Rutgers School of Nursing Test Success

Tips for Succeeding in Your Multiple Choice, Nursing Exams

Center for Academic Success, revised 9.27.2017
Univ of Toronto: How can Health Professional Students Manage Test Anxiety?

Copy and Paste the link in your browser:
https://youtu.be/SPaO3BXFiyQ
Successfully Preparing for Your Exams

- Preparing for nursing exams begins your first day of classes, weeks before the exam.
- In the next slides we will review strategies for how to approach test questions on the day of the exam.
- However, these strategies will only work if you’ve already:
  - Attended each class
  - Completed the assigned reading for each week
  - Understood the reading assignments
  - Tested your knowledge
  - Avoid lateness. Classes can be as long as 3 hours in length. For example consistently arriving 30 minutes late for a 3 hour class over the course of the semester means you have missed 2.5 classes.
CARDINAL RULES OF TEST-TAKING

• Read all instructions carefully.
• Read all test questions carefully. (Stem)
• Answer only what is being asked; do not read into a question anything beyond what is there.
• Pace yourself.
• Make sure you answer all of the questions on the exam.
Understand Parts of a Multiple Choice Question

1. **Case** (Scenario) - Description of the patient and what is happening.
2. **Stem** - That part of the question that asks the question.
3. **Distractors** - Incorrect but feasible choices.
4. **Correct Response** - The answer to the question.
SAMPLE QUESTION:

Case Scenario: A patient who is visibly upset says to the nurse. “I want to talk with the head nurse, no, get me the supervisor and the director of nursing and the owner of the hospital. I am mad.”

Stem: The best initial response for the nurse to make is:

Distractors: A. “Whom do you wish to see first?”  
B. “Don’t be angry.”  
C. “Why do you want to talk to them when I can help?”

Correct Answer: D. “You seem upset.”
ANSWER

A. “Whom do you wish to see first?”
   Incorrect. Does not promote communication and does not allow exploration and understanding of the issue.

B. “Don’t be angry.”
   Incorrect. Discounts feelings and does not promote communication.

C. “Why do you want to talk to them when I can help?”
   Incorrect. Places the patient on the defensive. Does not defuse the situation.

D. “You seem upset.”
   Correct. The nurse uses the technique of paraphrasing. Acknowledges the patient’s feelings. Promotes Communication.
READING THE QUESTION

1. Paraphrase the question: What is the question asking for in your own words? (Stem)
2. What are the key words in the question?
3. What is the time frame?
4. What is your first initial response?
5. Lastly, what are the answering options?
KEY WORDS

**Patient**—Factors such as age, sex, and marital status may be relevant.

- Age of a child may be very relevant.
- Who is the client—the patient, family or maybe even a staff member.

**Problem/Behavior**—the problem may be a disease, symptom or a behavior.

**Details of the Problem**—e.g. duration of disease, symptom, or behavior.
TIME FRAME

Whenever time is mentioned…it is important.

• Early vs. Late
• Pre Operative vs. Post Operative
• Surgical Day
ANSWERING OPTIONS

• Try to answer the question *before* looking at the answers.

• Come up with the answer in your head *before* looking at the possible answers.

• Read all the choices.

• Recall class lectures.

• If all else fails, use an educated guess.
EDUCATED GUESS STRATEGIES

Always use the process of elimination as a first step.

Beware of negative terms such as none, not, and never.

When you are undecided between two answers, try to express each in your own words. Then analyze the differences between the two.

Use logic and common sense to reason out the correct answer.
ELIMINATE OPTIONS

Read all of the distracters.

Eliminate distracters that are clearly incorrect.

With the elimination of each distracter, you increase the probability of selecting the correct option by 25%.
Deep Vein Thrombosis (DVT) is a condition wherein a blood clot forms in a vein of the deep venous system. DVTs can occur anywhere in the body, but are most frequently found in the deep veins of the legs, thighs, and pelvis. They may infrequently arise from the upper extremities usually because of trauma, or from an indwelling catheter (tubing) or device.
1. Deep Vein Thrombosis (DVT) is:
   a. blood clot in lungs
   b. varicose veins in lower extremities
   c. vasoconstriction of veins in legs
   d. blood clot in extremities.
2. The nurse is caring for a patient who had a (kō-lə-sis-tek-tə-mē) cholecystectomy 12 hours ago. To prevent deep vein thrombosis (DVT) the nurse will teach the patient to…

1. Keywords?
2. Time Frame?
3. Your First Response?

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2. The nurse is caring for a patient who had a cholecystectomy (kō-lə-sis-tek-tə-mē) 12 hours ago. To prevent deep vein thrombosis (DVT) the nurse will teach the patient to… :

a. keep legs immobile while in bed.
b. avoid ambulation except to go to the bathroom.
c. elevate the legs above the level of the heart at all times.
d. ambulate as soon as possible and frequently.
The correct answer is:
d. ambulate as soon as possible and frequently.
To answer this question you need to be able to draw on a wealth of information. You need to know at least 4 pieces of information:

a) That cholecystectomy is a surgery
b) That surgery increased the risk for DVT
c) What DVT is
d) What does and does not prevent DVT
Strategy: Assessment vs. Implementation

Is assessment needed to determine the safest course of action or does the question stem contain enough assessment information to justify a nursing implementation?

Step 1: What is the topic of this question?

Step 2: Is assessment needed, or should the nurse act now?

Step 3: Consider the implementations – what is going to make this patient safe right now?
Sample Question 1: A patient who has been receiving a blood transfusion for 20 minutes complains of dizziness, chills, feeling flushed, and shortness of breath. What is the best action by the nurse?

A. Check the pulse oximetry level.
B. Administer acetaminophen 650mg by mouth.
C. Obtain an oral temperature.
D. Stop the blood transfusion.
Rationale

Step 1: What is the topic of this question?
Priority action: Suspected blood transfusion reaction.

Step 2: Is assessment needed, or should the nurse act now?
Assessment is present in the question stem (signs and symptoms of a transfusion reaction) – client’s safety is at risk – ACT NOW! Eliminate “A” and “C” because they are assessments.
**If the nurse takes extra time to assess the patient, the blood is still infusing!!

Step 3: Consider the implementations – what is going to make this patient safe right now? If acetaminophen is administered first, the blood is left to infuse longer. The safest action is to stop the blood now. Correct answer: D
**Overarching goal on NCLEX-style questions – patient safety!!
Practice Question

The nurse is changing the weekly subclavian dressing on a homecare patient receiving Total Parenteral Nutrition (TPN). When assessing the catheter insertion site, the nurse notices the presence of yellow drainage around the sutures anchoring the catheter and the patient states she has had chills for a few days. What should the nurse do first?

A. Clean the insertion site and redress the area.
B. Document assessment findings in the electronic medical record.
C. Obtain an order for a culture of the drainage.
D. Check the patient’s temperature.
Rationale

Step 1: What is the topic of this question? Priority action: Suspected infection in the central line.

Step 2: Is assessment needed, or should the nurse act now? The assessment shows yellow drainage and chills (unexpected findings) - more assessment is needed to confirm your suspicion of infection.

Step 3: Consider the other answers - Clean the wound? No, you need to assess the problem further. Documentation – although that is important before you leave, it’s not a priority. Obtain a culture – yes, a good idea, BUT when you call the healthcare provider for the order, he is going to ask about a fever (yellow drainage = infection = fever usually). Don’t walk naked to the phone! Always have the assessment answers for the provider – anticipate what he will need to know to make an informed decision. Take the temperature first, and then call the provider for further orders.

Correct answer: D
Strategy: Priority Assessment

What is the most important assessment to make?

Step 1: What is the topic of this question?

Step 2: Physical versus psychosocial?

Step 3: What information is needed right now to provide safe nursing care?
70-year-old patient is brought to the emergency department in a coma believed to be caused by a stroke. What is the best question for the nurse to ask the family to determine whether the coma is related to a stroke?

A. How many hours does the patient usually spend sleeping at night and in the daytime?
B. Did the patient describe weakness in the lower extremities in the past few days?
C. Is there any history of seizures among the patient’s siblings or parents?
D. Does the patient have a history of drug or alcohol use or abuse?
Rationale

Step 1: What is the topic of this question? Priority assessment: Suspected stroke patient. Both physical and psychosocial interventions are included. Apply the Maslow strategy to eliminate choices.

Step 2: Physical versus psychosocial? Eliminate all psychosocial answer choices. In this case that means A and C – hours of sleep and familial history are psychosocial.

Step 3: What information is needed right now to provide safe nursing care? “Did the patient describe weakness in the lower extremities in the past few days?” - Not an indicator of a stroke - eliminate this answer. “Does the patient have a history or drug or alcohol use or abuse?” - Concurrent conditions such as drug or alcohol intoxication as well as hypoxemia and metabolic disturbances can cause profound neurological changes and must be investigated. Alcohol abuse and medication toxicity can lead to strokes in older adults.

Correct answer: D

**Many students want to pick B forgetting that this is not an indication of a stroke**
Strategy: ABCs

Airway-Breathing-Circulation (ABC) Priorities

Step 1: What is the topic of this question?

Step 2: Airway, Breathing, or Circulation?

Step 3: Consider the other answers – what is the priority?
A patient is one day post-op from a colon resection for cancer. The patient’s Hgb was 14.1 g/dl yesterday and today it is 7.2 g/dl. The patient’s oxygen saturation is 87%. The doctor’s orders include: NSS at 100 mL/hour, VS every 4 hours, Morphine Sulfate 4mg IV push every 4 hours PRN for pain, NPO, oxygen 2-4 L/min via nasal cannula. After reviewing the orders and notifying the health care provider, the nurse should first:

A. Take the VS every hour.
B. Increase the IVF to 125 mL/hour.
C. Administer oxygen at 2 L/min via nasal cannula.
D. Determine when the last pain medication was received.
Rationale

Step 1: What is the topic of this question? Priority action: Hypoxia.

Step 2: Airway, Breathing, or Circulation? The assessment shows the oxygen saturation is 87%. That is a low value (normal is >95). You want to do something about the oxygenation – airway/breathing is the priority.

Step 3: Consider the other answers – what is the priority? The orders states check VS every 4 hours (although you can check more frequently), but your assessment states the oxygen saturation is 87%. Checking vital signs is a circulation response (respiratory rate does not really matter when you know the oxygen saturation is 87%). Increasing the IV rate is a circulation response, and a provider order is needed to increase IVF. Pain medication is not airway, breathing, or circulation - eliminate. The priority is to administer the oxygen.

Correct answer: C
Additional Strategies

** Remain Calm:** High anxiety levels while taking an exam impair focus and prevent the critical thinking that is required to successfully answer challenging NCLEX-style questions (Cuellar, 2013).

**Study Skills to prepare for tests the day BEFORE (Kaplan, 2017):**
- Don’t eat any new or spicy foods
- Eat protein enriched meals
- Drink plenty of water
- No drugs or alcohol
- Get to bed early

**To prepare the DAY of your test:**
- Eat a balanced breakfast or lunch
- Wear your lucky whatever (socks? underwear?), bring lucky object
- Listen to motivational or inspirational music (like the “ROCKY” theme)
- Arrive 15 minutes early
- Go to bathroom when you get there!
- Take a deep breath
NURSING EXAMS

Exams not only test how much you remember or understand about a subject.

They are also designed to test your ability to think at the five higher cognitive levels. See examples.

Thinking like a nurse is essential to safe and competent nursing practice at the entry level.
FIVE COGNITIVE LEVELS

1. Remembering
2. Understanding
3. Applying
4. Analyzing
5. Evaluating
HOW TO PREPARE FOR EXAMS USING THE COGNITIVE LEVELS
EXAMPLE: STUDYING MEDICATIONS: FUROSEMIDE (LASIX)

Remembering: Memorize the classification of Furosemide (Lasix).

Understanding: Develop an understanding of the action of Furosemide (Lasix).

Applying: Identify specific patient situations where Furosemide (Lasix) would be used; Identify specific patient situations requiring the care of the patient receiving the medication.

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HOW TO PREPARE FOR NURSING EXAMS USING THE COGNITIVE LEVELS
EXAMPLE: STUDYING MEDICATIONS: FUROSEMIDE (LASIX)

Analyzing: Differentiate among the side effects of Furosemide (Lasix) and other medications. Determine priorities and explore relationships among data.

Evaluating: Make decisions based on reflection; what is the expected outcome of Furosemide (Lasix).
SUMMARY

- Understand parts of exam.
- Understand the question.
- Identify keywords & time frame.
- Eliminate options.
- Consider assessment versus implementation.
- Consider priority assessments.
- Consider ABCs.
- Apply your knowledge successfully.
Rutgers: The Science Behind Memory

https://youtu.be/mpdG3ZN1RLo
Recommended Videos

1. The Science Behind Memory
https://www.youtube.com/watch?v=mpdG3ZN1RLo
Video produced by Rutgers Today

2. Managing Test Anxiety for Health Professional Students
http://www.youtube.com/watch?v=SPaO3BXFiyQ
Video produced by Dr. Cathy Evans and Dr. Sharon Switzer-McIntyre. Illustrated by Meg Kirkland, University of Toronto.
REFERENCES


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