Student Success Day 09-28-2022

Test-Taking Strategies 3.0

NIK Z., PROFESSOR OF NURSING SCIENCE & A NURSE PRACTITIONER.

PERSONAL PRONOUNS: HE/HIM/THEY/THEM

Commercial disclosures:

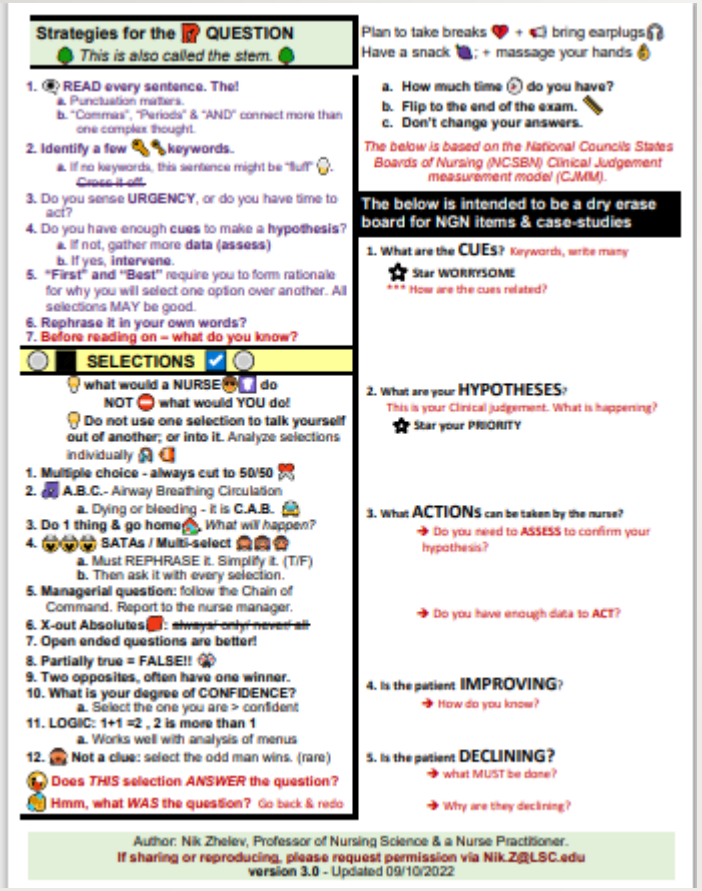
- I HAVE NO COMMERCIAL DISCLOSURES

Learning Objectives

1. The participants will be able to list “**good**” and “**bad**” test preparation practices and identify “good” and “bad” practices in which they engage.
2. The participants will be able to **distinguish** strategies used in the **stem**/question and strategies that are used in the **selections**/options.
3. The participants will identify **3-6 stages of clinical judgement formation** in correspondence with the National Consil States’ Boards of Nursing Clinical Judgement Measurement model.
4. The participants will leave with session with **increased confidence** in their test-taking strategies and abilities.
5. The participants may **attempt use of laminated test-taking strategies** sheet with use of a dry erase marker on their own time.

1 Min

Do you want the main handout?



Strategies for the QUESTION
This is also called the stem.

1. READ every sentence. The!
   a. Punctuation matters.
   b. "Commas", "Periods" & "AND" connect more than one complex thought.
2. Identify a few keywords.
   a. If no keywords, this sentence might be "fluff". ~~Cross it off.~~
3. Do you sense URGENCY, or do you have time to act?
4. Do you have enough cues to make a hypothesis?
   a. If not, gather more data (assess)
   b. If yes, intervene.
5. "First" and "Best" require you to form rationale for why you will select one option over another. All selections MAY be good.
6. Rephrase it in your own words?
7. Before reading on – what do you know?

SELECTIONS

what would a NURSE do
NOT what would YOU do!

Do not use one selection to talk yourself out of another; or into it. Analyze selections individually

1. Multiple choice - always cut to 50/50
2. A.B.C.- Airway Breathing Circulation
   a. Dying or bleeding - it is C.A.B.
3. Do 1 thing & go home. *What will happen?*
4. SATAs / Multi-select
   a. Must REPHRASE it. Simplify it. (T/F)
   b. Then ask it with every selection.
5. Managerial question: follow the Chain of Command. Report to the nurse manager.
6. X-out Absolutes: ~~always~~ ~~only~~ ~~never~~ ~~all~~
7. Open ended questions are better!
8. Partially true = FALSE!!
9. Two opposites, often have one winner.
10. What is your degree of CONFIDENCE?
    a. Select the one you are > confident
11. LOGIC: 1+1 =2 , 2 is more than 1
    a. Works well with analysis of menus
12. Not a clue: select the odd man wins. (rare)

Does *THIS* selection *ANSWER* the question?
Hmm, what *WAS* the question? Go back & redo

Plan to take breaks + bring earplugs
Have a snack ; + massage your hands

a. How much time do you have?
b. Flip to the end of the exam.
c. Don't change your answers.

The below is based on the National Councils States Boards of Nursing (NCSBN) Clinical Judgement measurement model (CJMM).

The below is intended to be a dry erase board for NGN items & case-studies

1. What are the CUEs? Keywords, write many
   Star WORRYSOME
   *** How are the cues related?
2. What are your HYPOTHESES?
   This is your Clinical judgement. What is happening?
   Star your PRIORITY
3. What ACTIONS can be taken by the nurse?
   → Do you need to ASSESS to confirm your hypothesis?
   → Do you have enough data to ACT?
4. Is the patient IMPROVING?
   → How do you know?
5. Is the patient DECLINING?
   → what MUST be done?
   → Why are they declining?

Author: Nik Zhelev, Professor of Nursing Science & a Nurse Practitioner.
If sharing or reproducing, please request permission via Nik.Z@LSC.edu
version 3.0 - Updated 09/10/2022

GOOD Test Taking Practices General

- Studying before the test (read, listen, write, rehearse)
- Utilizing **Positive** Self-talk during the test
- Answering each question and moving on
- Knowing the length of the exam (time and # of questions)
- Taking a mental break during an exam
- Getting a good night of sleep before a test
- Having a snack before or during an exam
- Acknowledging the Test is your *choice* not a MUST
- Positioning self in the room to avoid distractions
- Acknowledging you needs: Ear plugs, snack, Nicorrette gum.
- Taking it one question at a time

5 Min

BAD Test Taking Practices

General

- Not studying before the test
- Cramming before the test
- Not sleeping before the test
- Not eating before the test
- Not answering every question *"I'll come back to it"*
- Thinking that there is such a thing as a *PERFECT* score
- Negative Self-talk during the test
- Not caring where you sit in the room
- Looking ahead on the test (and answering sporadically)
- Not being on time or early for the test

3 Min

Components of Test Questions

Stem or Question: What is the PROBLEM

- Clear Problem:
  - generally test *knowledge or understating*
- Unclear Problem:
  - test students' ability to draw inferences from vague descriptions

Alternatives or Answers: What are the solutions

- Distractors- incorrect alternatives
- Correct Alternative: ***the solution to the problem***

1 Min

Have you wondered how are your test questions written?

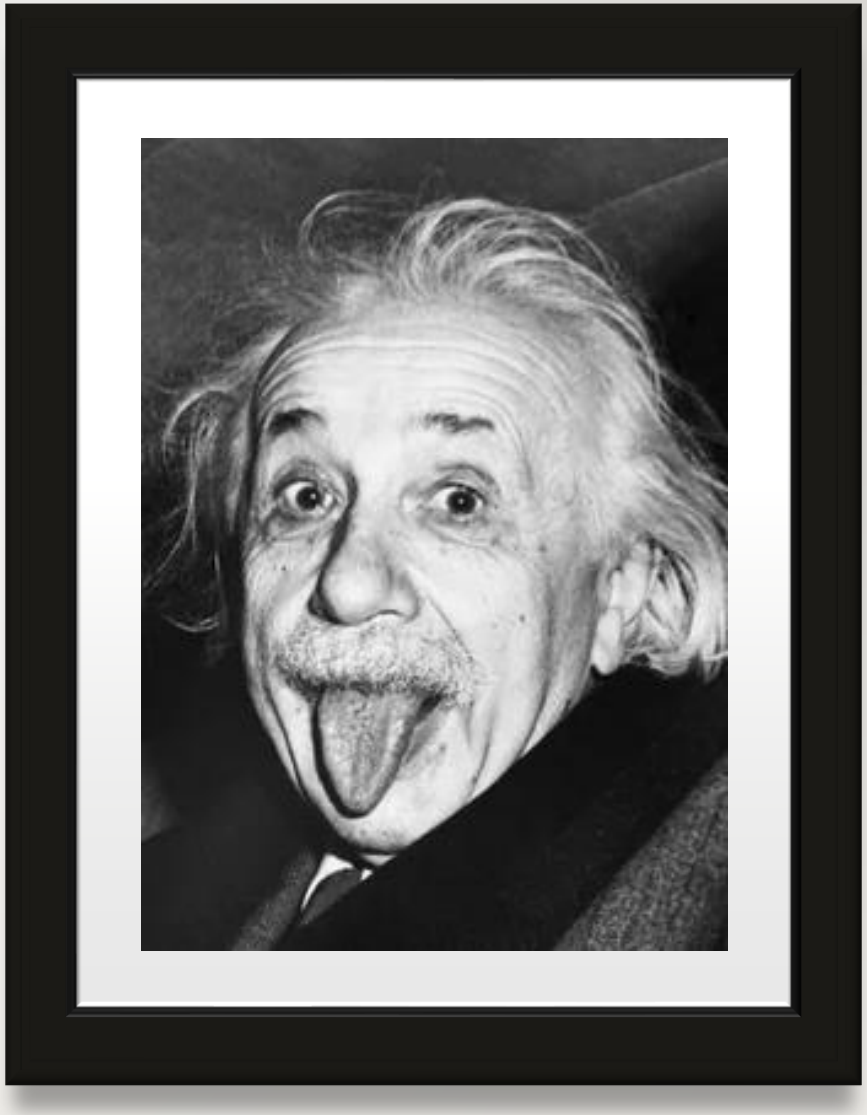
There are two types of NCLEX items

1. **Low level items** – they are below passing level on the NCLEX-RN
   Require Knowledge or Understanding

2. **High level items-** they are AT or ABOVE passing level on the NCLEX-RN
   Requires to apply/ evaluate / analyze data to form a clinical judgement

2 Min

On high level items
Consistent use of strategies is KEY



Strategies do NOT help you if you DO NOT KNOW THE MATERIAL

1 Min

“Insanity is doing the same thing over and over and expecting different results.”

usually attributed to Albert Einstein.

> *My general observation is that students who are not successful in nursing school in regards to aptitude (not life issues) make no attempt to review their exam, or meet with me. This is passive way of learning and it does NOT allow for evaluation of own practices. Thus students make the same thing over and over.*

1 Min

Thus, evaluate what needs to improve, change, or stay the same…

Review your exams/quizzes &
Evaluate what needs to:

1. Improve
2. Change
3. Or stay the same
4. How was the self care before and during the exam?
5. How was the studying in relation to the exam?
6. Did you connect with your instructor/professor?

1 Min

OK,
Let’s get started with the 3.0 version

1st Self Care During an Exam

Plan to take breaks  +  bring earplugs 

Have a snack  ; + massage your hands 

a. **How much time**  **do you have?**

b. **Flip to the end of the exam.** 

c. **Don't change your answers.**

1 Min

Strategies for the !? QUESTION

This is also called the stem.

1. **READ every sentence. The!**
   - **a.** Punctuation matters.
   - **b.** "Commas", "Periods" & "AND" connect more than one complex thought.
2. **Identify a few keywords.**
   - **a.** If no keywords, this sentence might be "fluff". ~~Cross it off.~~
3. Do you sense **URGENCY**, or do you have time to act?
4. Do you have enough **cues** to make a **hypothesis**?
   - **a.** If not, gather more **data (assess)**
   - **b.** If yes, **intervene**.
5. **"First" and "Best"** require you to form rationale for why you will select one option over another. All selections MAY be good.
6. **Rephrase it in your own words?**
7. **Before reading on – what do you know?**

5 Min

In the last 6 hours, an older adult client has received two and a half units of packed red blood cells (PRBCs). Half way through the transfusion of the third PRBC unit, the nurse notes that the client has distended neck veins while in the sitting position and has crackles upon auscultation.
What is the nurse's priority actions?

a. Slow down the rate of the third unit and update the primary care provider.
b. Check the type of infusing blood with the client's blood type.
c. Stop the infusion STAT and administer a Normal Saline to keep the vein opened.
d. Slow down the infusion rate and administer furosemide 20 mg IV push STAT as per protocol order.

1 Min

6 hours	- quickly
2.5 PRBCs were given	- that's a lot; nurse concern is volume &/or transfusion reactions
NEW JVD + crackles	- new data regarding FVO
priority action?	- the nurse has enough data to act; the nurse does NOT need to assess

The nurse needs to do something to remove the JVD & the crackle!

Also, may need to slow down the rate!

+ this is urgent

When giving lots of blood, client develops NEW FVO symptoms, what is the priority?

1 Min

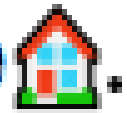
What strategies did I use?

1. **READ every sentence. The!**
   a. Punctuation matters.
   b. "Commas", "Periods" & "AND" connect more than one complex thought.
2. **Identify a few keywords.**
   a. If no keywords, this sentence might be "fluff" .
   ~~Cross it off.~~
3. Do you sense **URGENCY**, or do you have time to act?
4. Do you have enough **cues** to make a **hypothesis**?
   a. If not, gather more **data (assess)**
   b. If yes, **intervene**.
5. **"First" and "Best"** require you to form rationale for why you will select one option over another. All selections MAY be good.
6. **Rephrase it in your own words?**
7. **Before reading on – what do you know?**

1 Min

Looking ahead, what strategies did I use for the options?

a. Slow down the rate of the third unit and update the primary care provider.
   Yes + Yes but it doesn't improve JVD or crackles
b. ~~Check the type of infusing blood with the client's blood type.~~
   Should be done at the start of every unit not midway through
c. ~~Stop the infusion STAT and administer a Normal Saline to keep the vein opened.~~
   The third unit is needed, stopping it goes against order, TKO is for transfusion reaction
d. Slow down the infusion rate and administer furosemide 20 mg IV push STAT as per protocol order.
   Slowing down buys us more time, adheres to order
   + a diuretic will resolve/improve the FVO (crackled & JVD)
   Has 2 good actions.
   I have more rationale on this.
   My confidence is higher with "D" than "A"

1. **Multiple choice - always cut to 50/50** 
2.  **A.B.C.**- Airway Breathing Circulation
    a. Dying or bleeding - it is **C.A.B.** 
3. **Do 1 thing & go home**  . *What will happen?*

The 3 Main Strategies for Multiple Choice (MC)

1 Min

The Last Strategy before MAKING a selection!

Does *THIS* selection *ANSWER* the question?

Hmm, what *WAS* the question? Go back & redo

When giving lots of blood, client develops NEW FVO symptoms, what is the priority?

d. Slow down the infusion rate and administer furosemide 20 mg IV push STAT as per protocol order.

Slowing down buys us more time, adheres to order

+ a diuretic will resolve/improve the FVO (crackled & JVD)

Has 2 good actions.

I have more rationale on this.

My confidence is higher with "D" than "A"

Does *THIS* selection *ANSWER* the question?

SELECTIONS

what would a NURSE do

NOT what would YOU do!

Do not use one selection to talk yourself out of another; or into it. Analyze selections individually

1 Min

Historically, I called this

“No ifs or buts…“

When this is done, it tends to insert NEW meaning, which changes the question.

SELECT ALL THAT APPLY (SATAs)

4. 😱😱😱 **SATAs / Multi-select** 🙈🙉🙊

a. Must REPHRASE it. Simplify it. (T/F)

b. Then ask it with every selection.

⏱ 1 Min

A client has a newly prescribed hydrochlorothiazide (HydroDIURIL) which is administered by mouth. The nurse is preparing discharge instructions.

The client may experience which is the following side effects?

(Select all that apply.)

a. Diarrhea.
b. Dizziness.
c. Polyphagia.
d. Polyuria.
e. Muscle cramps.
f. Hypotension

1 Min

Rephrased into "Yes/No" question & simpler!

Is this a side effect of HCTZ (Diuretic)?

a. Diarrhea.
b. Dizziness.
c. Polyphagia.
d. Polyuria.
e. Muscle cramps.
f. Hypotension

1 Min

Is this a side effect of HCTZ (Diuretic)?

a.	Diarrhea.	No, this works in the kidneys, not GI
b.	Dizziness.	Yes, if they lose too much volume
c.	Polyphagia.	No, this is eating too much
d.	Polyuria.	Yes, this is peeing too much
e.	Muscle cramps.	Yes, this is related to loss of electrolytes
f.	Hypotension	Yes, if fluid loss, this can affect BP

Why dry Erase Board? NCLEX

The below is based on the National Councils States Boards of Nursing (NCSBN) Clinical Judgement measurement model (CJMM).

The below is intended to be a dry erase board for NGN items & case-studies

1 Min

Let’s delve into NGN NCLEX Case Studies And how to think through them!

The below are from https://www.ncsbn.org/public-files/NGN_Spring20_Eng_02.pdf

1 Min

1. What are the **CUEs**? Keywords, write many

☆ Star **WORRYSOME**

*** How are the cues related?

1 Min

The nurse is caring for a 78-year-old female in the Emergency Department (ED).

Nurses' notes

1000:

Client was brought to the ED by her daughter due to increased shortness of breath this morning. The daughter reports that the client has been running a fever for the past few days and has started to cough up greenish colored mucus and to complain of "soreness" throughout her body. The client was recently hospitalized for issues with atrial fibrillation 6 days ago. The client has a history of hypertension. Vital signs: 101.1° F (38.4° C), P 92, RR 22, BP 152/86, pulse oximetry reading 94% on oxygen at 2 L/min via nasal cannula. Upon assessment, the client's breathing appears slightly labored, and course crackles are noted in bilateral lung bases. Skin slightly cool to touch and pale pink in tone, pulse +3 and irregular. Capillary refill is 3 seconds. Client is alert and oriented to person, place, and time. The client's daughter states, "Sometimes it seems like my mother is confused."

Drag the top 4 client findings that would require follow-up to the box on the right.

Client Findings
vital signs
lung sounds
capillary refill
client orientation
radial pulse characteristics
characteristics of the cough

Top 4 Findings

1. What are the **CUEs**? Keywords, write many

 **Star WORRYSOME**

*** How are the cues related?

1 Min

The nurse is caring for a 78-year-old female in the Emergency Department (ED).

Nurses' notes

1000:

Client was brought to the ED by her daughter due to increased shortness of breath this morning. The daughter reports that the client has been running a fever for the past few days and has started to cough up greenish colored mucus and to complain of "soreness" throughout her body. The client was recently hospitalized for issues with atrial fibrillation 6 days ago. The client has a history of hypertension. Vital signs: 101.1° F (38.4° C), P 92, RR 22, BP 152/86, pulse oximetry reading 94% on oxygen at 2 L/min via nasal cannula. Upon assessment, the client's breathing appears slightly labored, and course crackles are noted in bilateral lung bases. Skin slightly cool to touch and pale pink in tone, pulse +3 and irregular. Capillary refill is 3 seconds. Client is alert and oriented to person, place, and time. The client's daughter states, "Sometimes it seems like my mother is confused."

What are the Cues?

1. 78-year-old
2. breathing-labored
3. increased shortness of breath
4. cough up greenish colored mucus
5. Soreness
6. atrial fibrillation 6 days ago + history of HTN.
7. 101.1° F, P 92, RR 22, BP 152/86, 94% on oxygen at 2 L/min via NC
8. course crackles
9. Radial HR is irregular
10. Seems confused

1 Min

Drag the top 4 client findings that would require follow-up to the box on the right.

Client Findings
vital signs
lung sounds
capillary refill
client orientation
radial pulse characteristics
characteristics of the cough

Top 4 Findings
Vital signs
Lung Sounds
Pulse characteristics
Characteristics of cough

1 Min

How are the Cues related?

1. Age + recent hospitalization = increased risk for I.D.
2. New A. fib + irregular HR + resp symptoms = possible Pulm. Emboli
3. Resp symptoms + SOB + greenish mucus + Fever = Pneumonia or viral respiratory infection
4. New A. fib. + history of HTN = increased risk of clotting disorder (such as Stroke, Pulm. Emboli, hearty attack, VTE)
5. Crackles = lead to bacterial I.D. in lungs or heart issue with fluid build up
6. Confusion – is it geriatric syndrome, or symptom of ID, UTI?

1 Min

For each client finding below, click to specify if the finding is consistent with the disease process of pneumonia, a urinary tract infection (UTI), or influenza. Each finding may support more than 1 disease process.

Client Findings	Pneumonia	UTI	Influenza
fever	✓	✓	✓
confusion	✓	✓	✓
body soreness			✓
cough and sputum	✓		
shortness of breath	✓		✓

Note: Each column must have at least 1 response option selected.

2. What are your **HYPOTHESES**?

This is your Clinical judgement. What is happening?

☆ **Star your PRIORITY**

➢ Complete the following sentence by choosing from the lists of options.

The client is at highest risk for developing Select... as evidenced by the client's Select...

1 Min

Complete the following sentence by choosing from the lists of options.

The client is at highest risk for developing Select... as evidenced by the client's Select...

Select...
- hypoxia
- stroke
- dysrhythmias
- a pulmonary embolism

Select...
- vital signs
- neurologic assessment
- respiratory assessment
- cardiovascular assessment

Complete the following sentence by choosing from the lists of options.

The client is at highest risk for developing [Select...] as evidenced by the client's [Select...]

[Select...]
- Select...
- vital signs
- neurologic assessment
- respiratory assessment ✓
- cardiovascular assessment

[Select...]
- Select...
- hypoxia ✓
- stroke
- dysrhythmias
- a pulmonary embolism

The Scenario continues

Nurses' Notes

1200:

Called to bedside by the daughter who states that her mother "isn't acting right." Upon assessment, client difficult to arouse, pale, and diaphoretic in appearance. Vital signs: T 101.5° F (38.6° C), P112, RR 32, BP 90/62, pulse oximetry reading 91% on oxygen at 2 L/min via nasal cannula.

1 Min

What's concerning?

Nurses' Notes

1200:

Called to bedside by the daughter who states that her mother "isn't acting right." Upon assessment, client difficult to arouse, pale, and diaphoretic in appearance. Vital signs: T 101.5° F (38.6° C), P112, RR 32, BP 90/62, pulse oximetry reading 91% on oxygen at 2 L/min via nasal cannula.

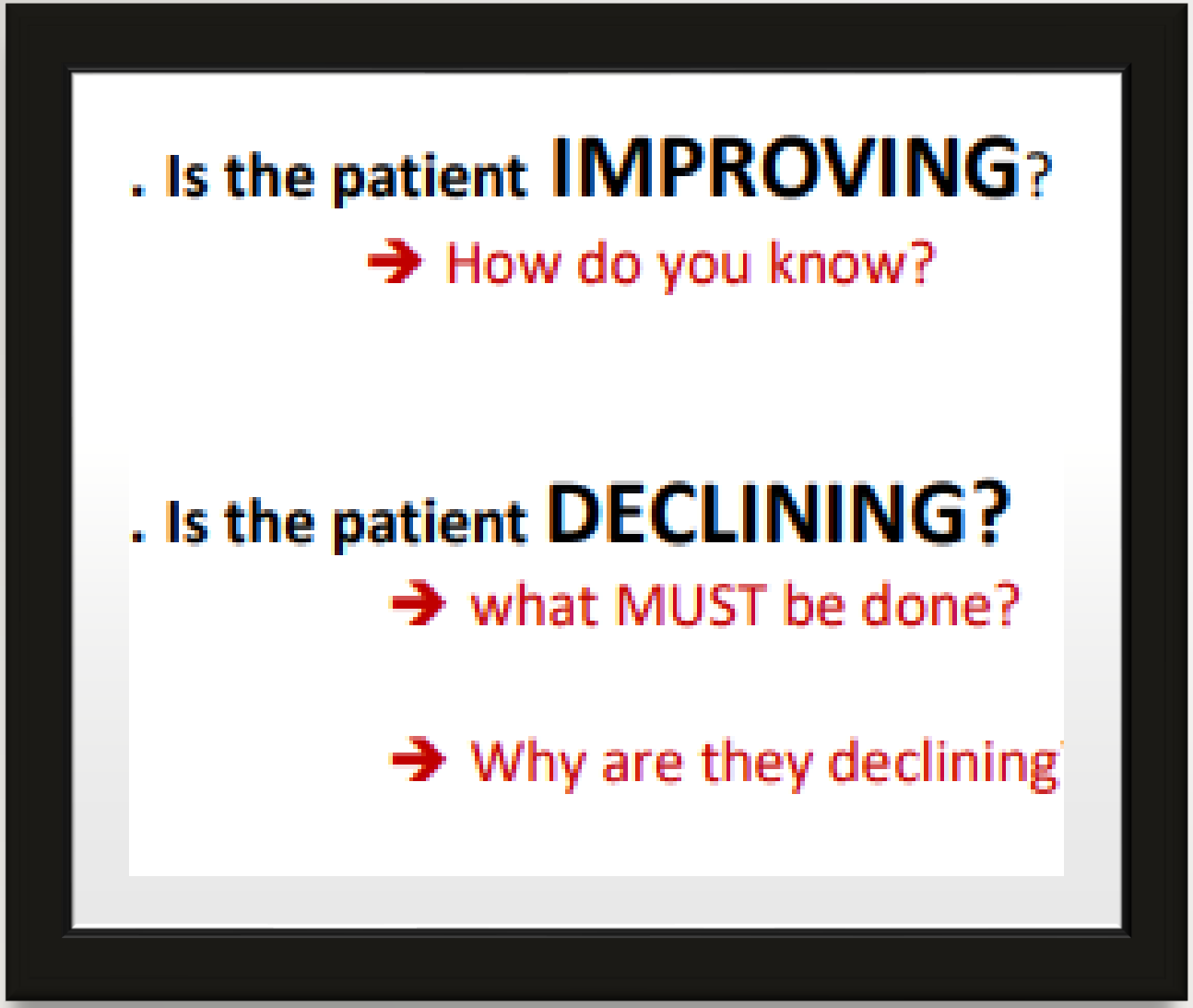
1 Min

What is the trend?

At 1200:

1. “isn’t acting right.” – this is evident of DECLINE
2. T 101.5° F is INCREASED by 0.4° F
3. P112 is INCREASED by 20 bpm
4. RR 32 is INCREASED by 10
5. BP 90/62 is DECREASED SIGNIFICANTLY
6. SATs 91% on 2 L/min via NC - is DECREASED SIGNIFICANTLY

1 Min



What may be happening?

1. Hypoxia
2. Respiratory distress
3. Increased metabolic demands
4. Decreased cardiac output
5. Shock (septic)

3. What **ACTIONS** can be taken by the nurse?

→ Do you need to **ASSESS** to confirm your hypothesis?

There is more than enough data

→ Do you have enough data to **ACT**?

This is URGENT, ABCs
A.B.- Increase Oxygen, Sit up
C.- Need to address C.O. with IV Fluids, PIV

1 Min

The nurse has reviewed the Nurses' Note entries from 1000 and 1200 and is planning care for the client.

➤ For each potential nursing intervention, click to specify whether the intervention is indicated, nonessential, or contraindicated for the care of the client.

Potential Intervention	Indicated	Nonessential	Contraindicated
Prepare the client for defibrillation.	O	O	O
Place client in a semi-Fowler's position.	O	O	O
Request an order to increase the oxygen flow rate.	O	O	O
Request an order to administer an intravenous fluid bolus.	O	O	O
Request an order to insert an additional peripheral venous access device (VAD).	O	O	O

For each potential nursing intervention, click to specify whether the intervention is indicated, nonessential, or contraindicated for the care of the client.

Potential Intervention	Indicated	Nonessential	Contraindicated
Prepare the client for defibrillation.	○	○	●
Place client in a semi-Fowler's position. Will help RR	●	○	○
Request an order to increase the oxygen flow rate. Will help RR, SATs, HR, Temp	●	○	○
Request an order to administer an intravenous fluid bolus. Will help Cardiac Output, low BP and fast HR	●	○	○
Request an order to insert an additional peripheral venous access device (VAD). Needed if further decline	●	○	○

Has a HR

The nurse has received orders from the physician.

Click to highlight below the 3 orders that the nurse should perform right away.

1215:

- insert an indwelling urinary catheter
- vancomycin 1 g, IV, every 12 hours
- computed tomography (CT) scan of the chest
- 0.9% sodium chloride (normal saline) 500 mL, IV, once
- laboratory tests: blood culture and sensitivity (C & S), complete blood count (CBC), arterial blood gas (ABG)

4. Is the patient IMPROVING?

→ How do you know?

Did it help?

1 Min

The nurse has performed the interventions as ordered by the physician for the client.

- For each assessment finding, click to specify if the finding indicates that the client's condition has improved, has not changed, or has declined.

Assessment Finding	Improved	No Change	Declined
RR 36	O	O	O
BP 118/68	O	O	O
pale skin tone	O	O	O
pulse oximetry reading 91%	O	O	O
interacting with daughter at bedside	O	O	O

The nurse has performed the interventions as ordered by the physician for the client.

- For each assessment finding, click to specify if the finding indicates that the client's condition has improved, has not changed, or has declined.

Assessment Finding	Improved	No Change	Declined
RR 36 @ 1200 was 32	○	○	●
BP 118/68 @ 1200 was 90/62	●	○	○
pale skin tone @ 1200 was also pale	○	●	○
pulse oximetry reading 91% @ 1200 was 91%	○	●	○
interacting with daughter at bedside	○ ? Implied improvement	●	○

Do you want this presentation?

Thank you for your time

If there is time…

5. **Managerial question:** follow the Chain of Command. Report to the nurse manager.
6. **X-out Absolutes** 💯: ~~always/ only/ never/ all~~
7. **Open ended questions are better!**
8. **Partially true = FALSE!!** 
9. **Two opposites, often have one winner.**

1 Min

If there is time…

9. **Two opposites, often have one winner.**
10. **What is your degree of CONFIDENCE?**
    a. Select the one you are > confident
11. **LOGIC: 1+1 =2 , 2 is more than 1**
    a. Works well with analysis of menus
12.  **Not a clue:** select the odd man wins. (rare)

1 Min