

NCLEX Archer Prioritization Practice Test (Sample)

Study Guide



Everything you need from our exam experts!

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Introduction

Preparing for a certification exam can feel overwhelming, but with the right tools, it becomes an opportunity to build confidence, sharpen your skills, and move one step closer to your goals. At Examzify, we believe that effective exam preparation isn't just about memorization, it's about understanding the material, identifying knowledge gaps, and building the test-taking strategies that lead to success.

This guide was designed to help you do exactly that.

Whether you're preparing for a licensing exam, professional certification, or entry-level qualification, this book offers structured practice to reinforce key concepts. You'll find a wide range of multiple-choice questions, each followed by clear explanations to help you understand not just the right answer, but why it's correct.

The content in this guide is based on real-world exam objectives and aligned with the types of questions and topics commonly found on official tests. It's ideal for learners who want to:

- Practice answering questions under realistic conditions,
- Improve accuracy and speed,
- Review explanations to strengthen weak areas, and
- Approach the exam with greater confidence.

We recommend using this book not as a stand-alone study tool, but alongside other resources like flashcards, textbooks, or hands-on training. For best results, we recommend working through each question, reflecting on the explanation provided, and revisiting the topics that challenge you most.

Remember: successful test preparation isn't about getting every question right the first time, it's about learning from your mistakes and improving over time. Stay focused, trust the process, and know that every page you turn brings you closer to success.

Let's begin.

How to Use This Guide

This guide is designed to help you study more effectively and approach your exam with confidence. Whether you're reviewing for the first time or doing a final refresh, here's how to get the most out of your Examzify study guide:

1. Start with a Diagnostic Review

Skim through the questions to get a sense of what you know and what you need to focus on. Your goal is to identify knowledge gaps early.

2. Study in Short, Focused Sessions

Break your study time into manageable blocks (e.g. 30 - 45 minutes). Review a handful of questions, reflect on the explanations.

3. Learn from the Explanations

After answering a question, always read the explanation, even if you got it right. It reinforces key points, corrects misunderstandings, and teaches subtle distinctions between similar answers.

4. Track Your Progress

Use bookmarks or notes (if reading digitally) to mark difficult questions. Revisit these regularly and track improvements over time.

5. Simulate the Real Exam

Once you're comfortable, try taking a full set of questions without pausing. Set a timer and simulate test-day conditions to build confidence and time management skills.

6. Repeat and Review

Don't just study once, repetition builds retention. Re-attempt questions after a few days and revisit explanations to reinforce learning. Pair this guide with other Examzify tools like flashcards, and digital practice tests to strengthen your preparation across formats.

There's no single right way to study, but consistent, thoughtful effort always wins. Use this guide flexibly, adapt the tips above to fit your pace and learning style. You've got this!

Questions

- 1. A 4-year-old girl presents to the emergency department with 20% of her body surface area burned. What is the first nursing action to take?**
 - A. Cover the wound with a clean cloth**
 - B. Assess airway, breathing, and circulation**
 - C. Remove the burned clothing and jewelry**
 - D. Stop the burning process**
- 2. How should the nurse respond to a patient with significant vital sign changes post-operatively?**
 - A. Notify the attending physician immediately**
 - B. Document changes and continue monitoring**
 - C. Assess the patient for pain level**
 - D. Provide reassurance to the patient**
- 3. For a patient experiencing tingling and numbness in the lower extremities, what is the most important nursing intervention to prevent injury?**
 - A. Perform Semmes-Weinstein monofilament test.**
 - B. Refer the patient for a diabetic diet consult.**
 - C. Teach the patient about appropriate footwear.**
 - D. Obtain an order for Gabapentin.**
- 4. What category does a sudden onset of dysarthria and ataxia fall under during triage?**
 - A. Urgent.**
 - B. Non-urgent.**
 - C. Emergent.**
 - D. Can wait for stabilization.**
- 5. What nursing intervention takes precedence for a post-operative patient showing signs of elevated blood pressure?**
 - A. Monitor vital signs closely**
 - B. Administer prescribed antihypertensives**
 - C. Document changes in patient condition**
 - D. Notify the surgeon about the situation**

- 6. What should the nurse do first when a patient diagnosed with appendicitis suddenly reports a pain reduction from 8/10 to 0/10?**
- A. Document the pain score and continue monitoring**
 - B. Check the WBC count**
 - C. Notify the healthcare provider**
 - D. Palpate McBurney's point**
- 7. What action would warrant intervention by the experienced RN regarding a new nurse's practice?**
- A. The nurse administers ceftriaxone via IV 30 minutes early for pneumonia.**
 - B. The nurse places a surgical mask on a patient with influenza.**
 - C. The nurse obtains green drainage from a nasogastric tube for culture.**
 - D. The nurse secures a Jackson-Pratt drain to the patient's gown.**
- 8. What is the primary concern for a nurse regarding a patient's respiratory status on a ventilator?**
- A. Ensure adequate sedation**
 - B. Monitor for respiratory infections**
 - C. Evaluate ventilator settings regularly**
 - D. Watch for alarms indicating distress**
- 9. A nurse receives reports on four clients. Which client should be seen first?**
- A. A client with a respiratory rate of 24 and O2 saturation of 92%**
 - B. A client who is scheduled for gastric surgery in two hours**
 - C. A post-op client complaining of nausea**
 - D. A client with a cast complaining of her arm feeling like it is "sleeping"**

10. Which client situation should a nurse prioritize first in follow-up care?

- A. A client displaying a stage III pressure ulcer positive for *Pseudomonas aeruginosa***
- B. A client with a reddened stoma two days post-ileostomy**
- C. A client with type 2 diabetes and a normal blood glucose level refusing breakfast**
- D. A client reporting increased pain with cough related to appendicitis**

Answers

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1. D
2. A
3. C
4. C
5. D
6. C
7. C
8. D
9. D
10. D

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Explanations

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1. A 4-year-old girl presents to the emergency department with 20% of her body surface area burned. What is the first nursing action to take?

- A. Cover the wound with a clean cloth**
- B. Assess airway, breathing, and circulation**
- C. Remove the burned clothing and jewelry**
- D. Stop the burning process**

In the case of a burn injury, the primary concern is to stop the burning process as quickly as possible. This is crucial because it minimizes further damage to the tissue and reduces the extent of the burn injury. Immediate action to remove the source of the burn—such as hot fluids, flames, or chemicals—helps to preserve skin integrity and limits potential complications. Though covering the wound, assessing airway, breathing, and circulation, and removing clothing and jewelry are important steps in the management of burn injuries, they should follow the immediate action of halting the burning process. Addressing the burn source first ensures the patient's safety and decreases the risk of additional injury. Therefore, prioritizing this action is essential for effective first aid and subsequent treatment.

2. How should the nurse respond to a patient with significant vital sign changes post-operatively?

- A. Notify the attending physician immediately**
- B. Document changes and continue monitoring**
- C. Assess the patient for pain level**
- D. Provide reassurance to the patient**

In cases where a patient exhibits significant vital sign changes post-operatively, the priority is ensuring the patient's safety and addressing potential complications. Notifying the attending physician immediately is crucial because vital sign changes can indicate issues such as hemorrhage, infection, or other critical conditions that require prompt medical intervention. Timely communication with the physician ensures that the patient receives the necessary evaluation and treatment to prevent deterioration. Continuing to monitor and documenting changes could be important, but it does not address the immediate need for intervention. Assessing for pain and providing reassurance, while valuable aspects of patient care, do not take precedence over the need for urgent medical evaluation in the context of concerning vital signs. Therefore, prompt notification of the physician is the appropriate nursing action in this scenario.

3. For a patient experiencing tingling and numbness in the lower extremities, what is the most important nursing intervention to prevent injury?

- A. Perform Semmes-Weinstein monofilament test.**
- B. Refer the patient for a diabetic diet consult.**
- C. Teach the patient about appropriate footwear.**
- D. Obtain an order for Gabapentin.**

Teaching the patient about appropriate footwear is a crucial nursing intervention for someone experiencing tingling and numbness in the lower extremities. This condition often indicates peripheral neuropathy, which can significantly increase the risk of foot injuries due to diminished sensation. Proper footwear can help provide adequate support and cushioning, reduce friction, and protect against injuries, such as cuts or blisters, which the patient may not feel due to their altered sensation. This proactive measure is essential in preventing complications such as ulcers or infections, particularly in patients with conditions like diabetes, where neuropathy is common. Other interventions may have their place, but they do not directly address the immediate need to prevent injury related to impaired sensation. For instance, the Semmes-Weinstein monofilament test is useful for assessing sensory function but does not offer immediate preventive benefit. Referring for a diabetic diet consult is beneficial for overall health and management of diabetes but does not directly relate to preventing injury from reduced sensation. Obtaining an order for Gabapentin may help manage neuropathic pain, but it does not prevent injuries that could arise from impaired protective sensation. Hence, the emphasis on appropriate footwear is vital for the patient's safety and injury prevention.

4. What category does a sudden onset of dysarthria and ataxia fall under during triage?

- A. Urgent.**
- B. Non-urgent.**
- C. Emergent.**
- D. Can wait for stabilization.**

A sudden onset of dysarthria and ataxia suggests a neurological event, potentially indicating conditions such as a stroke or other serious neurological disorder. In the context of triage, this categorization is critical as it underscores the need for immediate evaluation and intervention. When symptoms such as these arise suddenly, they may reflect an acute change in a patient's neurological status, warranting urgent assessment to determine the underlying cause and implement timely treatment. Immediate management can be crucial to limit potential long-term deficits or complications related to neurological events. Emergency care protocols prioritize conditions that have the potential for rapid deterioration or significant morbidity, placing sudden neurological symptoms in the emergent category. This classification ensures that patients receive expedited care, which is essential in minimizing adverse outcomes associated with these serious symptoms.

5. What nursing intervention takes precedence for a post-operative patient showing signs of elevated blood pressure?

- A. Monitor vital signs closely**
- B. Administer prescribed antihypertensives**
- C. Document changes in patient condition**
- D. Notify the surgeon about the situation**

In the context of a post-operative patient exhibiting elevated blood pressure, the priority nursing intervention is to notify the surgeon about the situation. This is because elevated blood pressure can indicate potential complications in the post-operative period, such as bleeding, pain, or fluid overload. Immediate communication with the surgeon allows for prompt evaluation and intervention, which can be critical in preventing further complications. While monitoring vital signs closely, administering prescribed antihypertensives, and documenting changes are all important nursing duties, they are secondary to ensuring that the surgical team is informed of significant changes in the patient's condition. The surgeon may need to assess the situation directly or offer specific treatment recommendations based on the patient's overall clinical picture. Timely notification ensures that the patient receives optimal care and that any necessary interventions are initiated without delay.

6. What should the nurse do first when a patient diagnosed with appendicitis suddenly reports a pain reduction from 8/10 to 0/10?

- A. Document the pain score and continue monitoring**
- B. Check the WBC count**
- C. Notify the healthcare provider**
- D. Palpate McBurney's point**

In a patient diagnosed with appendicitis, a sudden reduction in pain from a severe level to none can be indicative of a serious complication, such as the perforation of the appendix. This event often leads to a temporary relief of pain as the appendix can no longer create pressure due to perforation, but it significantly increases the risk of peritonitis and sepsis. Therefore, notifying the healthcare provider immediately is critical to facilitate further assessment and intervention. Recognizing this change in the patient's condition as an urgent clinical situation allows for timely medical evaluation and potential emergency procedures needed to manage the patient's safety and health. Immediate action in response to sudden changes in a patient's condition is essential to preventing further complications and ensuring proper care. Monitoring and documenting the pain score could lead to delays in addressing what may be a life-threatening situation. Checking the WBC count or palpating McBurney's point would also not provide the rapid intervention needed in this scenario, as they do not address the immediate clinical urgency of a potential perforation and its complications.

7. What action would warrant intervention by the experienced RN regarding a new nurse's practice?

- A. The nurse administers ceftriaxone via IV 30 minutes early for pneumonia.**
- B. The nurse places a surgical mask on a patient with influenza.**
- C. The nurse obtains green drainage from a nasogastric tube for culture.**
- D. The nurse secures a Jackson-Pratt drain to the patient's gown.**

The action that would warrant intervention by the experienced RN is the obtaining of green drainage from a nasogastric tube for culture. It is crucial to ensure that the nurse understands the protocol for collecting specimens, including the appropriateness of the sample and the specific technique required to avoid contamination. In clinical practice, drainage from a nasogastric tube may not always be indicative of a bacterial infection or suitable for culture without proper clinical judgment and guidance. If this fluid is contaminated or misidentified, it could lead to incorrect diagnoses or unwarranted treatments, which can compromise patient safety. On the other hand, administering ceftriaxone early is typically within a reasonable window for antibiotic therapy, and placing a surgical mask on a patient with influenza is appropriate to prevent the spread of infection. Securing a Jackson-Pratt drain to the patient's gown is also standard practice to ensure the drain remains in a safe and accessible position. Each of these actions reflects common protocols in nursing practice and does not warrant intervention as they are aligned with patient management guidelines.

8. What is the primary concern for a nurse regarding a patient's respiratory status on a ventilator?

- A. Ensure adequate sedation**
- B. Monitor for respiratory infections**
- C. Evaluate ventilator settings regularly**
- D. Watch for alarms indicating distress**

Monitoring for alarms indicating distress is crucial for a nurse caring for a patient on a ventilator because these alarms are designed to alert healthcare providers to immediate and potentially life-threatening problems. Alarms can indicate issues such as disconnections, high or low airway pressures, and oxygen desaturation, all of which require prompt assessment and intervention to ensure the patient's safety and effective respiratory function. While ensuring adequate sedation, monitoring for respiratory infections, and evaluating ventilator settings are important aspects of patient care, they are secondary when the immediate physiological status of the patient might be compromised. The presence of an alarm typically demands immediate attention to address critical changes in the patient's condition, making it the top priority in this scenario.

9. A nurse receives reports on four clients. Which client should be seen first?
- A. A client with a respiratory rate of 24 and O2 saturation of 92%
 - B. A client who is scheduled for gastric surgery in two hours
 - C. A post-op client complaining of nausea
 - D. A client with a cast complaining of her arm feeling like it is "sleeping"**

The most critical client to be seen first is the one with a cast complaining of her arm feeling like it is "sleeping." This description may indicate a potential complication known as compartment syndrome or circulatory compromise, which can occur when swelling or internal pressure increases within a confined space (like within a cast). If not addressed promptly, these conditions can lead to severe tissue damage, necrosis, and long-term disability. In contrast, while the other clients also have their concerns, they do not present an immediate risk of life-threatening complications. The client with a respiratory rate of 24 and O2 saturation of 92% might indicate a mild respiratory issue, but the oxygen saturation is not critically low, suggesting that immediate intervention for the breathing issue may not be as urgent as assessing circulation for the client with the cast. The client scheduled for gastric surgery does require attention to ensure timely care, but this can be managed until more pressing problems are addressed. The post-op client with nausea, while uncomfortable, can typically be managed with medication, and this condition does not pose an immediate threat to life or function. Therefore, prioritizing the client with the cast is the most appropriate choice, as their symptoms could lead to serious complications without timely assessment and intervention.

10. Which client situation should a nurse prioritize first in follow-up care?
- A. A client displaying a stage III pressure ulcer positive for *Pseudomonas aeruginosa*
 - B. A client with a reddened stoma two days post-ileostomy
 - C. A client with type 2 diabetes and a normal blood glucose level refusing breakfast
 - D. A client reporting increased pain with cough related to appendicitis**

In prioritizing client situations for follow-up care, assessing the client's immediate health concerns is crucial. In this case, the client reporting increased pain with a cough related to appendicitis indicates a potential risk for complications, such as perforation or infection. The presence of increased pain can suggest that the condition is worsening and may require urgent evaluation and intervention. Appendicitis, if left untreated, can lead to serious complications, including peritonitis or sepsis. Pain that is increasing, particularly in relation to a cough, could indicate increased intrabdominal pressure or other complications. Therefore, addressing this client's situation first ensures that any potential deterioration in their condition is managed promptly, which is vital in nursing care. The other situations, while important, involve different levels of urgency. For instance, a stage III pressure ulcer signifies a significant wound care need, but it does not present an immediate threat to life. Similarly, a reddened stoma post-ileostomy may warrant follow-up but does not require immediate action like suspected appendicitis. Lastly, a client with diabetes refusing breakfast and displaying normal glucose levels may need support, but this situation is usually less urgent compared to the potential risk of complications from appendicitis. In summary, the focus

Next Steps

Congratulations on reaching the final section of this guide. You've taken a meaningful step toward passing your certification exam and advancing your career.

As you continue preparing, remember that consistent practice, review, and self-reflection are key to success. Make time to revisit difficult topics, simulate exam conditions, and track your progress along the way.

If you need help, have suggestions, or want to share feedback, we'd love to hear from you. Reach out to our team at hello@examzify.com.

Or visit your dedicated course page for more study tools and resources:

<https://nclexarcherprio.examzify.com>

We wish you the very best on your exam journey. You've got this!