals, trach care).
2. Low BP? Don't raise HOB—lay flat.
3. NPO = nothing by mouth, including meds (unless specified).
4. Always use clean technique for urinary catheters—but sterile for insertion.
5. Skin breakdown starts fast—turn patients at least every 2 hours.
6. UAPs can't assess—but they can perform ADLs and report observations.

7. Pain is whatever the patient says it is. Believe and reassess.
8. Don't massage red bony areas—this worsens tissue damage.
9. Post-mortem care starts with documentation, not removal.
10. End-of-life care = presence, comfort, and respect for dignity.

Positioning Cheat Sheet

Situation	Best Position
Prevent aspiration	High Fowler's (90°)
Tube feeding	Semi-Fowler's (30–45°) or higher
Air embolism	Left side + Trendelenburg
After lumbar puncture	Flat for 4–8 hours
Prevent pressure ulcers	30° lateral + reposition q2h
Seizure safety	Side-lying, padded rails
Post-op abdominal surgery	Semi-Fowler's
Shock/hypotension	Supine or Trendelenburg

Nutrition & Diets

Common Diet Types

Diet	Indication
Clear liquid	GI rest, immediate post-op
Full liquid	Transition to soft foods

Diet	Indication
Pureed/mechanical soft	Chewing/swallowing problems
Low sodium	Hypertension, CHF
Renal	↓ protein, ↓ sodium, ↓ potassium, ↓ fluid
Diabetic (ADA)	Balanced carbs, avoid simple sugars
Low residue	Crohn's, colitis
High fiber	Constipation
Gluten-free	Celiac disease
NPO	Pre-op, acute GI issues

Aspiration Precautions:

- Sit upright (High Fowler's)
- Chin tuck when swallowing
- Thickened liquids as needed
- Suction at bedside
- Check for gag reflex before feeding after sedation

Elimination: Catheters, Ostomies, and Enemas
Catheter Care

- Keep bag below bladder
- Secure catheter to thigh
- Clean perineal area daily and after BMs
- Use **sterile technique** for insertion
- Report UO <30 mL/hr for 2 hours or more

Ostomy Basics

- Stoma = red/pink and moist

- Blue/dusky = compromised perfusion → emergency
- Change pouch when ⅓ full
- Clean with warm water only
- High ileostomy output = risk for dehydration/electrolyte loss

Enemas

- Position: **left lateral Sims**
- Insert 3–4 inches for adults
- Retain solution for 5–10 minutes
- If cramping: **slow the infusion**, don't stop

Mobility & ADLs

Task	Who Can Do It
Ambulating stable patient	UAP
Assisting with dressing	UAP
Transferring with gait belt	UAP (if trained)
ROM exercises	RN, LPN, UAP
Monitoring for pain/fatigue	RN only
Assessing fall risk	RN only

Ambulation Tips:

- Use gait belts
- Sit up first, dangle legs
- Watch for dizziness
- Walk on patient's **weak side**

Skin Integrity & Pressure Injuries

Risk Factors:

- Immobility
- Incontinence
- Poor nutrition/hydration
- Decreased sensation
- Shearing/friction forces

Prevention:

- Turn q2h (or more)
- Keep skin clean/dry
- Use barrier creams
- Float heels
- Use draw sheet to reposition
- No massage on red areas

Staging Overview:

Stage	Description
Stage 1	Non-blanchable redness
Stage 2	Open skin, partial thickness
Stage 3	Full-thickness into fat
Stage 4	Muscle/tendon/bone visible
Unstageable	Covered by slough/eschar
Deep Tissue Injury	Purple/maroon intact skin

Pain & Comfort Management

Pain Assessment:

- Numeric scale (0–10) or faces scale for kids
- Assess before and 30–60 min after treatment
- Consider **nonverbal cues** in nonverbal patients

Pain Interventions:

- **Opioids**: monitor RR, sedation, constipation
- **NSAIDs**: bleeding, GI risk
- **Nonpharm**: repositioning, heat/cold, massage, distraction, guided imagery

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End-of-Life & Palliative Care

- Provide comfort, not cure
- Avoid unnecessary tests or interventions
- Don't force food or fluids
- Manage secretions with anticholinergics
- Use morphine for dyspnea and pain
- Offer spiritual or emotional support
- Oral care q2h
- Let family stay as long as they want
- After death:
    - Document time
    - Remove lines/tubes unless autopsy is required
    - Clean body
    - Allow family time before transport

Common Student Mistakes

- Forgetting to turn patient regularly
- Using hand sanitizer for ostomy care (wrong—use soap and water)
- Documenting that "incident report was filed" in chart
- Using the wrong bedpan or position for post-op patients
- Skipping full pain reassessment
- Failing to advocate for pain relief in end-of-life care

- Forgetting that NPO means **no meds or sips** unless cleared

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Rapid Recap & Mnemonics

- **"SIDELIE":**
  - **S**ide-lying for seizure
  - **I**leostomy: empty early
  - **D**on't massage red spots
  - **E**nema = left Sims
  - **L**ay flat after LP
  - **I**V bag below bladder
  - **E**at upright
- **Pain = What the Patient Says**
- **Comfort = Presence > Fixing**

Chapter 8: Health Promotion & Maintenance

Screenings, Vaccines, Developmental Milestones, and Maternity Essentials

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Overview

This section makes up **6–12%** of the NCLEX and tests your knowledge of:

- Developmental milestones
- Pediatric care
- Immunizations
- Prenatal care
- Aging and geriatric safety
- Health screenings by age

Think of this chapter as the *"what's normal at what age"* section—vital for catching early signs of delay, risk, or disease.

Top 10 Testable Facts

1. Milestone delays = early red flags for autism or neurodevelopmental disorders.
2. Infants double birth weight by 6 months and triple by 12 months.
3. Vaccines are held for moderate/severe illness—not for mild fever or teething.
4. Pregnancy = avoid NSAIDs, hot tubs, deli meats, and unwashed veggies.

5. Folic acid is started before pregnancy to prevent neural tube defects.
6. Toddlers fear separation; preschoolers fear punishment.
7. Teens = risk-taking, identity formation. Safety > education.
8. Always assess developmental age before assigning play or teaching strategy.
9. Annual screenings for BP, mammograms, colonoscopies start at guideline ages.
10. Never give live vaccines to immunocompromised clients.

Pediatric Milestones (High-Yield Table)

Age	Milestones
2 months	Lifts head, coos, follows with eyes
4 months	Rolls front to back, laughs, pushes up
6 months	Sits with support, babbles, transfers objects
9 months	Pulls to stand, pincer grasp, stranger anxiety
12 months	Cruises, 1–3 words, waves bye, uses cup
18 months	Walks independently, 10–20 words, stacks 2–3 blocks
2 years	2-word phrases, 2-step commands, 2× birth weight
3 years	Rides tricycle, speaks in full sentences, knows name/age
4 years	Hops on one foot, draws person with 3–4 parts
5 years	Skips, ties shoes, knows address, prints name

Red Flag Example: No babbling by 9 months → refer for developmental screening

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Immunization Schedule Highlights

Birth to 1 Year:
- Hep B
- DTaP
- RV (rotavirus)
- Hib
- IPV (polio)
- PCV13 (pneumococcal)

1–4 Years:
- MMR
- Varicella
- Hep A
- Annual flu vaccine (start at 6 months)

4–6 Years:
- DTaP #5
- IPV #4
- MMR #2
- Varicella #2

11–12 Years:
- Tdap
- HPV (2–3 doses)
- Meningococcal

Adolescents + Adults:
- Flu yearly
- Tdap q10 years
- Shingles (age 50+)
- Pneumococcal (age 65+ or earlier if high risk)

Pregnancy Care & Prenatal Focus

Prenatal Visits

- Monthly until 28 weeks
- Every 2 weeks until 36 weeks
- Weekly after 36 weeks

First Trimester Screening:

- hCG
- Blood type/Rh
- Rubella titer
- Hep B, HIV, syphilis
- Pap smear
- Genetic testing (as needed)

Second Trimester:

- Quad screen (AFP, hCG, estriol, inhibin A)
- Anatomy ultrasound (18–20 weeks)
- GDM screen (24–28 weeks)
- Administer RhoGAM at 28 weeks if Rh– mom

Third Trimester:

- GBS screen (35–37 weeks)
- Fetal position check
- NST or BPP if high-risk pregnancy

Pregnancy Danger Signs (NCLEX Gold)

Symptom	Concern
Headache + blurry vision	Preeclampsia
No fetal movement	Fetal distress/death

Symptom	Concern
Lower back pain + bleeding	Preterm labor or miscarriage
RUQ pain + elevated liver enzymes	HELLP syndrome
Sudden swelling of face/hands	Preeclampsia

Health Screening Guidelines by Age

Test	Start Age	Frequency
Mammogram	40–50	Every 1–2 years
Colonoscopy	45	Every 10 years
Pap smear	21	Every 3 years (w/ HPV co-test = q5 years)
Lipid panel	20	Every 5 years
PSA (if male, high risk)	50	Discuss with provider
Bone density (DEXA)	65 (or earlier with risk factors)	Once, then as needed
Hearing/Vision	65+	Every 1–2 years
Blood pressure	18	At every visit
Diabetes (A1c or fasting BG)	35+	Every 3 years, or earlier if high risk

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Geriatric Considerations

- **Fall prevention**: assess environment, vision, meds, balance

- **Polypharmacy risk**: use lowest effective dose, avoid meds on Beers Criteria
- **Depression is common—but not normal in aging**
- **Vaccinations**: flu, shingles, pneumonia
- **Nutrition**: smaller portions, protein, hydration
- **Cognitive decline**: early signs = forgetfulness, word-finding difficulty

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Common Student Mistakes

- Giving MMR or varicella to pregnant or immunocompromised clients
- Ignoring a missed milestone like "no walking by 18 months"
- Assuming vaccines can't be given if child has a mild illness or low-grade fever
- Forgetting to screen for intimate partner violence during prenatal visits
- Using chronological age rather than developmental age when evaluating kids
- Assuming all old adults are confused—it could be **delirium** or medication-related

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Rapid Recap & Mnemonics

- **Vaccine Mnemonic:** *"B DR HIP"* (Birth to 6 mo)
  → **B** = Hep B, **D** = DTaP, **R** = Rotavirus, **H** = Hib, **I** = IPV, **P** = PCV
- **Pregnancy Weight Gain:**
  - Underweight: 28–40 lbs
  - Normal: 25–35 lbs
  - Overweight: 15–25 lbs

    - Obese: 11–20 lbs
- **Milestones = Motor + Verbal**
  → No words by 12 months = red flag
  → No walking by 18 months = red flag

Chapter 9: Test-Taking Strategy

Prioritization, SATA Mastery, Traps to Avoid, and Mental Readiness

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Overview

Even if you know the content, you can fail the NCLEX if you don't understand **how the test works**.

This chapter teaches you:

- How to approach prioritization and delegation
- How to break down SATA questions logically
- What test traps look like
- How to choose the safest answer
- How to manage time, anxiety, and stamina on test day

Top 10 Strategy Rules for NCLEX

1. ABCs always win—airway, breathing, circulation
2. Stable vs. unstable = priority (new, unexpected, post-op, deteriorating = unstable)
3. Never delegate what you can EAT (Evaluate, Assess, Teach)
4. Treat SATA like true/false—judge each one independently
5. Don't pick the aggressive intervention first—start with assessment or safety

6. Don't assume anything not stated in the question
7. If the patient is crashing, skip paperwork—act!
8. Look for words like "first," "best," "immediate," "priority" and slow down
9. Avoid absolute words: "always," "never," "must"
10. If all else fails—eliminate dangerous, invasive, or unrealistic choices

Prioritization Framework: What's Most Important

1. Airway → Breathing → Circulation → Disability
2. Actual problem > Potential problem
3. Acute > Chronic
4. New issue > Known issue
5. Unexpected signs/symptoms > Expected ones

Example:

- A diabetic client with BG of 50 = priority over a COPD client with cough
- Post-op day 1 fever (102.4°F) = more urgent than stable chronic heart failure

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Delegation: Who Gets What

Task	**RN**	**LPN**	**UAP**
Initial assessment	Y	N	N
Teaching	Y	N	N
Medication admin (non-IV)	Y	Y	N
IV meds/push	Y	N	N
Vital signs (stable)	Y	Y	Y
Dressing changes (simple)	Y	Y	N
Feeding stable patients	Y	Y	Y
Monitoring unstable patients	Y	N	N

Rule: The more unstable or complex the patient, the more likely it belongs to the RN.

SATA (Select All That Apply): Crack the Code

- **Don't look for patterns.** Each option is a separate **true/false** test.
- Avoid guessing based on what "sounds right" together.
- Think: "Is this safe, correct, and supported by the stem?"

If a SATA question has a clear priority cue, answer based on that (e.g., safety, infection control, airway, etc.).

NCLEX Test Traps & How to Avoid Them

Trap Type	What It Looks Like	What To Do
Too good to be true	"Reassure the client everything will be okay"	Avoid false reassurance
Too aggressive	"Defibrillate the client without checking pulse"	Pause—assess first
Too passive	"Document findings" when patient is actively crashing	ACT before documenting
Scope of practice violation	"Assign UAP to teach insulin injection"	Know who can do what

Trap Type	What It Looks Like	What To Do
Assumption trap	"You suspect an allergy" but it's not stated	Go only by what's written

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Test Day Game Plan

Night Before:

- Don't cram. Light review only.
- Prepare ID, snacks, clothes, directions.
- Get 6–8 hours of sleep minimum.
- Do something relaxing—no last-minute panic videos.

Morning Of:

- Eat a light, balanced breakfast
- Hydrate—but not too much
- Arrive early (30 minutes)
- Dress in layers (testing centers are weird)
- Bring required ID and confirmation email
- No phones, no watches, no lucky rabbit's foot—just you

Time Management on the Test

- You'll have up to **5 hours**
- Most finish between **75–145 questions**
- Aim for **1 minute per question**
- Flag tough ones, move on, come back if time allows
- You don't lose points for wrong answers—**never leave a question blank**

Mindset Mastery: Confidence Under Pressure

- Every question is a clean slate. Bombing one doesn't mean bombing the test.
- Breathe before answering—especially priority/SATA questions.
- If you're overwhelmed: close your eyes, inhale for 4 seconds, exhale for 6.
- Trust your training, not your doubt.
- You don't have to be perfect—you just have to be safe.

Rapid Recap & Mnemonics

- **"ADPIE" for nursing process:**
  - **A**ssess
  - **D**iagnose
  - **P**lan
  - **I**mplement
  - **E**valuate
    → If you haven't assessed yet, don't jump to implement

- **Don't delegate what you can EAT:**
  - **E**valuate
  - **A**ssess
  - **T**each

- **If stuck, pick the option that:**
  - Keeps the airway open
  - Prevents harm
  - Is least invasive
  - Involves assessment or reassessment

Chapter 10: Mnemonics, Red Flags, and NCLEX Traps

Your Final Memory Boost Before the Exam

Overview

This chapter is your final review zone—where we pack everything you need to remember into **easy-to-recall phrases, visual cues, and trap-spotting rules**.

We'll cover:

- The most testable **mnemonics**
- The most dangerous **red flags**
- The most common **NCLEX traps**
- Visual reminders and clinical clue triggers

Top NCLEX Mnemonics by Topic

Medication Mnemonics

- **"LOL" = Beta Blockers** (e.g., metoprolol) → slows HR
- **"PRIL" = ACE Inhibitors** (e.g., lisinopril) → cough, hyperkalemia
- **"PINE" = Calcium Channel Blockers** (e.g., amlodipine)
- **"STATIN" = Lipid-lowering → watch liver + muscles**
- **"ZEPAM/ZOLAM" = Benzos → sedation, fall risk**

- **"SULFA" = Sulfa drugs → allergy risk, sun sensitivity**

Priority Frameworks

- **ABCs** → Airway, Breathing, Circulation
- **Maslow's Hierarchy** → Physical > Safety > Psych > Love/Belonging > Esteem > Self-Actualization
- **ADPIE** → Assess, Diagnose, Plan, Implement, Evaluate
- **SAFETY always comes before documentation or comfort.**

Electrolytes

- **"K+ = Kills"** → watch for >6 or <3
- **"Salt, Bananas, Milk, Muscles, Bones"** = Na, K, Ca, Mg, Phos
- **Hypocalcemia = Chvostek + Trousseau**

Acid-Base Mnemonic

- **"ROME"**
  - **R**espiratory = **O**pposite
  - **M**etabolic = **E**qual
    → If pH and CO_2 go opposite = respiratory; if pH and HCO_3 go same = metabolic

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Isolation Precautions

- **"My Chicken Hez TB"** = Airborne
  → Measles, Chickenpox, Herpes zoster, TB
- **"SPIDERMAN"** = Droplet
  → Sepsis, Scarlet fever, Strep, Pertussis, Influenza, Diphtheria, Epiglottitis, Rubella, Mumps, Adenovirus
- **Contact** = MRSA, C. diff, RSV, lice, scabies

Cardiac

- **MONA for MI:**
  → Morphine, Oxygen, Nitroglycerin, Aspirin
- **"Left = Lungs"** (Left-sided HF = pulmonary congestion)
- **"Right = Rest of body"** (Right-sided HF = edema, JVD)

OB & Labor

- **VEAL CHOP:**
  - **V**ariable = **C**ord compression
  - **E**arly = **H**ead compression
  - **A**ccels = **O**kay
  - **L**ate = **P**lacental insufficiency
- **Fetal HR Decel → Turn Mom LEFT, stop Pitocin, O_2, IV bolus**

Cranial Nerves

- **"On Old Olympus Towering Tops…"** mnemonic
  → For name/number
- **"Some Say Marry Money…"**
  → Sensory/Motor/Both

Red Flag Symptoms You MUST Act On

Symptom	Meaning
Chest pain + shortness of breath	MI, PE, pneumothorax
Severe headache + blurred vision in pregnancy	Preeclampsia/HELLP
Restlessness + low O_2	Early hypoxia
Stridor or wheezing	Airway obstruction risk
Bloody stools in child	Intussusception, GI bleed
Sudden mental status change	Stroke, sepsis, hypoglycemia
Jaundice in first 24 hrs of life	Pathologic—always report
Cold/pale foot after cast	Compartment syndrome risk
Pain unrelieved by opioids post-surgery	Vascular emergency
High-pitched shrill infant cry	Increased ICP or withdrawal

NCLEX Traps and How to Avoid Them

1. False Reassurance Trap
"Don't worry, everything will be fine."
→ *Wrong.* Don't minimize. Be supportive, not dismissive.

2. Do-Too-Much Trap

"Call the doctor" before assessing
→ *Wrong.* Always assess before escalating (unless airway gone or client unresponsive)

3. Scope Violation Trap
Assign UAP to "teach incentive spirometry"
→ *Wrong.* Teaching = RN only

4. Safety Delay Trap
"Document the incident" before acting on a fall
→ *Wrong.* Intervene first, document after
5. Guessing From Experience Trap
"I saw it done this way on the floor"
→ *Wrong.* Choose the **NCLEX ideal** answer, not the hospital shortcut

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Final Test Hacks

- If it's **life over comfort**, choose life
- **If the question asks for what you should "do first,"** always:
    - Assess if not done
    - Act if already assessed and in crisis
    - Educate only if stable
    - Document only after safety is ensured
- **If you're guessing, eliminate:**
    - Unsafe
    - Invasive
    - Delaying
    - Out of scope

Final Words

You Were Built for This

Let's take a breath.

You've just made it through the most intense, no-fluff crash course out there. You've reviewed the most testable content, cracked the question strategies, and armed yourself with red flags, priorities, and power moves.

You're not here by accident.

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You didn't survive 12-hour clinicals, med-surg exams, simulations, and skills check-offs just to fold on test day.

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It's not a measure of your worth.
It's not even a full measure of your knowledge.
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NCLEX Lab Values: Essential Lab Review Guide

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Continue to the next page for the NCLEX Practice Questions!

NCLEX Practice Questions

Question 1

A nurse is caring for a client who is newly diagnosed with type 1 diabetes mellitus. Which action is the priority?

The nurse should:

a. Administer insulin as prescribed
b. Educate the client on dietary changes
c. Assess the client's blood glucose level
d. Encourage the client to attend diabetes support groups

Answer: C

Rationale: The NCLEX prioritizes the nursing process—assessment before implementation. Knowing the client's current blood glucose level is critical to determine immediate needs. Insulin administration is important but must be based on glucose levels. Education and support groups are helpful but not urgent.

Question 2

A client receiving morphine for post-operative pain reports difficulty breathing and becomes drowsy. What is the nurse's priority action?

a. Call the provider
b. Administer naloxone
c. Discontinue the morphine
d. Check the client's oxygen saturation

Answer: B

Rationale: The client is showing signs of opioid overdose (respiratory depression). Naloxone (Narcan) is the reversal agent and should be given immediately. This is a life-threatening emergency—act before assessing or notifying the provider.

Question 3

A nurse is reviewing discharge instructions with a client prescribed warfarin. Which statement indicates the need for further teaching?

a. "I'll avoid foods high in vitamin K."
b. "I'll report any unusual bruising or bleeding."
c. "I'll take aspirin if I have a headache."
d. "I'll come in for regular blood tests."

Answer: C

Rationale: Aspirin increases the risk of bleeding and should be avoided with warfarin. The other statements show correct understanding of warfarin precautions.

Question 4

Which of the following clients would the nurse see first during morning rounds?

a. Client with COPD and O_2 sat of 90%
b. Client with newly diagnosed diabetes needing insulin education
c. Client with a potassium level of 2.9 mEq/L

d. Client with chronic pain requesting PRN acetaminophen
Answer: C

Rationale: This is a critically low potassium level that can lead to life-threatening arrhythmias. COPD with 90% O_2 may be expected, and the other needs are not urgent.

Question 5

The nurse is caring for a client with a new tracheostomy. Which finding requires immediate action?

a. Small amount of pink-tinged mucus
b. Dressing saturated with serous drainage
c. Client attempts to speak but is unsuccessful
d. Tracheostomy tube dislodged during position change

Answer: D

Rationale: A dislodged trach can lead to airway obstruction—this is a priority emergency. Other findings are expected or non-urgent.

Question 6

A client is prescribed digoxin. Which finding would cause the nurse to hold the dose?

a. Heart rate of 58 bpm
b. Blood pressure of 136/82 mmHg
c. Potassium level of 4.0 mEq/L
d. Apical pulse regular with no murmur

Answer: A

Rationale: Digoxin is held if the apical pulse is <60 bpm due to risk of bradycardia. All other values are normal.

Question 7

The nurse prepares to administer a blood transfusion. What is the most important step to prevent a transfusion reaction?

a. Check the expiration date of the blood
b. Warm the blood before administration
c. Ensure IV access is patent
d. Verify the client's identity with another nurse

Answer: D

Rationale: The most effective way to prevent hemolytic transfusion reaction is confirming patient identity and blood compatibility. All steps are important, but this is the most critical.

Question 8 – (Select All That Apply)

Which interventions are appropriate for a client with neutropenia?

a. Place client in private room
b. Encourage raw fruits and vegetables
c. Monitor temperature regularly
d. Avoid rectal temperatures
e. Restrict visitors with recent infections

Answers: A, C, D, E

Rationale: Neutropenic patients are immunocompromised. Avoid infection risks like rectal temps, raw foods, and sick visitors. A private room and close monitoring are standard precautions.

Question 9 – Ordered Response

The nurse is preparing to insert an indwelling urinary catheter. Place the steps in the correct order.

1. Wash hands
2. Don sterile gloves
3. Cleanse urinary meatus
4. Inflate balloon
5. Insert catheter

Correct Order:
1. → 2. → 3. → 5. → 4.

Rationale: Maintaining sterile technique is essential. Inserting the catheter before cleansing or inflating before placement would cause harm or infection.

Question 10

A nurse is administering heparin subcutaneously. The ordered dose is 5,000 units. The vial is labeled 10,000 units/mL. How many mL should the nurse administer?

Answer: 0.5 mL

Rationale: (5,000 units ÷ 10,000 units/mL) = **0.5 mL**. Always double-check dosing on high-alert meds like heparin.

Question 11

A client receiving chemotherapy reports mouth pain and difficulty eating. Which nursing intervention is most appropriate?

A. Provide lemon-glycerin swabs
B. Encourage frequent tooth brushing with firm bristles
C. Offer bland, soft foods and a straw for fluids
D. Administer a saltwater rinse once per week

Answer: C

Rationale: Chemotherapy can cause mucositis. Bland, soft foods and straws reduce irritation and encourage intake. Lemon swabs and firm brushes worsen pain; rinses should be done frequently, not weekly.

Question 12

Which finding indicates a potential complication of a central venous catheter?

A. Mild erythema at the insertion site
B. Client reports chest pain and shortness of breath
C. Blood return is noted with flushing
D. Dressing is dry and intact

Answer: B

Rationale: Sudden chest pain and dyspnea suggest air embolism or pneumothorax, both emergencies.

Erythema, blood return, and dry dressings are expected or non-urgent findings.

Question 13

Which client is at the highest risk for aspiration pneumonia?

A. A 45-year-old with COPD using an incentive spirometer
B. A 76-year-old post-stroke client with dysphagia
C. A 60-year-old with diabetes receiving insulin
D. A 32-year-old with asthma using a nebulizer

Answer: B

Rationale: A client with impaired swallowing due to stroke has a direct risk for aspiration. The others are not at immediate risk.

Question 14

A nurse is teaching a client about preventing urinary tract infections (UTIs). Which statement by the client indicates a need for further teaching?

A. "I will wipe from front to back."
B. "I'll drink at least 2 liters of fluid daily."
C. "I'll empty my bladder after intercourse."
D. "I should take bubble baths instead of showers."

Answer: D

Rationale: Bubble baths can irritate the urethra and

increase UTI risk. All other statements are correct preventive measures.

Question 15

A nurse is caring for a client who has been placed in restraints. Which action is appropriate?

A. Remove restraints every 8 hours to assess circulation
B. Attach the restraints to the bed's side rail
C. Ensure a provider's order is renewed every 24 hours
D. Tie restraints in a double knot to prevent removal

Answer: C

Rationale: Restraint orders must be renewed every 24 hours. Restraints should be removed at least every 2 hours and never tied to side rails or in knots that are difficult to release.

Question 16 – Select all that apply

Which of the following are signs of increased intracranial pressure (ICP)?

A. Bradycardia
B. Dilated pupils
C. Hypertension
D. Hypothermia
E. Widened pulse pressure
F. Increased level of consciousness

Answers: A, B, C, E

Rationale: Signs of increased ICP include bradycardia, hypertension, dilated pupils, and widened pulse pressure. Hypothermia and increased LOC are not typically associated.

Question 17 – Select all that apply

A nurse is teaching a client about home care for a newly created colostomy. Which statements indicate correct understanding?

A. "I will use warm water to clean around the stoma."
B. "I can expect the stoma to bleed with each change."
C. "I will change the pouch every 3–7 days."
D. "I should avoid gas-producing foods like broccoli."
E. "I will apply moisturizer around the stoma to prevent dryness."

Answers: A, C, D

Rationale: The client should use warm water, change the pouch every 3–7 days, and avoid gas-producing foods. The stoma should not bleed regularly, and moisturizers can interfere with adhesion.

Question 18

A client with heart failure is receiving furosemide. Which assessment requires immediate action?

A. Decreased urinary output
B. Potassium level of 3.7 mEq/L

C. Weight loss of 1 kg over 24 hours
D. Blood pressure of 122/84 mmHg

Answer: A

Rationale: Decreased urinary output may indicate worsening heart failure or ineffective diuresis. The other findings are expected or stable.

Question 19 – Select all that apply

Which tasks are appropriate for the nurse to delegate to an experienced unlicensed assistive personnel (UAP)?

A. Ambulating a stable post-op client
B. Applying a condom catheter
C. Monitoring a blood transfusion for the first 15 minutes
D. Collecting a stool sample for occult blood
E. Teaching a client how to use an incentive spirometer

Answers: A, B, D

Rationale: UAPs may assist with ambulation, hygiene, and specimen collection. They cannot monitor blood transfusions or provide teaching.

Question 20

Which action by a nurse demonstrates appropriate documentation?

A. "Client appears angry and uncooperative today."
B. "Client reports pain 8/10 in left hip; acetaminophen 650 mg given."
C. "Vital signs within normal limits; no further concerns."
D. "Spoke to client about family drama; advised them to

remain calm."

Answer: B

Rationale: Documentation should be objective, specific, and measurable. "Reports pain 8/10" and documenting the med is appropriate. The other choices are vague or subjective.

Question 21

A nurse is assessing a client who had a thyroidectomy 12 hours ago. Which finding requires immediate intervention?

A. Hoarseness when speaking
B. Difficulty swallowing water
C. Tingling in fingers and around the mouth
D. Neck discomfort at the incision site

Answer: C

Rationale: Tingling around the mouth or fingers indicates hypocalcemia, likely due to parathyroid gland injury. This is a priority. Hoarseness and swallowing difficulty may occur post-op but require monitoring. Mild neck discomfort is expected.

Question 22

A nurse is caring for a client with C. difficile infection. Which infection control measure is required?

A. Surgical mask
B. Airborne precautions

C. Alcohol-based hand sanitizer
D. Soap and water for hand hygiene

Answer: D

Rationale: C. difficile spores are not killed by alcohol-based sanitizer. Soap and water must be used. Contact precautions are also required, but masks and airborne precautions are unnecessary.

Question 23

Which client statement indicates understanding of how to use a metered-dose inhaler (MDI)?

A. "I'll breathe in quickly right after pressing the inhaler."
B. "I'll use my steroid inhaler first, then the bronchodilator."
C. "I'll rinse my mouth after using my corticosteroid inhaler."
D. "I'll hold my breath for 3 seconds after inhaling the medication."

Answer: C

Rationale: Rinsing the mouth after a corticosteroid inhaler reduces the risk of oral thrush. Bronchodilators should be used before steroids. Inhale slowly and hold breath for at least 10 seconds, not 3.

Question 24

A nurse is monitoring a client receiving a blood transfusion. Which finding requires the nurse to stop the infusion immediately?

A. Mild back pain
B. Chills and flushing
C. Slight elevation in temperature
D. Headache and nausea

Answer: B

Rationale: Chills and flushing are early signs of a transfusion reaction and require stopping the transfusion immediately. Mild back pain and nausea can occur but should be assessed. Slight temp increase may not indicate a reaction.

Question 25 – Select all that apply

Which findings are consistent with fluid volume overload?

A. Bounding pulse
B. Hypotension
C. Crackles in lungs
D. Jugular vein distension
E. Increased hematocrit
F. Peripheral edema

Answers: A, C, D, F

Rationale: Fluid overload causes bounding pulse, crackles, JVD, and edema. Hematocrit is typically decreased due to dilution. Hypotension is more common in fluid deficit.

Question 26 – Select all that apply

The nurse is reviewing medications with a client

prescribed lithium. Which statements indicate the client understands the teaching?

A. "I should limit my sodium intake."
B. "I need to drink plenty of water each day."
C. "I'll let my provider know if I have diarrhea or vomiting."
D. "I can take ibuprofen if I have a headache."
E. "I need to get regular blood levels checked."

Answers: B, C, E

Rationale: Clients taking lithium must stay hydrated, report GI losses, and get regular level checks. Low sodium intake or NSAIDs can increase lithium toxicity.

Question 27

A nurse is caring for a client post-abdominal surgery. Which intervention best prevents venous thromboembolism (VTE)?

A. Encourage fluid intake
B. Elevate the head of the bed
C. Apply sequential compression devices (SCDs)
D. Provide a low-sodium diet

Answer: C

Rationale: SCDs promote venous return and help prevent VTE. Fluids and diet are helpful overall but not primary VTE prevention. Elevating HOB does not impact circulation significantly.

Question 28

A client with COPD is receiving home oxygen therapy. Which instruction should the nurse include?

A. "Increase the oxygen flow rate if short of breath."
B. "Store the oxygen tank near a heater for better flow."
C. "Avoid wearing wool blankets while using oxygen."
D. "Use petroleum jelly to moisturize inside the nose."

Answer: C

Rationale: Wool blankets can generate static electricity and increase fire risk with oxygen. Oxygen is combustible. Petroleum-based products and heat sources are also contraindicated. Never change flow rate without provider direction.

Question 29 – Select all that apply

A client with schizophrenia is experiencing auditory hallucinations. Which nursing interventions are appropriate?

A. Acknowledge the client's feelings without confirming the hallucination
B. Tell the client the voices are not real
C. Encourage participation in reality-based activities
D. Offer to sit quietly with the client
E. Ask detailed questions about the voices to understand them

Answers: A, C, D

Rationale: Therapeutic communication includes acknowledging feelings, offering support, and redirecting

to reality-based activities. Never argue or validate hallucinations. Probing about voices can increase distress.

Question 30

A nurse is caring for a client with a NG tube for decompression. Which finding requires immediate intervention?

A. Green drainage noted in tubing
B. Client reports nausea and abdominal distension
C. Tube is secured to the client's nose with tape
D. Client complains of mild throat discomfort

Answer: B

Rationale: Nausea and distension suggest that the NG tube is not functioning properly—this requires urgent assessment. Green drainage is expected. Mild discomfort and tape use are normal.

Question 31

A client receiving IV vancomycin begins to experience flushing of the face and neck. What is the nurse's priority action?

A. Discontinue the infusion immediately
B. Slow the infusion rate
C. Administer diphenhydramine and continue the infusion
D. Notify the healthcare provider after completing the dose

Answer: B

Rationale: Flushing with vancomycin is likely Red Man Syndrome, a histamine-mediated response. The correct action is to slow the infusion. It is not a true allergy, so stopping permanently or calling the provider is not the first step.

Question 32

A nurse is reviewing lab results for a client receiving warfarin. The INR is 5.4. What is the priority nursing action?

A. Prepare to administer vitamin K
B. Hold the next dose and notify the provider
C. Administer the next dose as scheduled
D. Encourage intake of leafy greens

Answer: A

Rationale: An INR > 5 indicates high bleeding risk. The priority is to reverse anticoagulation with vitamin K. The provider must also be notified, but action must come first.

Question 33 – Select all that apply

Which findings are associated with left-sided heart failure?

A. Crackles in lungs
B. Jugular vein distension
C. Dyspnea on exertion
D. Orthopnea
E. Peripheral edema

F. S3 heart sound

Answers: A, C, D, F

Rationale: Left-sided HF causes pulmonary congestion (dyspnea, orthopnea, crackles) and S3 gallop. JVD and peripheral edema are signs of right-sided HF.

Question 34

A client is newly prescribed sertraline. Which teaching point is most important to emphasize?
A. "You should take this medication at bedtime."
B. "You will notice effects immediately."
C. "Call your provider if you experience increased thoughts of self-harm."
D. "Avoid foods high in tyramine while on this medication."

Answer: C

Rationale: SSRIs like sertraline carry a black box warning for suicidal thoughts, especially in the first few weeks. Tyramine precautions apply to MAOIs, not SSRIs.

Question 35 – Select all that apply

A nurse is reinforcing teaching for a client prescribed furosemide. Which instructions should be included?

A. Change positions slowly
B. Monitor for signs of hypokalemia
C. Report hearing changes
D. Restrict fluid intake to less than 1 liter per day
E. Take medication at bedtime

Answers: A, B, C

Rationale: Furosemide is a loop diuretic, causing fluid loss, orthostatic hypotension, hypokalemia, and ototoxicity at high doses. It should be taken in the morning to prevent nocturia. Fluids are not routinely restricted.

Question 36

Which prescription should the nurse question?

A. Amoxicillin for a client with penicillin allergy
B. Atorvastatin for a client with hyperlipidemia
C. Lisinopril for a client with hypertension
D. Ondansetron for a client with nausea

Answer: A

Rationale: Amoxicillin is a penicillin derivative. It should not be given to clients with a known penicillin allergy. The other medications are appropriate.

Question 37

A nurse is assessing a client with a chest tube. Which finding should be reported to the provider?

A. Gentle bubbling in the suction control chamber
B. Continuous bubbling in the water seal chamber
C. Fluctuation (tidaling) with respiration
D. No drainage noted in the past hour

Answer: B

Rationale: Continuous bubbling in the water seal chamber indicates an air leak and should be reported. The other findings are normal.

Question 38 – Select all that apply

Which instructions should a nurse give to a client using a cane for ambulation?

A. Hold the cane on the stronger side
B. Move the cane forward with the stronger leg
C. Move the cane forward 6–10 inches with the weaker leg
D. Keep the cane close to the body for support
E. Use the cane only when going upstairs

Answers: A, C, D

Rationale: The cane should be held on the stronger side and moved forward with the weaker leg to support balance. It should be kept close to the body and used consistently—not just on stairs.

Question 39

A nurse is caring for a client with a history of alcohol use disorder admitted with confusion and ataxia. Which intervention is most important?

A. Administer thiamine
B. Begin withdrawal monitoring
C. Restrict fluid intake

D. Apply soft wrist restraints

Answer: A

Rationale: These are signs of Wernicke's encephalopathy, a thiamine deficiency emergency. Thiamine must be given first, even before glucose or fluids.

Question 40 – Select all that apply

Which actions are appropriate when caring for a client with a seizure disorder?

A. Keep suction equipment at bedside
B. Place padded side rails up
C. Use tongue blade during seizure activity
D. Turn client to side during seizure
E. Restrain the client during a seizure

Answers: A, B, D

Rationale: Safety measures include suction availability, side-lying positioning, and padded rails. Never place objects in the mouth or restrain during a seizure.

Question 41

A nurse is caring for a client experiencing alcohol withdrawal. Which medication does the nurse expect to administer?

A. Naloxone
B. Lorazepam

C. Flumazenil
D. Methadone

Answer: B

Rationale: Lorazepam, a benzodiazepine, is used to manage alcohol withdrawal symptoms and prevent seizures. Naloxone is for opioid overdose. Flumazenil reverses benzodiazepines. Methadone is for opioid use disorder.

Question 42

Which assessment finding indicates effective fluid resuscitation in a client with hypovolemic shock?

A. Blood pressure 82/60 mmHg
B. Heart rate 132 bpm
C. Capillary refill <2 seconds
D. Cool, clammy skin

Answer: C

Rationale: Capillary refill under 2 seconds indicates improved perfusion. The other findings (hypotension, tachycardia, cool skin) suggest ongoing hypovolemia.

Question 43 – Select all that apply

Which interventions should be included in the plan of care for a client with a pressure injury on the sacrum?

A. Reposition every 1–2 hours
B. Massage the reddened area to promote circulation
C. Maintain a high-protein, high-calorie diet
D. Use a moisture barrier cream
E. Elevate the head of the bed to 90 degrees

Answers: A, C, D

Rationale: Repositioning, nutrition, and moisture protection help promote healing and prevent worsening. Massage can damage tissue. HOB should be <30° to reduce sacral pressure.

Question 44

A nurse is assessing a client receiving magnesium sulfate for preeclampsia. Which finding requires immediate intervention?

A. Respiratory rate of 10 breaths/min
B. 2+ deep tendon reflexes
C. Urinary output of 40 mL/hr
D. Mild flushing of the skin

Answer: A

Rationale: A respiratory rate <12 indicates magnesium toxicity, which can progress to respiratory arrest. The other findings are within expected limits.

Question 45 – Select all that apply

Which foods should a client with celiac disease avoid?

A. Whole wheat pasta
B. Corn tortillas
C. Barley soup
D. Rye bread
E. Rice noodles
F. Spelt crackers

Answers: A, C, D, F

Rationale: Clients with celiac disease must avoid gluten, found in wheat, barley, rye, and spelt. Corn and rice are gluten-free.

Question 46

A nurse prepares to administer digoxin to a pediatric client. Which finding requires withholding the medication?

A. Apical heart rate of 72 bpm
B. Vomiting after breakfast
C. Serum potassium of 4.0 mEq/L
D. Occasional PVCs on cardiac monitor

Answer: A

Rationale: In children, an apical HR <90–110 bpm (depending on age) is a contraindication. Bradycardia is a sign of digoxin toxicity. Vomiting may also be a symptom, but HR is more urgent.

Question 47

Which lab value should the nurse review before administering enoxaparin?

A. PT
B. aPTT
C. INR
D. Platelet count

Answer: D

Rationale: Enoxaparin (Lovenox) can cause heparin-induced thrombocytopenia. Platelets must be monitored. aPTT, PT, and INR are not routinely used for LMWH monitoring.

Question 48 – Select all that apply

A nurse is assessing an older adult client for signs of elder abuse. Which findings are concerning?

A. Poor hygiene and malnutrition
B. Multiple bruises in various stages of healing
C. Medication bottles filled and labeled correctly
D. Unexplained withdrawal from normal activities
E. Reports of frequent falls without injury

Answers: A, B, D

Rationale: Malnutrition, inconsistent injuries, and behavioral changes can all suggest elder abuse. Well-managed meds and minor falls may not indicate abuse.

Question 49

Which client action indicates proper understanding of how to use an insulin pen?

A. "I'll dial the dose and inject without priming."
B. "I'll leave the needle in for 10 seconds after injection."
C. "I'll use the same needle for a few injections to save supplies."
D. "I'll store the pen in the freezer between uses."

Answer: B

Rationale: Leaving the pen in for 10 seconds prevents leakage. The pen must be primed, needles changed with each use, and pens stored at room temp, not frozen.

Question 50 – Select all that apply

Which actions are appropriate when administering medications via a PEG tube?

A. Flush with 30 mL water before and after each medication
B. Mix all medications together to reduce volume
C. Crush extended-release tablets before administration
D. Check tube placement before giving meds
E. Administer each med separately and flush between

Answers: A, D, E

Rationale: Flushing, verifying placement, and administering meds separately are all safe practices. Extended-release meds should never be crushed, and mixing all meds can cause interactions or clogs.

Question 51

A nurse is caring for a client post-lumbar puncture. Which position should the client maintain for several hours to prevent complications?

A. Prone
B. Supine
C. High Fowler's
D. Side-lying with knees to chest

Answer: B

Rationale: After a lumbar puncture, the client should remain supine to reduce the risk of headache from cerebrospinal fluid leakage. Prone is not standard. Side-lying is used during the procedure, not after.

Question 52

A client who is 24 hours postoperative for abdominal surgery reports pain rated 7/10. The abdomen is firm and distended. What is the nurse's priority action?

A. Administer prescribed opioid analgesic
B. Assess bowel sounds
C. Ambulate the client
D. Notify the provider immediately

Answer: D

Rationale: A firm, distended abdomen and significant pain may indicate a complication such as hemorrhage or ileus. Immediate provider notification is warranted before further intervention.

Question 53

A client is admitted with diabetic ketoacidosis (DKA). Which insulin should the nurse anticipate administering?

A. Regular insulin IV
B. NPH insulin subQ
C. Glargine insulin IV
D. Lispro insulin subQ

Answer: A

Rationale: Regular insulin is the only insulin type used IV and is preferred for DKA treatment. Glargine and lispro are subcutaneous only and inappropriate for acute DKA.

Question 54

The nurse is caring for a client with a tracheostomy. Which action is appropriate when suctioning the airway?

A. Apply suction during insertion of the catheter
B. Limit suctioning to 20 seconds per pass
C. Use sterile technique
D. Perform suctioning every hour routinely

Answer: C

Rationale: Sterile technique is required to prevent infection. Suction should be applied during withdrawal, and each pass should last no more than 10 seconds. Only suction as needed, not hourly.

Question 55

A client receiving chemotherapy reports mouth sores. Which recommendation should the nurse provide?

A. Use hydrogen peroxide rinse
B. Rinse with warm saline several times daily
C. Brush with firm-bristled toothbrush
D. Avoid drinking liquids until sores heal

Answer: B

Rationale: Warm saline rinses promote healing and comfort for stomatitis. Hydrogen peroxide and firm brushes are irritating. Clients should remain hydrated.

Question 56

A nurse prepares to administer lisinopril to a client with heart failure. Which lab value would cause the nurse to hold the medication?

A. Sodium 138 mEq/L
B. Potassium 5.9 mEq/L
C. Chloride 98 mEq/L
D. Calcium 9.0 mg/dL

Answer: B

Rationale: Hyperkalemia is a serious adverse effect of ACE inhibitors like lisinopril. A potassium level of 5.9 is dangerously high and should prompt holding the dose.

Question 57

The nurse receives the following change-of-shift report. Which client should be assessed first?

A. Client with cellulitis and WBC of 13,000
B. Client with chest pain unrelieved by nitroglycerin
C. Client with asthma reporting mild wheezing
D. Client scheduled for elective hip replacement

Answer: B

Rationale: Unrelieved chest pain may indicate myocardial infarction and is the most urgent. The others are stable or scheduled and can be seen afterward.

Question 58

A client with advanced dementia becomes increasingly agitated each evening. What is the best nursing intervention?

A. Restrain the client during episodes
B. Increase lighting and reduce stimulation at night
C. Administer prescribed haloperidol
D. Reorient the client frequently to person and place

Answer: B

Rationale: This describes sundowning syndrome, common in dementia. The best initial approach is to reduce environmental stressors. Restraints and medications should be avoided unless absolutely necessary.

Question 59

A nurse is preparing to insert a urinary catheter into a female client. Which step is essential to maintain sterile technique?

A. Use nonsterile gloves to cleanse the perineum
B. Place the catheter kit on the overbed table
C. Cleanse from front to back using sterile swabs
D. Inflate the balloon before insertion

Answer: C

Rationale: The perineum must be cleansed from front to back with sterile materials. Inserting the balloon early can damage tissue. Gloves must be sterile once sterile field is open.

Question 60 – Select all that apply

Which interventions are appropriate when caring for a client in skeletal traction?

A. Ensure weights hang freely at all times
B. Assess pin sites for signs of infection
C. Remove traction weights every 4 hours
D. Maintain alignment of the body
E. Keep head of bed elevated to 90 degrees at all times

Answers: A, B, D

Rationale: In skeletal traction, the weights must hang

freely, and the nurse should monitor for infection and maintain proper alignment. Weights are not removed routinely. Elevating the HOB too high can disrupt traction.

Question 61

A nurse is caring for a client with COPD. Which oxygen delivery device is most appropriate for precise oxygen delivery?

A. Simple face mask
B. Nasal cannula
C. Non-rebreather mask
D. Venturi mask

Answer: D

Rationale: Venturi masks provide the most precise oxygen concentrations, making them ideal for clients with COPD who require controlled O2.

Question 62

A client with type 1 diabetes reports feeling shaky, sweaty, and anxious. What is the nurse's first action?

A. Administer glucagon IM
B. Check blood glucose level
C. Provide a glass of orange juice
D. Notify the healthcare provider

Answer: B

Rationale: Symptoms suggest hypoglycemia, but the

nurse must confirm with a blood glucose check before treatment unless the client is unconscious.

Question 63

Which of the following clients is at highest risk for developing a hospital-acquired infection?

A. A 20-year-old post-appendectomy
B. A 55-year-old with a Foley catheter
C. A 30-year-old in traction for leg fracture
D. A 42-year-old with a BMI of 27

Answer: B

Rationale: Foley catheters are a common source of hospital-acquired urinary tract infections, especially in older adults.

Question 64

A nurse is caring for a client who has neutropenia. Which food item should be avoided?

A. Cooked vegetables
B. Canned fruit
C. Raw carrots
D. Baked chicken

Answer: C

Rationale: Clients with neutropenia should avoid raw

fruits/vegetables due to risk of bacterial exposure. All food should be fully cooked.

Question 65

A nurse receives a new medication order that is unclear. What is the most appropriate action?

A. Ask a colleague to interpret the order
B. Administer the medication based on best guess
C. Contact the prescribing provider for clarification
D. Call the pharmacist to rewrite the order

Answer: C

Rationale: The nurse must always clarify unclear or illegible orders directly with the provider before administering any medication.

Question 66

A client is prescribed metformin. Which lab value should be reviewed before administering this medication?

A. BUN
B. AST
C. Hemoglobin
D. Creatinine

Answer: D

Rationale: Metformin is contraindicated in renal impairment, which increases the risk of lactic acidosis. Creatinine should be assessed before starting.

Question 67

The nurse is reviewing the chart of a client with an NG tube to low intermittent suction. Which finding requires intervention?

A. Gastric pH of 2
B. Green aspirate from the tube
C. Absent bowel sounds
D. K+ level of 2.9 mEq/L

Answer: D

Rationale: NG suction can lead to hypokalemia due to loss of gastric fluids. A K+ level of 2.9 is dangerously low and must be corrected.

Question 68

Which teaching point is most important for a client beginning phenytoin therapy?

A. "You should take this medication with antacids."
B. "Avoid driving until you know how the medication affects you."
C. "You may stop the medication if seizures are controlled."

D. "This medication does not affect oral contraceptives."

Answer: B

Rationale: Phenytoin causes CNS effects like drowsiness, so safety precautions (e.g., avoiding driving) are key. It also decreases the effectiveness of oral contraceptives.

Question 69

A nurse is providing discharge teaching for a client with a new ileostomy. Which instruction is correct?

A. "You should expect your stool to be semi-formed."
B. "Limit fluid intake to reduce output."
C. "Empty the pouch when it is one-third full."
D. "Apply heat if you notice cramping around the stoma."

Answer: C

Rationale: To prevent leakage or detachment, ileostomy pouches should be emptied when one-third full. Output is liquid, and fluid intake should be encouraged.

Question 70 – Select all that apply

Which statements by a client with a new diagnosis of hypertension indicate understanding of the condition?

A. "I will take my medication even if I feel fine."
B. "I can stop taking the medication when my blood pressure improves."
C. "I'll reduce sodium in my diet."

D. “I will exercise regularly.”
E. “I no longer need to check my blood pressure at home.”

Answers: A, C, D

Rationale: Hypertension is a chronic condition. Clients should continue medications long-term, monitor their BP regularly, and incorporate lifestyle changes such as low sodium intake and regular activity.

Question 71

A nurse is reinforcing teaching with a client who is prescribed warfarin. Which statement by the client indicates a need for further teaching?

A. “I will use an electric razor when shaving.”
B. “I’ll avoid foods high in vitamin K.”
C. “I will take ibuprofen for headaches.”
D. “I’ll keep all follow-up appointments for INR testing.”

Answer: C

Rationale: Ibuprofen increases the risk of bleeding and should be avoided. Acetaminophen is a safer alternative. The other responses reflect safe practices for clients on warfarin.

Question 72

A nurse is assessing a client with a chest tube. Which finding requires immediate action?

A. Continuous bubbling in the water seal chamber
B. Serosanguinous drainage in the collection chamber
C. Gentle bubbling in the suction control chamber
D. Water level fluctuating with respirations

Answer: A

Rationale: Continuous bubbling in the water seal chamber indicates an air leak, which requires immediate intervention. The other findings are expected.

Question 73

A nurse is reviewing discharge instructions for a client recovering from a total hip replacement. Which statement indicates a need for further teaching?

A. "I will avoid crossing my legs when sitting."
B. "I will use a raised toilet seat at home."
C. "I will sleep on my non-operative side."
D. "I will bend at the waist to pick things up."

Answer: D

Rationale: Bending at the waist increases the risk of hip dislocation. Clients should use adaptive tools or bend at the knees instead.

Question 74

Which intervention is most important for a client receiving TPN (total parenteral nutrition)?

A. Monitor for signs of hypoglycemia
B. Administer oral supplements between TPN cycles
C. Change the IV tubing every 72 hours
D. Check blood glucose levels regularly

Answer: D

Rationale: TPN solutions contain high glucose concentrations, requiring frequent blood glucose monitoring. Hypoglycemia is less common than hyperglycemia in this case.

Question 75

A client develops urticaria and wheezing after receiving IV penicillin. What is the nurse's first action?

A. Administer diphenhydramine
B. Notify the healthcare provider
C. Stop the infusion immediately
D. Administer epinephrine

Answer: C

Rationale: The first action is to stop the infusion to prevent further exposure. Epinephrine may follow based on provider orders and severity.

Question 76

A nurse is caring for a client who had a thyroidectomy 2 hours ago. Which finding is most concerning?

A. Hoarseness when speaking
B. Difficulty swallowing water
C. Tingling around the lips and fingers
D. Small amount of serosanguinous drainage on the dressing

Answer: C

Rationale: Tingling is an early sign of hypocalcemia, often due to parathyroid gland damage. It requires immediate evaluation and calcium replacement.

Question 77

A nurse is caring for a client who has been newly diagnosed with tuberculosis. Which infection control precaution is appropriate?

A. Contact precautions
B. Droplet precautions
C. Airborne precautions
D. Standard precautions only

Answer: C

Rationale: TB is transmitted via airborne particles. The client requires airborne isolation, including a negative pressure room and N95 mask for staff.

Question 78

A nurse is caring for a client with end-stage liver disease.

Which finding suggests the client has developed hepatic encephalopathy?

A. Asterixis
B. Tarry stools
C. Bradycardia
D. Hypertension

Answer: A

Rationale: Asterixis (liver flap) is a classic sign of hepatic encephalopathy due to rising ammonia levels. It indicates worsening liver function and altered mental status.

Question 79

Which instruction is most important when teaching a client how to collect a clean-catch urine specimen?

A. Collect the urine from the first stream
B. Use a clean container from home
C. Wipe front to back before urinating
D. Fill the container to the top

Answer: C

Rationale: Cleaning front to back helps prevent contamination of the urine specimen. The midstream portion should be collected using a sterile container.

Question 80 – Select all that apply

A nurse is providing teaching for a client starting an MAOI. Which foods should the client avoid?

A. Aged cheeses
B. Bananas
C. Fresh apples
D. Red wine
E. Smoked meats

Answers: A, B, D, E

Rationale: MAOIs interact with tyramine-rich foods, potentially causing hypertensive crisis. These include aged cheeses, bananas, red wine, and smoked meats. Fresh apples are safe.

Question 81

A client receiving IV vancomycin suddenly develops flushing of the face, neck, and upper torso. What is the nurse's priority action?

A. Stop the infusion and notify the provider
B. Administer diphenhydramine
C. Slow the infusion rate
D. Check for airway swelling

Answer: C

Rationale: The client is experiencing Red Man Syndrome, a common reaction to rapid infusion of vancomycin. Slowing the infusion usually resolves the symptoms. It is not an allergic reaction, so stopping the drug is not required unless symptoms worsen.

Question 82

Which action is appropriate when collecting a wound culture from a client with a draining pressure ulcer?

A. Swab the area around the wound
B. Swab the drainage on the dressing
C. Swab the cleanest part of the wound
D. Irrigate the wound before collecting the sample

Answer: D

Rationale: The wound should be irrigated before culture collection to remove surface contaminants. This ensures that the culture reflects the actual pathogens within the tissue.

Question 83

Which symptom would alert the nurse to possible digoxin toxicity?

A. Increased appetite
B. Visual disturbances
C. Tachycardia
D. Weight gain

Answer: B

Rationale: Visual changes, such as yellow-green halos or blurred vision, are classic signs of digoxin toxicity. Bradycardia and nausea are also common.

Question 84

A client is prescribed clozapine for schizophrenia. Which lab value is most important to monitor?

A. WBC count
B. Hemoglobin
C. BUN
D. Platelet count

Answer: A

Rationale: Clozapine can cause agranulocytosis, a serious decrease in white blood cells. Clients must have routine WBC monitoring.

Question 85

A nurse is teaching a client with GERD about lifestyle changes. Which statement by the client indicates understanding?

A. "I will eat three large meals per day."
B. "I'll lie down after meals to aid digestion."
C. "I will avoid spicy and fatty foods."
D. "I'll drink peppermint tea after meals."

Answer: C

Rationale: Fatty, spicy, and peppermint-containing foods can worsen GERD by relaxing the lower esophageal sphincter. Small, frequent meals and remaining upright after eating are recommended.

Question 86

Which instruction is most important for the nurse to give a client taking alendronate for osteoporosis?

A. Take with a full glass of water and remain upright
B. Take with food to avoid stomach upset
C. Avoid sun exposure while on this medication
D. Limit fluid intake to reduce side effects

Answer: A

Rationale: Alendronate can cause esophageal irritation, so it must be taken with water, and the client should remain upright for 30 minutes after taking it.

Question 87

The nurse is caring for a client with a head injury who suddenly develops a decreased level of consciousness. What is the nurse's priority action?

A. Administer oxygen
B. Check pupillary response
C. Notify the healthcare provider
D. Assess airway, breathing, and circulation

Answer: D

Rationale: Any acute decline in LOC may indicate increased intracranial pressure or hemorrhage. Always assess airway, breathing, and circulation first.

Question 88

A client is undergoing hemodialysis. Which assessment finding should be reported immediately?

A. Blood pressure of 108/70 mmHg
B. AV fistula bruit present
C. Temperature of 101.2°F (38.4°C)
D. Fatigue after dialysis

Answer: C

Rationale: A fever in a dialysis patient could indicate sepsis or line infection and should be reported immediately. The other findings are expected or mild.

Question 89

Which symptom would indicate a potential complication in a client with a new colostomy?

A. Pink, moist stoma
B. Small amount of gas in the pouch
C. Bluish stoma color
D. Loose stool output

Answer: C

Rationale: A bluish or dusky stoma indicates poor perfusion and is a surgical emergency. A healthy stoma should be pink to red and moist.

Question 90 – Select all that apply

Which actions should the nurse take when administering ear drops to an adult client?

A. Pull the pinna up and back
B. Warm the solution in hands before administering
C. Pull the pinna down and back
D. Place the client in a side-lying position
E. Insert the dropper deep into the ear canal

Answers: A, B, D

Rationale: For adult clients, the pinna should be pulled up and back. Warming the solution reduces discomfort. The side-lying position ensures the drops stay in the canal. The dropper should not be inserted deep into the canal.

Question 91

A nurse is teaching a client with newly diagnosed type 2 diabetes about foot care. Which statement indicates a need for further teaching?

A. "I will check my feet every day."
B. "I'll go barefoot around the house to toughen my soles."
C. "I'll wear shoes that fit well and protect my feet."
D. "I will dry thoroughly between my toes after bathing."

Answer: B

Rationale: Clients with diabetes should never walk barefoot due to the risk of undetected injury and

infection. Daily foot checks and proper footwear are essential.

Question 92

Which action should the nurse take first when a fire alarm sounds on the unit?

A. Call the fire department
B. Remove all clients from the hallway
C. Shut all patient room doors
D. Pull the nearest fire alarm

Answer: B

Rationale: The RACE acronym guides fire response: Rescue, Alarm, Contain, Extinguish. The first action is to remove clients from immediate danger.

Question 93

A nurse is assessing a client with Cushing's syndrome. Which finding is most consistent with this diagnosis?

A. Low blood pressure
B. Thin, fragile skin
C. Hypoglycemia
D. Weight loss

Answer: B

Rationale: Cushing's syndrome causes excess cortisol,

leading to thin skin, central obesity, hyperglycemia, and hypertension. It does not cause weight loss.

Question 94

Which assessment finding indicates that lactulose therapy is effective for a client with hepatic encephalopathy?

A. Increased bowel sounds
B. Improved level of consciousness
C. Decreased abdominal distention
D. Decreased serum bilirubin levels

Answer: B

Rationale: Lactulose helps reduce ammonia levels, improving mental status in clients with hepatic encephalopathy. It is not given to affect bilirubin.

Question 95

A client is admitted with suspected appendicitis. Which action should the nurse avoid?

A. Keeping the client NPO
B. Placing the client in semi-Fowler's position
C. Applying a heating pad to the abdomen
D. Monitoring for signs of rupture

Answer: C

Rationale: Heat should not be applied to the abdomen in

suspected appendicitis as it can increase blood flow and risk of rupture. Cold compresses may be used instead.

Question 96

Which finding is most concerning in a newborn 1 hour after birth?

A. Respiratory rate of 60/min
B. Acrocyanosis
C. Nasal flaring
D. Positive Moro reflex

Answer: C

Rationale: Nasal flaring is a sign of respiratory distress in a newborn and requires immediate evaluation. Acrocyanosis and the Moro reflex are normal shortly after birth.

Question 97

A client is receiving chemotherapy and develops a fever of 100.9°F (38.3°C). What is the nurse's priority action?

A. Administer acetaminophen
B. Notify the healthcare provider
C. Obtain a sputum culture
D. Encourage oral fluids

Answer: B

Rationale: Even low-grade fever in immunocompromised clients is considered potentially life-threatening and must be reported immediately to the provider.

Question 98

Which finding is most concerning in a client who received spinal anesthesia 1 hour ago?

A. Complaints of headache
B. Numbness and tingling in feet
C. Inability to move legs
D. Decreased sensation at surgical site

Answer: C

Rationale: Inability to move the legs may indicate prolonged or excessive blockade from anesthesia or spinal cord injury. It must be assessed urgently.

Question 99

A nurse is assessing a client with hypocalcemia. Which finding is most consistent with this condition?

A. Bradycardia
B. Trousseau's sign
C. Hypertension
D. Absent deep tendon reflexes

Answer: B

Rationale: Trousseau's sign, a carpal spasm induced by inflating a BP cuff, is a classic sign of hypocalcemia and neuromuscular excitability.

Question 100 – Select all that apply

Which instructions should the nurse include when teaching a client about seizure precautions?

A. Keep padded side rails up
B. Place suction equipment at bedside
C. Use a tongue blade to prevent biting
D. Loosen restrictive clothing
E. Stay with the client during seizure activity

Answers: A, B, D, E

Rationale: Seizure precautions include padded rails, suction readiness, loosened clothing, and remaining with the client. Tongue blades should never be used during a seizure due to choking risk.

Thank You

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