CLINICALJUDGE™ · MASTER STUDY GUIDE

PRIORITIZATION & ANSWER SELECTION

The single most-tested skill on the 2026 Next-Generation NCLEX-RN: deciding who to see first, what to do first, what to delegate, and how to pick the correct answer when every option looks reasonable. Frameworks, decision principles, scope-of-practice, triage, and worked answer examples.

2026 NGN BLUEPRINT | MANAGEMENT OF CARE | ABC · MASLOW · NURSING PROCESS | DELEGATION & ASSIGNMENT | WORKED EXAMPLES

RED	BLUE	GREEN	ORANGE	YELLOW	PURPLE	TEAL
SEE/DO FIRST	PRINCIPLE	CORRECT ANSWER	URGENCY TIER	CAUTION	FRAMEWORK	STRATEGY

THE ONE RULE BEHIND EVERY PRIORITIZATION QUESTION

Find the client whose problem is the **most life-threatening, most unstable, most acute, and least expected** — and choose the action that **protects the airway or addresses the threat with the least risk.** Everything below is how to apply that quickly.

01 THE MASTER PRIORITY DECISION ORDER

RUN OPTIONS THROUGH THESE FILTERS, TOP TO BOTTOM

1 AIRWAY → BREATHING → CIRCULATION (ABC)

A patent airway beats everything. Then effective breathing/oxygenation, then circulation/perfusion. **Exception: in cardiac arrest, sequence is C-A-B** (compressions first).

2 MASLOW — PHYSIOLOGICAL BEFORE PSYCHOSOCIAL

After ABCs, physiological needs (oxygen, fluids, nutrition, elimination, pain, sleep) come before safety/security, then love/belonging, esteem, self-actualization. **A physical need usually outranks an emotional one.**

3 SAFETY / RISK OF HARM

Falls, errors, suicide risk, abuse, infection control, environmental hazards. Protect the client (and others) from imminent harm.

4 NURSING PROCESS — ASSESS BEFORE ACT

When no immediate emergency, **gather data / assess first** (ADPIE). The first action is often the least invasive assessment. **But if ABCs are threatened, intervene — don't reassess.**

5 ACUTE · UNSTABLE · UNEXPECTED · ACTUAL

Choose **acute over chronic**, **unstable over stable**, **unexpected over expected**, and **actual problems over potential/at-risk** ones.

02 CORE FRAMEWORKS IN DETAIL

THE TOOLS THE QUESTION IS TESTING

ABCS (AND CAB)

Airway · Breathing · Circulation

1. **Airway** — obstruction, stridor, choking, tongue, secretions, swelling
2. **Breathing** — apnea, severe dyspnea, ↓SpO_2, no chest rise, distress
3. **Circulation** — no pulse, hemorrhage, shock, severe dysrhythmia, chest pain

CAB exception: for a pulseless/unresponsive client (cardiac arrest), start **Compressions** first, then airway/breathing.

MASLOW'S HIERARCHY

Physiological → self-actualization

1. **Physiological** — air, water, food, elimination, pain, rest, temperature
2. **Safety/Security** — injury prevention, stable environment
3. **Love/Belonging** — relationships, support
4. **Esteem** — confidence, respect
5. **Self-actualization** — growth, meaning

Test use: a physiological need (e.g., airway, pain, nutrition) outranks a psychosocial concern (e.g., anxiety, body image) — unless the psychosocial issue *is* a safety threat (suicidal intent).

NURSING PROCESS (ADPIE)

Assess · Diagnose · Plan · Implement · Evaluate

1. **Assess** — collect data first (the usual "first action")
2. **Diagnose** — analyze, identify the problem
3. **Plan** — set goals/outcomes
4. **Implement** — carry out interventions
5. **Evaluate** — judge effectiveness, revise

Assess vs. act: when stable → assess first. When an emergency threatens ABCs → **act immediately** (don't pick "reassess" while someone is decompensating).

LEAST-INVASIVE / TREAT THE PATIENT

First-action logic

1. Choose the **least invasive** effective action first (reposition/O_2 before intubation)
2. **Treat the patient, not the monitor** — assess the client before responding to an alarm/number
3. Independent nursing actions before calling the provider, *unless* an order is required to act
4. Don't leave an unstable client to "go get" something or "call" first

03 "WHICH CLIENT DO YOU SEE FIRST?"

THE SEE-FIRST DECISION PRINCIPLES

UNSTABLE OVER STABLE

The client with deteriorating or unpredictable vitals/status comes before the one who is stable and predictable.

```
unstable > stable
```

ACUTE OVER CHRONIC

A new, acute problem outranks a long-standing chronic condition that is unchanged.

```
new acute > chronic baseline
```

UNEXPECTED OVER EXPECTED

A finding that is NOT expected for the diagnosis/post-op day is the priority over an expected, normal-for-the-situation finding.

```
unexpected > expected
```

ACTUAL OVER POTENTIAL/AT-RISK

An actual, present problem outranks a potential or "risk for" problem that hasn't happened yet.

```
actual > potential
```

MOST LIKELY TO DETERIORATE

Choose the client whose condition could rapidly worsen or become life-threatening if not addressed now.

```
↑risk of rapid decline first
```

ABC TRUMPS ALL

Among several "abnormal" clients, the one with an airway/breathing/circulation threat goes first regardless of other factors.

```
airway threat = #1
```

▲ SEE FIRST — RED-FLAG CUES

- ▲ New or worsening shortness of breath, stridor, ↓SpO_2
- ▲ Chest pain, new dysrhythmia, hypotension, active bleeding
- ▲ Sudden change in LOC / new confusion / neuro deficit
- ▲ Signs of a developing complication (e.g., post-op hemorrhage)
- ▲ Cue that is unexpected for the diagnosis or post-op day

▼ CAN WAIT — EXPECTED/STABLE CUES

- ▼ Pain controlled, stable vitals, scheduled routine care
- ▼ Findings expected for the condition (e.g., serosanguineous drainage day 1)
- ▼ Chronic, unchanged baseline symptoms
- ▼ A "risk for" problem with no current signs
- ▼ Client requesting comfort/teaching while physiologically stable

04 "WHAT ACTION DO YOU TAKE FIRST?"

FIRST-ACTION DECISION PRINCIPLES

PROTECT THE AIRWAY

If the airway is or may be compromised, the first action addresses it (position, suction, O_2) before anything else.

```
airway action > everything
```

ASSESS BEFORE INTERVENE (IF STABLE)

With no emergency, gather more data first — the least invasive assessment is usually the correct "first" step.

```
assess > act (when stable)
```

ACT BEFORE ASSESS (IF EMERGENCY)

When ABCs are actively threatened, intervene now; don't choose "reassess/recheck" while the client deteriorates.

```
act > reassess (in crisis)
```

LEAST INVASIVE FIRST

Try the simplest effective intervention before escalating (reposition/O_2 before calling for intubation).

```
simple > invasive
```

TREAT THE CLIENT, NOT THE MACHINE

An alarm or abnormal reading → assess the client first; the number may be artifact.

```
patient > monitor
```

STAY WITH THE CLIENT

Don't leave an unstable client to call/fetch; use the call light or delegate while you stay and stabilize.

```
stay > leave
```

05 SORTING CLIENTS FAST

STABLE vs UNSTABLE · ACUTE vs CHRONIC · EXPECTED vs UNEXPECTED

DIMENSION	LOWER PRIORITY (OFTEN WAITS)	HIGHER PRIORITY (OFTEN FIRST)
Stability	Stable, predictable vitals/status	**Unstable, changing, unpredictable**
Acuity	Chronic, unchanged baseline	**Acute, new onset**
Expectedness	Expected/normal for the situation	**Unexpected/abnormal for the situation**
Problem type	Potential / "risk for"	**Actual / currently happening**
Trajectory	Improving or steady	**Deteriorating / likely to worsen**
System threatened	Comfort, mobility, psychosocial	**Airway, breathing, circulation, neuro**

↻ REFRAME THE QUESTION
"Who is the priority?" really means **"who is the most physiologically unstable and most likely to be harmed without immediate nursing action?"** Rank each option on the dimensions above.

06 DELEGATION & ASSIGNMENT

RIGHT TASK · RIGHT PERSON · RIGHT SCOPE

THE 5 RIGHTS OF DELEGATION

Before you hand off a task

1. **Right Task** — appropriate to delegate, routine/predictable
2. **Right Circumstance** — stable client, expected outcome
3. **Right Person** — within that worker's scope/competence
4. **Right Direction** — clear, specific instructions
5. **Right Supervision** — follow-up & evaluation by the RN

THE RN KEEPS (NEVER DELEGATES)

"You can't delegate what you EAT"

1. **E**valuation of care/outcomes
2. **A**ssessment (initial & ongoing nursing assessment)
3. **T**eaching & nursing judgment/clinical decisions

Also RN-only: care of unstable clients, the first dose/IV titration of high-alert meds, and any task requiring nursing judgment.

ROLE	CAN DO	CANNOT DO
RN	**Assessment, planning, teaching, evaluation, unstable clients, IV push, blood, care requiring judgment**	—
LPN / LVN	**Stable clients with predictable outcomes, most routine meds (PO/IM/SubQ), wound care, tube feeds, foley care, reinforce teaching, monitor & collect focused data**	**Initial assessment, develop care plan, IV-push meds (most states), blood transfusion initiation, teaching new content, evaluate, care of unstable clients**
UAP / AP / CNA	**ADLs, bathing, feeding (no dysphagia), ambulation, hygiene, vital signs & I&O on STABLE clients, repositioning, weights, specimen collection**	**Assessment, teaching, meds, sterile procedures, evaluating, interpreting data, anything on unstable clients**

ASSIGNMENT PRINCIPLE	APPLY IT LIKE THIS
Match acuity to scope	Most complex/unstable clients → RN; stable/predictable → LPN; basic ADL/stable monitoring → UAP.
Match competency & experience	New grad or float gets stable, common conditions — not the highest-acuity or specialized cases.
Infection control & cohorting	Don't assign an immunocompromised client to the same nurse as an infectious client; consider isolation needs.
Continuity & geography	Cluster assignments logically; avoid pairing high-fall-risk & high-acuity unpredictably.
Pregnant staff & certain patients	Pregnant nurses avoid clients with rubella, CMV, radioactive implants, or shingles risk.

07 TRIAGE ORDERING

EMERGENCY DEPARTMENT & DISASTER (MASS-CASUALTY)

ED TRIAGE TIER	MEANING	EXAMPLES
Emergent (see now)	Life/limb threatening, immediate	Airway compromise, active MI/chest pain, severe bleeding, anaphylaxis, stroke, respiratory distress
Urgent (soon)	Serious but not immediately life-threatening	Stable fractures, moderate pain, fever, abdominal pain, lacerations needing repair
Non-urgent (can wait)	Stable, minor	Sprains, mild cold/sore throat, chronic stable complaints, simple rash

DISASTER TRIAGE (COLOR)	PRIORITY	WHO FITS
RED — Immediate	Highest — treat first	Life-threatening but **survivable** with rapid care (airway obstruction, severe but controllable bleed, tension pneumothorax)
YELLOW — Delayed	Can wait short time	Serious injuries, stable for now (large but stable fractures, abdominal injury without shock)
GREEN — Minimal	"Walking wounded"	Minor injuries, can self-care or wait (minor cuts, sprains)

DISASTER TRIAGE (COLOR)	PRIORITY	WHO FITS
BLACK — Expectant	Lowest in mass-casualty	Dead or injuries incompatible with survival given available resources

⚖ THE TRIAGE MINDSET FLIP
In **everyday care**, the sickest client is the priority. In a **mass-casualty disaster**, the goal shifts to the **greatest good for the greatest number** — so resources go to those who are salvageable, not necessarily the most critically injured.

08 WORKED ANSWER EXAMPLES

SCENARIO → PRINCIPLE → CORRECT PICK → WHY

EXAMPLE 01 · SEE FIRST

The nurse receives report on four clients. Which should the nurse assess first?

A A client 1 day post-op with pain rated 6/10 awaiting scheduled analgesia
B A client with COPD whose baseline SpO_2 is 90% on home oxygen
C **A client reporting new sudden shortness of breath and chest tightness**
D A client with chronic kidney disease scheduled for routine dialysis

ABC · ACUTE & UNEXPECTED OVER CHRONIC/EXPECTED

Answer: C. New, sudden dyspnea + chest tightness is an acute airway/breathing/circulation threat that could be a PE or cardiac event — assess immediately.

Why the others wait: A is expected post-op pain with a plan; B is the client's stable baseline; D is routine, scheduled, chronic care.

EXAMPLE 02 · FIRST ACTION

A postoperative client suddenly becomes restless with an SpO_2 of 85%. What should the nurse do first?

A Notify the surgeon immediately
B Document the findings in the chart
C **Reposition the client and apply supplemental oxygen**
D Prepare to draw arterial blood gases

AIRWAY/BREATHING FIRST · LEAST INVASIVE · ACT IN CRISIS

Answer: C. The breathing problem is the immediate threat; the first action is the least-invasive intervention that improves oxygenation — reposition and give O_2.

Why the others wait: Notify/document/ABGs all come after the airway-breathing intervention; you don't delay oxygenation to make a call or chart.

EXAMPLE 03 · FIRST ACTION (ASSESS VS ACT)

A client's cardiac monitor shows a flat line, but the client is awake, talking, and has a strong radial pulse. What should the nurse do first?

A Begin chest compressions
B Call a code
C **Assess the client and check the leads/equipment**
D Administer epinephrine

TREAT THE CLIENT, NOT THE MONITOR

Answer: C. An alert, talking client with a pulse is not in arrest — the flat line is almost certainly a lead/equipment issue. Assess the client first.

Why the others wait: Compressions, a code, and epinephrine are inappropriate for a client who is clearly perfusing — you'd be treating an artifact.

EXAMPLE 04 · MASLOW

Which client need should the nurse address first?

A A client who is crying and fearful about an upcoming surgery

B **A client reporting nausea and an inability to keep fluids down for 12 hours**

C A client asking questions about discharge teaching

D A client requesting a visit from the chaplain

MASLOW · PHYSIOLOGICAL BEFORE PSYCHOSOCIAL

Answer: B. Nausea + 12 h of no fluid retention is a physiological need (hydration/electrolytes) and takes priority over psychosocial concerns.

Why the others wait: A, C, and D are psychosocial/educational/spiritual needs — important, but they rank below an unmet physiological need.

EXAMPLE 05 · UNEXPECTED VS EXPECTED

Which postoperative finding requires immediate follow-up?

A Small amount of serosanguineous drainage on the dressing 4 hours post-op

B Pain rated 4/10 relieved by prescribed analgesia

C **Urine output of 20 mL over the past 2 hours**

D Drowsiness that resolves with stimulation in PACU

UNEXPECTED/ABNORMAL OVER EXPECTED

Answer: C. Output <30 mL/hr signals possible hypovolemia or renal compromise — unexpected and needs immediate evaluation.

Why the others wait: A, B, and D are all expected, normal post-op findings.

EXAMPLE 06 · DELEGATION TO UAP

Which task is appropriate for the nurse to delegate to unlicensed assistive personnel (UAP)?

A Assessing a new admission's lung sounds

B Teaching a client how to use an incentive spirometer

C **Assisting a stable client to ambulate and recording the distance**

D Evaluating whether a pain medication was effective

SCOPE OF PRACTICE · UAP = ADLS/STABLE

Answer: C. Ambulating a stable client and recording data is a routine, predictable task within UAP scope.

Why the others wait: Assessment (A), teaching (B), and evaluation (D) require nursing judgment — the RN keeps these ("E-A-T").

EXAMPLE 07 · DELEGATION TO LPN/LVN

Which client is most appropriate to assign to the LPN/LVN?

A A newly admitted client requiring an initial admission assessment

B **A stable client needing routine wound care and scheduled oral medications**

C A client requiring discharge teaching about a new diagnosis

D A client whose blood pressure is dropping after surgery

LPN = STABLE, PREDICTABLE, ROUTINE CARE

Answer: B. Stable client + routine wound care + scheduled PO meds is squarely within LPN scope.

Why the others wait: Initial assessment (A) and teaching new content (C) are RN-only; D is unstable and stays with the RN.

EXAMPLE 08 · ASSIGNMENT TO A NEW GRADUATE

The charge nurse is assigning clients to a newly licensed nurse. Which assignment is most appropriate?

A A client on a continuous insulin drip requiring hourly titration

B A client immediately post-cardiac arrest on multiple vasopressors

C **A stable client with community-acquired pneumonia on oral antibiotics**

D A client returning from the OR after a complex craniotomy

MATCH ACUITY TO COMPETENCY/EXPERIENCE

Answer: C. A stable client with a common condition is appropriate for a new grad; the others are high-acuity/unstable and need an experienced RN.

Why the others wait: A, B, and D require advanced judgment, titration, or close monitoring beyond a new grad's readiness.

EXAMPLE 09 · CALLING PROVIDER VS ACTING

A client with a chest tube has continuous bubbling in the water-seal chamber. What should the nurse do first?

A Clamp the chest tube immediately

B **Assess the system and tubing connections for an air leak**

C Notify the provider

D Document the finding and continue monitoring

ASSESS BEFORE ACT · INDEPENDENT ACTION FIRST

Answer: B. Continuous bubbling suggests an air leak; first assess/trace the system and connections — a loose connection is a correctable nursing action.

Why the others wait: Clamping (A) can cause tension pneumothorax and is generally avoided; notify/document come after assessment.

EXAMPLE 10 · SAFETY PRIORITY

On a behavioral-health unit, which client should the nurse attend to first?

A A client pacing and asking repeatedly when group therapy starts

B A client requesting a PRN sleep aid

C **A client who states they have a specific plan to harm themselves**

D A client tearful about a family visit being cancelled

SAFETY · RISK OF IMMINENT HARM

Answer: C. A client with a specific plan to self-harm is an immediate safety emergency — ensure safety and constant observation first.

Why the others wait: A, B, and D are real needs but pose no immediate danger; safety/life threats outrank them.

EXAMPLE 11 · DISCHARGE READINESS / STABILITY

Which client is most appropriate for the nurse to recommend for discharge to free a bed?

A A client whose oxygen requirement increased overnight

B A client with a new fever and rising white blood cell count

C **A client with stable vitals who has met all post-op milestones and is tolerating diet**

D A client awaiting results of an abnormal lab value

STABLE & MEETING EXPECTED OUTCOMES

Answer: C. Stable, milestone-meeting, diet-tolerating clients are appropriate for discharge; the others have new or unresolved instability.

Why the others wait: A (worsening), B (new infection), and D (pending abnormal result) all need continued evaluation.

EXAMPLE 12 · MULTI-STEP ORDER OF ACTIONS

A client is found on the floor after an unwitnessed fall. Place the nurse's actions in the best order.

1 **Assess responsiveness, airway, breathing, circulation, and for injury**

2 **Take vital signs and perform a neurologic check**

3 **Notify the provider of the findings**

4 **Complete documentation and an incident report**

ASSESS (ABC) → GATHER DATA → NOTIFY → DOCUMENT

Order: 1 → 2 → 3 → 4. Always assess the client (ABCs and injury) first, then obtain focused data, then notify the provider, and document last.

Why this order: Client safety/assessment precedes communication; documentation/incident reporting comes after the client is evaluated and the provider informed.

09 ANSWER-SELECTION STRATEGY CHECKLIST

HOW TO WORK A PRIORITIZATION ITEM UNDER PRESSURE

RUN THIS MENTAL SEQUENCE ✓

- ☑ Read the stem twice — is it asking "first," "priority," "best," "most important," or to delegate/assign?
- ☑ Decide: is this a "who do I see first" or a "what do I do first" question?
- ☑ Screen every option against ABCs — any airway/breathing/circulation threat wins
- ☑ If no ABC threat, apply Maslow (physiological before psychosocial), then safety
- ☑ Ask: is each client/finding stable or unstable? acute or chronic? expected or unexpected?
- ☑ For "first action": is this an emergency (act) or stable (assess first)?
- ☑ Choose the least invasive effective action before escalating
- ☑ Don't pick "notify the provider" if an independent nursing action is possible first
- ☑ Don't pick "document" or "leave the client" as a first action in a crisis
- ☑ For delegation, keep Evaluation, Assessment, Teaching (and unstable clients) with the RN
- ☑ Match the task to scope (RN / LPN / UAP) and the client's stability
- ☑ Treat the client, not the monitor — assess the person before the alarm/number
- ☑ In a disaster, switch to "greatest good for the greatest number"
- ☑ Eliminate options that are expected, stable, potential-only, or psychosocial when a physiological threat exists

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