

LPN / LVN EXAM PREP

NCLEX-PN STUDY GUIDE

220+ High-Yield Terms & Concepts for the Practical
Nursing Licensure Exam (LPN/LVN) — Updated for
the 2026 Test Plan



TemplateForge

Exam Prep Series

220+ High-Yield Terms & Concepts for the Practical Nursing Licensure Exam (LPN/LVN)

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How to Use This Guide

The NCLEX-PN is the national licensure exam for practical nurses (LPN/LVN) -- developed by NCSBN, administered by Pearson VUE, and required by every state board of nursing before you can practice. It is a computerized adaptive test (CAT): the computer selects each question based on your previous answers, so no two candidates see the same exam. You will answer a minimum of 85 items and up to 150 items within five hours (including breaks), and the test stops as soon as the computer can decide -- with 95% confidence -- whether your ability is clearly above or clearly below the passing standard. There are no per-question minimums, no numeric score, and no fixed percentage of candidates who pass or fail: you either meet the passing standard or you don't. Exam length says NOTHING about whether you passed. Content follows eight weighted categories from the 2026 Test Plan -- Coordinated Care (largest), Safety and Infection Prevention and Control, Health Promotion and Maintenance, Psychosocial Integrity, and the four Physiological Integrity subcategories (Basic Care and Comfort, Pharmacological Therapies, Reduction of Risk Potential, Physiological Adaptation). Every exam also includes three case studies (six items each) that walk the six steps of the NCSBN Clinical Judgment Measurement Model, plus roughly 10% stand-alone clinical judgment items and 15 unscored pretest items. This guide maps the exam the way it actually runs. Work Part 1 for the rules of the test, Part 2 for the new clinical-judgment item types, then grind the eight content areas in the order that matches your weakest category -- Coordinated Care and Pharmacological Therapies carry the most weight, so budget your study time the same way. Finish with Part 12 for your CAT study plan and test-day playbook. Honest positioning: this is an independent study aid, NOT approved, endorsed, or produced by NCSBN or Pearson VUE -- their official Test Plan, Candidate Bulletin, and candidate tutorial are free at nclex.com.

Exam Overview: The NCLEX-PN

CAT format, 85-150 items, 5 hours (all breaks included), 15 unscored pretest items, 3 clinical judgment case studies (18 items), ~10% stand-alone clinical judgment items. Content: Coordinated Care 18-24%, Safety & Infection Prevention and Control 10-16%, Health Promotion and Maintenance 6-12%, Psychosocial Integrity 9-15%, Basic Care and Comfort 7-13%, Pharmacological Therapies 10-16%, Reduction of Risk Potential 9-15%, Physiological Adaptation 7-13% (content may vary $\pm 3\%$ per category). Pass = ability at or above the NCSBN passing standard (95% confidence rule, maximum-length rule, or run-out-of-time rule). Administered by Pearson VUE; results from your board of nursing (within 6 weeks; paid Quick Results where available). Retake waiting periods (commonly 45 days) are set by your state's board of nursing.

Part 1: The NCLEX-PN & How CAT Works (14 Concepts)

The rules of the exam itself: format, scoring, registration, and results.

#	Term	Key Facts	Strategy Tip	Example
1	The NCLEX-PN	National Council Licensure Examination for Practical Nurses: the licensure exam for LPNs/LVNs, developed and owned by NCSBN and required by every U.S. state and territorial board of nursing.	Know it as "PN" (practical nurse), not RN -- the exam content is entry-level LPN practice.	An LPN-program graduate must pass the NCLEX-PN before receiving a practical-nursing license in their state.
2	Computerized Adaptive Testing (CAT)	The computer selects each item based on your previous answers and re-estimates your ability after every response -- tailoring difficulty to you.	Treat every item as if it counts -- the next question literally depends on it.	After correct answers, the next items get harder; after misses, easier -- the computer homes in on your true ability.
3	Item Selection Criteria	Items are chosen to (1) match the 2026 Test Plan percentages, (2) stay challenging at your ability level, and (3) avoid repeating items you've seen on a previous		

4	Minimum & Maximum Length	85 minimum items; 150 maximum items; five-hour limit	You can't control the mix -- but you can expect roughly the published category percentages.	A candidate strong in meds gets harder dosage items, yet Coordinated Care items still appear in proportion.
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that INCLUDES all breaks.
Every candidate gets a
different length based on their
response pattern.

Never read the item counter as
a pass/fail signal -- length

A candidate who stops at 96 items can pass; another who

5	NCLEX-PN Study Guide	The 15 Pretest Items	Every exam includes 15 unscored pretest items mixed in -- new items being calibrated for future exams; you cannot tell which they are.	Answer ALL items with full effort -- a pretest item costs the same time as a scored one.	A 150-item exam has 125 scored questions and 15 experimental ones scattered throughout.
6		The 95% Confidence Interval Rule	After the minimum number of items, the computer stops when it is 95% certain your ability is clearly above or clearly below the passing standard.	Trust the system: if you're solidly passing, the test can end quickly -- that's a good sign, not a red flag.	A strong candidate answers 90 well and the exam ends with a pass -- the computer was 95% sure by then.
7		The Maximum-Length Rule	If ability stays near the passing standard, items continue to 150; then the FINAL ability estimate decides pass or fail.	A 150-item exam means you were close to the line the whole way -- don't panic, just finish strong.	At item 150 the final estimate lands above the standard: pass, even though it took the full length.
8		The Run-Out-of-Time Rule	If time expires before 150 items: fewer than 85 answered = automatic FAIL; ?85 answered = scored on your final ability estimate.	Pace yourself so you ALWAYS clear 85 -- an unanswered-by-time exam below 85 fails regardless of quality.	A candidate answers 92 strong items but runs out of time -- the computer scores the 92 responses (no auto-fail).
9		No Skipping, No Going Back	Every item must be answered to advance (the system won't move on without an answer); once you confirm &#x26;NEXT&#x27;, you can never return.	Decide, answer, and release -- lingering for perfection wastes the time that protects your 85-item floor.	A candidate flags a hard SATA item but cannot return to it after moving on -- best guess beats a skipped question.
10		Partial-Credit Scoring	Items with more than one correct answer can earn partial credit via plus/minus, zero/one, or rationale scoring -- you don't need every key to score.	For SATA/bow-tie items, select what you are SURE of -- careful partial answers earn points.	A four-key SATA item where a candidate selects two correct choices may still earn credit under plus/minus rules.
11		The Passing Standard	NCSBN sets one uniform passing standard; performance is compared to it. There is NO fixed percentage of candidates who pass -- the NCLEX is not graded on a curve.	Ignore your classmates' results -- the only benchmark that matters is the standard, not the room.	In a year where 70% pass, that 70% reflects candidates meeting the standard -- the standard didn't move.
12		Results & Quick Results	Official results come ONLY from your board of nursing within 6 weeks; paid Quick Results (about 2 business days) are available where the NRB participates.	If your NRB offers Quick Results, order it once -- the wait anxiety is real and the cost is minor.	A candidate checks Pearson's Quick Results 48 hours after testing and sees "PASS" before the board's official letter.
13		Retake Rules	Waiting periods are set by your state's board of nursing -- commonly 45 days after a failed attempt. You must re-register, and the exam fee applies again.	Use the waiting window deliberately: re-study your Candidate Performance Report domains, don't re-test on hope.	After failing with "Below" in Pharmacological Therapies, a candidate drills meds for six weeks, then retakes.
14		Registration, ATT & ID	Your NRB grants eligibility and issues an Authorization to Test (ATT); you schedule at Pearson VUE and bring the ATT + government ID.	Register with the EXACT legal name on your ID -- a mismatch means you cannot test and pay again.	A candidate's ATT says "Marie Jones" but the driver's license says "Marie Jones-Smith" -- Pearson blocks check-in until corrected.

Part 2: Clinical Judgment & NGN Item Types (14 Concepts)

The Next Generation NCLEX (NGN) launched April 2023: case studies, new item formats, and the Clinical Judgment Measurement Model.

#	Term	Key Facts	Strategy Tip	Example
15	Next Generation NCLEX (NGN)	The exam format launched April 1, 2023 to better measure clinical judgment and decision-making: case studies, stand-alone items, and multiple new item formats.	Practice NGN-style questions, not just old MC -- the formats change how you answer.	A candidate who drills only single-answer questions is surprised by a bow-tie case-study item on exam day.
16	The Clinical Judgment Measurement Model	NCJMM: an iterative six-step process -- Recognize cues, Analyze cues, Prioritize hypotheses, Generate solutions, Take action, Evaluate outcomes.	Memorize the six steps IN ORDER; case-study items follow them sequentially.	A case study asks "which findings need follow-up?" -> cue recognition; then "which should you do first?" -> prioritize/take action.
17	The Three Case Studies	Every PN exam includes three case studies of six items each (18 items total) that unfold one client presentation across the six CJM steps.	Case-study items share one scenario -- read the whole scenario before answering any item.	A postoperative case study covers cues (vitals), analysis (suspected hemorrhage), priority, solution, action, and outcome evaluation.
18	Stand-Alone Clinical Judgment Items	About 10% of items are independent NGN-format		

questions (bow-tie, matrix, etc.)
not attached to a case study --
the exact count depends on
exam length.

Recognize the format quickly
so the question structure

A stand-alone bow-tie on medication administration asks

19	NCLEX-PN Study Guide	Multiple Choice & SATA	Traditional single-answer MC plus "Select All That Apply" -- SATA asks for EVERY correct option and grades partial credit.	For SATA, treat each option as true/false: select only what you're sure is right.	"Which findings indicate sepsis? Select all that apply" -- fever, tachycardia, and confusion are keys; a single borderline lab is not.
20		Bow-Tie Items	A three-part NGN format shaped like a bow tie: left column (condition/reason), middle actions the nurse takes, right column (parameters to monitor).	Fill the center action column FIRST, then match condition and monitors to it.	A bow-tie on hypoglycemia: left = cause (excess insulin), center = give fast-acting carb + recheck, right = glucose trend and neuro status.
21		Matrix & Grid Items	A table of rows and conditions with "Yes/No," "Complete/Incomplete," or option cells -- mark every row (no blanks).	Every row gets an answer -- an empty cell is always wrong.	A matrix asks "which are appropriate delegation tasks for the UAP?" -- mark each task row yes or no.
22		Highlight (Hot Spot Text) Items	A passage where you click/highlight the words or phrases that indicate a finding -- every highlighted phrase scores separately.	Highlight only strong, distinct findings -- too many weak highlights can cost partial credit.	The nurse highlights "sudden dyspnea," "chest pain," and "hypotension" in a report as cues of a pulmonary embolism.
23		Cloze & Drop-Down Items	Sentences with drop-down menus embedded -- choose the correct phrase for each blank; all blanks must be answered.	Read the full sentence before choosing each blank -- context resolves the option.	"The client's potassium of 6.8 mEq/L requires [immediate intervention / routine monitoring] and [insulin-dextrose / oral rehydration]."
24		Ordered Response (Drag & Drop)	Sequence steps in the correct order (e.g., airway-first interventions). Ordering errors give partial credit for correctly placed items.	Anchor the FIRST step with ABCs or the nursing process, then chain the rest.	Ordering seizure care: ease to floor -> protect head -> time the seizure -> turn to side -> document.
25		Graphic, Chart & Audio Items	Items may attach charts, dose tables, vital-sign graphs, or audio clips (heart/lung sounds) -- the data is part of the question.	Read the graphic BEFORE the stem, then re-read the question -- the data defines the answer.	A telemetry strip showing ST elevation supports the answer "myocardial ischemia" over "normal sinus rhythm."
26		Recognizing Cues	The first CJM step: identify relevant and important data from the history, vitals, labs, and assessment.	Ask "what matters here?" -- abnormal, sudden, or trending data are the cues.	Vitals: BP 82/50, HR 122, urine output 15 mL/hr -- the cues point to hypovolemic shock.
27		Analyze & Prioritize Hypotheses	Connect the cues to a clinical picture (analyze), then rank possible causes by urgency and likelihood (prioritize).	The highest-priority hypothesis is the one that kills fastest -- think ABCs and airway first.	In a client with chest pain + hypotension, "acute MI" outranks "anxiety" and "heartburn" as the priority hypothesis.
28		Generate Solutions, Take Action & Evaluate	Plan interventions toward expected outcomes (generate), implement the highest-priority one (take action), then compare actual outcomes to expected (evaluate).	Always evaluate AFTER acting -- most NCLEX evaluation questions ask "what indicates the action worked?"	After giving oxygen and calling the provider for a desaturating client, the nurse checks SpO2 -- outcome evaluation.

Part 3: Coordinated Care (22 Concepts)

The largest content category (18-24%): delegation, teamwork, client rights, and ethical-legal practice.

#	Term	Key Facts	Strategy Tip	Example
29	Coordinated Care	The Safe and Effective Care Environment category covering delegation, assignment, teamwork, client rights, and continuum-of-care management -- the single largest share of the PN exam.	Study it first: it is the biggest category and its rules appear across all other questions.	A delegation item, a client-rights item, and an advance-directive item all belong to Coordinated Care.
30	Delegation vs. Assignment	Delegation transfers a nursing task to ANOTHER NURSE or UAP and is RN responsibility; PN candidates know WHAT is appropriate to delegate to UAPs and what stays with licensed staff.	UAP tasks = routine, stable, physical care (vitals, ADLs, feeding a stable client); licensed tasks = assessment, meds, teaching, evaluation.	The LPN assigns the UAP to obtain routine vital signs and ambulate a stable client -- assessments and the first teaching stay with the nurse.
31	Prioritization: ABCs	Airway, Breathing, Circulation always outrank comfort, hygiene, or teaching; a compromised airway is the universal first priority.	When a question offers four problems, the client who can't breathe beats the one with a headache.	Four clients need care: stridor (airway), bleeding wound (circulation), pain 7/10 (comfort), discharge teaching (routine) -- airway first.
32	Prioritization: Maslow & Acuity	Physiological needs before psychosocial; the most acute, unstable client first -- stable		

Compare acuities: "just returned from surgery, BP dropping" outranks "scheduled

A postoperative client with falling BP is seen before a client requesting a backrub or

action; evaluation comes after.
When in doubt, the nurse
ASSESES first, then acts --
never act before assessing.

If the stem is a "first action"

A client reports chest pain: the

34	NCLEX-PN Study Guide	Interdisciplinary Team	Coordinated care includes the health care team: HCP/primary provider, nursing, pharmacy, PT/OT, nutrition, social work -- the nurse coordinates and communicates.	Match the discipline to the referral: nutrition = dietitian, mobility = PT, swallowing = speech therapy.	A client with new difficulty swallowing is referred to speech therapy; a fall-risk client to physical therapy.
35	Case Management & Care Coordination	Organizing care across the continuum: admissions, transfers, referrals, discharge planning -- the nurse coordinates services and continuity.	Discharge planning starts at ADMISSION, not at discharge -- expect that phrasing on the exam.	An LPN on admission begins discharge teaching (meds, follow-up) so the client leaves with a workable plan.	
36	Client Rights	The right to informed consent, privacy, confidentiality, dignity, refusal of care, and participation in care decisions -- every client has these, regardless of status.	The client can always refuse -- even a treatment the nurse believes is needed; the nurse informs, documents, and notifies.	A client refuses a scheduled med: the nurse respects refusal, explores the concern, documents, and notifies the provider.	
37	Informed Consent	Requires capacity, adequate information (purpose, risks, benefits, alternatives), and voluntariness. The HCP obtains consent; the nurse witnesses and clarifies, never pressures.	The nurse NEVER decides for the client -- the witness role is to confirm understanding and voluntariness.	Before surgery, the surgeon explains the procedure; the nurse witnesses the signature and reports confusion, not persuasion.	
38	Advance Directives	Living wills and durable power of attorney for health care document future wishes; the nurse respects and implements them.	A living will applies when the client cannot speak; it does not require resuscitation if it declines it.	An unconscious client with a living will declining life support is not resuscitated; the family's later objection doesn't override the documented directive.	
39	HIPAA & Confidentiality	Protected health information is shared only with those who need it for care; breaches include gossip, family member access without consent, and social media.	Ask "who needs to know for THIS client's care?" -- if the answer is no one, share nothing.	A nurse tells a friend about a celebrity admission -- a HIPAA violation even though the friend never repeats it.	
40	Incident Reports	Charting the FACTS of an untoward event (fall, med error) on the incident report; NEVER mention the report or the word "error" in the client's chart.	The chart documents the clinical facts; the incident report is the internal factual document -- they stay separate.	After a fall, the nurse charts "client found on floor at 0215, vitals stable" -- the incident report gets the root-cause details.	
41	Safety Event Reporting	Near misses and errors are reported internally for systems improvement; the focus is preventing recurrence, not punishment.	Report honestly -- cover-ups compound a bad outcome with a credibility breach.	A nurse gives the wrong dose, reports it immediately, the client is monitored, and the unit reviews the double-check system.	
42	Ethical Principles	Autonomy (client choice), beneficence (do good), nonmaleficence (do no harm), justice (fairness), fidelity (keep promises), veracity (truthfulness).	Match the principle to the scenario: choice = autonomy, fairness = justice, no harm = nonmaleficence.	A client choosing hospice over further chemo exercises autonomy; equal care for all clients regardless of insurance = justice.	
43	Negligence vs. Malpractice	Negligence = failure to act as a reasonable person; malpractice = professional negligence (duty, breach, causation, damages) by a licensed professional.	Four elements: duty -> breach -> causation -> harm. Missing any one means no malpractice.	A nurse fails to raise a bed rail (breach of duty) and a client falls and fractures a hip (harm) -- malpractice elements met.	
44	Documentation Standards	Chart facts objectively (what you saw/heard/did), in ink or the EMR, with date/time/signature; never chart in advance or for someone else.	"Chart what you do; do what you chart" -- if it wasn't documented, legally it didn't happen.	The nurse charts "client states pain 6/10, grimacing, med given at 1400, reassessed 1430 pain 3/10" -- objective and complete.	
45	SBAR Communication	Situation, Background, Assessment, Recommendation -- the structured handoff format that reduces errors.	For provider calls, give S-B-A-R in that order and end with a clear recommendation.	"S: BP is 80/50. B: post-op day 1, on epidural. A: suspect hypovolemia. R: assess and notify provider for a fluid bolus order."	
46	Telephone & Prescription Orders	Read-back verification (repeat the order back) is mandatory; verbal orders are for emergencies and require a co-signature per policy.	Repeat every verbal/telephone order back verbatim -- "I read back" prevents most transcription errors.	The provider gives a telephone order; the nurse repeats it word-for-word, writes the order, and the provider co-signs within the required window.	
47	Restraints Policy	Restraints require a provider order with time limits, frequent monitoring (every 15-30 min), release for exercise, and alternatives tried first: never			

A restraint order is NEVER as-needed -- it specifies type, duration, and reassessment.	A confused client gets a bed check and a sitter (alternatives) before a vest restraint is considered under a time-limited order.
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48	NCLEX-PN Study Guide	Quality Improvement	Process improvement uses data to prevent errors: root-cause analysis after incidents, audits, and plan-do-study-act cycles.	The nurse's role: report, participate, implement the new process -- improvement is everyone's job.	After three med errors trace to look-alike labels, the unit adopts tall-man lettering (e.g., hydrOXYzine vs hydrALAZINE).
49		Continuum of Care & Placement	Clients move along a continuum (acute, rehab, skilled, long-term, home, hospice); placement matches the level of care needed.	Ask "what level of daily care does this client need?" -- skilled nursing vs. custodial care vs. home.	A client needing daily skilled wound care and IV therapy goes to skilled care; a client needing only help with ADLs may go home with support.
50		Client Advocacy	The nurse protects the client's interests: speaks up about unsafe orders, explains options, and supports the client's choices.	When a question asks "what should the nurse do about a questionable order?" -- question it, don't silently follow.	A provider orders a dose outside safe parameters; the nurse calls to clarify rather than administering it.

Part 4: Safety & Infection Prevention and Control (20 Concepts)

10-16% of the exam: standard precautions, isolation, PPE, and environmental safety.

#	Term	Key Facts	Strategy Tip	Example
51	Standard Precautions	The baseline for ALL clients: hand hygiene, gloves for body fluids, masks/eye protection for splash, gowns as needed -- regardless of diagnosis.	Apply standard precautions to every client every time -- they are diagnosis-independent.	The nurse wears gloves to start an IV on every client, even without a known infection.
52	Hand Hygiene	The single most effective infection-prevention measure: wash with soap and water for visibly dirty hands or after C. difficile; sanitizer (60%+) otherwise; before/after every client.	Soap+water beats sanitizer exactly when hands are visibly soiled or the client has diarrhea (spore-forming C. diff).	After caring for a client with C. difficile diarrhea, the nurse washes with soap and water -- sanitizer does not kill the spores.
53	Transmission-Based Precautions: Contact	For known/suspected infections spread by direct/indirect contact (MRSA, VRE, C. diff, wound infections): gown + gloves, dedicated equipment.	Contact = touch: gown and gloves before entering; remove at the door.	A client with MRSA in a wound gets contact precautions; the nurse gowns and gloves for every entry and uses a dedicated stethoscope.
54	Transmission-Based Precautions: Droplet	For large-droplet spread within ~3 feet (influenza, meningococcal, pertussis, strep): surgical mask within 3 feet; no N95 needed.	Droplet = mask within 3 feet; think "big, wet, close-range" bugs.	A client with influenza is placed with a mask for anyone within 3 feet; the door can stay open and no negative airflow is needed.
55	Transmission-Based Precautions: Airborne	For small-particle spread (TB, measles, varicella, COVID aerosol procedures): N95 (fit-tested) or PAPR, negative-pressure room, door closed.	Airborne = N95 + negative-pressure + door closed; think "tiny, hangs in the air" bugs.	A client with active TB is in a negative-pressure airborne infection isolation room with an N95 for everyone entering.
56	PPE: Donning & Doffing Order	DON: gown first, mask, goggles/face shield, gloves last. DOFF: gloves first, goggles, gown, mask last; perform hand hygiene after.	"Gown, mask, goggles, gloves" on; reverse off -- gloves come off FIRST so the most-contaminated item leaves first.	Entering an isolation room the nurse dons gown->mask->goggles->gloves; exiting, removes gloves->goggles->gown->mask, then washes hands.
57	Donning PPE: which mask	Surgical mask = droplet precautions; N95 (fit-tested) = airborne. Wear the mask that matches the precaution, not the fanciest one.	Match the mask to the bug: droplet -> surgical; airborne -> N95.	The nurse wears a surgical mask for droplet-precautions influenza care and an N95 for airborne-precautions TB care.
58	Surgical Asepsis (Sterile Technique)	Sterile field, sterile gloves, and sterile supplies for invasive procedures (catheter insertion, wound packing, dressing changes); the sterile field is kept dry and above waist level.	The sterile field stays dry and above the waist -- anything wet, low, or unsterile touching it breaks sterility.	Inserting a urinary catheter, the nurse keeps the sterile field dry and at waist height; a splash of saline contaminates the field.
59	Breaking Sterility	The field is contaminated if it gets wet, is below waist level, is turned away from, or is touched by an unsterile object -- restart with fresh supplies.	When in doubt, throw it out -- restarting is cheaper than an infection.	A nurse's sterile glove touches the bare skin of the client's thigh during dressing change -- the nurse regloves before continuing.
60	Medical vs. Surgical Asepsis	Medical asepsis (clean technique) reduces organisms -- hand hygiene, clean gloves; surgical asepsis (sterile technique) eliminates organisms -- for invasive procedures.	Clean ? sterile: clean for general care, sterile for anything that enters the body.	Clean gloves for a bed bath; sterile gloves and field for inserting an indwelling catheter.
61	The Chain of Infection	Infectious agent -> reservoir ->		

portal of exit -> mode of
transmission -> portal of entry
-> susceptible host. Break any
link to stop the spread.

Most nursing actions break a

link: hand hygiene breaks transmission; PPE blocks portals; vaccination protects the host.

Hand hygiene after toileting a

62	Healthcare-Associated Infections	HAIs develop during care (CAUTI, CLABSI, SSI, VAP); nursing prevention: early catheter removal, sterile insertion, hand hygiene, elevating the head of bed.	Each HAI has a nursing prevention: urinary catheter = remove early; surgical site = aseptic dressing technique.	An indwelling catheter is removed on post-op day 2 because every extra day raises the CAUTI risk -- a cleared nursing action.
63	Isolation Room Entry	Gather ALL needed supplies before entering; limit entries; remove PPE in the anteroom/doorway; perform hand hygiene last.	"Plan your work, then do it" -- batching care and supplies reduces entries and exposure.	The nurse enters the airborne room once with vitals, meds, and assessment supplies to minimize time in the negative-pressure room.
64	Fire Safety: RACE	R = remove clients from danger, A = activate the alarm, C = contain the fire (close doors/windows), E = extinguish (using PASS).	The ORDER matters: people before property -- remove clients, THEN fight the fire.	Smoke appears on a unit: the nurse removes clients from the area, pulls the alarm, closes doors, and uses the extinguisher on a small fire.
65	Fire Extinguisher: PASS	P = pull the pin, A = aim at the base, S = squeeze the handle, S = sweep side to side.	Aim at the BASE of the fire (the fuel), not the flames, and sweep.	A small trash-can fire: pull, aim low at the base, squeeze, sweep until out -- then evacuate if it grows.
66	Fall Prevention	Identify fall risk (history of falls, age, meds, gait, confusion), use bed alarms, low beds, side rails, non-skid socks, call light within reach, hourly rounding.	"High-risk = high-touch": bedside perimeter checks and call light placement are first-line, before restraints.	A confused elderly client with a previous fall gets a bed alarm and hourly checks; the nurse keeps the call light and walker within reach.
67	Restraint Alternatives	Toileting schedules, bed alarms, sitters, repositioning, lighting, and comfort measures are tried BEFORE restraints whenever possible.	The exam loves alternatives -- the nurse tries a sitter and a toileting routine before ever considering a vest.	A restless client at night gets a toileting schedule and a bed alarm instead of a vest -- alternatives reduce restraint use.
68	Seizure Precautions	Padded side rails, bed in lowest position, oxygen and suction at bedside, seizure pads; during a seizure: protect the head, time it, turn to side; NEVER hold the client down or force objects into the mouth.	Protect, time, turn -- never restrain, never bite blocks/mouth guards, never put anything in the mouth.	During a tonic-clonic seizure the nurse eases the client to the floor, shields the head, times the episode, and turns the client to the side.
69	Med Safety: The Six Rights	Right client, drug, dose, route, time, documentation -- plus allergies checked, two identifiers, and independent double-checks for high-risk meds.	Two identifiers (name + DOB) are non-negotiable; a med error is prevented at the bedside, not in the Pyxis.	Before giving insulin, the nurse checks two identifiers, verifies the dose against the order, and double-checks with a second nurse.
70	Two-Client Identifiers	Confirm identity with TWO identifiers (name and date of birth, or name and ID band number); room number is NEVER an identifier.	Room number = never; name + DOB = always.	A nurse gives meds only after the client states their name and birth date match the armband -- the room number alone proves nothing.

Part 5: Health Promotion and Maintenance (22 Concepts)

6-12% of the exam: growth and development, pregnancy and newborn basics, prevention, and teaching.

#	Term	Key Facts	Strategy Tip	Example
71	Health Promotion	Preventing illness and promoting wellness across the lifespan: immunizations, screenings, nutrition, exercise, safety teaching, and lifestyle counseling.	Match the intervention to the stage: vaccines for children, mammograms for adults, fall prevention for elders.	A school nurse runs a vision screening (promotion) and checks immunization records (prevention).
72	Erikson: Infant (Trust vs. Mistrust)	0-12 months: consistent, responsive care builds trust; neglect or inconsistency breeds mistrust.	Meet needs promptly and consistently -- "feeding on demand, responding to cries" is trust-building.	A 6-month-old who is fed and comforted predictably develops a sense of basic trust in the world.
73	Erikson: Toddler (Autonomy vs. Shame & Doubt)	1-3 years: toddlers assert independence -- "me do it"; over-control or ridicule creates shame and doubt.	Offer limited choices ("red cup or blue cup?") -- autonomy wins without chaos.	A toddler who is allowed to choose between two outfits and feed themselves develops autonomy; constant correction breeds doubt.
74	Erikson: Preschooler (Initiative vs. Guilt)	3-6 years: imagination and initiative flourish with encouragement; guilt develops when efforts are dismissed or punished.	Praise effort and play -- "let the child try, even if imperfect."	A preschooler who is praised for "helping" set the table develops initiative; a child punished for spilling learns guilt.
75	Erikson: School-Age (Industry vs. Inferiority)	6-12 years: accomplishment through school and skills; repeated failure or criticism breeds inferiority.	Set achievable tasks and celebrate mastery -- success builds industry.	A child who learns to ride a bike and earns praise for schoolwork develops industry; constant comparison breeds inferiority.
76	Erikson: Adolescent (Identity			

12-18 years: exploration of

A teen trying different clothes,

77	NCLEX-PN Study Guide	Piaget's Stages	Sensorimotor (0-2: object permanence), Preoperational (2-7: symbols, egocentrism, magical thinking), Concrete operational (7-11: logic on concrete things), Formal operational (12+: abstract reasoning).	Match the milestone: object permanence = infant; conservation = concrete; hypotheticals = formal.	A 4-year-old playing pretend with a block as a phone is preoperational; a 14-year-old debating abstract ethics is formal operational.
78	Prenatal Care Basics	First visit confirms pregnancy and dates; visits monthly then weekly near term; teaching covers nutrition (folic acid), exercise, danger signs (bleeding, decreased fetal movement, ruptured membranes, severe headache).	Danger signs to teach: any vaginal bleeding, gush of fluid, decreased fetal movement, severe headache, blurred vision, epigastric pain -- report immediately.	A 34-week client reports new fluid leakage -- the nurse instructs her to come in now for membrane rupture evaluation.	
79	Fetal Development Key Markers			A client asking about alcohol safety at 8 weeks is taught: no amount is safe, and the first trimester is when organs form.	
80	Stages of Labor	Stage 1: latent -> active -> transition (cervix dilates to 10 cm); Stage 2: full dilation to birth; Stage 3: placenta delivery; Stage 4: recovery (2 hours).	Transition (7-10 cm) is the hardest -- the "I can't do this" phase means pushing is near.	A laboring client at 8 cm is irritable and demanding -- the nurse recognizes transition and prepares for the pushing phase.	
81	APGAR Scoring	Assessed at 1 and 5 minutes: Appearance (color), Pulse, Grimace (reflex), Activity (tone), Respiration -- each 0-2, total 10.	Score the five domains at 1 and 5 minutes; 7-10 = good; <4 = severe distress, resuscitate.	A newborn with pink body/blue feet (1), HR 110 (2), crying (2), active (2), strong respirations (2) = APGAR 9 -- reassuring.	
82	Newborn Reflexes	Rooting (touch cheek -> turns), sucking, Moro (startle), grasp (palmar), Babinski (toes fan), tonic neck (fencing).	Reflexes are expected at birth; absent or asymmetric reflexes need evaluation.	A nurse elicits rooting by stroking the newborn's cheek; the Moro response appears when the head is suddenly released.	
83	Newborn Care Teaching	Umbilical cord care (keep clean/dry, report redness/odor), circumcision care (petroleum gauze, report bleeding), supine sleep (SIDS prevention), feeding cues.	Back to sleep, tummy to play -- the SIDS-prevention message is non-negotiable teaching.	The nurse teaches the new mother to place the infant on its back for sleep and on the tummy only during supervised play.	
84	Breastfeeding Basics	Feed on cue (8-12 times/day), latch includes areola, audible swallowing, 6+ wet diapers/day by day 5-6, proper positioning; weight gain signals adequacy.	Teach the signs of adequacy: wet diapers and weight gain beat the clock for feeding intervals.	A 5-day-old with six wet diapers and back-to-birth-weight is feeding well; fewer wet diapers triggers an evaluation.	
85	Postpartum Care & Danger Signs	Fundus: firm, midline, descends ~1 cm/day; lochia progresses rubra->serosa->alba; report soaking a pad in an hour, fever, calf pain, breast redness, heavy bleeding, headache/blurred vision.	Teaching danger signs: hemorrhage, infection, PE, preeclampsia -- "call us, don't wait."	A day-2 postpartum client reports a saturated pad within the hour and a boggy fundus -- the nurse intervenes for hemorrhage risk.	
86	Well-Child & Immunization Schedule	Childhood vaccines: HepB at birth; DTaP, IPV, Hib, PCV, RV at 2/4/6 months; MMR & varicella at 12-15 months; annual flu; HPV series at 11-12.	Know the milestone schedule loosely: birth -> 2/4/6 months -> 12-15 months -> 4-6 years -> teen boosters.	A 6-month-old is due for DTaP, IPV, Hib, PCV3, and RV3 -- the nurse verifies before administration and documents the lot.	
87	Health Screenings by Age	BP and vision screening in childhood; cervical cancer screening in the 20s; mammograms in the 40s-50s by guidelines; colorectal screening at 45-50; bone density for older adults.	Screenings follow age/risk, not symptoms -- prevention happens before problems.	A 50-year-old client is counseled about colorectal screening and a mammogram interval even though feeling perfectly well.	
88	Nutrition Across the Lifespan	Infants: breast/formula, introduce iron-fortified solids ~6 months; toddlers: small frequent meals; adolescents: calcium and iron needs; older adults: fewer calories, more protein, fiber, vitamin D/B12.	Age maps to nutrient: infant = iron at 6 months; teen girl = iron + calcium; elder = B12, D, protein.	An adolescent female is taught about iron and calcium needs; an older adult at home is screened for B12 deficiency.	
89	Teaching & Learning Principles	Assess readiness and learning barriers first; teach in small			

chunks, use return demonstration, repeat, and evaluate learning (not just delivery).

Return demonstration is the gold standard for psychomotor

Teaching insulin injection: the
nurse demonstrates, then the

client injects into a pad and
self-administers with
supervision -- return
demonstration confirms
learning.

90	NCLEX-PN Study Guide	Discharge Teaching & Readiness	Assess discharge readiness (knowledge, resources, environment, follow-up), teach meds and warning signs, confirm follow-up appointments before discharge.	Discharge planning begins at admission; warning-sign teaching is the last critical piece.	Before discharge, the client can state the purpose and schedule of each med and can recite the two warning signs to call about -- ready for home.
91	Geriatric Health Promotion		Aging changes: reduced thirst perception, skin thinning, falls, polypharmacy, sensory changes, cognitive changes (not all decline is dementia).	The older adult needs fall-risk screening, medication review, and hearing/vision checks even when "fine."	A 78-year-old reports feeling fine but has 12 meds and a recent balance wobble -- the nurse schedules a med review and fall-risk screening.
92	Community & Home Health		Care moves to the community: home visits, long-term care, clinics, shelters -- the nurse adapts teaching and safety to the setting.	Home care = teach the caregiver too; the family is part of the client system.	A home-health LPN teaches a daughter how to turn and transfer her mother safely at home and to call with any skin redness.

Part 6: Psychosocial Integrity (18 Concepts)

9-15% of the exam: therapeutic communication, mental health conditions, crisis, and coping.

#	Term	Key Facts	Strategy Tip	Example
93	Therapeutic Communication	Goal-directed, client-centered communication: active listening, open-ended questions, reflection, silence, clarification, and empathy -- the nurse facilitates the client's expression.	Open-ended questions and reflection ("You sound frustrated...") beat closed questions and advice.	"Tell me more about what's been keeping you up at night" opens dialogue; "Did you sleep well?" closes it.
94	Barriers to Therapeutic Communication	Blocks: giving premature advice, false reassurance, changing the subject, probing, agreeing/disagreeing, and "why" questions that put the client on guard.	If an option offers advice or a platitude ("Don't worry, it'll be fine"), it is almost always the wrong answer.	A client says "I feel like a burden" -- the nurse reflects ("Being dependent is hard") instead of replying "That's silly, you're not!"
95	Anxiety Levels & Interventions	Mild: heightened perception, learning possible. Moderate: narrowed focus. Severe: difficulty concentrating. Panic: loss of control, distorted perceptions -- stay calm, short sentences, reduce stimuli.	Match action to level: mild/moderate = teach and stay present; panic = stay with the client, minimize stimulation, use simple directions.	A client in panic is placed in a quiet room with a calm nurse saying short, simple phrases -- stimulus reduction is the priority.
96	Generalized Anxiety & Panic Disorder	Chronic excessive worry (GAD) and sudden intense panic attacks: palpitations, chest pain, dizziness, fear of dying.	Panic attacks feel like an emergency but are not life-threatening -- stay with the client, breathe slowly together.	A client in a panic attack with chest tightness is taken to a quiet area; the nurse stays, models slow breathing, and reassures safely.
97	Major Depressive Disorder	Persistent low mood, anhedonia, sleep/appetite changes, fatigue, worthlessness, poor concentration -- screening for SUICIDE is the priority nursing action.	Always ask directly about suicidal thoughts -- asking does not plant the idea.	A client with depression says "what's the point" -- the nurse directly asks if they've had thoughts of harming themselves and initiates safety planning if yes.
98	Bipolar Disorder: Mania	Manic phase: elevated energy, decreased sleep need, grandiosity, pressured speech, impulsivity, poor judgment -- protect the client from harm and provide structure.	Mania care: reduce stimuli, set limits gently, high-calorie finger foods, monitor sleep and behavior; never argue with the client.	A manic client with racing speech is moved to a quiet room, offered frequent small meals, and redirected from grandiose plans without arguing.
99	Schizophrenia	Positive symptoms: hallucinations, delusions, disorganized speech/behavior. Negative: flat affect, avolition, social withdrawal.	Respond to the FEELING behind the hallucination, not the content -- "You seem frightened" never "those voices aren't real."	A client hearing voices says "they're telling me I'm evil" -- the nurse says "you seem distressed right now; let's talk about what's happening around you."
100	Eating Disorders	Anorexia (restriction, fear of weight gain, distorted body image), bulimia (binge-purge), and the priority: refeeding and monitoring for cardiac/electrolyte complications.	Eating-disorder care guards against refeeding syndrome: monitor electrolytes (K, Mg, PO4) and cardiac status during refeeding.	A client with anorexia beginning a feeding plan gets daily potassium and phosphorus checks and EKG monitoring.
101	Substance Use & Withdrawal	Alcohol withdrawal can be life-threatening: tremors, tachycardia, hypertension, sweats, hallucinations, seizures -- treat with benzodiazepines per protocol and monitor.	CIWA-style monitoring: early tremor + tachycardia means withdrawal is starting; seizures are the late danger.	A client admitted 12 hours after last drink is diaphoretic and tremulous with HR 110 -- the nurse starts withdrawal monitoring and notifies the provider.

102	Opioid Overdose & Withdrawal	Overdose triad: respiratory depression, pinpoint pupils, unresponsiveness -- naloxone (Narcan) reverses; withdrawal is miserable but not usually lethal: yawning, cramps, diarrhea, piloerection.	Overdose = airway first + naloxone; withdrawal = comfort care and monitoring now, detox planning later.	A client found unresponsive with slow respirations and pinpoint pupils receives naloxone and ventilatory support -- opioid overdose management.
103	Crisis Intervention	Crisis = acute overwhelming response to a stressor; the nurse assesses safety first, uses reassurance and concrete problem-solving, and involves support systems.	In any crisis question, safety (suicide/homicide) is assessed FIRST; then stabilize, then mobilize resources.	After a sudden job loss, a client states "I can't go on" -- the nurse first assesses suicide risk, then problem-solves supports.
104	Grief & Loss: Kübler-Ross	Denial, anger, bargaining, depression, acceptance -- stages are not linear; grief is individual, and anticipatory grief exists too.	The exam asks you to identify the client's current stage from their words, not push them past it.	"Why me?! It's not fair!" = anger; "Maybe if I try another treatment it will work" = bargaining; "I know it's over, I'm making peace" = acceptance.
105	Adaptive vs. Maladaptive Coping	Adaptive: problem-solving, exercise, social support, humor, relaxation. Maladaptive: substance use, avoidance, denial, self-harm, overeating.	Reinforce adaptive coping and gently redirect maladaptive patterns with concrete alternatives.	After a cancer diagnosis, a client takes walks with a friend (adaptive) rather than drinking nightly (maladaptive) -- the nurse reinforces the walk.
106	Suicide Precautions	Directly assess intent/plan/means; remove dangerous objects; one-to-one observation per policy; never leave the client alone; report and document.	The exam's highest-priority intervention for a suicidal client is safety: remove means + continuous observation.	A suicidal client is placed on one-to-one observation, and sharps and cords are removed from the room -- the space is made safe.
107	Child Abuse & Neglect	Identify physical indicators (bruises in patterns, fractures, burns, failure to thrive) and behavioral cues; the nurse MUST report suspected abuse to child protective services.	Reporting is mandatory and anonymous -- suspicion, not proof, triggers the report.	A toddler with spiral fractures and bruising in various healing stages and inconsistent histories is reported; the nurse documents objectively.
108	Elder & Vulnerable Adult Abuse	Types: physical, emotional, financial, neglect; report suspected abuse of vulnerable adults to adult protective services.	Suspected = report; documentation is objective, and the client is interviewed privately.	A caregiver who controls an elder's finances and refuses to allow time alone triggers an APS referral and a private, supportive interview.
109	Post-Traumatic Stress Disorder	Re-experiencing (flashbacks, nightmares), avoidance, hyperarousal (startle, anger, insomnia), negative mood after trauma.	Grounding techniques and a trusting, consistent nurse-client relationship support recovery.	A veteran with nightmares, startle responses, and avoidance of crowds is offered grounding (describe 5 things you see now) in a calm environment.
110	Obsessive-Compulsive Disorder	Obsessions (intrusive thoughts) and compulsions (repetitive behaviors to reduce anxiety).	Never interrupt a compulsion abruptly -- ritual removal raises anxiety; structure time and set limits gradually with the plan.	A client who checks the door lock 10 times before bed is given a gradually reduced checking schedule rather than being told to "just stop."

Part 7: Basic Care and Comfort (18 Concepts)

7-13% of the exam: ADLs, positioning, mobility, nutrition, elimination, pain, and comfort.

#	Term	Key Facts	Strategy Tip	Example
111	Activities of Daily Living (ADLs)	Bathing, dressing, grooming, toileting, feeding, mobility -- the nurse supports independence and delegates routine ADLs to UAPs.	ADLs = delegate; anything requiring assessment (new skin breakdown, swallow change) = nurse.	A stable client gets UAP help with bathing; the nurse personally assesses a new reddened sacral area uncovered during the bath.
112	Body Positioning	Fowler's (45-60°, respiratory/cardiac ease), Semi-Fowler's (30°, after eating/NG), High-Fowler's (90°, dyspnea), Supine, Prone (some pulmonary benefit but airway risk), Side-lying (aspiration risk, pregnant), Trendelenburg (rarely used now).	Match position to need: dyspnea = Fowler's; aspiration risk = side-lying or upright; shock = flat with legs elevated per protocol.	A client with COPD and dyspnea is placed in high Fowler's; a client who just vomited is turned to side-lying to protect the airway.
113	Positioning: Orthostatic Safety	Change positions slowly; dangle at the bedside before standing to prevent orthostatic hypotension and falls; call light within reach.	"Dangle before you dangle free" -- sit the client at the edge of the bed 1-2 minutes before rising.	After bed rest, the nurse raises the head, has the client sit on the edge of the bed for a minute, checks for dizziness, then assists standing.
114	Range of Motion (ROM)	Passive ROM (nurse moves		

the joint), active ROM (client moves it), active-assistive; maintains joint function and prevents contractures; support joints above and below.

Move each joint to its natural

During the morning bath the

nurse moves each major joint of a bed-bound client through passive ROM, splinting above and below the joint.

115	Ambulation Aids	Cane on the STRONG side (2-point gait: cane moves with the weak leg); walker = advance it, step in; crutches = swing-to/gait patterns, weight bearing per order.	Cane = strong hand; walker = step into it; crutches = no leaning on armpits (nerve damage risk).	A client with a weak right leg uses the cane in the LEFT hand -- cane and weak leg step together. Crutch tips rest on the floor, not the axillae.
116	Transfer Techniques	Use the strongest muscles (legs/large muscles), widen the base of support, lower the center of gravity, lock wheelchair brakes before transfer.	Lock brakes on every chair/bed before any transfer -- a moving chair is a fall.	Before transferring a client from bed to wheelchair, the nurse locks both brakes, positions the chair at 45°, and blocks the client's weaker side.
117	Immobility Complications	Pneumonia, DVT, pressure injury, contractures, muscle atrophy, constipation, osteoporosis, orthostatic hypotension -- prevent with early mobility, turning, incentive spirometry, and repositioning.	Prevent with mobility: turn q2h, out of bed ASAP, incentive spirometry q1-2h, compression devices.	A bed-bound client receives q2h repositioning, calf pumps/exercise, and incentive spirometry to prevent DVT, pressure injury, and atelectasis.
118	Pressure Injury Staging & Care	Stage 1: non-blanchable redness; Stage 2: partial-thickness; Stage 3: full-thickness; Stage 4: deep tissue/bone; Unstageable: eschar/slough. Prevent with repositioning q2h and pressure offloading.	Repositioning q2h is the number-one prevention; document stage objectively without guessing.	A reddened heel that does not blanch is Stage 1 -- the nurse offloads the heel with a pillow, keeps skin clean/dry, and continues q2h turns.
119	Nutrition: Dysphagia Care	Dysphagia = difficulty swallowing; aspiration risk: thickened liquids, pureed foods, upright positioning 90°, small bites, chin tuck, supervision during meals.	Sit upright 90°, chin tuck, thicken, supervise -- thicker and slower beats thinner and desperate.	A stroke client with dysphagia is fed pureed food with nectar-thick liquids, upright at 90°, head slightly tucked, with the nurse present.
120	Feeding & Aspiration Precautions	Check the mouth for pocketing (stroke clients), offer small bites, monitor coughing/choking, keep suction at the bedside; NPO status = nothing by mouth including ice chips.	Pocketed food + cough = aspiration signal; thicken or advance texture only per speech therapy.	A client pockets food on the left side of the mouth; the nurse alternates sides, gives small bites, and reports to speech therapy.
121	Elimination: Urinary Catheter Care	Sterile insertion, keep the drainage bag below the bladder and off the floor, no dependent loops (kink prevention), empty bag without touching the port, perineal hygiene front-to-back.	The bag never touches the floor and never rises above the bladder -- height = reflux = infection.	During ambulation the nurse carries the bag below the waist; at the bed the bag hangs off the frame, never on the floor.
122	Bowel Care & Constipation	Decreased mobility and opioids cause constipation: fluids, fiber, activity, privacy, toileting routine; report absence of BM per the client's baseline.	Prevent, don't react: fluids + fiber + mobility + bathroom routine for the opioid client.	A post-op client on opioids receives stool softener, fluids, ambulation, and a scheduled toileting time to prevent constipation.
123	Bowel Elimination: Ostomy Care	Stoma color: pink/red = healthy; pale, dusky, or blue = compromised blood flow (notify provider). Change the pouch when 1/3-1/2 full; clean around with water; protect peristomal skin.	Healthy stoma is pink and moist like gum tissue; anything dusky or pale is a vascular emergency.	A new ostomy appears pale blue -- the nurse notifies the provider immediately and checks the integrity of the appliance fit.
124	Sleep & Rest Promotion	Cluster care, reduce noise/light at night, limit caffeine, plan meds and assessments around sleep periods, comfort measures.	Protect sleep: cluster and schedule -- waking a client for a non-urgent task at 0300 steals restorative rest.	The nurse batches vitals, meds, and insulin at 2200 so the client gets uninterrupted sleep until morning.
125	Pain: Nonpharmacologic Measures	Positioning, heat/cold, massage, distraction, relaxation, imagery, music -- used ALONGSIDE (not instead of) ordered analgesia.	Nonpharm measures complement meds; never refuse a pain med in favor of a backrub.	A client with post-op pain receives the ordered analgesic plus repositioning and slow-breathing guidance -- multimodal comfort.
126	Pain Assessment Basics	Pain is what the client says it is; assess onset, location, duration, character, severity (0-10 scale or validated tool), aggravating/relieving factors, and reassess after treatment.	Reassess pain within a defined interval after giving meds (typically 30-60 min oral) and DOCUMENT the response.	A client rates pain 7/10; the nurse gives the ordered analgesic and rechecks at 45 minutes, documenting 3/10.
127	Heat & Cold Therapy	Heat: relaxes muscles, increases blood flow (not for acute injury, not on fresh wounds/edema); Cold:		

Acute = cold (reduce swelling); chronic muscle = heat; never heat a fresh injury or active bleed.	A client with a new ankle sprain gets ice 20 minutes on/off; a client with chronic back stiffness gets a warm
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128	NCLEX-PN Study Guide	Personal Hygiene Care	Bathing is done at the client's preferred time; assess skin during hygiene; perineal care front-to-back; mouth care (including for NPO clients); eye care for the unconscious client (lubricate, close lids).	Hygiene is also assessment -- the bath is the skin check; front-to-back always for perineal care.	During a bed bath the nurse assesses the skin, provides mouth care for the NPO client, and lubricates the eyes of the unconscious client.
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Part 8: Pharmacological Therapies (25 Concepts)

10-16% of the exam: medication administration, calculations, drug classes, and IV therapy.

#	Term	Key Facts	Strategy Tip	Example
129	Medication Administration: The Rights	Right client, drug, dose, route, time, documentation -- plus right to refuse, right indication, and allergy verification.	Two identifiers, allergy band, and the MAR at the bedside -- the routine prevents the error.	Before an IV antibiotic, the nurse verifies the client by name/DOB, checks the allergy band, and confirms the indication on the order.
130	The Six Rights Expanded	Six rights = client, drug, dose, route, time, documentation. Always add: correct assessment before giving, right to refuse, and the right education.	Think "right of refusal" -- the client may refuse, and the nurse documents the refusal and notifies the provider.	A client refuses the scheduled laxative after seeing the pill -- the nurse respects the refusal, documents it, and tells the provider.
131	Dosage Calculation: Basic	Dose ordered ÷ dose available × volume available = volume to give. Dimensional analysis keeps units straight.	Write the units -- a calculation without units is a guess; always ask "does this amount make sense?"	Order: 250 mg PO; available: 500 mg/5 mL. $250 \div 500 \times 5 = 2.5$ mL to administer.
132	Dosage Calculation: Weight-Based	mg/kg/day divided into doses: total daily dose ÷ number of doses = per-dose amount.	Convert pounds to kg (÷ 2.2) FIRST -- a lb/kg mix-up can be lethal.	A 44-lb child (20 kg) needs 10 mg/kg/day divided q12h: 200 mg/day -> 100 mg per dose.
133	IV Flow Rate Calculation	mL/hr = total volume ÷ hours; drops/min = (volume × drop factor) ÷ minutes.	Convert everything to the same units (mL and minutes) before multiplying.	1,000 mL over 8 hours = 125 mL/hr. With a 15 gtt/mL set: $(1000 \times 15) \div 480 \text{ min} = 31$ gtt/min.
134	Medication Routes	PO (swallow), sublingual (under tongue, none swallowed until dissolved), buccal (between cheek and gum), topical/transdermal (rotate sites, remove old patch), inhaled, IM/SC, IV.	Route changes the speed and the rules: sublingual nitroglycerin is NOT swallowed; remove the old patch before placing a new one.	A client with chest pain places a nitroglycerin tablet under the tongue and lets it dissolve -- swallowing it would blunt the effect.
135	Intramuscular Injection Sites	Deltoid (1-2 mL), vastus lateralis (largest, safest for infants), ventrogluteal (preferred adult IM, up to 3-4 mL), dorsogluteal (avoid -- sciatic nerve risk).	Ventrogluteal = safest adult IM; vastus lateralis = infant; deltoid = small volumes only.	A 2-mL adult IM injection is given in the ventrogluteal site, aspirated, and the site rotated from the last injection location.
136	Insulin Therapy	Rapid (lispro/aspart: with meals, ~15 min), Short (regular: 30 min), Intermediate (NPH: peaks in hours), Long (glargine/detemir: basal once daily, clear).	Glargine is NEVER mixed in the same syringe with other insulins; NPH is the cloudy one -- roll, don't shake.	A client takes lispro before meals and glargine at bedtime; the nurse teaches that glargine is never mixed and NPH bottles are rolled gently.
137	Insulin Administration Timing	Rapid-acting given within 15 minutes of a meal; regular 30 minutes before; always have food available; rotate injection sites.	Rapid = eat within 15 minutes -- "draw, inject, eat."	A client draws lispro and eats at the tray's arrival, 10 minutes after injection, to match the onset window.
138	Anticoagulants	Heparin (SC/IV, monitor aPTT, antidote protamine sulfate) and warfarin (oral, monitor INR 2-3, antidote vitamin K); signs of bleeding to report.	Heparin = aPTT + protamine; warfarin = INR + vitamin K. Together (until INR is therapeutic) is the classic bridge.	A client on warfarin after a DVT is taught to report bruising or dark stools; the nurse checks the INR before the daily dose.
139	Digoxin Teaching	Monitor HR before giving: hold for HR < 60 (adults) and notify; signs of toxicity: anorexia, nausea, vision changes (yellow-green halos), confusion.	The pulse rule saves lives: never give digoxin below 60 without checking with the provider.	A client's apical pulse is 52 -- the nurse holds the digoxin, documents, and notifies the provider; the client had also noted new nausea and halos.
140	Opioid Analgesics	Morphine/hydromorphone for moderate-severe pain; watch respiratory depression (RR < 12), sedation, constipation; naloxone is the antidote.	Monitor the RR before and after opioids -- a RR of 8 with sedation needs naloxone and stimulation.	After morphine, a client's RR drops to 9 with drowsiness -- the nurse stimulates, calls for naloxone, and prepares oxygen.
141	NSAIDs & Acetaminophen	NSAIDs (ibuprofen, naproxen): GI bleeding, renal effects, take with food; acetaminophen: hepatotoxic at high doses, max ~4 g/day (less for some		

NSAID = stomach/kidneys; acetaminophen = liver. Teach the daily ceilings.	A client on daily ibuprofen is taught to take it with food and report dark stools; an acetaminophen user is warned about the 4 g/day ceiling.
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142	Antibiotics: Key Teaching	Take the FULL course; common classes: penicillins, cephalosporins, macrolides, fluoroquinolones, tetracyclines, vancomycin (IV, monitor levels, red-man syndrome with rapid infusion).	Full course + report watery diarrhea (C. diff risk with broad agents).	A client on amoxicillin is taught to finish all capsules even when feeling better and to report severe diarrhea.
143	Anaphylaxis Management	Sudden onset: hives, angioedema, wheezing, hypotension, stridor -- stop the drug, call for help, epinephrine IM (thigh), airway management, supine with legs elevated.	The drug stops, epinephrine goes, oxygen flows, and the provider is called -- in that spirit, immediately.	Minutes after an IV antibiotic, a client develops urticaria and wheezing -- the nurse stops the infusion, gives epinephrine IM, and calls a rapid response.
144	Beta Blockers	Metoprolol, propranolol: lower HR/BP, treat HTN/angina/arrhythmias -- check HR/BP before giving; hold for bradycardia and hypotension; do NOT stop abruptly (rebound).	Hold for HR < 60 or systolic < 90 (per parameters); never stop suddenly.	A client's HR is 54 with dizziness -- the nurse holds the metoprolol and notifies the provider; the client is also warned against skipping doses at home.
145	Nitroglycerin	Sublingual for angina: one tablet, repeat q5 min up to 3, call 911 if no relief after 3; keep in the original dark bottle; head tingling is expected.	"1 every 5, up to 3, then 911" is the teaching mantra for home use.	A client with angina takes one SL tab with no relief, takes a second at 5 minutes, and a third at 10 -- still unrelieved, so the client calls 911.
146	Diuretics	Loop (furosemide): potent, monitor K; thiazide (HCTZ): monitor K/Na; potassium-sparing (spironolactone): HOLD potassium and avoid salt substitutes.	Loop/thiazide = replace K; potassium-sparing = restrict K. Weigh daily and report rapid gains.	A client on furosemide eats bananas daily and takes no potassium supplement -- the nurse reinforces potassium-rich foods and daily weights.
147	Corticosteroids	Prednisone: taper, never stop abruptly (adrenal crisis); take with food; monitor glucose and infection risk; report moon face, easy bruising, mood changes.	Taper, taper, taper -- abrupt stops cause adrenal insufficiency.	A client on a prednisone taper who feels well decides to stop -- the nurse explains adrenal-insufficiency risk and why tapering is prescribed.
148	Antipsychotics	First-gen (haloperidol): EPS/extrapyramidal symptoms; second-gen (risperidone, olanzapine): metabolic effects (weight, glucose). Teach: don't stop abruptly, report EPS and rigidity.	Watch for acute dystonia and rigidity -- withhold and notify; metabolic monitoring every visit.	A client on haloperidol develops neck stiffness and eye rolling (acute dystonia) -- the nurse holds the med, notifies, and prepares for an anticholinergic.
149	Benzodiazepines & Antidotes	Lorazepam, diazepam: anxiolytic/sedative; respiratory depression risk; flumazenil is the antidote; no abrupt cessation of chronic use (withdrawal seizures).	Use with caution in the elderly (falls, confusion); triage respiratory status first after overdose.	A client who took "a few extra" diazepam is drowsy with slow breathing -- the nurse monitors respirations closely and prepares flumazenil.
150	IV Therapy Basics	Check the site before and during infusion; signs of infiltration (swelling, coolness, pain -- stop, restart elsewhere), phlebitis (redness, warmth, cord), and air embolism (sudden dyspnea, chest pain, clammy).	Infiltration = cool/swollen (restart); phlebitis = red/warm (restart); extravasation of vesicants = urgent.	An IV site is swollen and cool with a sluggish drip -- the nurse stops it, removes the catheter, and restarts in another extremity.
151	IV Fluid Types	Crystalloids: isotonic (NS, LR -- expand volume), hypotonic (0.45% NS -- hydrate cells), hypertonic (3% NS -- pull fluid in; cardiac monitoring, ICU only).	Match the fluid to the goal: blood loss = isotonic bolus; dehydration = isotonic maintenance; 3% = critical hypertonic, never routine.	A client in hypovolemic shock receives an NS bolus; a client with cerebral edema is on 3% saline under close cardiac monitoring.
152	Total Parenteral Nutrition	TPN = concentrated nutrition via central line; check blood glucose and site, use a dedicated line, never infuse quickly or stop suddenly (hypoglycemia rebound).	TPN is never a peripheral push; slow taper prevents rebound hypoglycemia.	A client on TPN has the infusion tapered over hours before a line change to avoid a hypoglycemia crash -- the nurse monitors glucose.
153	Medication Errors & Reporting	On discovering an error: assess the client first, notify the provider, document the facts, and file an incident report -- safety and honesty, not blame.	Priority order: client safety -> provider notification -> accurate documentation -> incident report.	A nurse gave a double dose of a beta blocker; the client is assessed, the provider notified, and the event documented with an incident report.

9-15% of the exam: lab values, diagnostics, perioperative care, and early complication detection.

#	Term	Key Facts	Strategy Tip	Example
154	Normal Vital Signs (Adult)	Temp 97-99°F (36-37.2°C), pulse 60-100, respirations 12-20, BP systolic < 120 / diastolic < 80, SpO2 95%+	Memorize the adult ranges -- they are the baseline you compare everything against.	An adult with HR 118, RR 22, BP 88/56, SpO2 91% is outside every normal range -- a red flag requiring action.
155	Temperature: Fever vs. Hypothermia	Fever = infection/inflammation (monitor, culture before antibiotics); hypothermia = exposure, treat with rewarming, monitor for shivering and arrhythmias.	Cultures are drawn BEFORE the first antibiotic dose whenever possible.	A client spikes to 102.4°F -- the nurse draws ordered blood cultures first, then gives the scheduled antibiotic.
156	Complete Blood Count (CBC)	WBC 4,500-11,000 (? infection), Hgb 12-16 g/dL (women) / 13.5-17.5 (men), Hct ~36-50%, platelets 150,000-450,000 (? = bleeding risk).	RBC drops = anemia; WBC climbs = infection; platelets fall = bleeding risk. Flag all three.	A client with WBC 14,000 and new fever is monitored for sepsis; a client with platelets 90,000 is placed on bleeding precautions.
157	Electrolytes: Sodium (Na)	Normal 135-145 mEq/L. Hyponatremia: confusion, seizures, weakness -- fluid restriction/swelling risk; Hypernatremia: thirst, restlessness, dry mucous membranes.	Sodium tracks WATER: too much water dilutes it down; too little water concentrates it up.	A client on free-water flushes post-op becomes confused with Na 128 -- the nurse flags hyponatremia and seizure precautions.
158	Electrolytes: Potassium (K)	Normal 3.5-5.0 mEq/L. Hypokalemia: weakness, arrhythmias, U waves, ileus (hold digoxin ?); Hyperkalemia: peaked T waves, bradycardia, cardiac arrest -- insulin+dextrose, kayexalate.	K is cardiac -- dysrhythmias on both ends; report out-of-range K before the next dose of any K-wasting diuretic.	A client's K is 6.2 with peaked T waves -- the nurse holds potassium, starts ECG monitoring, and prepares insulin-dextrose per protocol.
159	Electrolytes: Calcium & Magnesium	Ca 8.5-10.5 mg/dL (? : tetany, Chvostek/Trousseau, seizures; ? : constipation, stones, confusion); Mg 1.3-2.1 (? with alcohol, cramps, tremors).	Low calcium = tetany -- check Chvostek (cheek tap) and Trousseau (BP-cuff hand spasm) signs.	After thyroid surgery a client's hands spasm when a BP cuff inflates (Trousseau) -- the nurse flags hypocalcemia from parathyroid injury.
160	Glucose & HbA1c	Fasting glucose 70-100; HbA1c < 5.7% normal, 5.7-6.4% prediabetes, ? 6.5% diabetes; glucose < 70 = hypoglycemia (treat, recheck 15 min).	The 15-15 rule: 15 g fast carbs, recheck in 15 minutes, repeat until > 70.	A client on insulin feels shaky with glucose 62 -- the nurse gives 4 oz juice, rechecks at 15 minutes, and documents recovery.
161	Coagulation Labs	INR (warfarin target 2-3), aPTT (heparin, ~1.5-2.5× control), platelets > 150k. Elevated INR = bleeding risk -- hold warfarin and notify.	INR = warfarin; aPTT = heparin; teach bleeding signs with both.	A client's INR is 4.6 -- the nurse holds the warfarin, notifies the provider (who orders vitamin K), and institutes bleeding precautions.
162	Cardiac Labs	Troponin: myocardial damage (rises in MI); BNP: heart failure marker (rises with volume overload); CK-MB: muscle injury.	Troponin is THE MI marker; BNP flags HF. Trend troponin over hours.	A client with chest pain has an elevated troponin -- the nurse prepares the cardiac protocol and continuous monitoring.
163	Renal Function Labs	BUN 7-20, creatinine 0.6-1.3; creatinine is the better kidney marker. Rising BUN/Cr = declining renal function; report oliguria (< 30 mL/hr).	Urine output < 30 mL/hr for 2+ hours = report; creatinine trend tells the story.	A client's urine output drops to 20 mL/hr with creatinine rising from 1.0 to 1.8 -- the nurse notifies the provider and reviews nephrotoxic meds.
164	Preoperative Teaching	NPO after midnight (per order), informed consent, deep-breathing/coughing and incentive spirometry, early ambulation, splinting incisions, DVT prevention -- teach BEFORE surgery.	The client learns the post-op routine BEFORE the incision exists -- teach now, reinforce later.	The evening before surgery, the nurse teaches incentive spirometry, splinting, and early ambulation; the client demonstrates return technique.
165	Preoperative Checklist	Verify consent, ID/allergies, NPO status, labs (especially K and glucose), site marking, valuables removed, baseline vitals, and pre-op meds given per order.	The checklist ends with verification -- "does anything not match the order?" is the last question.	Before transport, the nurse verifies the signed consent, NPO time, allergy band, site mark, and baseline vitals -- all green flags.
166	Postoperative Assessment	Airway first (patency, SpO2), then circulation (BP, HR, bleeding), then pain, intake/output, and incision sites; monitor for hemorrhage,		

The PACU ABC sequence:
airway -> breathing ->
circulation -> then everything
else.

A post-op client wakes with
stridor and SpO₂ 88% -- the
nurse opens the airway and
calls for evaluation before
touching the dressing or pain

Report: tachycardia,

hypotension, cool clammy skin,
oliguria, bright-red drainage or
a rapidly saturating dressing;
pressure, elevate, support
vitals, call for help.

Tachycardia + hypotension +

A client's HR climbs to 120 and

BP falls to 92/58 with a blood-soaked dressing -- the nurse applies pressure, drops the head, and calls the provider.

168	NCLEX-PN Study Guide	Post-Op Complications: Pulmonary	Atelectasis (decreased breath sounds, low SpO2 post-op) and pneumonia are prevented with incentive spirometry, early ambulation, coughing/deep breathing, and splinting.	The incentive spirometer is a nursing tool -- hourly use beats "when I remember."	A client whose SpO2 drops to 90% on day 1 with diminished bases is coached through incentive spirometry q1h and ambulation -- atelectasis reverses.
169		Wound Assessment & Infection Signs	Report: redness, swelling, warmth, purulent drainage, increasing pain, wound separation, or fever -- culture before antibiotics, use aseptic technique for every dressing change.	The infected wound gets cultured BEFORE the antibiotic and the dressing change uses sterile technique.	A surgical site is red, warm, and draining yellow fluid -- the nurse cultures it, notifies the provider, and reinforces sterile dressing changes.
170		Expected vs. Unexpected Findings	Expected: mild post-op pain, low-grade temp < 100.4 on day 1, serosanguineous drainage, first void within 6-8 hours. Unexpected: high fever, hemorrhage, oliguria, severe uncontrolled pain, wound dehiscence.	The exam tests triage: recognize "expected" so you can spot the "unexpected" that needs action.	A post-op client with a 99.8 temp and scant pink drainage is expected; a temp of 102 with purulent drainage and oliguria is not -- notify.
171		Diagnostic Test Prep	Know the prep: fasting for lipid/glucose; NPO for some imaging; hydration for contrast (unless contraindicated); withholds for certain meds; contrast allergy screening before any contrast study.	Contrast = ask about allergies and metformin; that pair of questions prevents the classic disasters.	Before a CT with contrast, the nurse confirms no contrast allergy and asks about metformin (held per protocol), and confirms hydration status.
172		ECG Monitoring Basics	Normal sinus rhythm: P wave, QRS, T wave, 60-100 bpm. Dysrhythmias: tachycardia (>100), bradycardia (<60), fibrillation (irregular), and ST elevation (ischemia/MI).	Know what the waves mean: P = atrial, QRS = ventricular, ST = ischemia -- that trio answers most rhythm items.	A client with chest pain shows new ST elevation on the monitor -- the nurse reports ischemia and prepares the cardiac response.
173		Blood Transfusion Precautions	Verify per protocol (two-person check: blood product, client, order); stay with the client the first 15 minutes (most reactions); baseline vitals; monitor for chills, fever, rash, dyspnea, back/flank pain.	The first 15 minutes are the danger window; a transfusion reaction = STOP the blood, keep the line with saline, notify, save the bag.	Fifteen minutes into a transfusion, a client spikes chills and fever -- the nurse stops the blood, hangs saline, and notifies the provider.

Part 10: Physiological Adaptation (27 Concepts)

7-13% of the exam: body-system disorders, fluid/electrolytes, and emergency care.

#	Term	Key Facts	Strategy Tip	Example
174	Myocardial Infarction	Chest pain/pressure (may radiate), diaphoresis, nausea, dyspnea; women/elders may have atypical symptoms. Care: oxygen, aspirin, nitroglycerin, morphine per protocol, monitor ECG, rest.	The MI client is kept on strict bed rest with the head elevated; pain unrelieved by 3 NTG = 911.	A client with crushing chest pain and ST elevation receives O2, aspirin 324 mg chewed, and SL nitroglycerin while the cardiac team is called.
175	Heart Failure	Fluid overload: dyspnea, orthopnea, edema, crackles, weight gain, fatigue. Care: daily weights, sodium restriction, oxygen, upright positioning, monitor I&O.	Daily weight is THE heart-failure gauge -- 2+ lb overnight = fluid retention, report it.	A client with HF gains 4 lb overnight and sleeps propped on three pillows -- the nurse reports, restricts sodium/fluids, and monitors for further decompensation.
176	Hypertension	Persistent BP ? 130/80 (stage 1) or ? 140/90 (stage 2 per guidelines); teaching: DASH-style diet, low sodium, exercise, med adherence, home BP log.	Teach "silent disease" -- the client takes meds even when feeling fine; report home readings consistently.	A client with BP 152/96 is taught sodium restriction, daily home BP logging, and to never stop the prescribed meds abruptly.
177	COPD & Emphysema	Chronic airflow limitation: pursed-lip breathing, tripod position, low-flow oxygen (per order, usually 1-2 L -- avoid high FiO2 in CO2 retainers), sputum clearance.	Pursed-lip breathing and tripod positioning are the client's tools; oxygen is titrated to the ORDER, not SpO2 greed.	A COPD client uses pursed-lip breathing and sits in tripod during dyspnea; oxygen stays at 2 L per the order because high flow suppresses drive in CO2 retainers.
178	Asthma	Bronchospasm: wheezing, chest tightness, cough. Care: quick-relief bronchodilator (albuterol), controller inhaled steroids daily; teach spacer use and asthma action plan.	SABA = rescue; ICS = controller; spacers improve delivery; report worsening night symptoms.	A client with an asthma attack uses albuterol via spacer; at home they continue the daily inhaled steroid even when no symptoms.
179	Pneumonia	Cough, fever, crackles, tachypnea; care: antibiotics		

(culture first), oxygen, fluids,
incentive spirometry, elevate
head of bed,
turn/cough/deep-breathe.

Hydration + spirometry +
upright positioning are the

A client with pneumonia and
SpO2 91% is positioned

upright, given O2 and coached
with the incentive spirometer
while cultures go before
antibiotics.

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negative-pressure room), first-line drugs (INH, rifampin, pyrazinamide, ethambutol), and teaching: complete the full multi-month course, report hemoptysis.

Airborne precautions from the

moment TB is suspected;
sputum clearance x3 negative
to discontinue isolation.

A client with suspected TB is

masked at entry, placed in a negative-pressure room, and staff wear N95s until sputum is negative ×3.

181	Pulmonary Embolism	Sudden dyspnea, pleuritic chest pain, tachypnea, hypoxia, hemoptysis; risk: immobility, surgery, oral contraceptives, cancer. Care: oxygen, anticoagulation, elevate head, report urgently.	Any sudden dyspnea on a bed-bound client = PE until proven otherwise -- oxygen, call, anticoagulation prep.	A post-op client suddenly gasps with SpO2 82% and chest pain -- the nurse calls for help, gives oxygen, and starts the PE response.
182	Cerebrovascular Accident (Stroke)	FAST: Face droop, Arm weakness, Speech difficulty, Time to call. Ischemic = clot (tPA window, BP control, swallow evaluation); Hemorrhagic = bleed (strict BP control).	NPO until a swallow evaluation passes -- silent aspiration kills stroke clients; tPA is time-sensitive.	A client with facial droop and arm weakness arrives within the tPA window -- the stroke team starts the fibrinolytic protocol after imaging.
183	Stroke Care Priorities	Maintain airway, NPO + swallow screen before anything oral, elevate head 30°, monitor neuro status (GCS), prevent aspiration, DVT, and pressure injury; family teaching.	"Keep them safe, keep them moving tomorrow" -- early rehab beats bed rest; never feed until swallow-clear.	A hemiplegic stroke client is positioned with the head elevated, kept NPO pending the swallow study, and turned q2h with passive ROM.
184	Seizure Disorders & Status Epilepticus	Tonic-clonic: protect, time, turn to side, never restrain or place objects in the mouth. Status epilepticus (seizure > 5 min or multiple without recovery) = emergency: IV benzodiazepine per protocol.	In status, the clock matters: > 5 minutes = call for emergency drugs now, not later.	A client seizes for 6 minutes without stopping -- the nurse protects the airway, times it, and the team gives IV lorazepam per emergency protocol.
185	Acute Kidney Injury & CKD	AKI: sudden rise in creatinine, oliguria -- treat cause, adjust nephrotoxic meds, monitor K. CKD: progressive -- teach low-potassium/low-phosphorus diet, daily weights, report decreasing urine.	CKD diet: low K, low P, low Na, controlled protein; nephrotoxic meds (NSAIDs, contrast) are avoided.	A CKD client is taught to avoid NSAIDs and contrast, follow the low-potassium diet, and weigh daily -- slowing progression is the goal.
186	Diabetes: Hyperglycemia & DKA	DKA (type 1): hyperglycemia, ketones, Kussmaul respirations, fruity breath, dehydration -- insulin, fluids, K monitoring. HHS: extreme hyperglycemia without ketones (type 2 elderly).	DKA = insulin + fluids + potassium; the potassium follows the insulin (insulin drives K into cells).	A client with glucose 480, deep rapid respirations, and fruity breath starts insulin, an NS bolus, and hourly K checks -- DKA protocol.
187	Hypoglycemia vs. Hyperglycemia	Hypo (< 70): tremor, sweating, confusion, hunger -- treat with 15 g carbs, recheck 15 min. Hyper: thirst, polyuria, blurred vision, fatigue -- give insulin per order, fluids, monitor.	Hypo is the emergency you treat NOW (brain needs glucose); hyper is managed over hours.	A shaky, sweaty client with glucose 58 gets juice immediately and is rechecked at 15 minutes; a glucose of 240 with thirst gets insulin per sliding scale and fluids.
188	Thyroid Disorders	Hyperthyroidism: heat intolerance, weight loss, tachycardia, exophthalmos -- calm environment, monitor HR/BP. Hypothyroidism: cold intolerance, weight gain, bradycardia, constipation -- med adherence, watch myxedema.	Hyper = hot and fast; hypo = cold and slow. Monitor cardiac status in both.	A client with hyperthyroidism and HR 118 is kept in a cool quiet room; a hypothyroid client takes levothyroxine daily and is taught to never skip doses.
189	Peptic Ulcer Disease	Epigastric pain, GI bleeding (melena, hematemesis), NSAID/alcohol risk; care: PPI/H2 blocker, small frequent meals, avoid NSAIDs/alcohol, report black stools.	Black tarry stools = bleeding until proven otherwise; NSAIDs are the avoid list.	A client on naproxen reports coffee-ground emesis and melena -- the nurse flags upper-GI bleeding, holds NSAIDs, and prepares endoscopy prep.
190	Appendicitis Warning	Periumbilical pain migrating to the right lower quadrant, anorexia, rebound tenderness, fever. Surgical emergency -- NPO, IV fluids, prepare for surgery; report sudden relief of pain (rupture risk).	A sudden decrease in pain with rising fever = rupture -- do not celebrate; report immediately.	A client with RLQ pain and rigidity is kept NPO awaiting OR; a sudden pain "improvement" with fever spikes a rupture alert.
191	Dehydration & Fluid Volume Deficit	Weight loss, dry mucous membranes, decreased skin turgor, tachycardia, hypotension, oliguria, concentrated urine; replace with oral fluids or isotonic IV.	Weigh daily -- a 1 kg change = ~1 L of fluid; tachycardia + oliguria = volume deficit.	A client with vomiting 2 days has dry membranes, HR 108, and urine output 20 mL/hr -- the nurse starts the ordered NS replacement and rehydrates gradually.
192	Fluid Volume Overload	Edema, crackles, weight gain, dyspnea, JVD, hypertension, bounding pulse; sodium/fluid		

Daily weight and I&O tell the truth; report +2 lb overnight and new crackles at once.	A client with HF has +3 lb in 24 hours, 2+ edema, and new crackles -- the nurse reports,
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192	NCLEX-PN Study Guide	Acid-Base Basics: ABGs	pH 7.35-7.45, PaCO2 35-45 (respiratory), HCO3 22-26 (metabolic). Respiratory = CO2; metabolic = HCO3. Remember: ROME.	ROME = Respiratory Opposite (pH ?/CO2 ?), Metabolic Equal (pH ?/HCO3 ?). Name the gas before treating.	pH 7.28, PaCO2 55 -> respiratory acidosis (hypoventilation); pH 7.50, HCO3 30 -> metabolic alkalosis.
194	Burns: Rule of Nines & Care	Rule of Nines estimates body surface: head/neck 9%, each arm 9%, anterior trunk 18%, posterior trunk 18%, each leg 18%, perineum 1%. Care: ABCs, fluid resuscitation (Parkland), wound care, pain.	Airway is the first burn concern (inhalation injury); then fluids -- the first 24 hours are all about resuscitation.	An adult with both legs and anterior trunk burned = 18+18+18 = 54% TBSA -- the nurse prepares for aggressive fluid resuscitation and airway monitoring.	
195	Shock: Recognition & Response	Hypovolemic (bleeding, dehydration), septic (fever, warm then cool skin), cardiogenic (HF, MI). Early: tachycardia, tachypnea, anxiety; late: hypotension, oliguria, altered mentation.	Tachycardia + anxiety + rising lactate = early shock -- act before hypotension (which is LATE).	A client with HR 124, BP 96/60, urine 15 mL/hr after surgery -- the nurse recognizes early hypovolemic shock and calls the provider with SBAR.	
196	Sepsis & Septic Shock	Suspected infection + organ dysfunction; qSOFA/SEPSIS-3: hypotension, altered mentation, tachypnea. Bundle: lactate, cultures before antibiotics, fluids, antibiotics within the hour.	Cultures FIRST, antibiotics within the hour, fluids running -- the sepsis bundle is time-driven.	A client with fever, confusion, RR 24, and hypotension gets blood cultures, then antibiotics and a fluid bolus within the first hour -- sepsis bundle.	
197	Oncology: Chemo Precautions & Nadir	Nadir = lowest blood counts ~7-14 days post-chemo: infection and bleeding risk; neutropenic precautions (no fresh flowers, hand hygiene, avoid crowds, report fever immediately).	Neutropenia = fever is an emergency; a single temperature spike is reportable, not "wait and see."	A client post-chemo with WBC 1,200 and a 100.6 fever is treated as neutropenic emergency -- cultures, empiric antibiotics, protective isolation.	
198	Anemia & Iron Deficiency	Fatigue, pallor, dyspnea on exertion, tachycardia; iron: with vitamin C, between meals, dark stools expected; monitor Hgb trend and teach fall safety.	Iron causes dark stools -- teach it so the client doesn't fear bleeding; pair with vitamin C.	A client starting iron supplements is told stools may turn dark (expected), to take iron with vitamin C, and to report severe fatigue or shortness of breath.	
199	IV Push & Medication Safety Final	High-alert meds (insulin, heparin, opioids, KCl) need double-checks; never use abbreviations (U, IU, QD); question any unclear order.	If it looks wrong, it is wrong -- verify before you give; the safest med is the one checked twice.	A nurse questions a written "U" order (instead of "units") for insulin and confirms the dose -- a near-miss caught at the bedside.	
200	Chronic Wound Care	Wound healing: assess color (red = granulating, yellow = slough, black = eschar), clean per order, sterile dressing, offload pressure, nutrition (protein, vitamin C), monitor for infection.	RED-yellow-black = granulating/slough/eschar -- choose the dressing and treatment to match.	A sacral wound bed is 60% yellow slough -- the nurse initiates debridement per order, offloads the area, and adds protein to meals.	

Part 11: Maternal-Newborn, Pediatrics & Special Populations (22 Concepts)

High-yield lifespan content: pregnancy risks, newborn transition, pediatric care, and age-specific practice.

#	Term	Key Facts	Strategy Tip	Example
201	Prenatal Danger Signs	Vaginal bleeding, fluid leakage, decreased fetal movement, severe headache, blurred vision, epigastric pain, fever, dysuria -- all require immediate evaluation.	Teach "call us, don't wait" -- every danger sign is a phone call or visit now.	At 32 weeks a client reports epigastric pain and a severe headache with visual spots -- she is evaluated urgently for preeclampsia.
202	Preeclampsia	Hypertension + proteinuria/end-organ changes after 20 weeks; headache, visual changes, epigastric pain, hyperreflexia. Care: bed rest, BP monitoring, seizure precautions (magnesium sulfate), report right-upper-quadrant pain.	Epigastric pain + headache + blurred vision = the preeclampsia alarm; magnesium protects against seizures.	A preeclamptic client on magnesium has hyperreflexia and a headache -- the nurse maintains seizure precautions, dark quiet room, and monitors reflexes.
203	Labor: Fetal Monitoring Basics	Reassuring: baseline 110-160 bpm, moderate variability, accelerations, no late/variable decelerations. Non-reassuring: late decelerations (uteroplacental insufficiency), variable (cord compression),		

placental flow); knee-chest
often relieves
cord-compression variables;
avoid supine in late pregnancy.

NEVER supine in late labor --
the uterus compresses the

A laboring client feels faint and hypotensive lying flat -- the

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205	NCLEX-PN Study Guide	The Four Stages of Labor Recap	Stage 1: dilation (latent 0-3 cm, active 4-7, transition 8-10); Stage 2: pushing to birth; Stage 3: placenta; Stage 4: 2-hour recovery -- vital-sign and hemorrhage monitoring.	Transition behavior (irritability, "I can't") = near full dilation; the LPN prepares the birthing area.	A client at 9 cm says she can't do this anymore and vomits -- the nurse recognizes transition and gets the delivery team ready.
206		APGAR (5 Signs)	Appearance (color), Pulse, Grimace (reflex), Activity (tone), Respirations -- scored 0, 1, or 2 each at 1 and 5 minutes (and later if low). 7-10 = reassuring, 4-6 = moderate, <4 = severe distress.	The 5-min score predicts more than the 1-min; <7 at 5 minutes triggers continued resuscitation.	A newborn scores 8 at 1 minute (1 point off for acrocyanosis) and 9 at 5 minutes -- reassuring transition.
207		Newborn Thermoregulation	Newborns lose heat fast (cold stress -> increased O2 needs); dry immediately, skin-to-skin, warm blankets, cap, warm room; monitor for cold stress signs.	Cold = O2 burn: dry, wrap, cap, skin-to-skin -- the first 30 minutes are the heat-critical window.	A newborn is dried immediately, placed skin-to-skin on the mother, and capped; temperature stays 97.7-99.5°F.
208		Newborn Hypoglycemia Screen	Risk: IDM (infants of diabetic mothers), preterm, LGA/SGA; screen early; signs: jitteriness, lethargy, poor feeding, cyanosis; treat: feed early, recheck glucose.	Jittery + lethargic newborn = check glucose now; early feeding prevents and treats most cases.	A jittery infant of a diabetic mother has glucose 38 -- the nurse feeds immediately and rechecks in 30-60 minutes per protocol.
209		Neonatal Jaundice	Physiologic jaundice appears day 2-3; pathologic: within 24 hours, rising fast, or extending -- bilirubin level, phototherapy (eyes covered, monitor temp and skin), increase feeding.	Jaundice in the first 24 hours is ALWAYS pathologic -- never waved off as normal.	A 12-hour-old newborn with yellowing skin gets a bilirubin level -- early jaundice triggers the workup, not waiting.
210		Postpartum Hemorrhage	Defined as > 500 mL vaginal (or > 1,000 cesarean): boggy fundus, heavy bleeding, tachycardia, hypotension; nursing: massage fundus, oxytocin per order, position, fluids, call for help.	Uterine massage + oxytocin + call -- hemorrhage is minutes-driven, not hours.	A client's fundus is boggy with a saturated pad in 30 minutes and HR 112 -- the nurse massages, gives oxytocin, and notifies for hemorrhage response.
211		Postpartum Assessment & Teaching	Fundus firm and midline (descends ~1 cm/day), lochia rubra->serosa->alba, perineal ice for swelling, sitz baths, report fever, calf pain, heavy bleeding.	Calf pain + swelling + dyspnea in a postpartum client = PE/DVT suspect; report immediately.	A day-3 client reports left calf pain and swelling with a low-grade fever -- the nurse notifies the provider for a DVT evaluation.
212		Pediatric Medication Administration	Weight-based dosing, use the smallest accurate measurement, never call meds "candy," double-check dosage math, EMLA/comfort measures for injections, family teaching.	"Lbs get converted to kg first" and "the older child helps choose the arm" -- age-appropriate technique.	A 30-lb child needs amoxicillin 40 mg/kg/day divided q12h -- the nurse converts to 13.6 kg and verifies the 272 mg/dose with a second nurse.
213		Pediatric Dehydration & Rehydration	Assess: dry mucous membranes, sunken fontanelle, decreased tears, tenting skin, tachycardia, decreased urine; oral rehydration first for mild-moderate; IV for severe; monitor I&O closely.	Sunken fontanelle + no tears + decreased wet diapers = dehydration; weigh daily -- weight is the I&O truth serum.	A toddler with gastroenteritis has no tears and 4 hours without urine -- the nurse starts the ordered oral rehydration and tracks every wet diaper.
214		Pediatric Fever Management	Treat fever for comfort (not the number alone), acetaminophen/ibuprofen per weight, fluids, light clothing, watch for red flags (lethargy, stiff neck, petechiae, poor perfusion, < 3 months old).	< 3 months + fever = sepsis workup until proven otherwise; a stiff neck and petechiae = call NOW.	A 2-month-old with a temp of 100.8 is evaluated as a potential serious bacterial infection -- age trumps the number.
215		SIDS Prevention Teaching	Back to sleep on a firm surface, no loose bedding/pillows/bumpers, no co-sleeping, room-sharing without bed-sharing, avoid overheating and smoke exposure.	The ABCs of safe sleep: Alone, on the Back, in the Crib -- every sleep, every nap.	New parents receive safe-sleep teaching: supine, firm mattress, nothing in the crib, room-sharing not bed-sharing.
216		Pediatric Growth & Nutrition	Birth weight doubles ~5 months, triples ~1 year; head circumference tracks brain growth; iron-fortified foods at ~6 months; cow's milk not before 12 months.	Milestone math: 2x by 5 months, 3x by 1 year; solids at 6 months; no honey under 1 year (botulism).	A 6-month-old starts iron-fortified cereal; the parents are taught to avoid honey and cow's milk until age 1.
217		Child Abuse: Nursing Response	Suspected abuse is reported to child protective services --		

mandatory for nurses;
document objectively (injuries
photographed per policy),
interview the child alone, never
accuse.

"Suspected, not proven, is
enough to report" -- the nurse's

Bruises in different healing stages on a 3-year-old's back

218	NCLEX-PN Study Guide	The Older Adult: Polypharmacy	Multiple meds raise fall, interaction, and adherence risk; review all meds (including OTC/supplements) at every visit; use pill organizers and simplified schedules.	Bring the brown bag -- reviewing every bottle beats a med list recited from memory.	An 82-year-old on 11 meds gets a brown-bag review: two duplicates are identified and the provider consolidates the regimen.
219		The Older Adult: Delirium vs. Dementia	Delirium = ACUTE, fluctuating, often reversible (infection, meds, dehydration, hypoxia -- assess these first); dementia = chronic, progressive (Alzheimer's).	New confusion = delirium until proven otherwise -- look for the infection first.	A client who was fine yesterday is now confused and has a UTI -- delirium from infection; treat the UTI and safety-monitor.
220		The Older Adult: Fall-Prone Care	History of falls is the top risk factor; review gait, meds (sedatives, antihypertensives), vision, footwear; keep the call light and walker close; low bed; nightlight; hourly rounding.	Each fall is a systems event: review meds, environment, and gait together -- not just "be careful."	After a fall, the client's sedative is reviewed, a bed alarm placed, the bed lowered, and PT consulted for gait training.
221		The Older Adult: Nutrition	Decreased appetite, taste changes, dental issues, and social isolation reduce intake; smaller frequent meals, nutrient-dense foods, monitor weight, dysphagia screening.	Weight loss in elders = evaluate, don't accept "old age"; every 5% loss in a month is a red flag.	An 80-year-old who lost 6 lb this month gets a nutrition consult, dental review, and a family meal plan -- weight loss is never shrugged off.
222		The Older Adult: Sensory Changes	Hearing and vision decline with age; face the client when speaking, reduce background noise, use large-print materials, verify understanding by return demonstration.	"Face them, speak clearly, confirm understanding" -- hearing loss masquerades as confusion.	A client with hearing loss nods along -- the nurse faces the client, uses short sentences, and asks for a return explanation of the teaching.

Part 12: CAT Strategy & Test-Day Playbook (16 Concepts)

How to study for the adaptive exam and how to survive the five hours.

#	Term	Key Facts	Strategy Tip	Example
223	Study by Content Weight	Allocate study time by category weight: Coordinated Care (18-24%) and Pharmacological Therapies (10-16%) deserve the most hours; don't over-study small categories at the expense of the big ones.	Build your study plan from the 2026 Test Plan percentages -- study the biggest categories hardest.	A candidate budgets 25% of study time to Coordinated Care, 20% to meds, and smaller blocks for the rest -- matching the exam mix.
224	Practice with CAT-Style Questions	The exam adapts to your ability, so practice sets should be mixed-difficulty and randomized, not topic-by-topic handholding; do timed sets to simulate the 5-hour pressure.	Timed mixed sets train stamina and time-pacing; untimed topic drills build knowledge first.	A candidate does 85-question timed sets each week, then reviews every missed item and its rationale.
225	The 85-Item Floor Mindset	The exam cannot fail you for finishing early if you are clearly above the standard -- and it cannot pass you on length alone. Guard the 85-item floor so you are never auto-failed by time.	Pace at roughly 1-2 minutes per item to always clear 85; a strong 95-item exam beats a rushed, incomplete one.	A candidate tracks ~75 minutes of elapsed time after 45 items and speeds up slightly -- staying safely above the 85-item floor.
226	One Item at a Time	Each item is a fresh decision; you cannot carry "momentum" or "streaks" between items because the computer recalibrates after every response.	Forget the last item instantly -- the next question is independent and all that matters.	After a tough SATA item, a candidate takes a breath and treats the next bow-tie as a brand-new problem.
227	Don't Skip, Don't Check the Clock	Every item must be answered; you cannot return. The clock is your pacing tool, not your anxiety meter -- check it at planned intervals, not constantly.	Answer every item, even a guess -- a reasoned guess beats an unanswered auto-fail.	A candidate guesses confidently on a pharmacology item rather than stalling, because any answer keeps the exam progressing.
228	The Breath-and-Reason Method	Read the stem fully, identify what the question is really asking (priority? delegation? teaching?), eliminate distractors, and pick the safest answer.	"What is this question ABOUT?" before reading options -- 30 seconds of framing saves 3 minutes of flailing.	For "which client should the LPN see first?", a candidate frames it as a PRIORITY question and picks the unstable airway client.
229	Safety Is the Tiebreaker	When two answers both sound reasonable, choose the one that keeps the client most physically safe -- safe care beats comprehensive care on the NCLEX.	The safety-first answer wins close calls: no harm > comfort > convenience > teaching.	A question asks what to do with a confused client wandering: a sitter and bed alarm (safety) beats an activity group (engagement).

220	NCLEX-PN Study Guide	The "First Action" Reflex	First-action questions reward assessment or immediate safety: "assess," "call for help," "ensure an open airway" are rarely wrong first steps.	Never jump to a medication or procedure before an assessment action is offered.	After a client reports sudden chest pain, "first action" options: assess vitals and pain character beats "give the PRN nitroglycerin" on first glance.
231	Delegation Questions: Know the Layer		UAP = routine physical care and ADLs; LPN = stable-client care, meds (per state law), and data collection; RN = assessments, unstable clients, teaching, and evaluation.	If a task requires judgment or assessment, it stays with licensed staff; if it's routine and stable, it can go to the UAP.	Delegating routine vitals and ambulation to the UAP is fine; delegating the first assessment of a new admission is not.
232	Refusal of Care & Client Autonomy		Clients can refuse any treatment; the nurse respects the refusal, explores the reason, informs of consequences, documents, and notifies the provider.	"The client refuses" almost always means respect + document + notify -- never force, never abandon.	A client refuses the wound dressing change -- the nurse listens to the concern (fear of pain), offers analgesia first, documents the refusal, and notifies.
233	The 5-Hour Energy Plan		300 minutes is plenty if paced: about 2-3 minutes per item average; use the scheduled break to eat a snack, use the restroom, and reset -- breaks count against the clock.	Plan the breaks before they happen: one scheduled mid-exam reset, one small snack, water at your seat.	A candidate sets checkpoints: ~40 items by the first hour, break at 2.5 hours, ~110 items by hour 4, and a final push to completion.
234	Don't Judge the Test by Its Length		A short exam can be a pass; a full-length exam can be a fail. Never let the item counter or stopping point shake your confidence.	Whatever the computer decides, your job was the same: answer each item carefully until it stops.	A candidate whose exam ends at 92 items leaves confident -- a clearly-above-standard pass can be quick.
235	The Week Before: Calm, Not Cram		Final week: light review of high-yield tables (rights, precautions, APGAR, ABGs), sleep & 7 hours nightly, arrange logistics (ATT, ID, route, arrival), no all-nighters.	Sleep and logistics beat last-minute reading -- a rested brain takes a better test than a crammed one.	A candidate reviews 45 minutes nightly, packs the ATT and two IDs, and sleeps 8 hours the night before.
236	Test Day Logistics		Arrive early, bring the ATT and valid government ID, dress in layers, know the personal-item rules (locker use), and confirm the check-in procedure.	Layers + snacks in the locker + a known route = fewer on-test-day surprises.	A candidate arrives 45 minutes early with the ATT, two IDs, a light sweater, and a snack for the break.
237	After the Exam: Results & CPR		Results come from your NRB within 6 weeks (paid Quick Results where available); the Candidate Performance Report shows "near/above/below" per content area -- useful for retake planning only.	If you must retake, use the CPR to target your weakest categories instead of re-studying everything.	A candidate who fails with "Below" in Pharmacological Therapies and Reduction of Risk rebuilds those two domains before the next attempt.
238	The Retake Mindset (45-Day Window)		Waiting periods (commonly 45 days) are set by your NRB; treat the window as a structured recovery: one content plan, timed sets, honest review -- not panic re-cramming.	A failed exam is data, not identity: one category at a time, one timed set at a time.	A retaker maps 6 weeks: week 1 meds, week 2 risk reduction, week 3 mixed sets, week 4+ full-length mocks -- then re-registers confidently.

Final Checklist: Your NCLEX-PN Command List

- [] Know the format cold: CAT, 85 minimum / 150 maximum items, 5 hours INCLUDING breaks, 15 pretest items, 3 case studies (18 items), ~10% stand-alone clinical judgment.
- [] Know the order of the six CJM steps: Recognize -> Analyze -> Prioritize -> Generate -> Take action -> Evaluate.
- [] Walk into every priority question with ABCs and acuity; walk into every delegation question knowing what UAPs can and cannot do.
- [] Memorize the safety non-negotiables: two identifiers, hand hygiene, the six rights, RACE, standard + transmission-based precautions, allergies before meds.
- [] Memorize the numbers that show up every year: adult vitals, WBC/Hgb/platelets, Na/K/Ca/Mg, glucose and HbA1c, INR/aPTT, APGAR, five-hour clock, 85-item floor.
- [] Practice SATA and NGN formats until they feel routine -- include them in every timed set.
- [] Commit to your pacing plan, planned break, and the "answer every item" rule.
- [] Verify your ATT, ID, test center, and arrival plan the week before.
- [] Read the free official materials: the 2026 NCLEX-PN Test Plan and Candidate Bulletin at nclex.com -- this guide complements them, it does not replace them.

Final Note

You have everything you need: the rules of the exam, the content that matters, and the strategy to survive five hours of adaptive questions. The NCLEX-PN is not a test of memorization alone -- it is a test of safe, organized thinking under pressure. Answer each item as if a real client depends on it, because the standard you are measured against is exactly that:

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