

NCLEX ARCHER PRIORITIZATION PRACTICE TEST (SAMPLE)

STUDY GUIDE



**SAMPLE STUDY GUIDE
WITH LIMITED QUESTIONS**

**VISIT US ONLINE FOR
THE FULL VERSION STUDY GUIDE**

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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

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- 1. In the case of carbon monoxide poisoning, what should a nurse be alert for in the patient?**
 - A. Increased appetite
 - B. Rising blood sugar levels
 - C. Potential for dysrhythmias
 - D. Increased skin temperature
- 2. 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
- 3. Which action should the nurse prioritize when caring for a client needing an emergency laparotomy?**
 - A. Teaches the client how to ambulate with crutches
 - B. Calculates the intake and output for a client with diabetes insipidus
 - C. Irrigates a client's ostomy who reports abdominal cramping
 - D. Witnesses informed consent for the surgical procedure
- 4. What action should a nurse take if a client is experiencing a severe allergic reaction?**
 - A. Provide the client with solid food to stabilize
 - B. Administer epinephrine as prescribed
 - C. Apply ice to the affected area
 - D. Instruct the client to remain calm
- 5. What is the nurse's priority action for a patient with a slowing infusion and signs of phlebitis at the IV site?**
 - A. Stop the infusion and remove the IV catheter
 - B. Insert a new IV in the left arm
 - C. Prepare the patient for PICC line placement
 - D. Elevate the right arm to reduce swelling

- 6. Which client situation should a nurse prioritize for assessment first?**
- A. A client post-thyroidectomy with difficulty swallowing
 - B. A client with pneumonia who hasn't used the incentive spirometer
 - C. A client who reports pain after a dressing change
 - D. A client awaiting an adrenalectomy without signed consent
- 7. The nurse is caring for a client experiencing an asthma exacerbation. Which situation should be prioritized?**
- A. A client experiencing wheezing while receiving albuterol.
 - B. A client putting on their nasal cannula before eating.
 - C. A client ambulating with pneumonia while wearing a mask.
 - D. A client with oxygen saturation of 92% on a nonrebreather.
- 8. What is the initial priority action for a patient who is unconscious and pulseless?**
- A. Check the patient for a patent airway
 - B. Ask another health care professional to check the carotid artery
 - C. Administer two rescue breaths
 - D. Begin chest compressions
- 9. Which client has the greatest need to be referred for outpatient community services?**
- A. A client newly diagnosed with skin cancer that lives with family.
 - B. A client recovering from a stroke and is discharged to inpatient rehab.
 - C. A client who is homeless and has a substance use disorder.
 - D. A client leaving against medical advice for the treatment of cellulitis.
- 10. Which patient should the nurse arrange for immediate evaluation in the emergency department?**
- A. A febrile 8-year-old girl complaining of pain during urination
 - B. A child diagnosed with leukemia displaying petechiae
 - C. A child diagnosed with acute epiglottitis two days ago and is drooling
 - D. A child with otitis media having fever

Answers

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

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Explanations

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1. In the case of carbon monoxide poisoning, what should a nurse be alert for in the patient?

- A. Increased appetite
- B. Rising blood sugar levels
- C. Potential for dysrhythmias**
- D. Increased skin temperature

In cases of carbon monoxide poisoning, it is essential for the nurse to be alert for the potential for dysrhythmias in the patient. Carbon monoxide binds to hemoglobin with a much greater affinity than oxygen, reducing oxygen delivery to tissues and leading to hypoxia. This lack of oxygen can negatively impact heart function, resulting in electrical disturbances that can manifest as dysrhythmias. Monitoring for dysrhythmias becomes particularly crucial because these can lead to serious complications, including cardiac arrest if not identified and addressed promptly. The risk is further exacerbated in patients with existing heart conditions, as they may already be vulnerable to arrhythmias. In contrast, while other symptoms such as increased appetite, rising blood sugar levels, and increased skin temperature might occur for various reasons in different clinical contexts, they are not characteristic or significant indicators in the case of carbon monoxide poisoning. Prioritizing the assessment for dysrhythmias helps ensure timely intervention and improves patient outcomes.

2. 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.

3. Which action should the nurse prioritize when caring for a client needing an emergency laparotomy?

- A. Teaches the client how to ambulate with crutches
- B. Calculates the intake and output for a client with diabetes insipidus**
- C. Irrigates a client's ostomy who reports abdominal cramping
- D. Witnesses informed consent for the surgical procedure

In the context of a client needing an emergency laparotomy, the most critical action for the nurse to prioritize is witnessing informed consent for the surgical procedure. This is essential because informed consent is a legal requirement prior to surgery and involves ensuring that the patient understands the procedure, potential risks, benefits, and alternatives. In emergency situations, there may be pressing needs for surgery, and having documented consent is vital for both ethical and legal protection. When considering the other options, teaching a client how to ambulate with crutches is not relevant in an urgent pre-operative context, as the focus should be on ensuring that the client is prepared for the surgery rather than on post-operative mobility aids. Similarly, calculating intake and output for a client with diabetes insipidus can be important for managing fluid balance, but it does not address the immediate needs regarding surgical consent. Additionally, while caring for a client with an ostomy who reports abdominal cramping is significant for their comfort and care, it is not as time-sensitive as the consent process for a surgical intervention. Thus, prioritizing witnessing informed consent aligns with the immediate legal and ethical responsibility of the nurse in the surgical care setting.

4. What action should a nurse take if a client is experiencing a severe allergic reaction?

- A. Provide the client with solid food to stabilize
- B. Administer epinephrine as prescribed**
- C. Apply ice to the affected area
- D. Instruct the client to remain calm

In the case of a severe allergic reaction, also known as anaphylaxis, the most critical and immediate action to take is to administer epinephrine as prescribed. Epinephrine is a life-saving medication that works quickly to reverse severe allergic reactions by constricting blood vessels, relaxing airway muscles, and improving heart function. The timely administration of epinephrine can significantly reduce the risk of severe complications or death associated with anaphylaxis. The other options do not address the immediate life-threatening nature of the situation. Providing solid food is inappropriate because the client may be experiencing difficulty swallowing or their airway may be compromised. Applying ice to an affected area may offer some relief for localized reactions but is not effective in treating systemic symptoms or restoring airway patency. While instructing the client to remain calm may be beneficial for anxiety, it does not treat the underlying physiological changes occurring during a severe allergic reaction and should not be the primary intervention in an emergency situation.

5. What is the nurse's priority action for a patient with a slowing infusion and signs of phlebitis at the IV site?

- A. Stop the infusion and remove the IV catheter**
- B. Insert a new IV in the left arm
- C. Prepare the patient for PICC line placement
- D. Elevate the right arm to reduce swelling

The priority action for a patient showing signs of phlebitis at the IV site is to stop the infusion and remove the IV catheter. Phlebitis is characterized by inflammation of a vein, which can occur as a result of irritation from the intravenous catheter or solution. Signs may include redness, swelling, pain, and a slowing infusion rate. By stopping the infusion, the nurse prevents further irritation and potential complications, such as infection or thrombophlebitis, which can occur if the catheter is left in place. Removing the catheter also allows for the assessment of the site and the identification of any further intervention needed. This action prioritizes patient safety and addresses the immediate concern effectively. In contrast, while inserting a new IV in the left arm may eventually be necessary, it should only be done after addressing the phlebitis in the current site. Preparing a patient for a PICC line placement may not be appropriate at this moment, as the phlebitis needs to be handled first. Elevating the arm can help reduce swelling but does not address the underlying issue of the IV site irritation and does not prevent further complications. Therefore, stopping the infusion and removing the IV catheter is the most appropriate and critical nursing action in this scenario.

6. Which client situation should a nurse prioritize for assessment first?

- A. A client post-thyroidectomy with difficulty swallowing**
- B. A client with pneumonia who hasn't used the incentive spirometer
- C. A client who reports pain after a dressing change
- D. A client awaiting an adrenalectomy without signed consent

Focusing on the client post-thyroidectomy with difficulty swallowing is crucial because this situation may indicate a potential airway compromise or stridor, which are serious complications that can arise after thyroid surgery. The neck area is very vascular and contains important structures like the trachea and esophagus; edema or hematoma formation in this area can quickly lead to airway obstruction. Difficulty swallowing, also known as dysphagia, may be a sign of swelling or nerve damage, and it is critical to ensure that the airway is not compromised. In comparison, while the other situations present valid concerns, they are generally less urgent. The client with pneumonia who hasn't used the incentive spirometer may require intervention for pulmonary hygiene but is unlikely to have an immediate life-threatening issue. A client reporting pain after a dressing change requires assessment and possible pain management strategies, but again, this is not as time-sensitive as airway management. The client awaiting an adrenalectomy without signed consent indicates a procedural issue, but this does not pose an immediate risk to the client's safety or wellbeing in the same way that respiratory distress can. Prioritizing the assessment of the client post-thyroidectomy aligns with the principles of prioritization in nursing, particularly the importance of addressing airway issues first

7. The nurse is caring for a client experiencing an asthma exacerbation. Which situation should be prioritized?

- A. A client experiencing wheezing while receiving albuterol.
- B. A client putting on their nasal cannula before eating.
- C. A client ambulating with pneumonia while wearing a mask.
- D. A client with oxygen saturation of 92% on a nonrebreather.**

In the context of a nursing assessment during an asthma exacerbation, prioritizing the client with an oxygen saturation of 92% on a nonrebreather is crucial because it indicates a potential respiratory compromise. An oxygen saturation level below 92% suggests that the client may not be receiving adequate oxygenation, which can lead to severe hypoxia and related complications. Using a nonrebreather mask is a critical intervention aimed at delivering high-flow oxygen to patients who are experiencing significant respiratory issues, such as during an asthma attack. Ensuring that this client's oxygen saturation is improved is essential for stabilizing their condition and preventing further deterioration. In comparison, the other scenarios involve clients who may be stable or in less immediate need of intervention. For example, a client who is wheezing while receiving albuterol is likely receiving a bronchodilator for relief, but their situation may not require immediate intervention if they are still tolerating the treatment. Similarly, the client putting on their nasal cannula before eating and the client ambulating with pneumonia while wearing a mask indicate that these individuals can manage their situations without urgent nursing intervention at that moment. Each of these scenarios has its own significance, but the urgency presented by a low oxygen saturation measurement makes it the pressing priority.

8. What is the initial priority action for a patient who is unconscious and pulseless?

- A. Check the patient for a patent airway
- B. Ask another health care professional to check the carotid artery**
- C. Administer two rescue breaths
- D. Begin chest compressions

In an unconscious and pulseless patient, the primary concern is to initiate immediate life-saving measures. The most appropriate action is to begin chest compressions, as this is a crucial step in cardiopulmonary resuscitation (CPR) that helps to restore blood circulation and maintain oxygenation to vital organs. Initiating chest compressions right away is essential because it helps to circulate the blood that may still be present in the patient's body, prolonging the potential for successful resuscitation. Key guidelines emphasize that the responder should start compressions within a few seconds of confirming the absence of a pulse, as this can significantly improve outcomes. While checking for a patent airway and administering rescue breaths are important components of CPR, they do not take precedence over starting chest compressions in a pulseless patient. Prompt action is critical during cardiac emergencies, and delivering compressions first can enhance the chances of survival until advanced medical help arrives.

9. Which client has the greatest need to be referred for outpatient community services?

- A. A client newly diagnosed with skin cancer that lives with family.
- B. A client recovering from a stroke and is discharged to inpatient rehab.
- C. A client who is homeless and has a substance use disorder.**
- D. A client leaving against medical advice for the treatment of cellulitis.

The client who is homeless and has a substance use disorder represents the greatest need for referral to outpatient community services due to the complexity of their situation. Individuals experiencing homelessness often face multiple barriers to accessing healthcare, including lack of stable housing, financial instability, and potential social isolation. Furthermore, substance use disorders require ongoing support and resources that community organizations can provide, such as counseling, rehabilitation programs, and access to healthcare services. Outpatient community services are specifically designed to address the needs of marginalized populations, including those struggling with addiction and homelessness. These services can help this individual find housing, connect to treatment programs, and establish a support network, which are all crucial for recovery and stabilization. In contrast, the other clients—while they may need support—are in circumstances that are less critical in terms of immediate risk and resource requirements. The newly diagnosed client with skin cancer has family support, the client recovering from a stroke is transitioning to inpatient rehab which focuses on rehabilitation needs, and the client leaving against medical advice may require further monitoring, but their situation does not highlight the urgent need for a community service referral as prominently as that of the homeless client with a substance use disorder.

10. Which patient should the nurse arrange for immediate evaluation in the emergency department?

- A. A febrile 8-year-old girl complaining of pain during urination
- B. A child diagnosed with leukemia displaying petechiae
- C. A child diagnosed with acute epiglottitis two days ago and is drooling**
- D. A child with otitis media having fever

The child diagnosed with acute epiglottitis who is drooling should be prioritized for immediate evaluation in the emergency department due to the potential for a life-threatening airway obstruction. Acute epiglottitis is an inflammation of the epiglottis that can lead to rapid swelling and compromise the airway, making it a medical emergency. The presence of drooling indicates difficulty in swallowing and potential respiratory distress, highlighting the urgency of the situation. In comparison, while a febrile child with urination pain, a leukemia patient with petechiae, and a child with otitis media and fever all require attention, their conditions do not represent the immediate threat to life that drooling from epiglottitis poses. Hence, the priority should be given to the child exhibiting signs of severe airway compromise.

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:

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

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