The Fatal Mistakes Report

By Claire Corter

IMPORTANT:

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How to Avoid Six Fatal HESI Mistakes

Claire Corter – YourBestGrade.com

On the free HESI practice exam at https://www.yourbestgrade.com/hesi/tests/1/tos, most students failed to choose the correct answer to the same six questions on the test.

I was surprised to find that these questions stumped so many students... Just look at the chart below and you`ll see I`m not kidding – these questions STUMPED!

Question	Students Who Answered Correctly
1 (#19)	16%
2 (#12)	32%
3 (#15)	29%
4 (#17)	38%
5 (#6)	42%
6 (#2)	61%

What is it about these questions that challenged so many students?

To delve into this, I sat back in my chair and wrote this report on the 6 most difficult questions in the practice exam according to the test outcome statistics.

I thought this should really help you out in gaining that EXTRA layer of understanding and NEVER repeating those mistakes again.

The Six Fatal Questions

Let's review these six questions that were missed so frequently and try to develop some baseline information that you can recall next time you face a similar question on your actual HESI Exit Exam.

1. A client is prescribed to receive one-quarter strength tube feeding at 40 ml per hour. If the nurse has 80 ml of full strength tube feeding solution, how many hours of feeding is available? (Only enter the numeric value.)

Correct answer: 8
80 ml / 40 ml per hour = 2 hours of feeding at full strength feeding. However, ***the question asks how long one-quarter strength feeding will last.*** Take the 2 hours and divide by 0.25 = 8 hours of one-quarter strength continuous feeding.

I think there are only two reasons this question didn't receive more correct answers. The first reason is it's well known that the HESI plants extra information in questions that can distract you from the real question and answer. In this case, you may have skipped over the "one-quarter strength" and you might have just focused on the 40 ml per hour and worked the math from there. Your answer might have been 80 ml / 40 ml per hour = 2 hours of feeding.

When you see one-quarter strength in the formula, you must work the original problem as above. Then take your answer 2 and divide by .25. This will give you the correct answer of 8 hours of one-quarter strength continuous feeding.

One technique that I use to prevent myself from skimming a calculation problem is to write down the figures and set up the equation on a piece of paper. Then I check my equation with the on-screen question to be sure I've have done it correctly. ***Don't ever just solve a HESI calculation in your head no matter how easy it appears.*** Remember, less than twenty percent of students chose the right answer to this question.

The only other reason why anyone would miss this question is if you are uncertain about how to calculate these problems. In that case, I'd suggest a crash revisit to your medication calculation book, or, even better, taking some of our Dosage Cal practice tests in our premium program. Work as many of the problems as you can to gain competence. On the HESI, missing a numeric calculation is a big strike against your test score, and it's why we made sure to cover every type of calculation question you can possibly encounter in our Dosage Cal practice tests (you can access them at www.yourbestgrade.com/hesi/members).

2. A client is prescribed 1200 units of intravenous heparin per hour. The medication is provided as 25,000 units in 2.5 dl (deciliters) of normal saline. Calculate the rate in which the nurse should administer this medication in ml (milliliters) per hour. (Only enter the numeric value.)

Correct answer: 12

Another calculation question; only 32% of the students computed the correct answer. I think the problem here is a conversion error from deciliter (dl) to milliliter (ml). So let's do a brief review of conversions. If you can commit these prefixes to memory and you can do calculations, you should never miss another math answer again.

Common Prefixes to Know in Medical Measurements	
Kilo – one thousand times	1kg = 1000 g
Hecto – one hundred times	100L = 1hL
Deka – ten times	10L = 1 dal
Deci – one tenth	1L = 10 dL
Centi – one hundredth part of	1L= 1
Milli – one thousandth part of	1g=1000 mg, 1L = 1000 mL
Micro – tiny	1000 mcg = 1mg, 1 million mcg = 1 g

The client is receiving 1200 units of heparin every hour.
One deciliter equals 100 milliliters. Convert the 2.5 dl to 250 ml
25,000 units / 250 ml = 100 units/ml
1200 units/hour divided by 100 units/ml
1200 / 100 = 12 ml/hour

If you knew how to make the conversion and you still missed this question, hit the calculation practice questions at www.yourbestgrade.com/hesi/members.

3. When reviewing the laboratory results of a client with a proximal small bowel obstruction, which finding should the nurse anticipate?

A. Metabolic acidosis
B. Hypokalemia
C. Decreased serum amylase levels
D. Hyperchloremia

Correct Answer: B Hypokalemia

This is one of those HESI questions that require that you know about the first condition and that information will lead you to the correct second condition.

A bowel obstruction is a partial or complete blockage of the bowel that prevents the passage of intestinal contents. Now take a close look at the symptoms of this type of blockage.

Symptoms:

- Nausea and Vomiting;
- Inability to pass stool or flatus;
- Breath odor;
- Abdominal distention, fullness, pain and cramping.

By recalling these symptoms, you unlock the key to the correct answer. If a client with an SBO experiences vomiting, this means loss of potassium, and increased risk for hypokalemia. Vomiting also leads to hypochloremia and metabolic alkalosis due to loss of hydrochloric acid in the stomach.

When reviewing the stats on this question, I noticed many people selected A, Metabolic Acidosis, as the correct answer. I feel this is partly because we're all intimidated by arterial blood gas results (ABGs) and then simply stop thinking. Our brain just gives up because "this is difficult," and instead of carefully thinking through the scenario, we pick something that sounds correct-ish. "Metabolic" feels like a reasonable choice when dealing with a GI illness, so we jump towards that answer choice.

Next time you run into an ABG scenario (or any lab scenario for that matter), force yourself to take the time to properly break down the question. As I outlined above, start with the condition and recall what you know about it. SBO means gastric contents cannot flow through. This leads to build-up in the stomach and eventually to vomiting and leads loss of gastric contents.

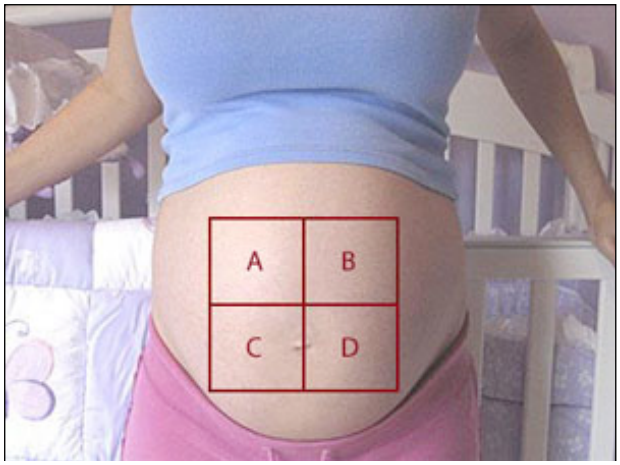
The next step is easy. When we say "loss of gastric contents," what exactly is lost? The stomach plays a major role in digestion, making 1) digestive enzymes and 2) stomach acid. Even if you don't know that stomach acid is "hydrochloric acid," you can still deduct that loss of "acid" of any kind will push the internal pH from neutral to base, as there is less acid to balance out our carefully calibrated balance. That means we expect this patient to experience alkalosis, not acidosis. Choice A is out.

Anytime you encounter an Acid-Base problem, break it down into these simple steps. Let's say you're asked about the expected Acid-Base profile in a client who is hyperventilating. How does hyperventilation or rapid breathing affect the body? It makes us lose CO2. Is CO2 an acid or a base? An acid. (This part is knowledge, just like you should know that HCO3 or bicarbonate is the body's main base). So, in hyperventilation, we expire more acid than usual. What does this do to our pH? Exactly! If we lose acid, we push the internal pH from neutral to base, so again, we expect this patient to be alkalotic. They will experience respiratory alkalosis.

When you break it down like this, there is nothing intimidating about ABGs. So, next time you encounter an ABG question, and your mind is like, "I never get those right, so

let me just give up and pick something," stop yourself and get into it. They are easy once you allow yourself to believe you can handle them. Confidence is everything!

4. The nurse is assessing a client in labor and finds the fetus has a right sacrum anterior (RSA) position. In order to place the fetal heart transducer properly, the monitor should be placed in which of the following areas?



Correct Answer: A

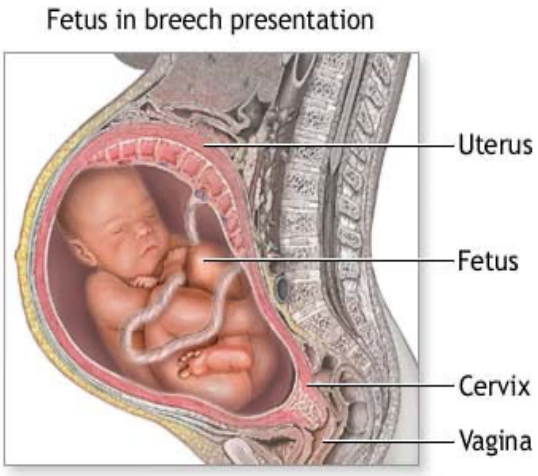
The right sacrum anterior (RSA) position indicates the baby buttocks faces anteriorly and towards the mother's right side of the abdomen. If you're familiar with fetal lie positions before delivery, you recognize that RSA is a breech position.

In breech presentations, fetal heart sounds are usually heard above the level of the umbilicus. This is because the fetus is situated with the head and upper body toward the upper quadrant and the legs and feet closer to the vagina. The heartbeat is best heard over the baby's back. In this case, the back faces the front of the abdomen. Therefore, the nurse should place the fetal monitor within the right upper quadrant (A).

Only 38% of the students taking our practice HESI test chose the correct answer to this one. It's no surprise. If you read any of the discussions posted on the nursing student pages online, you'll see that one of the biggest Achilles' heel of many nurses is the topic of maternity. Many of these nurses and student nurses leaving comments are women and many of them are also mothers. Don't assume because you're a parent, that you know this information. Maternity questions are always popular with the test writers. This is one area that requires your study focus.

Fetal lie is difficult to become test-ready on without using visual aids. You probably have at least one nursing text that graphically depicts the different fetal positions. Try to commit all of the positions to your memory. Be sure you can recognize all positions

that may require a C-section delivery including a frank breech, a complete breech and a transverse lie. There's a very good chance you'll be tested in this area.



If you find the hotspot question format intimidating, we have over 100 hotspot questions to practice on, available in our premium program at www.yourbestgrade.com/hesi/members.

5. The nurse is caring for a client who received four liters of intravenous fluid during an orthopedic surgical procedure yesterday and has continuous intravenous fluids running. Upon assessment, the client is confused, lethargic, and keeps asking for water or ice chips. Based on the client's presentation, what action should the nurse take?

A. Measure orthostatic vital signs.
B. Obtain order for Cortisol level.
C. Initiate workup for Diabetes Insipidus.
D. Review most recent serum sodium level.

Correct Answer: D

This is another question that may look intimidating at first glance. The trick is to focus on what matters. In order to correctly answer this question, the first step is identifying a diagnosis to match the client's symptoms.

In this scenario, the client is exhibiting excessive thirst, lethargy, and confusion and has received copious amounts of intravenous fluid over the past day. The nurse should recognize that this presentation is suggestive of an electrolyte imbalance, particularly a sodium abnormality. Intravenous fluid administration, especially in large volumes, can significantly impact the electrolyte balance, potentially leading to either

hyponatremia or hypernatremia. Both conditions can cause neurologic symptoms such as confusion and lethargy, and both can stimulate thirst as the body attempts to correct the imbalance.

Hyponatremia can occur if the administered IV fluids administered are hypotonic (having a lower osmolality than plasma), such as 0.45% saline or 5% dextrose in water, which can dilute the sodium in the blood if the kidneys don't excrete the excess water efficiently.

Hypernatremia can result from the administration of isotonic fluids like normal saline (0.9% saline) in large volumes, particularly if the client has underlying conditions that limit renal excretion of sodium, such as kidney dysfunction, or if the client has excessive losses of water with comparatively less sodium loss (e.g., insensible water loss from fever, sweating, or respiratory illness).

Now that we've established a likely diagnosis, let's look at the listed answer choices and review them one by one. Again, we'll use our existing knowledge of each condition (step 1) to predict how they would fit in the listed scenario (step 2).

"Measure orthostatic vital signs:**"** Orthostasis means a drop in blood pressure when changing positions, resulting in dizziness, lightheadedness, and syncope. These findings do not directly align with the client's presentation. On top of that, it is unlikely that the client is experiencing orthostasis in the setting of continuous IV fluid administration. While measuring orthostatic vital signs provides information on volume status changes, this is more relevant is scenarios of underfilling, not overfilling. We can eliminate this choice.

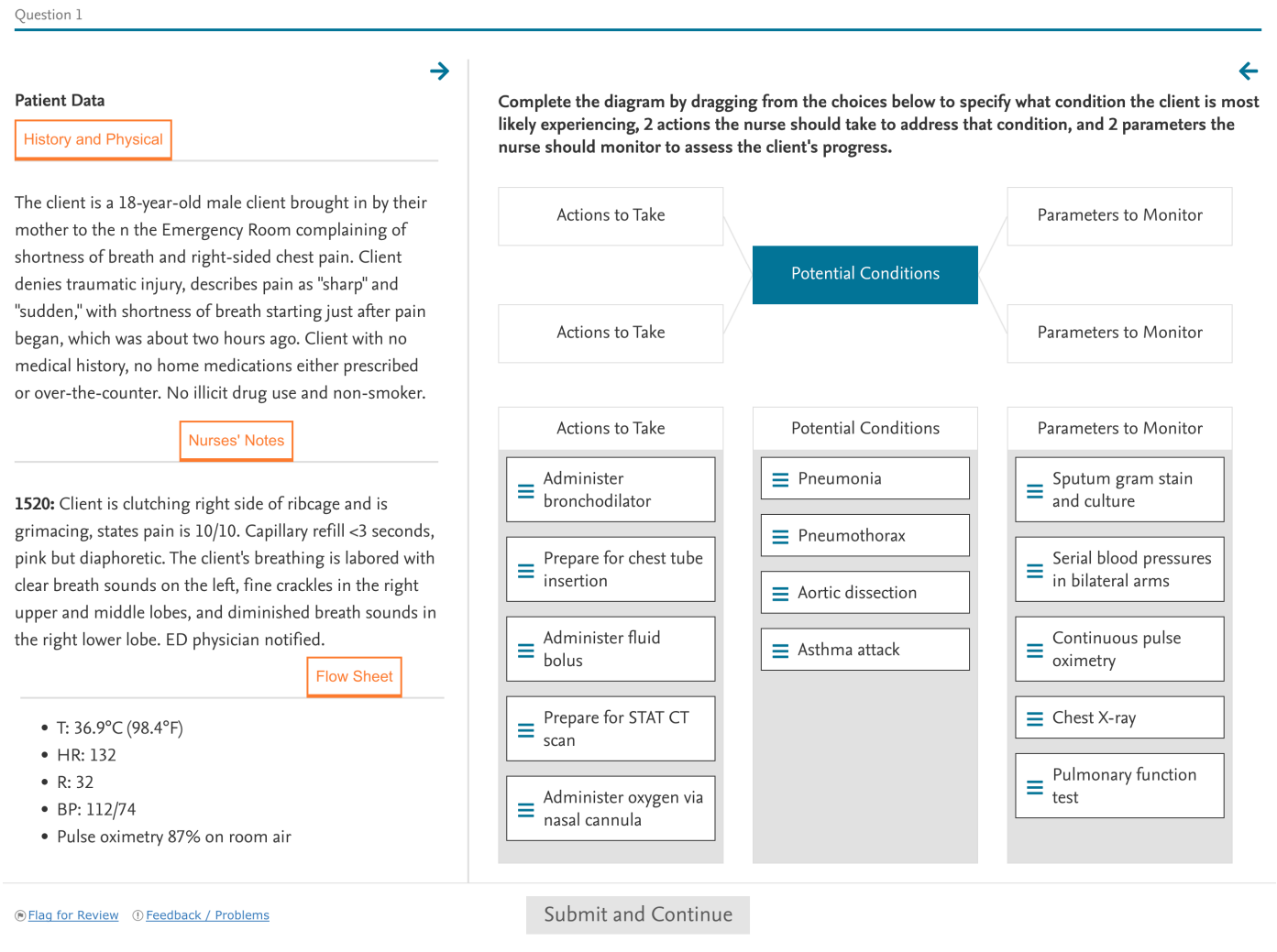
"Obtain order for Cortisol level:" Cortisol is a hormone produced by the adrenal glands in response to stress. It leads to sodium and water retention in the kidneys. This could explain the client's symptoms. This is where step 2 comes in. Why would this client with no listed medical history all of a suddenly develop a problem with their cortisol levels? Could it be related to the surgery? While surgery is a form of "stress," it does not typically throw off our hormone levels to the degree that we end up with massive electrolyte abnormalities. People with pre-existing Addison disease may be thrown into an "adrenal crisis" but there is no mention of this condition in the stem. Instead, the client's symptoms and recent fluid history suggest their electrolyte imbalance is more likely due to excessive IV fluid administration. As such, obtaining cortisol levels is probably not the first action the nurse should pursue.

"Initiate workup for diabetes insipidus:" DI is a condition where too little antidiuretic hormone (ADH) is produced by the pituitary, resulting in extreme thirst and hypernatremia. Again, this is a possible explanation for the client's symptoms. But why would they have DI all of a sudden? DI typically develops in clients with head trauma or following neurosurgical procedures due to damage to the hypothalamus/pituitary. Again, this is not the best fit in the current scenario. A workup

for DI can be considered if more obvious causes have been eliminated but would not be the prioritized initial test for this client.

"Review most recent serum sodium level:" Given the client's suspected sodium imbalance, reviewing the serum sodium level is critical. Whether the administered fluids have resulted in hyponatremia or hypernatremia, the sodium level will guide further interventions to correct the imbalance and address the symptoms of confusion, lethargy, and thirst. This action is a direct measure that reflects the impact of IV fluid administration on the client's electrolyte status. This means option D is correct.

6. Last but not least, students scored an average of 3 out of 5 points for this question. Because many students are worried about Next Generation questions, I wanted to discuss this bowtie and show you how partial credit grading can work in your favor:



Perhaps the most "strange" looking Next Generation question format is Bowtie. Bowtie questions are unique in their layout, as they resemble a bowtie on the screen, with antecedents on the left side and outcomes on the right side. These questions assess all six aspects of the NCSBN Clinical Judgment Measurement Model (*Recognize cues, Analyze the cues, Prioritize hypotheses, Generate solutions, Take action, Evaluate outcomes)* at once, and you are required to match the antecedents with the appropriate outcomes.

Bowtie items are based on a clinical scenario, and often contain Nurses' Notes, Labs, Vital Signs, and other clinical information. Make sure you open all tabs before attempting to answer the question. Once you've accessed all available information, start by focusing on the "Potential Condition." This is the corner stone of the Bowtie. Once you've selected your potential condition, you'll use it to guide your antecedents and outcomes selection. If you do not adhere to this order, you're sure to end up making costly mistakes!

In this scenario, we're dealing with 4 potential conditions:

- Pneumonia
- Pneumothorax
- Aortic dissection
- Asthma attack

We can simply eliminate the choices one by one, based on the information provided in the side tabs. Remember to look at, and critically review, all answer options, even if one is jumping out at you!

- **Pneumonia** is unlikely to be correct because this client is not showing signs and symptoms of infection such as fever or cough.

- **Spontaneous pneumothorax** is a likely diagnosis for this client, as they present with sudden, sharp chest pain accompanied by shortness of breath, tachypnea, and tachycardia. Lung auscultation reveals diminished or absent lung sounds over the lung or part of the lung. On pulse oximetry, clients can be hypoxemic, as seen in this scenario. Young males are at higher risk for spontaneous pneumothorax than females.

- **Aortic dissection** would present with intense, sudden onset back pain, hypotension, or stroke-like symptoms such as unilateral weakness and difficulty speaking. This is not consistent with the presented scenario.

- **Asthma** is likely to be incorrect because this client does not have any history of asthma and does not have any wheezing upon auscultation of the breath sounds. Asthma would affect both lungs. Diminished breath sounds over a single lobe does not fit with this diagnosis.

Based on our assessment, pneumothorax is the most "Probable Condition" in this scenario. At this point, drag your choice to the center of the bowtie.

Next, move on to the column on the left, labeled "Actions to Take." We now know that the actions to take should focus on care items that are appropriate for a client with a pneumothorax. Again, we go through the listed items in a systematic order.

- **Administer bronchodilator:** Incorrect, as this would be appropriate for a client with asthma.

- **Prepare for chest tube insertion**: Correct, as this would help remove trapped air from the thorax and allow for re-expansion of the lung.

- **Administer fluid bolus**: Incorrect, as the client is not hypotensive or dehydrated, so there is no need for fluids.

- **Prepare for STAT CT scan**: Incorrect, as a pneumothorax is typically diagnosed by X-ray alone. This would be more appropriate for a suspected Aortic Aneurysm.

- **Administer oxygen via nasal cannula**: Correct, as the client's pulse oximetry is 87% on room air.

After you drag over the correct answers to the "Actions to Take" boxes, move on to the "Parameters to Monitor" Column. Again, we go through the listed items in a systematic order, looking for appropriate monitoring interventions for a client with a pneumothorax.

- **Sputum gram stain and culture**: Incorrect, as this is appropriate for a client with pneumonia, but does not have a role in the management of a pneumothorax.

- **Serial blood pressures in bilateral arms:** Incorrect, as this is appropriate for a client with an Aortic Aneurysm, but does not have a role in the management of a pneumothorax.

- **Continuous pulse oximetry:** Correct, as this will help the nurse to titrate oxygen flow and determine how well the client is oxygenating in response to lung re-inflation following chest tube placement.

- **Chest x-ray:** Correct, as a chest X- ray is the imaging modality of choice to diagnose pneumothorax and to monitor lung re-expansion following chest tube placement. Once a chest tube is in place, an x-ray is completed daily to determine response to treatment.

- **Pulmonary function test:** Incorrect, as this is appropriate for a client with asthma or COPD.

Drag over the correct answers to the to the "Parameters to Monitor" boxes, and you've successfully completed your bowtie!

At the first page of this report, you may have noticed that this question had the highest average of students who answered it correctly. That is not because this is the easiest test item from the 6 (in my opinion). This is the new partial credit grading in action!

As discussed in the Critical Thinking Report I sent you last week, all Next Generation questions allow for partial credit scoring. This is a significant change because it means you can now get points even if you answer only some parts of the question correctly. That's good news, as it gives you a better chance of earning points for your responses, and the stats show it!

(If you didn't read the Critical Thinking Report, I recommend checking it out at https://www.yourbestgrade.com/hesi/CT-Report.pdf)

While many students freak out about how difficult the Next Gen questions look, our statistics show that, if you are well prepared, the new question format should actually help you perform better!

For example, if you had correctly identified the condition as pneumothorax but only selected 2 out of the 4 other correct answers, you would have still scored 3 out of the 5 available points. That's a lot better compared to Legacy Multiple Response ("Select All That Apply") questions where you needed to correctly identify all 5 answers just to score 1 point!

Do keep in mind that, some items, like the Next Gen extended multiple-response questions, will have points subtracted for incorrect answers. Therefore, to guarantee

your top performance, we explore the updated scoring guidelines and resulting test-taking strategies in much greater detail in our new HESI Review Guide, which you can find in our premium program at www.yourbestgrade.com/hesi/review

*** Next Generation Bonus ***

Before ending this report, I would like to take some time and share a bit more about the new Next Generation questions.

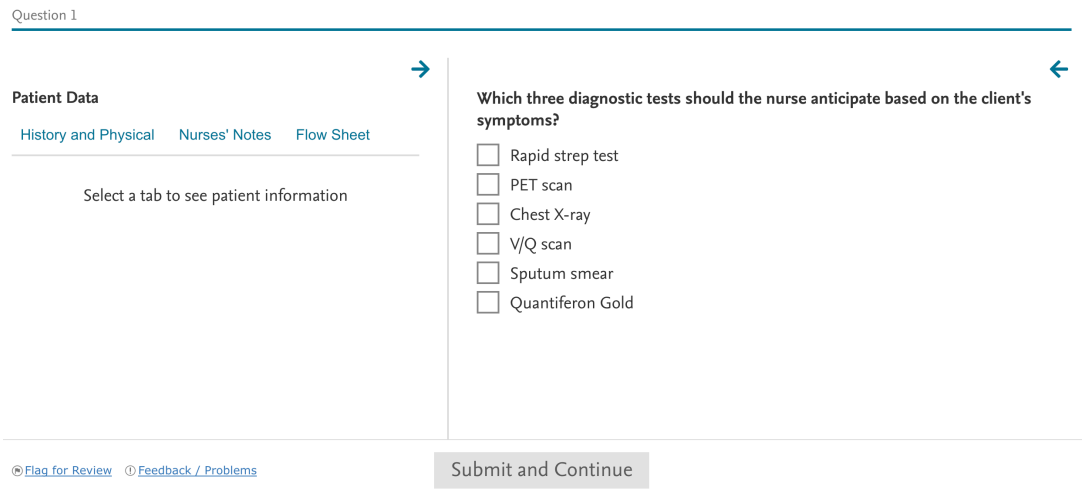
As you may remember from the Critical Thinking Report, if you need to take the HESI Exit Exam in 2024, depending on your school, you will either be taking the *HESI Exit Next Gen* or the *HESI Exit Legacy Exam*.

The difference between the two exams is that the *HESI Exit Next Gen* exam includes new Next Gen style questions, such as the bowtie item we just discussed.

As mentioned, in our premium program, we include a comprehensive overview of everything Next Gen, implications for your exam, and Next Gen strategies.

But because I want to help as many students as possible succeed on the HESI, I'd like to give you a little sneak peek right here and now.

In the free practice test, you completed an unfolding case study that started with the following question:



Rather than focusing on the content of this specific unfolding case study (UCS), I want to dedicate a few words to some general principles when dealing with these questions.

Unfolding case studies consist of a series of 6 linked questions that refer to one unfolding clinical scenario. Throughout the case, more and more information becomes available about the client's condition and response to interventions. An unfolding case study follows a client throughout their hospitalization or throughout multiple visits in the outpatient setting. This question format is presented as a client chart, and new information is constantly added as it becomes available (e.g., labs, vital signs, diagnostic tests). Once you've answered a question, you cannot click back to an earlier question in the case study.

There are 15 new question styles that could be used in the unfolding case study format. For example, in this specific UCS you encountered an "Extended Multiple Response Select N" item, an Extended Multiple Response Select All That Apply" item, a "Drop Down Cloze" item, a "Drag and Drop Rationale" item, a "Matrix Multiple Response Grouping" item, and a "Highlight in text" item. Each question style item comes with a different scoring rule. Familiarize yourself with the different styles and their respective scoring keys before your exam to get the most out of each question! You can find a detailed review of NGN question styles, scoring, and other relevant NGN strategies in the HESI Review Report that we have created for our members.

That being said, I'll give away one super important UCS strategy tip right here.

This sounds like a no brainer, but it is the number one error saver: **Make sure you recheck every single tab every time you answer a new question.** New information is being made available throughout the case, and you don't get notified of new results, nursing notes entries etc. Often, this new information contains important clues to correctly answer the questions. **Make sure you don't just "click" a tab, but actively scroll down** as new information is added below previous entries, and not everything is available at a single glance.

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Well, that was a brief review of six HESI practice questions that seemed difficult for most students, as well as some Next Generation test taking tips. I hope you gained some insight and understanding from it.

The purpose of the HESI is really to help you identify the study areas you need to double up on. Therefore, before taking the HESI Exit Exam, track your difficult topics and start to master them.

If this report got you motivated to adequately prepare yourself for the HESI Exit Exam, and if you want to learn and practice answering HESI Exit questions in a true HESI format, you can…

I'll show you exactly how to do that in my course HESI Study Insider and you can check it out at www.YourBestGrade.com/hesi/letter today.

It's all about helping you pass your HESI Exit Exam and it is backed by a 100% guarantee!

To your HESI success,

Claire Corter