

Test-Taking Techniques

Performing well on nursing questions requires both roots and wings. The information in the previous chapters provided you with roots by giving you information about formulating a positive mental attitude, using critical thinking, employing time-management strategies, exploring a variety of study skills, and developing an understanding of the multiple-choice question and the nursing process. In this chapter an attempt is made to provide you with the wings necessary to “fly through” multiple-choice questions. Flying through multiple-choice questions has nothing to do with speed; it relates to being test wise and able to navigate through complex information with ease.

Tests in nursing involve complex information that has depth and breadth. In addition to having its own body of knowledge, nursing draws from a variety of disciplines, such as sociology, psychology, and anatomy and physiology. To perform well on a nursing examination, you must understand and integrate the subject matter. Nothing can replace effective study habits or knowledge about the subject being tested. However, being test wise can maximize the application of the information you possess. Being test wise entails specific techniques related to individual question analysis and general techniques related to conquering the challenge of an examination. One rationale for learning how to use these techniques is to provide you with skills that increase your command over the testing situation. If you are in control, you will maintain a positive attitude, which will affect your performance in a positive manner. When you have knowledge and are test wise, you should fly through a test by gliding and soaring, rather than by flapping and fluttering.

SPECIFIC TEST-TAKING TECHNIQUES

A specific test-taking technique is a strategy that uses skill and forethought to analyze a test item before selecting an answer. A technique is not a gimmick but a method of examining a question with consideration and thoughtfulness to help you select the correct answer. When an item has four options, the chance of selecting the correct answer is one out of four, or 25%. When you eliminate one distractor, the chance of selecting the correct answer is one out of three, or 33.3%. If you are able to eliminate two distractors, the chance of selecting the correct answer is one out of two, or 50%. Each time you successfully eliminate a distractor, you dramatically increase your chances of correctly answering the question.

Before you attempt to answer a question, break the question into its components. First, read the stem. What is it actually asking? It may be helpful to paraphrase the stem to focus on its content. Then, try to answer the question being asked in your own words before looking at the options. Often, one of the options will be similar to your answer. Then examine the other options and try to identify the correct answer.

If you know, understand, and can apply the information being tested, you can often identify the correct answer. However, do not be tempted to select an option too quickly, without careful thought. An option may contain accurate information, but it may not be correct because it does not answer the question asked in the stem. Be careful. Each option deserves equal consideration.

Use test-taking techniques for every question. However, the use of test-taking techniques becomes more important when you are unsure of the answer, because each distractor that you are able to eliminate will increase your chances of selecting the correct answer. Most nursing students are able to reduce the number of plausible answers to two. Contrary

to popular belief, multiple-choice questions in nursing have only one correct answer. Use everything in your arsenal to conquer the multiple-choice question test: effective studying, a positive mental attitude, and, last but not least, test-taking techniques.

The correct answers for the sample items in this chapter and the rationales for all the options are at the end of the chapter.

Identify the Word in the Stem That Indicates Negative Polarity

Read the stem slowly and carefully. Look for key words such as **not**, **except**, **never**, **contraindicated**, **unacceptable**, **avoid**, **unrelated**, **violate**, and **least**. These words indicate negative polarity, and the question being asked is probably concerned with what is false. Some words that have negative polarity are not as obvious as others. A negatively worded stem asks you to identify an exception, detect an error, or recognize nursing interventions that are unacceptable or contraindicated. If you read a stem and several of the options appear correct, reread the stem because you may have missed a key negative word. These words are sometimes brought to your attention by an underline (not), italics (*except*), bold-face (**never**), or capitals (VIOLATE). Many nursing examinations avoid questions with negative polarity. However, examples of these items are included for your information.

SAMPLE ITEM 7-1

Which action violates medical asepsis when the nurse makes an occupied bed?

1. Returning unused linen to a linen closet
2. Wearing gloves when changing the linen
3. Tucking clean linen against the frame of the bed
4. Using the old top sheet for the new bottom sheet

The key term in this stem is *violates*. The stem is asking you to identify the option that does not follow correct medical aseptic technique. If you missed the word *violates* and were looking for the answer that indicated correct medical aseptic technique, there will be more than one correct answer. When this happens, reread the stem for a word with negative polarity. In this item, you had to be particularly careful because the word *violates* is not emphasized for your attention.

SAMPLE ITEM 7-2

A patient is receiving a low-sodium diet. Which food should the nurse teach the patient to *avoid* because it is high in sodium?

1. Stewed fruit
2. Luncheon meats
3. Whole-grain cereal
4. Green, leafy vegetables

The key word in this stem is *avoid*; it is brought to your attention because it is italicized. The stem is asking you to select the food that a patient receiving a low-sodium diet should not eat. If you missed the word *avoid* and were looking for foods that are permitted on a low-sodium diet, then there will be more than one correct answer. When there appears to be more than one correct answer, reread the stem for a key negative word that you may have missed.

SAMPLE ITEM 7-3

Which should a nurse **never** do when rubbing a patient's back?

1. Apply pressure over vertebrae
2. Use continuous strokes
3. Wipe off excess lotion
4. Knead the skin

The key word in this stem is *never*. The stem is asking you to identify which option is not an acceptable practice associated with a back rub. If you missed the word *never* and were looking for what the nurse should do for a back rub, there will be more than one correct answer. This should alert you to the fact that you may have missed a key negative word.

Identify the Word in the Stem That Sets a Priority

Read the stem carefully while looking for key words such as **first**, **initially**, **best**, **priority**, **safest**, and **most**. These words modify what is being asked. This type of question requires you to put a value on each option and then place them in rank order. If the question asks what the nurse should do first, what the initial action by the nurse should be, or what the best response is, then rank the options in order of importance from 1 to 4, with the most desirable option as number 1 and the least desirable option as number 4. The correct answer is the option that you ranked number 1. If you are having difficulty ranking the options, eliminate the option that you believe is most wrong among all the options. Next, eliminate the option you believe is most wrong from among the remaining three options. At this point, you are down to two options, and your chance of selecting the correct answer is 50%. When key words such as “most important” are used, frequently all of the options may be appropriate nursing care for the situation. However, only one of the options is the *most* important. When all the options appear logical for the situation, reread the stem to identify a key word that asks you to place a priority on the options. These words occasionally are emphasized by an underline, *italics*, **boldface**, or CAPITALS.

Answering a test question that asks you to establish a priority (which is “most important,” “best,” “initial,” and “first”) requires you to make a decision using clinical judgment. It requires you to use perceptual, inferential, and/or diagnostic judgment to arrive at the correct answer based on the data in the question and options. To do this, you must draw on your knowledge of theory, concepts, principles, and nursing standards of practice. The student who has a strong foundation of knowledge and who is a critical thinker is best equipped to arrive at the correct answer. For additional information about making clinical decisions and types of clinical judgments, refer to Chapter 2, Critical Thinking, in the section titled Clinical Judgments.

A strategy you can draw on to help you answer priority questions is to refer to basic guiding theories that are part of the foundation of nursing. Maslow's Hierarchy of Needs, the Nursing Process, Kübler-Ross's Theory of Death and Dying, Man as a Unified Being, the theory that the patient is the center of the health team, teaching/learning theory, emotional support and communication theory, and the ABCs (Airway, Breathing, Circulation) of prioritizing physical care, to name a few, present clear parameters of practice that are the building blocks of the foundation of nursing practice. Choosing which theory or principle to draw on when answering a test question comes with practice. You first have to identify “what is happening” and “what should I do.” You then have to identify which theory or principle applies best in the scenario presented in the question in light of the options offered.

Keeping these theories in mind when answering test questions, you should recognize that:

- Physiological needs generally need to be met first before higher-level needs.
- Disbelief and denial are generally a person's first response to news of a loss or anticipated loss.
- Meeting the needs of the patient comes first over other tasks.
- Patient readiness to learn must be assessed first before designing a teaching program.
- A patient's emotional status must be assessed as part of the first step in the nursing process.
- Nurses need to use interviewing techniques to effectively communicate in a nonthreatening way with patients.
- The nurse must deliver care in a nonjudgmental manner.
- Maintaining a patient's airway is always a priority.
- The patient's safety is always a priority.
- A thorough assessment must be completed before other steps in the nursing process.

Practice the questions in Chapter 11 that ask you to set a priority and study the rationales for the right and wrong answers. Priority questions are identified by the statement, "Identify key words in the stem that set a priority," which appears in the TEST-TAKING TIP after the question. This will help you build a body of knowledge associated with determining what the nurse should do first in different clinical situations presented in practice questions.

SAMPLE ITEM 7-4

Which should the nurse do first before administering an enema?

1. Collect the appropriate equipment.
2. Verify the order for the procedure.
3. Inform the patient about the procedure.
4. Ensure the patient's bathroom is empty.

The key word in this stem is *first*. Each of these options includes a step that is part of the procedure for administering an enema. You must decide which option is the *first* step among the four options presented. Before you can teach a patient, collect equipment, or actually administer the enema, you need to know the type of enema ordered. The type of enema will influence the other steps of the procedure. If option 2 were different, such as "Use medical asepsis to dispose of contaminated articles," the correct answer among these four options would be option 3. You can choose the first step of a procedure only from among the options presented.

SAMPLE ITEM 7-5

A patient has significant short-term memory loss and does not remember the primary nurse from day to day. When the patient asks, "Who are you?," which is the **most** appropriate response?

1. "You know me. I take care of you every day."
2. "Don't worry. I'm the same nurse you had yesterday."
3. Say nothing, because it probably will upset the patient.
4. State your name and say, "I am the nurse caring for you."

The key words in this stem are *most appropriate*. You are asked to select the best or most suitable response from among the four options presented. You may dislike all of the statements. You may even think of a response that you personally prefer to the offered options. YOU CANNOT REWRITE THE QUESTION. You must select your answer from the options presented in the item. The words *most appropriate* are not highlighted in this item, and therefore you must be diligent when reading the stem.

SAMPLE ITEM 7-6

A nurse is caring for a patient who just had a long leg cast applied for a compound fracture of the femur. Which is the **most** important nursing intervention when caring for this patient?

1. Turn and position every 4 hours.
2. Take pulses proximal to the casted area.
3. Cover rough edges of the cast with tape.
4. Inspect the cast for signs of drainage or bleeding.

The word *most* in the stem sets a priority. Use the ABCs (Airway, Breathing, Circulation) to identify the *most* important option. No options are associated with airway or breathing. However, options 2 and 4 are associated with circulation. If you identify that assessing a distal, not proximal, pulse is important, then you can eliminate option 2. You have arrived at the correct answer.

Identify Key Words in the Stem That Direct Attention to Content

Generally, a stem of an item is short and contains only the information needed to make it clear and specific. Therefore, the use of a word or phrase in the stem has significance. A key word is the intentional or unintentional use of a word or phrase that provides information that leads you to the correct answer. Sometimes a key word is a word or phrase that modifies another word or phrase in the stem. It takes a broad concept and focuses the reader toward a more specific aspect of the concept (see Sample Item 7-7). Other times a word or phrase in the stem is significant because it is similar to or a paraphrase of a word or phrase in the correct answer (see Sample Item 7-8). Occasionally, a word or phrase in the stem is identical to a word or phrase in the correct answer and is called a **clang association** (see Sample Item 7-9). Every word in the stem is important, but some words are more significant than others. The identification of important words and the analysis of the significance of these words in relation to the stem and the options require critical thinking.

SAMPLE ITEM 7-7

To meet a patient's basic physiological needs according to Maslow's Hierarchy of Needs, which should the nurse do?

1. Maintain the patient's body in functional alignment.
2. Pull the curtain when the patient is on a bedpan.
3. Respond to a call light immediately.
4. Raise both side rails on the bed.

An important word in the stem is *physiological*. It is an intentional use of a word to specifically limit consideration to one aspect of Maslow's theory.

SAMPLE ITEM 7-8

Which should the nurse do to help meet a patient's self-esteem needs?

1. Encourage the patient to perform self-care when able.
2. Ask family members to visit the patient more often.

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3. Anticipate needs before the patient requests help.
4. Give the patient a complete bath.

An important word in the stem is *self-esteem*. The word “self-esteem” is similar to the word “self-care.” Thoughtfully examine option 1. An option that incorporates words that are similar to words in the stem is often the correct answer. In addition, the word *self-esteem* in the stem is the intentional use of a word that focuses on one aspect of Maslow’s theory. This question exemplifies the use of two clues in the stem when answering a question.

SAMPLE ITEM 7-9

Which should the nurse do to meet a patient’s basic physical needs?

1. Pull the curtain when providing care.
2. Answer the call bell immediately.
3. Administer physical hygiene.
4. Obtain vital signs.

An important word in the stem is *physical*. It is a clue that should provide a hint that option 3 is the correct answer. The use of the word “physical” in both the stem and the option is called a *clang association*. It is the repetitious use of a word. Examine option 3 because when a clang association occurs, it is often the correct answer.

Identify the Central Person in the Question

Test questions usually require the nurse to respond to the needs of a patient. When a stem is limited to just the patient and the nurse, the patient is almost always the central person in the question. However, some questions focus on the needs of others, such as a child, parent, spouse, or roommate. To select the correct option, you have to identify the central (significant) person in the stem. The significant person is the person who is to receive the care. Sometimes, in addition to the patient, a variety of people are included in the stem. The inclusion of others may set the stage for the question or test your ability to discriminate. These people also may distract you from who is actually the significant person in the stem. Therefore, to answer the question accurately, you must determine WHO is the central person in the question.

SAMPLE ITEM 7-10

A nurse will be going on vacation. To involve the patient in the excitement, which is the **best** response by the nurse?

1. “Tell me about some of your favorite past vacations.”
2. “Do you want to hear about the plans for my trip?”
3. “I’ll bring the brochures for you to see.”
4. “What do you think about vacations?”

Continued

There are two people in this stem, the patient and the nurse. There are two clues in the stem. The first clue is “involve the patient.” To involve the patient, the patient must be active. Therefore, options 2 and 3 can be eliminated because they focus on the nurse, who is not the central person in the question. The second clue is the word *best*. The word “best” is asking you to set a priority. More than one option may include appropriate nursing care, but only one is the “best” action. Options 1 and 4 include appropriate nursing care. However, option 1 requires a more detailed response than option 4. Reminiscing involves more than just giving an opinion.

SAMPLE ITEM 7-11

A patient who has experienced the surgical removal of a breast (mastectomy) says to the nurse, “My husband can’t look at my incision and hasn’t suggested having sex since my surgery.” Which should be the initial action of the nurse?

1. Arrange to speak with the husband about his concerns.
2. Plan to teach the husband that the wife needs his support.
3. Explore the patient’s feelings about her husband’s behavior.
4. Make an appointment with Reach for Recovery for the patient.

There are three people in this stem: the patient, the husband, and the nurse. There are two clues in the stem. The first clue is the quoted statement by the patient about her husband’s behavior. The second clue is the word *initial*. The word “initial” is asking you to set a priority. The situation may require one or more of these responses, but only one of them should be done first. The patient’s statement reflects the patient’s concern. Addressing the patient’s concern should come first. The patient is the central person in this question, not the husband. Options 1 and 2 focus on the husband, who is not the central person in this question and can be eliminated. In option 4, the nurse is using a referral to evade the issues involved and avoid professional responsibility.

SAMPLE ITEM 7-12

A patient is friendly, has many visitors, and appears happy. However, when the patient’s daughter visits, the patient cries and reports the presence of pain. The daughter’s eyes are filled with tears and she is visibly upset when she leaves her mother’s room. Which should the nurse do?

1. Explore the situation with the daughter.
2. Encourage the patient to be more positive.
3. Tell the daughter that the patient usually does not cry.
4. Observe the interaction between them without intervening at this time.

There are many people in this situation: visitors, the patient, the daughter, and the nurse. The question expects the nurse to follow one course of action when the daughter becomes upset. The phrase “she is visibly upset” shifts the focus of the question to the daughter. Options 1 and 3 focus on the daughter. By eliminating two options (options 2 and 4) you have increased your chances of getting this question correct to 50%.

Identify Patient-Centered Options

Nursing is a profession that provides both physical and emotional care to patients. Therefore, the focus of the nurse's concern usually is the patient. Items that test your ability to be patient centered tend to explore patient feelings, identify patient preferences, empower the patient, afford the patient choices, or in some other way put emphasis on the patient. Because the patient is the center of the health-care team, the patient often is the priority.

SAMPLE ITEM 7-13

When assisting a patient who recently had an above-the-knee amputation to transfer into a chair, the patient starts to cry and says, "I am useless with only one leg." Which is a therapeutic response by the nurse?

1. "Losing a leg can be very difficult."
2. "You still have the use of one good leg."
3. "A prosthesis will make a big difference."
4. "You'll feel better when you can use crutches."

Option 1 is patient centered. It focuses on the patient's feelings by using the interviewing technique of reflection. Option 2 denies the patient's feelings, and options 3 and 4 provide false reassurance. When a patient's feelings are ignored or minimized, the nurse is not being patient centered. To be patient centered, the nurse should concentrate on the patient's feelings or concerns.

SAMPLE ITEM 7-14

An oriented patient states, "I always forget the questions I want to ask when my doctor visits me." Which is the nurse's **best** response?

1. Offer to stay when the doctor visits.
2. Remind the patient of the doctor's next visit.
3. Give the patient materials to write questions to ask the doctor.
4. Suggest that a family member be available to question the doctor.

Option 3 is patient centered. It focuses on the patient's ability, fosters independence, and empowers the patient. Option 2 does not address the patient's concern, and options 1 and 4 promote dependence, which can lower self-esteem. Avoiding patient concerns and promoting dependence are actions that are not patient centered. To be patient centered, the nurse should encourage self-care.

SAMPLE ITEM 7-15

Which should the nurse do first when combing a female patient's hair?

1. Use tap water to moisten the hair.
2. Apply a hair conditioner before combing.
3. Comb the patient's hair using long strokes.
4. Ask the patient how she prefers to wear her hair.

Option 4 is patient centered. It allows choices and supports the person as an individual. Options 1, 2, and 3 do not take into consideration patient preferences. A procedure that is begun before determining patient preferences is not patient centered. The Patient Care Partnership (formerly the Patient's Bill of Rights) mandates that the patient has a right to considerate and respectful care and to receive information before the start of any procedure and/or treatment.

SAMPLE ITEM 7-16

A patient enjoys television programs about animals. After one of these programs, the patient cries and sadly talks about a beloved cat that died. Which should be the nurse's initial response?

1. Tell the patient a story about a cat.
2. Hang a picture of a cat in the patient's room.
3. Ask the patient to share more about the cat she loved.
4. Obtain a book about cats for the patient from the library.

Option 3 is patient centered. It encourages the patient to communicate further. Options 1, 2, and 4 may eventually be done because they take into consideration the patient's interest in cats. However, they should not be the initial actions because they do not focus on the patient's feelings at this time. The nurse is being patient centered when encouraging additional communication and verbalization of feelings and concerns from the patient.

Identify Specific Determiners in Options

A specific determiner is a word or statement that conveys a thought or concept that has no exceptions. Words such as **just**, **always**, **never**, **all**, **every**, **none**, and **only** are absolute and easy to identify. They place limits on a statement that generally is considered correct. Statements that use all-inclusive terms frequently represent broad generalizations that usually are false. Frequently these options are incorrect and can be eliminated. However, some absolutes, such as "all patients should be treated with respect," are correct. Because there are few absolutes in this world, options that contain specific determiners should be examined carefully. Be discriminating.

SAMPLE ITEM 7-17

A nurse is giving a patient a bed bath. How can the nurse **best** improve the patient's circulation during the bath?

1. Use firm strokes.
2. Utilize only hot water.
3. Keep the patient covered.
4. Apply soap to the washcloth.

In option 2 the word *only* is a specific determiner. It allows for no exceptions. Hot water can burn the skin and also is contraindicated for patients with sensitive skin such as children, older adults, and people with dermatological problems. Because option 2 allows for no exceptions, it can be eliminated as a viable option.

SAMPLE ITEM 7-18

When providing perineal care for patients, by which action can nurses **most** appropriately protect themselves from microorganisms?

1. Washing their hands before giving care
2. Disposing contaminated water in the toilet
3. Wearing clean gloves when providing perineal care
4. Encouraging patients to provide all of their own care

In option 4 the word *all* is a specific determiner. It is a word that obviously includes everything. Expecting patients to provide all of their own care is unreasonable, is unrealistic, and may be unsafe. Option 4 can be eliminated. This increases your chances of choosing the correct answer because you have to choose from among three options rather than four.

SAMPLE ITEM 7-19

A patient states that the elastic straps of the oxygen face mask feel too tight. How should the nurse respond?

1. Explain the face mask must always stay firmly in place.
2. Replace the face mask with a nasal cannula.
3. Pad the straps with gauze.
4. Adjust the straps.

In option 1 the word *always* is a specific determiner. It is an absolute term that places limits on a statement that might otherwise be true. This option can be eliminated. By deleting option 1, the chances of your selecting the correct answer become 33.3% rather than 25%.

Identify Opposites in Options

Sometimes an item contains two options that are the opposite of each other. They can be single words that reflect extremes on a continuum, or they can be statements that convey converse messages. When opposites appear in the options, they must be given serious consideration. One of them will be the correct answer, or they both can be eliminated from consideration. When one of the opposites is the correct answer, you are being asked to differentiate between two responses that incorporate extremes of a concept or principle. When options are opposites, more often than not, but not always, one of them is the correct answer. When the opposites are distractors, they are attempting to divert your attention from the correct answer. This test-taking technique usually cannot be applied to options that reflect numerical values (e.g., heart rates, blood pressures, respiratory rates, laboratory values). If you correctly evaluate opposite options, you can increase your chances of selecting the correct answer to 50% because you have reduced the plausible options to two. The Sample Items that follow provide a variety of examples of how opposites appear in options.

SAMPLE ITEM 7-20

A nurse understands that the progress of growth and development in all older adults:

1. Slips backward.
2. Moves forward.
3. Becomes slower.
4. Remains stagnant.

Options 1 and 2 are opposites. They should be considered carefully in relation to each other and then in relation to the other options. These options are the reverse sides of a concept, movement in relation to growth and development. Options 3 and 4, although true for some individuals, are not true statements about *all* older adults as indicated in the stem. You now must select between options 1 and 2. Option 2 is the correct answer. By focusing on options 1 and 2 and then progressively examining and deleting options 3 and 4, you have systematically scrutinized this item.

SAMPLE ITEM 7-21

Anti-embolism stockings are ordered for a patient. When should the nurse apply the anti-embolism stockings?

1. While the patient is still in bed
2. Once the patient reports having leg pain
3. When the patient's feet become edematous
4. After the patient gets out of bed in the morning

Continued

Options 1 and 4 are opposites. Examine these options first. They are contrary to each other in relation to before or after an event, getting out of bed. Now assess options 2 and 3. These options expect the nurse to apply anti-embolism stockings after a problem exists. The purpose of these stockings is to foster venous return, thereby preventing edema and discomfort. Options 2 and 3 can be omitted from further consideration. The final selection is between options 1 and 4. You have increased your chances of correctly answering the question from 25% to 50%. Because edema can occur when the feet are dependent, anti-embolism stockings should be applied before, not after, the patient gets out of bed. You have arrived at the correct answer, option 1, using a methodical approach.

SAMPLE ITEM 7-22

A wrist restraint is ordered for a patient on bedrest. To which part of the patient's bed should the nurse tie the restraint?

1. Side rails
2. Footboard
3. Bed frame
4. Headboard

There are two sets of opposites in this question. Options 1 and 3 are opposites and options 2 and 4 are opposites. Examine each set of opposites in relation to each other. Options 2 and 4 are the opposite ends of a hospital bed. Neither option is more appropriate than the other. They are probably both distractors. Now examine options 1 and 3. Side rails are movable, and a restraint must be applied to something that is stationary. Now consider option 3. The bed frame is immovable. Options 1, 2, and 4 can be eliminated, and option 3 is the correct answer. In this question, two sets of opposites complicate analysis of these options. However, after examining each set of opposites, you should be able to use critical thinking to eliminate the incorrect options.

SAMPLE ITEM 7-23

Which type of intravenous solution is normal saline in relation to body fluids?

1. Hypertonic
2. Hypotonic
3. Acidotic
4. Isotonic

Options 1 and 2 are opposites. Appraise these words in relation to each other and their relationship to body fluids and normal saline. They are extremes in the concentration of solutes. Because normal saline is equal to body fluids in the concentration of solutes, these options are probably distractors. Now examine options 3 and 4. Acidotic refers to a low pH in body fluids and is not a type of intravenous solution. Option 3 can be deleted from consideration. In this question, the options that are opposites (1 and 2) are distractors and can be eliminated.

Identify Equally Plausible or Unique Options

Sometimes items contain two or more options that are similar. It is difficult to choose between two similar options because they are comparable. One option is no better or worse than the other option in relation to the statement presented in the stem. When analyzing options use the "If → Then" technique. Ask yourself, "If I perform this intervention in the option, then what will be the outcome?" In equally plausible options the outcomes frequently are the same or similar. Suddenly, equally plausible options are distractors and can

be deleted from consideration. In this question, the options that are opposites (1 and 2) are distractors and can be eliminated.

be eliminated from consideration. You have now improved your chances of selecting the correct answer to 50%. If you find three equally plausible options when initially examining the options, the fourth option probably will be different from the others and appear unique. Children's activity books present a game based on this concept. Four pictures are presented, and the child is asked to pick out the one that is different. "Which one of these is not like the others? Which one of these is not the same?" For example, the picture contains three types of fruit and one vegetable, and the child is asked to identify which one is different. The correct answer to a test item can sometimes be identified by using this concept of similarities and differences.

SAMPLE ITEM 7-24

Which should the nurse do to effectively help meet a patient's basic safety and security needs?

1. Serve adequate food.
2. Provide sufficient fluid.
3. Place the call bell near the patient.
4. Store the patient's valuables in the bedside table.

Options 1 and 2 are similar because they both provide nutrients. They are equally plausible when compared to each other and particularly when assessed in relation to the concepts of safety and security; neither relates to meeting a patient's safety and security needs. These options are distractors and can be eliminated from consideration. By just having to choose between options 3 and 4, you have raised your chances of correctly answering the question to 50%.

SAMPLE ITEM 7-25

How can the nurse promote circulation when providing a back rub?

1. Place the patient in the prone position.
2. Use moisturizing cream.
3. Apply Keri lotion.
4. Knead the skin.

Options 2 and 3 use substances when performing the back rub. Ask yourself, "If I use moisturizing cream, then what is the outcome?" Ask yourself, "If I use Keri lotion, then what is the outcome?" In both instances the outcome is the skin will become less dry and more supple. Because the outcomes are similar, the options are equally plausible. Equally plausible options usually are distractors; therefore, you can delete these options. Now evaluate the remaining options. One of them is the correct answer.

SAMPLE ITEM 7-26

Which is the reason why passive range-of-motion (PROM) exercises are performed?

1. Increase endurance
2. Prevent loss of mobility
3. Strengthen muscle tone
4. Maximize muscle atrophy

Continued

Options 1, 3, and 4 all include words (increase, strengthen, and maximize) that address improvement of something (endurance, muscle tone, and atrophy). They are alike. Option 2 is different. It prevents something from happening, loss of mobility. Option 2 is unique when compared with the presentation of the other options, and it should be given careful consideration. Even if you do not know the definition of “atrophy” and do not understand that the loss of muscle mass should not be maximized, you can still use the test-taking technique of identifying similar and unique options. “Which one of these is not like the others? Which one of these is not the same?”

SAMPLE ITEM 7-27

Which should the nurse plan to do immediately before performing any patient procedure?

1. Shut the door.
2. Wash the hands.
3. Close the curtain.
4. Drape the patient.

Options 1, 3, and 4 are similar in that they all somehow enclose the patient. Ask yourself about the outcome of each intervention (If → Then). Options 1, 3, and 4 all provide for patient privacy. They are all plausible interventions when providing patient care. It is difficult to choose the most correct answer from among these three options. Option 2 is different. It relates to microbiological safety rather than emotional safety. Because this option is unique when compared with the other options, it should be thoroughly examined in relation to the stem because it is likely to be the correct answer.

Identify the Global Option

A global option is more comprehensive and general than the other options. Although unspoken, the global option may include under its mantle a specific concept identified in one or more of the other options. Identifying global options is similar to identifying unique options. The global option usually is a broad general statement, whereas the three distractors generally are specific. You must pick out the option that is different. “Which one of these is not like the others? Which one of these is not the same?”

SAMPLE ITEM 7-28

The most effective way for the nurse to prevent the spread of infection in a nursing home is by:

1. Administering antibiotics to sick patients.
2. Limiting the spread of microorganisms.
3. Isolating residents who are sick.
4. Keeping all unit doors closed.

Options 1, 3, and 4 are all incorrect as indicated in the rationales. However, if you did not know that they were incorrect and you just examined the four options, you should have noticed that options 1, 3, and 4 all identify specific actions while option 2 is broad and general and is different from the other options.

SAMPLE ITEM 7-29

When the nurse is repositioning a patient, which is the **most** important principle of body mechanics?

1. Elevating the arms on pillows
2. Maintaining functional alignment
3. Preventing external rotation of the hips
4. Placing a small pillow under the lumbar curvature

Options 1, 3, and 4 are something you might do to support a patient in a specific position. However, option 2 is comprehensive and broad and identifies something the nurse should do when positioning all patients regardless of the specific position.

Identify Duplicate Facts Among Options

Sometimes items are designed so that each option contains two or more facts. Usually identical or similar facts appear in at least two of the four options. If you identify a fact as incorrect, you can eliminate all the options that contain this fact. By deleting distractors, you increase your chances of selecting the correct answer.

SAMPLE ITEM 7-30

A patient has a vest restraint. While making this patient's occupied bed, which must the nurse do to promote patient safety?

1. Keep the vest restraint tied, and lower both side rails.
2. Keep the vest restraint tied, and lower one side rail.
3. Untie the vest restraint, and lower both side rails.
4. Untie the vest restraint, and lower one side rail.

This item is testing two concepts: whether a vest restraint should be tied or untied when providing direct care and whether one or both side rails should be lowered when providing direct care. If you only know the fact that the side rail should be lowered just on the side on which you are working, you can eliminate options 1 and 3. If you only know the fact that a vest restraint can be untied when the nurse is at the bedside providing direct care, you can eliminate options 1 and 2. In either case, you can eliminate two options as distractors, and you have increased your chances of selecting the correct answer from 25% to 50%.

SAMPLE ITEM 7-31

A 2-gram sodium diet is ordered for a patient. Which group of nutrients is **most** appropriate for this diet?

1. Fruit, vegetables, and bread
2. Hot dogs, mustard, and pickles
3. Hamburger, onions, and ketchup
4. Luncheon meats, rolls, and vegetables

This item is testing your knowledge about the sodium content of foods. If you know that hot dogs and luncheon meats are both processed foods that are high in sodium, you can eliminate options 2 and 4. If you understand that ketchup and mustard are both condiments that are high in sodium, you can delete options 2 and 3. By knowing either fact, you can reduce the final selection to between two options. The similarities between these options are less clear than if the parts were identical, but the technique of identifying duplicate facts in options can still be used.

SAMPLE ITEM 7-32

A nurse is monitoring a patient who is at risk for hemorrhage. For which clinical manifestations should the nurse assess the patient?

1. Warm, dry skin; hypotension; bounding pulse
2. Hypertension; bounding pulse; cold, clammy skin
3. Weak, thready pulse; hypertension; warm, dry skin
4. Hypotension; cold, clammy skin; weak, thready pulse

This item is testing your knowledge about patient responses associated with hemorrhage. Three patient responses are presented: the condition of the skin, the blood pressure, and the characteristic of the pulse. Even if you know only one of these facts about hemorrhage, you can reduce your final selection to between two options. If you know that hypotension is associated with hemorrhage, you can eliminate options 2 and 3. If you know that cold, clammy skin is related to hemorrhage, you can delete options 1 and 3. If you know that a weak, thready pulse is associated with hemorrhage, you can eliminate options 1 and 2. If you know only one or two of the facts presented, you can maximize your chance of correctly answering this type of item. Options that have two or three parts work to your advantage if you use the technique of identifying duplicate facts in options.

Identify Options That Deny Patient Feelings, Concerns, or Needs

Because nurses are human and caring, and primarily want their patients to get well, they often assume the role of champion, protector, or savior. However, by inappropriately adopting these roles, nurses often diminish patient concerns, provide false reassurance, and/or cut off further patient communication. To be a patient advocate, the nurse cannot always be a Pollyanna. Pollyanna, the heroine of stories by Eleanor Hodgman Porter, was a person of irrepressible optimism who found good in everything. Sometimes nurses must focus on the negative rather than the positive, acknowledge that everything may not have the desired outcome, and concentrate on patients' feelings as a priority. Options that imply everything will be all right deny patients' feelings, change the subject raised by the patient, encourage the patient to be cheerful, or transfer nursing responsibility to other members of the health-care team usually are distractors and can be eliminated from consideration.

SAMPLE ITEM 7-33

The day before surgery for a hysterectomy, a patient says to the nurse, "I am worried that I might die tomorrow." Which response by the nurse is therapeutic?

1. "It is really routine surgery."
2. "The thought of dying can be frightening."
3. "You need to tell your surgeon about this."
4. "Most people who have this surgery survive."

Options 1 and 4 minimize the patient's concern because these messages imply that there is nothing to worry about; the surgery is routine and most patients survive. In option 3 the nurse avoids the opportunity to encourage further discussion of the patient's feelings and surrenders this responsibility to the surgeon. After collecting more information, the nurse should inform the surgeon of the patient's concern about death. Options 1, 3, and 4 deny the patient's feelings and can be eliminated because they are distractors. Option 2 is the correct answer because it encourages the patient to focus on the expressed feelings about death.

SAMPLE ITEM 7-34

After surgery, a patient reports mild incisional pain while performing deep-breathing and coughing exercises. Which is the nurse's **best** response?

1. "Each day it will hurt less and less."
2. "This is an expected response after surgery."
3. "With a pillow, apply pressure against the incision."
4. "I will get the pain medication that was prescribed."

Option 1 is a Pollyanna-like response that may provide false reassurance. The nurse does not know that the pain will get less and less for this patient. Option 1 can be deleted from consideration. Although option 2 is a true statement, it cuts off communication because it diminishes the patient's concern and does not explore a solution for minimizing the pain. Option 2 can be eliminated as a distractor. You now must choose between options 3 and 4. The stem indicates that the patient has pain when coughing; the pain is not continuous. Option 4 can be deleted because it is inappropriate to administer an analgesic at this time. Mild pain should subside after the activity is completed. The correct answer is option 3 because it recognizes the mild pain and offers an intervention to help relieve the temporary discomfort. Each time you eliminate an option that denies a patient's feelings, you increase your chances of selecting the correct answer.

SAMPLE ITEM 7-35

An older woman with a right-sided hemiplegia and tears in her eyes sadly states, "I used to brush my hair 100 strokes a day and now I have to rely on others to do it." Which should be the initial response by the nurse?

1. "It's hard not being able to do things for yourself."
2. "With physical therapy you will be able to brush your own hair someday."
3. "Let me brush your hair 100 strokes, and then I'll help you with breakfast."
4. "That's true, but there are lots of other things you are capable of doing for yourself."

Option 2 is a Pollyanna-like response because it implies that everything will be all right eventually. Option 3 changes the subject and cuts off communication. Option 4 initially accepts the patient's statement but then attempts to refocus the patient on the positive. Options 2, 3, and 4 in one way or another deny the patient's feelings, concerns, and/or needs. The correct answer is option 1 because it is an open-ended statement that focuses on the patient's feelings.

Use Multiple Test-Taking Techniques

You have just been introduced to a variety of test-taking techniques. As you practice applying each of these techniques to test items, you will become more skillful at being test wise. As you become better at applying test-taking techniques, you can further maximize success in choosing the correct option if you use more than one test-taking technique within an item.

SAMPLE ITEM 7-36

A patient's plan of care indicates that active range-of-motion (AROM) exercises of the right leg are to be done every 4 hours while the patient is awake. Which should the nurse do?

1. Explain that all patients do AROM exercises by themselves.
2. Take the patient to physical therapy for the AROM exercises.
3. Move the patient's leg through AROM exercises as ordered.
4. Demonstrate for the patient how to perform AROM exercises.

Continued

Option 1 includes the specific determiner *all* and should be carefully evaluated. Some patients are able to perform AROM exercises themselves and others require assistance. Because some patients cannot totally perform AROM exercises independently, there are exceptions to the statement in option 1. This option can be deleted from consideration by using the technique *Identify Specific Determiners in Options*. Option 2 transfers the responsibility for care that the nurse is educated and licensed to provide. This option can be eliminated from consideration by using the technique *Identify Options That Deny Patient Feelings, Concerns, or Needs*. By using two test-taking techniques, you have eliminated options 1 and 2, reduced the number of options to two, and increased your chances of selecting the correct answer to 50%.

SAMPLE ITEM 7-37

Which patient responses are unexpected in response to the general adaptation syndrome?

1. Dilated pupils and bradycardia
2. Mental alertness and tachycardia
3. Increased blood glucose level and tachycardia
4. Decreased blood glucose level and bradycardia

By carefully reading the stem, you should identify that the word *unexpected* is a significant word in this item. You have just used the test-taking technique *Identify the Word in the Stem That Indicates Negative Polarity*. If you know that tachycardia is associated with the general adaptation syndrome, you can eliminate options 2 and 3. This reasoning uses the test-taking technique *Identify Duplicate Facts Among Options*. If you identify that options 3 and 4 are opposites, you should give these options particular consideration. By seriously considering these options, you are using the test-taking technique *Identify Opposites in Options*. A variety of test-taking techniques can be applied to analyze and answer this item.

SAMPLE ITEM 7-38

Which patient need is being met when the nurse administers a back rub to reduce the physical discomfort of a backache?

1. Safety
2. Security
3. Self-esteem
4. Physiological

By thoughtfully reading the stem, you should identify that the important words are “reduce the physical discomfort of a backache.” When reviewing the options, you should recognize that the word “physiological” in option 4 is closely related to the word “physical” in the stem. Option 4 should be given serious consideration. This reasoning uses the test-taking technique *Identify Key Words in the Stem That Direct Attention to Content*. Options 1 and 2 present the words “safety” and “security.” They are comparable, and choosing between them is difficult. They are distractors. This reasoning uses the test-taking technique *Identify Equally Plausible Options*. Options 1, 2, and 3 all begin with the letter “S” whereas option 4 begins with the letter “P.” Option 4 is different from the others and should be considered carefully because it may be the correct answer. You have just used the test-taking technique *Identify the Unique Option*. The use of multiple test-taking techniques in considering an item can facilitate the deletion of distractors and the selection of the correct answer.

GENERAL TEST-TAKING TECHNIQUES

A general test-taking technique is a strategy that is used to conquer the challenge of an examination. To be in command of the situation, you must be able to manage your internal and external domains. The test taker who approaches a test with physical, mental, and emotional authority is in a position to regulate the testing situation, rather than to have the testing situation dominate.

Follow Your Regular Routine the Night Before a Test

Follow your usual routine the night before a test. This is not the time to make changes that may disrupt your balance. If you do not normally eat pepperoni pizza, exercise, or study until 2 a.m., do not start now. Go to bed at your usual time. Avoid the temptation to have an all-night cram session. Studies have demonstrated that sleep deprivation decreases reaction times and cognitive skills. An adequate night's sleep is necessary to produce a rested mind and body that provide the physical and emotional energy required to maximize performance on an examination.

Arrive Early for the Examination

Plan your schedule so that you arrive at the testing site 15 to 30 minutes early. Arrange extra time for unexpected events associated with traveling. There may be a traffic jam, a road may have a detour, the car may not start, the train may be late, the bus may break down, or you may have to park in the farthest lot from the testing site. If the location of the testing site or classroom is unfamiliar to you, it is wise to take a practice run at the same time of day of the scheduled test and locate the room. On the day of the examination, this should help you avoid getting lost or being late.

By arriving early, you have an opportunity to visit the rest room, survey the environment, and collect your thoughts. Because anxiety is associated with an autonomic nervous system response, you may have urgency, frequency, or increased intestinal peristalsis. Visit the rest room before the test to avoid using testing time to meet physical needs. The test may or may not be administered in the room in which the content is taught. Arriving early allows you to become more comfortable in the testing environment. Decide where you want to sit if seats are not assigned. Students have preferences such as sitting by a window, being in the back of the room, or surrounding themselves with friends. Selecting your own seat allows you to manipulate one aspect of your environment. In addition, this time before the test provides you with an opportunity to collect your thoughts. You may desire to review content on a flash card, perform relaxation exercises, or reinforce your positive mental attitude. However, avoid comparing notes with other students. They may have inaccurate information or be anxious. Remember, anxiety is contagious. If you are the type who is affected by the anxiety of other people, avoid these people until after the test.

Bring the Appropriate Tools

To perform a task, you need adequate tools. A pen may be required to complete the identifying information on a form or answer sheet. A pencil usually is necessary to record your answers on the answer sheet if it is a paper and pencil test that uses a computer answer form. Use number 2 pencils because they have soft lead that facilitates the computer scoring of the answer sheet. Bring at least two pens and two or more pencils. Backup equipment is advisable because ink can run out and points can break. Have at least one eraser. You may decide to change an answer or need to erase extraneous marks that you make on the question book or the answer sheet. A watch also is a necessary tool if permitted when a clock is not available in the room. Depending on your individual needs, other tools might include eyeglasses or a hearing aid. If you are taking the test using a computer students often are not permitted to bring anything into the testing environment. All electronic devices including

watches and calculators must be left outside the room. A clock and calculator may be accessed on the computer when desired. Assemble all your equipment the night before the test, and be sure to take them with you to the testing site.

Understand All the Directions for the Test Before Starting

It is essential to understand the instructions before beginning the test. On some tests you are responsible for independently reading the instructions, whereas on others the proctor verbally announces the instructions. However, more often than not you will have a written copy of the instructions while the proctor reads them aloud. In this instance, do not read ahead of the proctor. The proctor may elaborate on the written instructions, and you do not want to miss any additional directions. If you do not understand a particular part of the instructions, immediately request that the proctor explain them again. You must completely understand the instructions before beginning the examination.

Manage the Allotted Time to Your Advantage

All tests have a time limit. Some tests have severe time restrictions in which most test takers do not complete all the questions on the examination. These are known as “speed tests.” Other tests have a generous time frame in which the majority of test takers have ample time to answer every question on the examination. These are known as “power tests.” The purpose of tests in nursing is to identify how much information the test taker possesses about the nursing care of people. Most nursing examinations are power tests. Regardless of the type of test, you must use your time well.

To manage your time on an examination, you must determine how much time you have to answer each item, leaving some time for review at the end of the testing period if permitted. To figure out how much time you should allot for each item, divide the total time you have for the test by the number of items on the test. For example, if you have 90 minutes to take a test that has 50 items, divide 90 by 50. This allots 1 minute and 48 seconds for each item. If you actually allot 1½ minutes per item, you will leave 15 minutes for a final review. Be aware of the time as you progress through a test. If you determine that you have approximately 1½ minutes for each question, by the time you have completed 10 items, 15 minutes should have passed. Pace yourself so that you do not spend more than 1½ minutes on an item if possible. If you answer an item in less than 1½ minutes, you can use the extra time for another item that may take slightly longer than 1½ minutes or add this time to the end for review. The allocation of time for test completion depends on the complexity of the content, the difficulty of the reading level, and the number of options presented in the items.

Read each item slowly and carefully including all the options presented. It may be necessary to read the question twice. If you process items too quickly, you may overlook important words, become careless, or arrive at impulsive conclusions. If you find that you are spending too much time, you may want to immediately eliminate obvious distractors and not belabor them. Then only work with the remaining viable options. In addition, you want to avoid getting bogged down on a difficult question because you can lose valuable time, become flustered, and lose focus and concentration when upset. Clearly indicate the question so that you can return to it later if permitted. Move on; this puts you back in control! Some computerized tests do not allow you to review past items. In this situation a question must be answered before the next question is presented. Answer the question to the best of your ability and then move on. Work at your own pace. Do not be influenced by the actions of other test takers. If other test takers complete the examination early, ignore them and do not become concerned. Just because they finish early does not indicate that they will score well on the test. They may be imprudent speed demons. A cautious, discriminating, and judicious approach is to your advantage. Be your own person and remember that time can be your friend rather than your enemy.

Time allocation varies for tests taken on a computer. See Chapter 9, Computer Applications in Education and Evaluation, for more information.

Concentrate on the Simple Before the Complex

Answer the easy questions before the difficult questions. This uses the basic teaching/learning principle of moving from the simple to the complex. By doing this, you can maximize your use of time and maintain a positive mental attitude. Begin answering questions. When you are confronted with a difficult item, have already used your allotted time to answer it, and still do not know the answer, then skip over this item and move on to the next one. Make a notation on scrap paper, next to the item in the question booklet, next to the number of the skipped item on the answer sheet or in the appropriate location on a computer administered examination so that you can return to this item later in the test if permitted. When you reach the end of the test, return to those items that you saved for the end. You should have time to spend on these items, and you may have accessed information from other items that can assist you in answering these questions. Concentrating on the simple before the complex permits you to answer the maximum number of items in the time allocated for the examination.

On computer-administered examinations this strategy may not be applicable. You may be required to enter an answer before the next item will appear on the screen.

Avoid Reading Into the Question

A nursing question has two parts. The first part is known as the stem. The stem is the statement that asks a question. The second part contains the possible responses, which are called options. The stem of a question also has two parts. One part presents information about a clinical event, topic, concept, or theory. The other part asks you to respond in some way. The response part asks you to choose the best option that answers the question based on the information presented in the stem. The information presented in the stem needs to be separated in your mind from the response part of the stem. In some questions the information and response parts of the question are very clear. Other questions are presented in a manner that is less clear about which is the information part and which is the response part.

The following questions illustrate the difference between the information and the response parts of the stem. In each example, the information part of the stem is boldfaced and the response part is italicized.

While walking, a patient becomes weak and the patient's knees begin to buckle. *What should the nurse do?*

Which is an example of a patient goal?

Before administering medication for pain, *what should the nurse do first?*

Questions generally are designed to test common principles and concepts. Therefore it is important that you avoid overanalyzing the facts in the question. In an attempt to achieve this goal, consider the following suggestions.

When reading the stem:

- Identify the important words.
- Do not add information from your own mind.
- Do not make assumptions (read between the lines) about the information presented in the stem.

When reading the options:

- Read all the options before choosing the correct answer.
- Refer back only to the words that you identified as being important in the stem.
- Do not add information to an option.

- Relate an option to just what is being asked in the response part of the stem.
- Focus on commonalities, principles, and concepts associated with your level of learning that is being tested.
- Do not focus only on your experiences, which may be too narrow for a point of reference.
- Recognize that an option can contain correct information but it may or may not have anything to do with the information and response parts of the stem.

When reading options, it is important that you read all the options before selecting the correct answer. This may sound like a ridiculous suggestion; however, we found that students often selected options 1, 2, or 3 over option 4. We tested this theory by placing the correct answer as option 1 and then placing it as option 4 on a different examination. When the correct answer was 4 instead of 1, fewer students selected the correct option. When we asked students who got the question wrong when the correct answer was option 4, did they examine option 4, the students admitted that they did not read all the options.

Most students find it helpful when they can separate the information part of the question from the response part of the question. By incorporating these suggestions, you should have a better ability to identify what information is in the scenario and what you are being asked to do. As a result, your chances of answering the question correctly, without reading into the question, should increase.

Make Educated Guesses

An educated guess is the selection of an option based on partial knowledge, without knowing for certain that it is the correct answer. When you have reduced the final selection to two options, usually it is to your advantage to reassess these options in the context of the knowledge you do possess and make an educated guess. Making a wild guess by flipping a coin or choosing your favorite number should depend on whether the test has a penalty for guessing.

Some examinations assign credit when you answer a question correctly and do not assign credit when you answer a question incorrectly. The directions for these examinations may state that only correct answers will receive credit, that you should answer every question, that you should not leave any blanks, or that there are no penalties for guessing. In these tests it is to your advantage to answer every question. First, select answers based on knowledge. If you are unsure of the correct answer, reduce the number of options and then make an educated guess. If you have absolutely no idea what the answer can be, then make a wild guess because you will not be penalized for a wrong answer.

Some tests assign credit when you answer a question correctly and subtract credit when you answer a question incorrectly. The instructions for these examinations may inform you not to guess, that credit will be subtracted for incorrect answers, or that there is a penalty for guessing. In these tests a statistical manipulation is performed to mathematically limit the advantage of guessing. When taking these tests, it is still to your advantage to make an educated guess if through knowledge you can reduce your final selection to two options. However, wild guessing is not to your advantage because your chance of selecting the correct answer is only 25%.

Maintain a Positive Mental Attitude

It is important that you foster a positive mental attitude and a sense of relaxation. A little apprehension can be motivating, but too much can interfere with your attention, concentration, and problem-solving ability. Use the positive techniques you have practiced and that work for you to enhance relaxation and a positive mental attitude. For example, feel in control by skipping the difficult questions; enhance relaxation by employing diaphragmatic breathing for several deep breaths, rotating your shoulders, or flexing and extending your head; foster a positive mental attitude by telling yourself, "I am prepared to do this well!" or "I know I have studied hard and I will be successful!"

Check Your Answers and Answer Sheet

It is important to record your answers accurately, particularly when using a computer scoring sheet. Paper and pencil computer-scored tests usually use separate answer sheets in which each item has numbers or letters that represent the corresponding responses to each item in the test. You do not want to lose points because you placed your answer in the wrong row. You need to verify the number of the question with the number on the answer sheet at least two times when recording your answer. You should conscientiously do this every time you record an answer.

At the end of the examination, again review your answer sheet for accuracy. Make sure that every mark is within the lines, heavy and full, and in the appropriate space. Erase any extraneous marks on the answer sheet. Additional pencil marks, inadequately erased answers, and marks outside the lines will confuse the computer and alter your score. Also, make sure that you have answered every question, especially on tests that do not penalize for guessing. An effective and thorough review should leave you with a feeling of control and a sense of closure at the end of the examination.

If you take an examination on a computer you may be able to select or change an answer before submitting your final choice. Double-check your selected response before hitting the key that finalizes your answer.

ANSWERS AND RATIONALES FOR SAMPLE ITEMS IN CHAPTER 7

7-1 1. Linens cannot be returned to a linen storage area once they are removed because they are exposed to microorganisms in the hallways and/or patient rooms.

2. Used linens may be contaminated with body secretions; wearing gloves is part of standard precautions.
3. Tucking clean linen against the frame of the bed is an acceptable practice; the entire bed is washed with a disinfectant between patients.
4. Reusing a top sheet for the bottom sheet is an acceptable practice if the sheet is not wet or soiled.

7-2 1. Stewed fruit is low in sodium.

2. Luncheon meats generally are processed with large amounts of sodium.

3. Whole-grain cereal is low in sodium.
4. Green, leafy vegetables are low in sodium.

7-3 1. Applying pressure over the vertebrae should be avoided because it can cause unnecessary pressure over bony prominences; back rub strokes should massage muscle groups, not vertebrae.

2. Using continuous, firm strokes is soothing and relieves muscle tension; this action is based on the gate-control theory of pain relief.
3. Excess lotion can be an irritant to the skin and should be removed.
4. Kneading the skin increases circulation and should be part of a back rub unless contraindicated.

7-4 1. Collecting equipment is not done first because each type of enema has different equipment requirements.

2. The order should be verified first. It is essential that the specific type of enema ordered be given; enemas have different solutions, volumes, and purposes.

3. Informing the patient about the procedure is not done first because the nurse's explanation depends on the type of enema being administered.
4. Arranging for an empty bathroom should be done after the equipment and patient are prepared and ready.

7-5 1. This statement is a demeaning response and does not answer the patient's question.

2. This statement denies the patient's concern and does not answer the question.
3. Not responding may make the patient more upset; the patient has a right to know who is providing care.

4. This statement answers the question, which meets the patient's right to know; also, it is a respectful response.

7-6 1. The patient should be turned and positioned every 1 to 2 hours to help expose the cast to air, which facilitates even drying of the cast. Also, frequent changes of position will help minimize venous stasis, which may contribute to deep vein thrombosis, as well as relieve pressure, which can contribute to skin breakdown.

2. Distal, not proximal, pulses should be taken to ensure that circulation is not compromised by the pressure of the cast.
3. Although it is important to cover rough edges of the cast with tape, these interventions are not the priority.
4. Bleeding may occur with a compound fracture. Drawing a ring around the drainage on the cast and adding the date, time, and initials helps to establish the degree of bleeding or discharge over time.

7-7 1. Maintaining functional alignment supports a basic physiological need; this reduces physical strain and potential injury to joints, muscles, ligaments, and tendons and can prevent the formation of contractures.

2. Pulling the curtain supports the patient's need for self-esteem; it provides privacy.
3. Responding to the call light immediately supports the patient's need for security and safety; patients should know that help is available immediately when needed.
4. Raising both side rails on the bed supports the patient's need for safety and security; bed rails prevent a patient from falling out of bed.

7-8 1. Self-care encourages a patient's independence, which increases self-esteem.

2. Family member visits generally meet the patient's need for love and belonging, not self-esteem.
3. When a person is dependent on another, such dependency often lowers self-esteem.
4. Providing a complete bath promotes dependency; the patient should be as independent as possible.

- 7-9** 1. Pulling a curtain when providing care supports the patient's self-esteem needs.
2. Answering a call bell immediately meets the patient's safety needs.

3. Administering hygiene meets a patient's basic physiological need to be clean.

4. Vital signs are not a physiological need of the patient. They are an assessment done by the nurse to determine the patient's needs.

7-10 1. This response directly involves the patient and invites the patient to relive a past vacation.

2. This response focuses on the nurse rather than the patient.
3. This response focuses on the nurse's vacation rather than focusing on the patient.
4. This question by the nurse asks for an opinion, which can be answered with a short response.

- 7-11** 1. Speaking with the husband might be done later. It is not the initial action.
2. Eventually the husband also will need support after the patient's needs are met first. This intervention avoids the husband's needs.

3. The fact that the patient raised the issues about her husband indicates that she is concerned about his behavior. Her feelings need to be explored and her self-esteem supported.

4. Making an appointment with Reach to Recovery is not the initial intervention. This may be done eventually after the patient's initial needs are met.

7-12 1. Exploring the situation provides the daughter with an opportunity to verbalize her feelings with regard to her mother's behavior. All behavior has meaning, and talking about the situation may provide insight. Eventually, the situation should be explored with the patient and the daughter together.

2. Encouraging the patient to be more positive denies the patient's feelings and ignores the daughter's feelings; both cut off communication.
3. This information may further upset the daughter and may precipitate feelings such as guilt or anger.
4. The nurse has a responsibility to intervene.

7-13 1. This statement focuses on the patient's feelings by the use of reflection.

2. This statement denies the patient's feelings.
3. This statement is an assumption and offers false reassurance.
4. The nurse cannot predict that the patient will feel better. This response offers false reassurance.

7-14 1. Although this may eventually be done, it does not promote independence; also, it may violate the patient's privacy if the patient's questions are personal.

2. Reminding the patient of the primary health-care provider's next visit does not address the patient's concern; the patient forgets the questions to be asked, not when the primary health-care provider will visit.

3. Providing a paper and pen to write down questions promotes independence, self-esteem, and privacy.

4. This may foster feelings of dependence and may violate the patient's privacy if the questions to be asked are personal.

- 7-15** 1. Moistening the hair may be done after obtaining the patient's permission.
2. Applying a hair conditioner may be done if desired by the patient. A procedure should be explained and the patient's consent obtained before beginning a procedure.
 3. Initially short strokes, beginning at the ends and progressively moving toward the roots as tangles are removed, should be used to comb/brush the hair.

4. Seeking preferences promotes individualized care by allowing personal choices.

- 7-16** 1. This intervention is not patient centered. This intervention focuses on the nurse's perspective, not the patient's perspective.
2. Although this may eventually be done if desired by the patient, it is not the primary intervention.

3. This intervention is patient centered. Asking the patient to share more encourages verbalization of feelings.

4. The nurse may eventually do this if the patient expresses an interest in reading a book about cats.

7-17 1. Pressure and friction produce local heat, which dilates blood vessels, improving circulation.

2. Hot water can damage delicate tissue and should be avoided; bath water should be between 110°F and 115°F.
3. Keeping the patient covered prevents chilling.
4. Soap lowers the surface tension of water, which promotes cleaning.

7-18 1. Hand hygiene before care protects the patient from the nurse.

2. The nurse is still exposed to body secretions if not wearing gloves when discarding contaminated water.

3. Gloves are a barrier against body secretions and are used with standard precautions.

4. Expecting patients to provide all of their own care is unreasonable and inappropriate; some patients require assistance with meeting their needs.

7-19 1. Straps and a mask that are firm against the skin can cause tissue trauma.

2. Changing the method of oxygen delivery requires a primary health-care provider's order.

3. Padding the straps with gauze without adjusting the straps will make the mask tighter against the face.

4. Loosening the elastic straps will reduce the pressure of the mask against the face; the elastic straps can be adjusted for comfort while keeping the edges of the mask gently against the skin.

7-20 1. Aging is progressive and does not move backward.

2. Aging, from conception to death, advances and moves onward.

3. Although this may be true for some older adults, it is not true for all.

4. Although this may be true for some older adults, it should not be generalized to the entire population of older adults.

7-21 1. Dependent edema is minimal while the feet are still elevated; anti-embolism stockings should be applied before the legs are moved to a dependent position.

2. The purpose of anti-embolism stockings is to promote venous return, not reduce pain.
3. This will cause tissue trauma because of the presence of fluid in the interstitial compartment; anti-embolism stockings are applied to prevent, not treat, edema.
4. Fluid will accumulate in an extremity when dependent in patients with peripheral vascular disease or congestive heart failure. The application of anti-embolism stockings when there is fluid in the interstitial compartment will cause tissue trauma.

7-22 1. Side rails do not provide a stable base of support. Injury can occur if the rails are lowered before the straps are removed.

2. Tying a restraint to the footboard requires an excessively long strap in which the patient's legs may get entangled.

3. The bed frame is a stable base of support and is beyond the patient's reach.

4. Tying a restraint to the headboard may result in an uncomfortable line of pull with the arm above the head.

7-23 1. A solution is hypertonic when the electrolyte content is more than the electrolyte content of body fluid.

2. A solution is hypotonic when the electrolyte content is less than the electrolyte content of body fluid.

3. Acidotic refers to excessive levels of hydrogen ions in the blood affecting pH values. This term is not related to intravenous fluids.

4. A solution is isotonic when the electrolyte content is approximately equal to the electrolyte content of body fluids. Normal saline (0.9% sodium chloride) is isotonic.

7-24 1. Serving adequate food meets basic physiological needs, not safety and security needs.

2. Providing sufficient fluid meets basic physiological needs, not safety and security needs.

3. Being able to summon help when needed provides a sense of security and physical safety for the patient.

4. The bedside table is not a secure place to store valuables.

7-25 1. Placing the patient in the prone position exposes the entire area to permit a thorough back rub; it does not promote circulation.

2. Moisturizing creams hold moisture within the skin, making it more supple; they do not promote circulation.
 3. Keri lotion is a moisturizing lotion that helps make skin more supple. Keri lotion does not promote circulation,
 4. **Kneading causes friction and pressure against the skin that promotes localized heat, which precipitates vessel dilation, improving circulation.**
- 7-26**
1. Active range-of-motion (AROM), not passive range-of-motion (PROM), exercises can increase endurance.
 2. **PROM exercises prevent shortening of muscles, ligaments, and tendons, which causes joints to become fixed in one position, limiting mobility.**
 3. Active, not passive, range-of-motion exercises can strengthen muscle tone.
 4. Maximizing muscle atrophy will never be a patient goal. Atrophy is the loss of muscle mass because of lack of muscle contraction. AROM exercises will minimize, not maximize, muscle atrophy.
- 7-27**
1. Shutting the door provides privacy and prevents drafts, but it may contaminate the nurse's hands.
 2. **Between patients and before and after providing care the nurse must wash the hands to remove dirt and microorganisms; otherwise, equipment and the patient will be affected by cross-contamination. Medical asepsis is a priority. Hand washing is also known as hand hygiene.**
 3. Closing the curtain should occur before washing the hands; curtains are considered contaminated.
 4. Draping the patient provides for privacy and prevents chilling, but if the nurse's hands are not clean they will contaminate the linen and the patient.
- 7-28**
1. Antibiotics are administered to treat patients with infections, not all sick patients.
 2. **This is a broad statement that incorporates under its mantle many different actions that may be implemented to prevent the spread of microorganisms.**
 3. Isolating a resident is not necessary unless the resident has a communicable disease; implementing standard precautions is sufficient.
 4. Keeping all unit doors closed is unnecessary; this action is not part of standard precautions. Closing the door is part of airborne precautions.
- 7-29**
1. This is not required for all positions. The arms are supported when a patient is placed in a lateral or a Sims position.
 2. **Functional alignment refers to maintaining the body in an anatomical position that supports physical functioning, minimizes strain and stress on muscles, tendons, ligaments, and joints, and prevents contractures.**
 3. This is not required for all positions. External rotation of the hips is prevented when a patient is in the supine (dorsal recumbent) position.
 4. This is not required for all positions. A pillow is placed under the lumbar curvature when a patient is in the low-Fowler or supine (dorsal recumbent) positions.
- 7-30**
1. Both actions may injure the patient. The patient may fall out of bed on the side opposite the nurse, and moving a restrained patient exerts stress on the patient's musculoskeletal system.
 2. Although one side rail can be lowered, moving a restrained patient may injure the patient.
 3. Although the vest restraint can be untied while the nurse is at the bedside, lowering the rail on the side opposite to which the nurse is working may result in the patient falling out of bed.
 4. **Untying a restraint permits free movement, which limits stress on the patient's musculoskeletal system. Lowering one side rail allows the nurse to provide direct care. Keeping the side rail raised on the side opposite to which the nurse is working provides a barrier to prevent the patient from falling out of bed.**
- 7-31**
1. These foods—fruits, vegetables, and bread—contain the least amount of sodium compared with the foods listed in the other options.
 2. Hot dogs, mustard, and pickles all contain a high level of sodium and should be avoided.
 3. Ketchup is high in sodium and should be avoided.

4. Luncheon meats are processed foods that contain a high level of sodium and should be avoided.

- 7-32**
1. With hemorrhage, the patient's skin will be cold and clammy, not warm and dry, and the pulse will be weak and thready, not bounding. Hypotension is associated with hemorrhage because of hypovolemia.
 2. Because of the reduced blood volume associated with hemorrhage, the patient's blood pressure will decrease, not increase, and the pulse will be weak and thready, not bounding. Cold, clammy skin is associated with hemorrhage because of peripheral vasoconstriction.
 3. With hemorrhage, the patient's blood pressure will decrease, not increase, and the skin will be cold and clammy, not warm and dry. A weak, thready pulse is associated with hemorrhage because of hypovolemia.
 4. **Because of the decreased blood volume associated with hemorrhage, the blood pressure will be reduced and the pulse will be weak and thready; because of the autonomic nervous system response and the constriction of peripheral blood vessels, the patient's skin will be cold and clammy.**

- 7-33**
1. This statement denies the patient's feelings about death and cuts off further communication.
 2. **This statement uses reflective technique because it focuses on the underlying feeling expressed in the patient's statement.**
 3. This statement abdicates the responsibility of the nurse (to explore the patient's feelings) to the surgeon; it cuts off communication and does not meet the patient's immediate need to discuss fears of death; eventually the surgeon should be notified of the patient's feelings.
 4. This statement minimizes the patient's concern about dying; it cuts off communication.

- 7-34**
1. Although this is true for most patients, it may not be true for this patient. This is a Pollyanna-like response that may provide false reassurance.
 2. Although this is a true statement, it cuts off communication and does not present an intervention to help limit the patient's present discomfort.

3. **This response recognizes the mild pain and offers the patient an intervention to help limit the temporary discomfort.**

4. This response is inappropriate at this time. If more than mild pain is expected, analgesics should be administered before pain-inducing activities.

- 7-35**
1. **This response identifies the patient's concern and offers an opportunity to further discuss the topic.**

2. This is a Pollyanna-like response that provides false reassurance; the patient may never be able to brush her own hair.
3. This response offers a solution before allowing the patient to discuss concerns, thereby cutting off communication.
4. After the patient's present feelings are explored, then pointing out the patient's abilities is appropriate.

- 7-36**
1. Some patients are not capable of performing AROM exercises, depending on the strength of the affected and unaffected extremities and their physical, mental, and/or emotional status.
 2. Taking the patient to physical therapy every 4 hours is unrealistic and transfers the nurse's responsibility to another member of the health team.
 3. **AROM exercises should be performed by the patient. Passive range-of-motion exercises should be performed by a nurse.**
 4. **Assisting patients with mobility issues is within the scope of nursing practice.**

- 7-37**
1. Tachycardia, not bradycardia, is associated with the general adaptation syndrome; dilated pupils are expected.
 2. Both mental alertness and tachycardia are expected autonomic nervous system responses that occur during the alarm stage of the general adaptation syndrome. These are part of the "fight or flight" mechanism.
 3. Both increased blood glucose level and tachycardia are expected autonomic nervous system responses that occur during the alarm stage of the general adaptation syndrome. These are part of the "fight or flight" mechanism.
 4. **During the alarm stage of the general adaptation syndrome, both the blood glucose level and heart rate of the patient increase not decrease.**

- 7-38**
1. Safety and security needs, the second level of needs according to Maslow, are met when the patient is protected from harm.
 2. Security needs are related to safety needs, the second level of needs according to Maslow. A patient will feel protected and safe when safety and security needs are met.
 3. Self-esteem needs, a third-level need, are met when the patient is treated with dignity and respect.
 - 4. Being free from pain or discomfort is a basic physiological need; a back rub improves local circulation, reduces muscle tension, and limits pain.**