

NCLEX ARCHER PRIORITIZATION PRACTICE TEST (SAMPLE)

STUDY GUIDE



**SAMPLE STUDY GUIDE
WITH LIMITED QUESTIONS**

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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. Which lab result should the nurse report to the healthcare provider immediately?**
 - A. An elevated amylase result in a client diagnosed with acute pancreatitis
 - B. An elevated white blood cell (WBC) count in a client with a septic leg wound
 - C. A urinalysis positive for leukocytes and nitrites in a chemotherapy client
 - D. A serum glucose of 235 mg/dL in a client with type 1 diabetes mellitus
- 2. When preparing for initial rounds, which client should the nurse assess first?**
 - A. The client with diabetes who is being discharged today
 - B. A 32-year-old female with a tracheostomy experiencing copious secretions
 - C. A 16-year-old scheduled for physical therapy
 - D. An 80-year-old male with a decubitus ulcer needing a dressing change
- 3. Which client should the nurse at a mental health clinic assess first?**
 - A. A client with post-partum depression
 - B. A client expressing desire to be with their deceased family
 - C. A client suspected of anorexia nervosa
 - D. A client washing their hands multiple times
- 4. Which patient should the nurse assess first after receiving shift report?**
 - A. A patient with hemothorax attached to a chest drainage system
 - B. A restless elderly patient with pneumonitis
 - C. A febrile young patient with influenza
 - D. A patient with sinusitis and nasal drainage
- 5. A new patient has just been admitted with multiple orders. Which order should the nurse perform first?**
 - A. Vital signs every 4 hours
 - B. Amoxicillin 250 mg by mouth first dose now
 - C. Collection of CBC, electrolytes, urinalysis, and blood cultures
 - D. Insulin 2 units Humulin subcutaneous now

- 6. 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.
- 7. What is the nurse's priority action when encountering a patient with a nasogastric tube that has green drainage?**
- A. Notify physician.
 - B. Hold bolus and recheck residual volume in 1 hour.
 - C. Assess for abdominal distension.
 - D. Document findings with no further action.
- 8. What is the highest priority intervention for a patient with a suspected pneumothorax?**
- A. Monitor oxygen saturation levels
 - B. Administer an intravenous bolus
 - C. Prepare for chest decompression
 - D. Position the patient for comfort
- 9. Which scenario indicates that immediate evaluation and treatment are required by the healthcare provider?**
- A. A patient with prolonged PR interval
 - B. A patient showing improvement post-hospital discharge
 - C. A patient with persistent nausea after medication therapy
 - D. A patient reporting increased lethargy after surgery
- 10. While inserting a urinary catheter, which symptom requires immediate intervention?**
- A. Resistance when inflating the balloon
 - B. A brief pinching sensation
 - C. The patient feels the need to urinate
 - D. Proper positioning of patient's labia

Answers

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

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Explanations

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1. Which lab result should the nurse report to the healthcare provider immediately?

- A. An elevated amylase result in a client diagnosed with acute pancreatitis
- B. An elevated white blood cell (WBC) count in a client with a septic leg wound
- C. A urinalysis positive for leukocytes and nitrites in a chemotherapy client**
- D. A serum glucose of 235 mg/dL in a client with type 1 diabetes mellitus

The rationale for reporting a positive urinalysis for leukocytes and nitrites in a chemotherapy client immediately is centered on the risk of urinary tract infections (UTIs) in patients undergoing chemotherapy. Chemotherapy can compromise the immune system, making the client more susceptible to infections. The presence of leukocytes indicates inflammation, while nitrites suggest the presence of bacteria, which typically leads to UTIs. In a chemotherapy client with a compromised immune system, a UTI can escalate quickly and lead to systemic infection or sepsis, both of which can be life-threatening. Therefore, this lab result requires prompt intervention to initiate appropriate antibiotic therapy and further evaluation. In contrast, other lab values listed may indicate important health issues, but they may not require immediate reporting. For instance, while an elevated amylase level is concerning in acute pancreatitis, it is a common finding and is typically monitored rather than immediately communicated unless there are significant changes or clinical deterioration. An elevated WBC count in a septic leg wound is common and tends to be monitored as part of the overall assessment. A serum glucose level of 235 mg/dL in a client with type 1 diabetes, while requiring treatment, is not an immediate emergency unless the client exhibits signs of diabetic ketoacidosis.

2. When preparing for initial rounds, which client should the nurse assess first?

- A. The client with diabetes who is being discharged today
- B. A 32-year-old female with a tracheostomy experiencing copious secretions**
- C. A 16-year-old scheduled for physical therapy
- D. An 80-year-old male with a decubitus ulcer needing a dressing change

Assessing the client with a tracheostomy who is experiencing copious secretions is the priority in this scenario due to the immediate risk to their airway. Clients who have a tracheostomy are at a higher risk for airway obstruction, especially if they are producing excessive secretions that can hinder breathing. The vital nature of maintaining a clear airway means that this client's situation requires urgent attention to prevent complications, such as respiratory distress or hypoxia. The other clients also have needs that require care, but they do not present the same level of immediate risk. For instance, the client with diabetes who is being discharged does require careful assessment to ensure all discharge instructions are understood, but this is not an acute situation. The 16-year-old scheduled for physical therapy is likely stable and can be assessed after clients with more pressing concerns. Similarly, while the 80-year-old male with a decubitus ulcer requires a dressing change, this is more of a routine care issue that can be attended to later once immediate airway concerns are addressed. Prioritizing clients based on the severity of their condition is essential in nursing practice, particularly when it comes to life-threatening issues such as compromised airways.

3. Which client should the nurse at a mental health clinic assess first?

- A. A client with post-partum depression
- B. A client expressing desire to be with their deceased family**
- C. A client suspected of anorexia nervosa
- D. A client washing their hands multiple times

The rationale for prioritizing the client expressing a desire to be with their deceased family lies in the potential for suicidal ideation and the immediate risk factors associated with that expression. This statement might indicate deep emotional distress, feelings of hopelessness, or a longing for escape from current circumstances, all of which could suggest that the client is contemplating self-harm or has thoughts of suicide. In mental health settings, assessing for risk to self is a critical priority, as suicide is a leading cause of death among individuals with mental health disorders. While the other clients have important needs as well, they may not present an immediate crisis requiring urgent intervention. The client with post-partum depression may need support and treatment, but their condition typically involves a longer-term management plan. The client suspected of anorexia nervosa requires careful nutritional assessment and may be at risk for various health complications, but they are not necessarily in immediate danger. The client who is washing their hands multiple times may exhibit symptoms of obsessive-compulsive disorder, which can be distressing, yet it does not typically indicate acute risk to self. Therefore, the client expressing a desire to be with their deceased family should be prioritized for immediate assessment and intervention to ensure their safety.

4. Which patient should the nurse assess first after receiving shift report?

- A. A patient with hemothorax attached to a chest drainage system
- B. A restless elderly patient with pneumonitis**
- C. A febrile young patient with influenza
- D. A patient with sinusitis and nasal drainage

Assessing the restless elderly patient with pneumonitis first is crucial due to the potential for respiratory complications, especially in an older adult population who may have a decreased reserve and higher risk for deterioration. Pneumonitis can significantly impair gas exchange, leading to hypoxia and increased work of breathing. The patient's restlessness may indicate anxiety, hypoxia, or an exacerbation of their condition, which necessitates immediate evaluation to determine if further interventions, such as oxygen therapy or additional medications, are needed. In contrast, while the patient with hemothorax requires monitoring, the chest drainage system typically allows for adequate management unless there are significant changes noted. The febrile young patient with influenza, while needing care, is generally at lower risk for rapid deterioration compared with someone experiencing respiratory distress. The patient with sinusitis and nasal drainage is also less likely to require immediate assessment, as these symptoms are usually manageable and pose less acute risk compared to potential respiratory failure in the elderly patient with pneumonitis.

5. A new patient has just been admitted with multiple orders. Which order should the nurse perform first?

- A. Vital signs every 4 hours
- B. Amoxicillin 250 mg by mouth first dose now
- C. Collection of CBC, electrolytes, urinalysis, and blood cultures
- D. Insulin 2 units Humulin subcutaneous now**

Administering insulin subcutaneously should be the nurse's first action in this scenario due to its critical role in maintaining the patient's metabolic stability, particularly if there is a known history of diabetes or elevated blood sugar levels. Insulin's effects are rapid, and timely administration can prevent the serious consequences of hyperglycemia, such as diabetic ketoacidosis or hyperglycemic hyperosmolar state. Immediate attention to blood sugar levels is essential for the safety and well-being of the patient, especially if the admission is due to concerns about metabolic or glucose management. In contrast, while other tasks like checking vital signs, administering antibiotics, and collecting laboratory samples are important, they generally do not present the same level of immediate risk to the patient's safety. Vital signs provide ongoing patient assessment but do not require immediate action like insulin can. The administration of amoxicillin is important for addressing potential infections, but antibiotic stewardship often allows for a short delay, especially if there is no immediate threat to the patient's condition. Similarly, while collecting lab tests is crucial for diagnosis and treatment planning, these can often be done after addressing any immediate critical needs, such as administering insulin.

6. 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.

7. What is the nurse's priority action when encountering a patient with a nasogastric tube that has green drainage?

- A. Notify physician.
- B. Hold bolus and recheck residual volume in 1 hour.
- C. Assess for abdominal distension.**
- D. Document findings with no further action.

In the scenario of a patient with a nasogastric tube that has green drainage, the priority action is to assess for abdominal distension. This is crucial because green drainage can indicate the presence of bile, which may suggest that the gastrointestinal tract is compromised or that there is a blockage or other underlying issue. Assessing for abdominal distension allows the nurse to evaluate the patient's condition more thoroughly, potentially detecting complications such as an obstruction, ileus, or other abdominal issues that may require immediate intervention. Identifying the cause of green drainage through assessment will guide subsequent actions, such as notifying the physician or adjusting the feeding plan. Therefore, the assessment is the foundational step before deciding on further measures. In this context, assessing the patient's abdomen provides valuable information that could influence the management plan.

8. What is the highest priority intervention for a patient with a suspected pneumothorax?

- A. Monitor oxygen saturation levels
- B. Administer an intravenous bolus
- C. Prepare for chest decompression**
- D. Position the patient for comfort

The highest priority intervention for a patient with a suspected pneumothorax is to prepare for chest decompression. A pneumothorax occurs when air enters the pleural space, leading to decreased lung expansion and potential respiratory distress. In severe cases, this condition can compromise the patient's ability to breathe adequately and can lead to tension pneumothorax, a life-threatening situation where increased pressure in the thoracic cavity can compromise cardiac output and respiratory function. Preparing for chest decompression directly addresses the underlying issue of trapped air in the pleural space, which is crucial for restoring adequate lung expansion and function. This intervention is prioritized over others because timely decompression can prevent the progression of respiratory failure and stabilize the patient. Monitoring oxygen saturation, administering an intravenous bolus, and positioning the patient for comfort are all important supportive measures in managing a pneumothorax, but they do not resolve the immediate threat that a pneumothorax poses. While monitoring oxygen saturation helps assess the patient's respiratory status, it cannot rectify the underlying cause. Similarly, an intravenous bolus may be necessary for hydration or blood pressure support, but it does not address the critical need for airway management in the context of a pneumothorax. Positioning the patient for comfort might improve

9. Which scenario indicates that immediate evaluation and treatment are required by the healthcare provider?

- A. A patient with prolonged PR interval
- B. A patient showing improvement post-hospital discharge
- C. A patient with persistent nausea after medication therapy
- D. A patient reporting increased lethargy after surgery**

The scenario involving a patient reporting increased lethargy after surgery indicates a need for immediate evaluation and treatment by the healthcare provider. Increased lethargy can signal several underlying issues that may require prompt intervention, such as complications from anesthesia, infection, bleeding, or other post-operative complications. This change in the patient's condition is significant because it diverges from expected recovery patterns and could impact the patient's overall safety and recovery trajectory. In contrast, while prolonged PR interval can indicate potential atrioventricular block, it may not necessarily require immediate intervention without other critical symptoms or changes in the patient's status. The patient showing improvement post-hospital discharge indicates that they are recovering and do not need urgent evaluation. Persistent nausea after medication therapy warrants attention but may not be as urgent as the changes in lethargy post-surgery.

10. While inserting a urinary catheter, which symptom requires immediate intervention?

- A. Resistance when inflating the balloon**
- B. A brief pinching sensation
- C. The patient feels the need to urinate
- D. Proper positioning of patient's labia

Resistance when inflating the balloon of a urinary catheter indicates a potential issue that requires immediate intervention. The balloon is designed to hold the catheter in place within the bladder by inflating with sterile water after proper placement. If there's resistance when attempting to inflate the balloon, it may suggest that the catheter is not correctly positioned within the bladder, potentially indicating that it is lodged in the urethra or that there may be trauma to the bladder wall. This situation can lead to complications such as bladder distension, pain, or even injury. Therefore, it is crucial to stop the inflation and reassess the catheter's placement before proceeding. The other symptoms listed do not indicate an immediate concern. A brief pinching sensation can be a normal part of catheter insertion due to the manipulation of tissues but does not necessarily require immediate action. Feeling the need to urinate is also common during catheterization as the bladder becomes irritated, and proper positioning of the patient's labia is important for ensuring a sterile procedure but does not signal a complication requiring urgent intervention.

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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