DAY 01 · 15-DAY SERIES

Prioritization & *Establishing Priorities*

A daily NGN-style review for the 2026 NCLEX-RN. Built on the NCSBN Clinical Judgment Measurement Model, focused on Management of Care under Safe and Effective Care Environment.

CLIENT NEEDS: MANAGEMENT OF CARE (15–21%) **COGNITIVE LEVEL:** APPLICATION / ANALYSIS

ITEM MIX: MC · SATA · MATRIX · BOW-TIE · ORDERED · CLOZE · CASE

TODAY'S LESSON MAP

01 High-Yield Overview
02 10 Must-Know Rules
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SECTION 01

High-Yield Overview

What prioritization actually means on the 2026 NGN exam — and why "first" almost never means "call the provider."

Prioritization is the heart of Management of Care. On NGN, every "who do you see first?" or "what is the priority action?" question is secretly testing the Clinical Judgment Measurement Model: *can you recognize cues, analyze them, prioritize the right hypothesis, and take the safest action first?*

An entry-level RN must decide quickly: **Which client is most likely to deteriorate? Which problem will kill or injure first? Which action protects the airway, restores oxygenation, stops bleeding, or prevents a fall right now?** Memorization will not save you. What works is layering frameworks — *ABC → unstable/stable → acute/chronic → actual/risk → unexpected/expected → Maslow → nursing process* — until one answer survives.

Trap to remember: NCLEX rewards **assessment before action** when the client is stable, but rewards **action before assessment** when the client is in immediate danger (no pulse → start CPR; no airway → open it). Reading the stem for stability is half the battle.

FRAMEWORK 1

ABC

Airway → Breathing → Circulation. Airway problems trump everything.

FRAMEWORK 2

Stability

Unstable > Stable. New change in VS, LOC, or mentation wins.

FRAMEWORK 3

Acuity

Acute > Chronic. New problem beats known long-term condition.

FRAMEWORK 4

Actual vs Risk

Actual problem > Potential / at-risk problem.

FRAMEWORK 5

Expected?

Unexpected > Expected finding (e.g., new post-op fever day 5).

FRAMEWORK 6

Maslow

Physiological > Safety > Belonging > Esteem > Self-actualization.

FRAMEWORK 7

Nursing Process

Assess → Diagnose → Plan → Implement → Evaluate. Assess first if stable.

FRAMEWORK 8

Safety

Suicide ideation, abuse, fall risk, violence: non-negotiable priority.

SECTION 02

10 Must-Know Rules

If you internalize these, you will answer 80% of prioritization questions correctly without overthinking.

01 **Airway is always first.**
Stridor, gurgling, drooling, neck swelling, tongue swelling, or no chest rise trumps every other finding on the question.

02 **Unstable beats stable.**
Look for new VS abnormalities, sudden LOC change, sudden pain, sudden bleeding. Stable chronic problems wait.

03 **Acute beats chronic.**
A new finding (new chest pain, new confusion, new dyspnea) is more dangerous than a known long-standing finding.

04 **Actual beats potential.**
A real problem outranks an “at risk for” problem — unless the “risk” client is actively about to fall, code, or self-harm.

05 **Unexpected beats expected.**
Post-op day 1 incision pain is expected. Post-op day 5 fever and purulent drainage is not.

06 **Assess before you act when stable.**
When the client is stable, the “first” answer is almost always to *assess*, not to medicate or notify.

07 **Act before you assess when life is threatened.**
No pulse → CPR. No airway → open the airway. No breathing → rescue breaths. Don’t auscultate while they die.

08 **Calling the provider is rarely “first.”**
First you assess, stabilize, and gather data. Then you call with a complete SBAR.

09 **Maslow only applies after ABCs.**
Physiological > psychological — but pain, panic, and suicidal ideation can be physiological-grade priorities.

10 **Safety always wins on a tie.**
Falls, self-harm, restraints, abuse, suicide — if two answers tie, pick the one that prevents physical harm.

SECTION 03

RN Safety Decision Table

Real prioritization situations — the correct RN action, why it’s safest, and the NCLEX trap to dodge.

SITUATION	BEST RN ACTION	WHY THIS IS SAFEST	COMMON NCLEX TRAP
Post-op client with audible stridor and restlessness	**Open airway, prepare for emergency intubation, call rapid response**	Stridor = upper airway obstruction. Airway is always first; restlessness is an early hypoxia sign.	"Notify provider" sounds right but wastes time — you act on the airway *and* call simultaneously.
Four clients on a med-surg unit; one has new confusion, BP 86/52, HR 122	**See this client first; suspect sepsis/shock**	Unstable + new acute change in LOC + hypotension + tachycardia = early shock. Time-critical.	Choosing the post-op pain 8/10 client — pain is uncomfortable but not unstable.
Client just received morphine 4 mg IV, now RR 6 and lethargic	**Stimulate, oxygenate, administer naloxone, then notify provider**	Respiratory depression is an actual airway/breathing problem. Reverse it now.	"Document the response" or "recheck in 15 minutes" — both let the client stop breathing.
Client states "I have a plan to end my life tonight"	**Stay with the client, ensure constant 1:1 observation, remove means of harm**	Stated plan with intent = imminent safety risk. Never leave alone.	"Notify the psych provider" first — you don't leave a suicidal client to make a phone call.
Newly admitted client with chest pain, T-wave inversion on ECG	**Apply O2, IV access, ECG, ASA/nitro per protocol, troponin, notify provider**	MONA-style bundle treats the most likely killer (MI) without waiting for confirmation.	Sending the client to imaging first — you do not move an unstable cardiac client off the unit.
Two post-op clients need pain medication; one is 1 hr post-PCA basal increase	**Assess respiratory rate & LOC of the PCA client first**	Recent opioid dose escalation = high risk for respiratory depression. Assess before the next push.	Treating "who asked first" or "who is more vocal." Acuity, not order of request.
Client on heparin drip with new bruising, gum bleeding, & aPTT pending	**Hold the heparin, notify provider, recheck aPTT, assess for bleeding**	Active bleeding is actual harm. The aPTT can be redrawn; the bleeding can't be undone.	"Wait for the lab" — you don't wait when active bleeding is in front of you.
Charge RN with five admissions, two transfers, and one rapid response in progress	**Address the rapid response first; reassign or delay non-urgent admissions**	Rapid response = unstable client. Admissions are stable by definition (already triaged).	"Finish admissions first to clear the ED" — flow pressure does not outweigh an unstable client.
Client refuses ordered blood transfusion citing religious belief; Hgb 6.2	**Stop, document refusal, ensure informed refusal, contact provider & ethics**	Autonomy is a client right. Refusal is valid; the role of the nurse is to ensure understanding.	Coercing or guilt-tripping the client — never. Calling the family to convince them — never.
UAP reports BP 78/40 on a post-op client; you are mid-medication pass	**Stop the med pass, go assess immediately**	Reported instability outranks an ongoing routine task. Verify before delegating again.	"Tell the UAP to recheck" — you don't hand off verification of an unstable VS to UAP.

SECTION 04

Delegation & Scope of Practice Table

Even prioritization questions hide delegation traps. Use the "Five Rights of Delegation": right task, right circumstance, right person, right direction/communication, right supervision/evaluation. Remember: **RNs cannot delegate assessment, teaching, evaluation, or care of an unstable client.**

TASK	RN	LPN/VN	UAP	DELEGATE?	WHY / WHY NOT
Initial admission assessment of new client	Yes	No	No	No	Initial assessment of a new/unstable client is RN-only. Cannot be delegated.
Vital signs on stable post-op day 2 client	Yes	Yes	Yes	Yes	Stable, routine, predictable outcome — UAP scope.

TASK	RN	LPN/VN	UAP	DELEGATE?	WHY / WHY NOT
Vital signs on a client just transferred from ICU	Yes	Reinforce	No	No	Recently unstable — RN must verify stability before delegating.
Reinforce discharge teaching the RN already gave	Yes	Yes	No	LPN only	Initial teaching is RN. LPN can reinforce. UAP cannot teach.
Administer routine PO meds to stable client	Yes	Yes	No	LPN yes	LPN gives most PO/IM/SQ meds. UAP cannot administer meds.
Administer first-time IV push opioid	Yes	No	No	No	IV push narcotics are RN scope (state-dependent but NCLEX = RN).
Ambulate stable client for the second time	Yes	Yes	Yes	Yes	Stable, second time (first ambulation = RN assessment).
Bathing & oral care for stable client	Yes	Yes	Yes	Yes	Classic UAP task. Predictable outcome, low risk.
Evaluate response to a new medication	Yes	No	No	No	Evaluation is an RN function. Never delegated.
Re-position immobile client q2h	Yes	Yes	Yes	Yes	Predictable, routine, all levels qualified.
Triage which of 4 incoming clients to see first	Yes	No	No	No	Prioritization across multiple clients = RN judgment.

SECTION 05

Red-Flag Cues by Action Required

Read the stem, match the cue to the bucket, and the answer reveals itself.

Immediate Bedside Assessment

GO NOW — DON'T FINISH WHAT YOU'RE DOING

- New onset confusion, agitation, or change in LOC
- Sudden chest pain, sudden dyspnea, or new wheeze/stridor
- SpO_2 drop below baseline or below 90% on supplemental O_2
- Sudden BP drop (>20 mmHg systolic) or new tachycardia >120
- UAP states the client "doesn't look right"
- New bleeding, sudden severe pain, or facial droop

Notify the Provider

AFTER YOU ASSESS AND HAVE DATA READY (SBAR)

- Critical lab value (e.g., K >6.0, glucose <50, Hgb <7)
- Unrelieved pain despite ordered intervention
- Failed protocol step or new finding requiring a new order
- Medication error or near-miss
- Refusal of treatment
- Significant deterioration after a stable trend

Call Rapid Response / Code

DON'T WAIT, DON'T DEBATE

- Respiratory rate <8 or >30 with distress
- Sustained SBP <90 unresponsive to position/fluids
- Sustained HR <40 or >130 with symptoms
- Acute change in mental status / unresponsive
- New seizure activity
- "Worried" — nurse's clinical gut counts as a criterion

Escalate Up the Chain of Command

PROVIDER NOT RESPONDING, UNSAFE ORDER, OR SYSTEMIC ISSUE

- Provider unreachable in a clinically time-sensitive situation
- Unsafe or wrong order that the provider will not clarify
- Impaired staff member at work
- Unsafe staffing or assignment
- Unresolved conflict between provider and family
- Ethical dilemma without clear pathway

Mandatory Reporting

BY LAW, NOT YOUR CHOICE

- Suspected child, elder, or dependent-adult abuse / neglect
- Intimate partner violence reportable per state law
- Communicable disease per CDC / state list (e.g., TB, measles)
- Gunshot, stab, or assault wounds
- Imminent harm to self or others (duty to warn)
- Impaired licensed colleague who poses a client risk

Hold Delegation & Reassess

TAKE THE TASK BACK TO THE RN

- Client status changed (now unstable)
- UAP/LPN reports an abnormal finding
- The task now requires assessment, teaching, or evaluation
- The task now requires nursing judgment
- You don't have direct line-of-sight supervision of the delegatee
- The delegatee tells you they're not comfortable

SECTION 06

Advanced NGN Practice Questions

Ten items in mixed NGN formats. Each item is followed by a full rationale, the NCLEX trap being tested, and the Clinical Judgment step being measured.

Q 01 MULTIPLE CHOICE · PRIORITY

The RN receives report on four clients on a medical unit at the start of the shift. Which client should the nurse assess **first**?

A A 68-year-old with chronic COPD on 2 L NC; SpO_2 94%, RR 22, reports "feeling tired but okay."

B A 45-year-old post-op day 1 laparoscopic cholecystectomy; T 100.4°F, incision clean and dry, ambulating in hall.

C A 72-year-old admitted yesterday with pneumonia; new-onset confusion, BP 86/52, HR 122, RR 26, SpO_2 91% on 2 L.

D A 30-year-old in sickle cell pain crisis; reports pain 7/10, IV opioid dose due in 30 minutes.

RATIONALE

Correct: C

Why C is correct: New-onset confusion plus hypotension (86/52), tachycardia (122), tachypnea (26), and an O_2 sat dropping despite supplemental oxygen in a known infected client is classic *early septic shock*. The qSOFA criteria (altered mentation, SBP ≤100, RR ≥22) are met. This is unstable, acute, unexpected, and life-threatening.

Why A is wrong: Chronic COPD with baseline-acceptable saturations is stable; client's words confirm no acute distress.

Why B is wrong: Low-grade fever on POD 1 is expected (inflammatory response). Incision is clean. Client is mobile.

Why D is wrong: Pain 7/10 is uncomfortable but not life-threatening; medication is scheduled. Pain < sepsis.

NCLEX trap: Choosing the most vocal client (sickle cell pain) or the highest fever (post-op). Pain and fever feel urgent; sepsis with shock is actually killing the client.

CJMM STEP TESTED · RECOGNIZE CUES → PRIORITIZE HYPOTHESES

Q 02 SATA · RECOGNIZE CUES

Which findings require **immediate** RN assessment? *Select all that apply.*

A Post-op client with SpO_2 87% on room air, 1 hour after extubation.

B Client with chronic heart failure, 2+ pitting edema, weight unchanged from yesterday.

C New onset slurred speech and facial droop in a 65-year-old with hypertension.

D 24-hour post-op client reports pain 6/10; ambulating in hall.

E Type 1 diabetic with finger-stick glucose 52 mg/dL, diaphoretic and tremulous.

F UAP reports: "Room 6 looks pale and is harder to wake up than this morning."

G 80-year-old reports new-onset chest tightness; denies SOB.

RATIONALE

Correct: A, C, E, F, G

A: O_2 sat 87% post-extubation = airway/breathing emergency. **C:** Slurred speech + droop = stroke (FAST positive); time-critical for tPA window. **E:** Hypoglycemia with symptoms = imminent neurologic risk. **F:** Change in LOC reported by UAP = always assess; UAP intuition is data. **G:** New chest tightness in an older adult = MI until proven otherwise.

B is wrong: Stable chronic findings with no change. **D is wrong:** Expected post-op pain; client is mobile and engaged.

NCLEX trap: Skipping option F because the UAP's words sound vague. "Doesn't look right" is a cue, not an excuse to dismiss. The RN goes and looks.

CJMM STEP TESTED · RECOGNIZE CUES

Q 03 MATRIX / GRID · PRIORITIZE HYPOTHESES

For each client below, indicate the priority ranking the nurse should assign.

CLIENT	SEE FIRST	SEE SECOND	SEE LAST
Client A: COPD, RR 32, accessory muscle use, SpO_2 84% on 4 L NC	✓	–	–
Client B: T2DM, glucose 168, awaiting AM insulin	–	–	✓
Client C: Post-op hip, pain 7/10, PCA in use, RR 16	–	✓	–

RATIONALE

Client A — first: Acute respiratory failure in progress (low sat despite O_2, increased work of breathing). Airway/breathing always wins.

Client C — second: Uncontrolled pain matters, but the PCA is in use and RR is stable; intervene after stabilizing A.

Client B — last: Glucose 168 mildly elevated and scheduled insulin pending; no acute symptoms. Stable.

NCLEX trap: Treating pain 7/10 as the worst finding. Pain is urgent psychologically, not physiologically when ABCs are unmet elsewhere.

CJMM STEP TESTED · PRIORITIZE HYPOTHESES

Q 04 BOW-TIE · GENERATE SOLUTIONS & TAKE ACTION

A 68-year-old admitted for pneumonia now has: T 102.6°F, HR 118, RR 26, BP 88/54, SpO_2 89% on 4 L NC, confused, lactate 4.1, WBC 19,800. Drag the most likely condition into the center, and identify 2 cues and 2 priority actions.

PRIORITY CUES

1. SBP 88 with HR 118 & new confusion
2. Lactate 4.1 with WBC 19,800 & T 102.6

Septic Shock

PRIORITY ACTIONS

1. Initiate sepsis bundle: blood cultures & broad-spectrum antibiotics within 1 hour
2. Aggressive IV crystalloid fluid resuscitation (30 mL/kg) & titrate O_2

RATIONALE

The cues meet qSOFA (RR ≥22, SBP ≤100, altered mentation) *plus* elevated lactate ≥2 and source of infection = septic shock. The 1-hour bundle is the standard: cultures before antibiotics (if it doesn't delay antibiotics), broad-spectrum antibiotics, lactate, fluids, and vasopressors if MAP <65 after fluids.

Distractors to reject: "administer antipyretic" (treats symptom only), "notify provider then wait" (delays bundle), "hold antibiotics until cultures back" (delays antibiotics).

NCLEX trap: Picking a symptomatic action (Tylenol) over the etiologic intervention (antibiotics + fluids). Treat the cause when the cause is identified.

CJMM STEPS TESTED · GENERATE SOLUTIONS → TAKE ACTION

Q 05 ORDERED RESPONSE · TAKE ACTION

The RN enters a room and finds an adult client unresponsive. Place the following actions in priority order.

1. Check responsiveness (tap and shout)
2. Activate emergency response system / call for help
3. Assess pulse and breathing simultaneously for no more than 10 seconds
4. Begin high-quality chest compressions if no pulse
5. Attach AED / defibrillator as soon as it arrives

RATIONALE

This is BLS sequence per current AHA guidelines for adult in-hospital arrest: *check → call → check pulse/breathing → compressions → defibrillation*. Compressions take priority over rescue breaths in an unwitnessed arrest in adults.

NCLEX trap: Starting compressions before activating the code. You will be alone with no defibrillator and no help if you skip the call.

CJMM STEP TESTED · TAKE ACTION

Q 06 CLOZE / DROP-DOWN · ANALYZE CUES

Complete the sentence by selecting the option in each blank that completes a safe priority statement.

The nurse is caring for four clients. The client most at risk for `airway compromise` is the `22-year-old with new-onset audible stridor after a wasp sting`, and the nurse's first action should be to `apply oxygen, prepare epinephrine IM, and activate rapid response` rather than to `administer a PRN diphenhydramine and reassess in 15 minutes`.

RATIONALE

Stridor = upper-airway narrowing in evolving anaphylaxis. Epinephrine IM is first-line; diphenhydramine alone does not reverse airway edema. Waiting 15 minutes can be fatal.

NCLEX trap: Choosing Benadryl. Antihistamines treat hives, not airway obstruction. Epinephrine treats airway and shock.

CJMM STEP TESTED · ANALYZE CUES → TAKE ACTION

Q 07 PRIORITIZATION · ORDER OF CLIENTS

A med-surg RN is assigned 4 clients. Place them in the correct order in which the nurse should make rounds at the start of the shift.

1. Client W: 70-year-old admitted with new dyspnea and SpO_2 88% on 2 L NC.
2. Client X: 56-year-old with new-onset slurred speech and unilateral weakness, last known well 90 minutes ago.
3. Client Y: 48-year-old post-op day 0 cholecystectomy, pain 5/10, due for analgesic.
4. Client Z: 80-year-old awaiting discharge, daughter is at bedside packing.

(Note: This is the correct order. Client X — possible stroke — within the tPA window is the highest priority because brain tissue is dying every minute; Client W is unstable but the trajectory is slower; pain and discharge follow.)

RATIONALE

X first: Stroke symptoms within the tPA window (≤4.5 hrs of last-known-well) require immediate assessment, imaging, and intervention. “Time is brain.”

W second: Hypoxia with low sat on supplemental O_2 — unstable, but slightly less time-critical than active stroke window.

Y third: Pain is real but stable and treatable; not life-threatening.

Z last: Discharge is stable; family is present; can wait.

NCLEX trap: Choosing W first because of vital sign abnormality. Hypoxia is dangerous but a treatable stroke is a closing window.

CJMM STEP TESTED · PRIORITIZE HYPOTHESES

Q 08 CASE-STUDY STYLE · MULTI-STEP REASONING

A nurse assumes care of 5 clients on a step-down unit at 0700. Review the assignment and answer the questions that follow.

Clients:
1) 78-year-old day 2 of pneumonia, on 3 L NC, last sat 92%.
2) 62-year-old post-cath day 1, right groin dressing intact, peripheral pulses present.
3) 55-year-old with new chest pain at 0645, ECG ordered, troponin pending.
4) 40-year-old admitted overnight for alcohol withdrawal, last CIWA score 18.
5) 68-year-old awaiting discharge after CHF exacerbation, family at bedside.

8a. Which client should the nurse see first?

A Client 1

B Client 2

C Client 3

D Client 4

RATIONALE · 8A

Correct: 3

Active new chest pain with ECG pending is most likely an acute coronary event. Time-critical. Client 4 (CIWA 18) is unstable for withdrawal but the next intervention is a benzodiazepine that can be ordered/given quickly; chest pain in an undifferentiated client is the larger killer in the moment.

CJMM · PRIORITIZE HYPOTHESES

8b. The nurse delegates to an LPN. Which task is appropriate?

A Initial admission assessment of a new ED transfer.

B Administer scheduled lorazepam IV push to Client 4.

C Reinforce previously taught CHF discharge teaching with Client 5.

D Evaluate the response to nitroglycerin in Client 3.

RATIONALE · 8B

Correct: C

LPNs may reinforce teaching already provided by the RN. Initial admission assessment (A) is RN-only. IV push narcotics/benzos (B) are RN scope on NCLEX. Evaluation of response (D) is RN-only.

CJMM · TAKE ACTION (DELEGATION)

8c. The nurse calls the rapid response team for which client?

A Client 1, SpO_2 now 88% on 3 L NC despite repositioning.

B Client 2, dressing pink-tinged, pulses 2+ bilaterally.

C Client 5, daughter wants the discharge to happen quickly.

D All four except Client 3.

RATIONALE · 8C

Correct: A

Failure to maintain saturation with supplemental O_2 in a known pneumonia client = impending respiratory failure. Rapid response criterion met. Client 2 finding is normal post-cath. Client 5 issue is logistical, not clinical.

CJMM · EVALUATE OUTCOMES → TAKE ACTION

Q 09 DELEGATION SCENARIO

The charge RN is making the assignment for the oncoming shift. Which of the following can be appropriately delegated to a UAP?

A Initial assessment of a client just admitted with chest pain.

B Discharge teaching on a new heart-failure diet.

C Obtaining vital signs on a stable post-op day 2 client.

D Evaluating effectiveness of pain medication given 30 minutes ago.

RATIONALE

Correct: C

Routine VS on a stable client is the most classic UAP delegation. (A) is RN-only (initial assessment). (B) is RN initial teaching. (D) requires nursing judgment / evaluation = RN.

NCLEX trap: Believing UAPs can "ask the client about pain." They can *report* what the client says but cannot *evaluate* medication response.

CJMM · TAKE ACTION (DELEGATION)

Q 10 HANDOFF / SBAR SCENARIO

The RN is calling a rapid response on a deteriorating client. Which SBAR opening is most appropriate?

A "Hi, I'm the nurse from 4-West. The client in room 412 is not doing well, can someone come?"

B "This is Jamie, RN on 4-West. I'm calling about Mr. Lee in 412 — admitted for pneumonia. He's now confused, RR 28, BP 86/52, SpO_2 88% on 4 L. I think he's septic. I need an immediate eval and orders for fluid bolus and broad-spectrum antibiotics."

C "The client in room 412 has bad vitals. Please send someone."

D "Mr. Lee in 412 looks worse than this morning. Can you come check?"

RATIONALE

Correct: B

SBAR = **S**ituation, **B**ackground, **A**ssessment, **R**ecommendation. Option B contains all four: who's calling (situation), pneumonia admit (background), VS & concern for sepsis (assessment), and a specific recommendation (eval + fluids + antibiotics).

A, C, D are vague and missing data — common reasons rapid responses are delayed.

NCLEX trap: Choosing the shortest option, thinking "urgent" means "brief." SBAR is fast *and* complete.

CJMM · TAKE ACTION (COMMUNICATION)

SECTION 07

Unfolding NGN Case Study

One client, six questions, all six steps of the NCSBN Clinical Judgment Measurement Model.

CASE · 74F · MED-SURG · DAY SHIFT

Mrs. Theresa “Terry” Lopez

NURSE’S NOTES · 0700

74-year-old female admitted 2 days ago with community-acquired pneumonia. Day shift report: slept poorly. Reports increasing shortness of breath at rest. Coughing thick yellow sputum. Daughter at bedside reports “Mom seemed confused this morning — she asked me where her husband was. He died 6 years ago.” Skin warm, flushed. PIV right forearm, patent. Foley draining concentrated amber urine, output 40 mL in last 4 hours. Refused breakfast.

VITAL SIGNS · 0700

TEMP	HEART RATE	RR	BP	SpO_2
101.4°F	112 bpm	28 / min	96 / 58	88% / 2 L NC

PAIN
2 / 10 chest

PROVIDER ORDERS · ACTIVE

- O_2 titrate to keep SpO_2 > 92%
- Vancomycin 1 g IV q12h
- Piperacillin-tazobactam 3.375 g IV q6h
- Acetaminophen 650 mg PO q6h PRN T >101°F
- Albuterol nebulizer q4h
- 0.9% NS at 75 mL/hr
- Strict I&O, Foley to gravity
- Daily CBC, BMP, blood cultures ×2, lactate

LAB DATA · DRAWN 0600

- WBC 18,200 (high) · Bands 12% (left shift)
- Lactate 3.2 mmol/L (high)
- Creatinine 1.5 (baseline 0.8) · BUN 32 (high)
- Na 132 · K 4.0 · Glucose 168
- Blood cultures: pending
- Procalcitonin 4.8 (high)

FAMILY / CLIENT STATEMENT

Daughter: “She was talking yesterday. This morning she said weird things. She gets pneumonia a lot but she’s never been confused like this. I’m really scared.”
Client: “I just want to rest. I don’t feel right. Can you turn that light off?”

1 RECOGNIZE CUES

Highlight the findings the nurse should recognize as concerning. *Select all that apply.*

A Temperature 101.4°F

B Heart rate 112 bpm

C RR 28/min, SpO_2 88% on 2 L NC

D BP 96/58

E New-onset confusion / asking for deceased husband

F Urine output 40 mL in 4 hours

G Lactate 3.2; WBC 18,200 with bands

H Creatinine 1.5 (baseline 0.8)

I Pain 2/10 chest

J Foley draining concentrated amber urine

RATIONALE

Correct: 1, 2, 3, 4, 5, 6, 7, 8

Every finding except "pain 2/10 chest" is abnormal and concerning. Concentrated urine reflects #6 (low output / volume depletion). The pattern is: **infection (WBC, bands, fever, procalcitonin) + organ dysfunction (AKI, low UOP, hypoxia, altered mentation) + perfusion failure (lactate, BP, HR)**. That = septic shock.

CJMM STEP MEASURED · RECOGNIZE CUES

2 ANALYZE CUES

Match each cue category to its meaning for this client.

CUE CLUSTER	WHAT IT MEANS
WBC 18,200, bands 12%, procalcitonin 4.8, T 101.4°F	**Active bacterial infection with a left shift** — immune system actively fighting.
HR 112, BP 96/58, RR 28, lactate 3.2	**Tissue hypoperfusion / early shock** — meets qSOFA & sepsis-3 criteria.
New confusion, talking about deceased husband	**Acute mental status change** — sepsis-associated encephalopathy until proven otherwise.
Creatinine 1.5 (baseline 0.8), UOP 10 mL/hr	**Acute kidney injury** — organ dysfunction from poor perfusion.
SpO_2 88% on 2 L	**Worsening hypoxemia** — pneumonia progressing despite antibiotics; respiratory organ dysfunction.

RATIONALE

Analyzing cues means asking: *what story do these cues tell together?* Here the story is septic shock with multi-organ involvement (brain, kidney, lungs, circulation). Each cue alone could mean something else; together they point to one diagnosis.

CJMM STEP MEASURED · ANALYZE CUES

3 PRIORITIZE HYPOTHESES

Of the following, which is the **highest-priority** hypothesis the nurse must address right now?

A Acute delirium related to hospitalization in an older adult

B Septic shock with multi-organ involvement

C Worsening community-acquired pneumonia without sepsis

D Acute kidney injury from contrast dye exposure

RATIONALE

Correct: B

Septic shock encompasses and explains all of the other findings (delirium, AKI, hypoxia) and is the most rapidly life-threatening process. Pneumonia *plus* hypoperfusion (lactate, hypotension, AMS) is sepsis — not just pneumonia. Treating the umbrella diagnosis is more efficient than chasing each downstream consequence.

Trap: A "delirium" or "pneumonia worsening" framing seems gentler and may feel tempting because it's familiar, but they undercall the urgency and lead to wrong actions (e.g., reorienting instead of resuscitating).

CJMM STEP MEASURED · PRIORITIZE HYPOTHESES

4 GENERATE SOLUTIONS

Which interventions should the nurse anticipate or initiate within the next hour? *Select all that apply.*

A Administer broad-spectrum IV antibiotics on schedule (already ordered)

B Initiate 30 mL/kg IV crystalloid bolus per sepsis bundle

C Increase O_2 — titrate to keep SpO_2 > 92%

D Draw repeat lactate; confirm blood cultures are drawn

E Activate rapid response team / notify provider STAT

F Administer acetaminophen 650 mg PO PRN for fever

G Place client in Trendelenburg position for hypotension

H Insert second large-bore IV for volume resuscitation

I Strict I&O; monitor UOP hourly

J Hold antibiotics until blood cultures are resulted

RATIONALE

Correct: 1, 2, 3, 4, 5, 8, 9

The sepsis "Hour-1 Bundle" = lactate, blood cultures before antibiotics (only if no delay), broad-spectrum antibiotics, 30 mL/kg crystalloid for hypotension or lactate ≥4, vasopressors if MAP <65 after fluids. The RN escalates, secures access, titrates oxygen, and monitors UOP as an indicator of perfusion.

Why 6 is wrong: Treating the fever does not treat the sepsis — and lowering temperature without lowering bacterial load is a symptomatic distraction.

Why 7 is wrong: Trendelenburg is not recommended; it does not reliably improve perfusion and can worsen breathing.

Why 10 is wrong: Never delay antibiotics for cultures in septic shock — mortality rises every hour antibiotics are delayed.

CJMM STEP MEASURED · GENERATE SOLUTIONS

5 TAKE ACTION

Place the following actions in priority order for the next 10 minutes.

1 Increase O_2 via non-rebreather to maintain SpO_2 > 92%

2 Call rapid response / provider STAT

3 Initiate 30 mL/kg IV NS bolus through existing line; start second IV

4 Confirm blood cultures drawn; administer next antibiotic dose immediately

5 Draw repeat lactate after fluid resuscitation; monitor for response

RATIONALE

Airway/breathing first (oxygen) → escalate (RRT/provider so orders catch up to interventions) → restore perfusion (fluids + access) → treat cause (antibiotics) → evaluate response (repeat lactate).

Trap: Drawing the second lactate before giving fluids. You can't evaluate fluid response before giving fluid.

CJMM STEP MEASURED · TAKE ACTION

6 EVALUATE OUTCOMES

One hour after the bundle is completed, the nurse reassesses. Which findings indicate the interventions were **effective**? *Select all that apply.*

A BP 112/68, HR 92, RR 22, SpO_2 95% on 4 L NC

B Repeat lactate 1.9 mmol/L (was 3.2)

C UOP 60 mL in past hour (was 10 mL/hr)

D Client is alert and oriented ×3, recognizes daughter

E Repeat WBC 17,800 (was 18,200)

F BP 92/52, HR 124, mottled extremities

RATIONALE

Correct: A, B, C, D

Improved BP/HR/SpO_2, falling lactate, restored UOP, and cleared sensorium are the four classic markers of successful early sepsis resuscitation. WBC change (E) lags — it doesn't fall within an hour, so it's a non-marker. F is worsening, not improving.

Trap: Looking only at vital signs. Evaluation in sepsis is a *cluster*: perfusion (BP, lactate), organ function (UOP, mentation), and oxygenation (SpO_2).

CJMM STEP MEASURED · EVALUATE OUTCOMES

SECTION 08

"What Should the Nurse Do First?"

Five micro-scenarios. Read fast, decide, then check the reasoning.

01 A client on morphine PCA suddenly has RR 6 and SpO_2 84%, with shallow breathing. What is the first action?

Stop the PCA, stimulate the client, and provide oxygen / bag-valve-mask if needed. Then administer naloxone per protocol and notify provider. Reverse the cause before documenting or calling. Airway/breathing trumps everything.

02 A client states, "I have a gun at home and I'm going to use it tonight after discharge." What is the first action?

Stay with the client; ensure 1:1 monitoring is in place; remove any nearby means of harm; alert charge nurse and provider. Imminent safety threat — never leave the client to make a phone call alone.

03 A post-op client has new sudden-onset chest pain, dyspnea, and tachycardia 4 hours after total hip replacement. What is the first action?

Apply O_2, elevate HOB, assess VS & lung sounds, and call rapid response. Suspect pulmonary embolism — high mortality if untreated; intervention starts before imaging confirms.

04 A client receiving a unit of PRBCs spikes a fever from 98.6°F to 100.6°F with chills 15 minutes into the infusion. What is the first action?

Stop the transfusion immediately, keep the IV line open with normal saline using new tubing, then assess VS and notify provider/blood bank. The first move in any transfusion reaction is to *stop the transfusion.*

05 The UAP tells the RN: "The client in 3B looks pale and is harder to wake up than this morning." What is the first action?

Go directly to assess the client at the bedside. A reported change in LOC is never deferred. Don't ask the UAP to recheck or wait until you finish your med pass.

SECTION 09

"Can This Be Delegated?"

Five real assignment moments. Decide who should do the task and why.

01 Performing first ambulation post-knee replacement on POD 1.

RN only. First ambulation requires assessment of safety, pain, hemodynamic response, and gait. After the RN documents safe first ambulation, subsequent walks can be delegated to UAP/PT.

02 Obtaining a fingerstick blood glucose on a stable, well-known type 2 diabetic.

UAP — yes. Predictable, routine task on a stable client. The RN still interprets and acts on the result.

03 Reinforcing previously taught wound-care instructions to a client awaiting discharge.

LPN/VN — yes. Initial teaching is RN scope; LPNs may *reinforce*. UAPs cannot teach or reinforce.

04 Administering an IV push opioid for breakthrough pain.

RN only. IV push opioids carry high risk of respiratory depression and require RN assessment, administration, and evaluation. On NCLEX, IV push narcotics are RN scope.

05 Repositioning an immobile client every 2 hours and providing skin care.

UAP — yes. Predictable, routine, low-risk. RN still completes the skin assessment and evaluates outcomes (e.g., presence of new redness).

SECTION 10

"Who Should the Nurse Contact?"

Right team member, right time. Save provider calls for clinical urgency.

01 A client post-stroke is coughing and choking during meals; you suspect dysphagia.

Speech-Language Pathologist (SLP). SLPs perform swallow evaluations and recommend diet modifications. Also: hold PO intake, notify provider for NPO order pending eval.

02 A newly diagnosed insulin-dependent diabetic states, "I can't afford insulin or the syringes."

Case manager / social worker. They coordinate manufacturer assistance, community resources, and pharmacy benefits. Without affordability, the discharge plan fails.

03 A client with a non-healing pressure injury has increasing drainage and odor on POD 4.

Wound, Ostomy, & Continence (WOC) Nurse / Wound Care Team. They reassess staging and product selection; provider is notified for cultures and antibiotics.

04 A dying client with a DNR asks to speak to someone about meaning, regret, and family forgiveness.

Chaplain / spiritual care. Even if the client is not religious, spiritual care addresses meaning and reconciliation. The nurse can also stay and listen.

05 A client's family member confides that the spouse is "rough" with the older client at home, with bruises that don't match the explanations.

Adult Protective Services (APS) per mandatory reporting laws, plus social work and provider. Suspected elder abuse is reportable — the nurse does not need proof, only reasonable suspicion.

SECTION 11

Legal / Ethical Trap Mini-Scenarios

Five common traps. Know the principle, not just the answer.

01 A client signed a surgical consent yesterday and now states, "I don't really understand what they're going to do."

Stop the process. Notify the surgeon to return and re-explain. Consent requires understanding (capacity, voluntariness, information). The nurse witnesses the signature but the *provider* obtains consent. If understanding is missing, the consent is invalid.

02 An alert client refuses a needed blood transfusion citing religious belief; Hgb is 6.0 and dropping.

Honor the client's autonomy after ensuring informed refusal. Document refusal, notify provider, explore alternatives (volume expanders, erythropoietin), involve ethics if needed. Never coerce. Autonomy > beneficence.

03 A coworker is seen taking a controlled substance dose from the Pyxis but does not document administration. The same coworker appears unsteady.

Report to the charge nurse / nurse manager immediately; impaired practice is mandatory to report. Confronting the coworker yourself or "giving them a chance" risks client harm. Document objectively.

04 A new graduate posts on social media: "Crazy shift — lost a 60yo CHF guy in room 412 tonight." No name was used.

HIPAA breach. Room number, age, condition, and timing constitute identifying information. The nurse must remove the post, notify

the manager, and may face board action. Anonymity isn't enough — the standard is identifiability.

05 A 7-year-old presents with a spiral fracture, multiple bruises in various stages of healing, and a story that doesn't match the injury.

Mandatory report to Child Protective Services. Nurses are legally obligated to report suspected child abuse — you do not investigate, confirm, or wait for the provider. Reporting in good faith is protected by law.

SECTION 12

End-of-Day Quick Review

Final pass before you close the book.

10 Must-Remember Points

1. Airway first — always.
2. Unstable beats stable.
3. Acute beats chronic.
4. Actual beats potential.
5. Unexpected beats expected.
6. Stable client? Assess before you act or call.
7. Dying client? Act before you assess (CPR, naloxone, epinephrine).
8. UAPs cannot assess, teach, evaluate, or care for unstable clients.
9. SBAR every escalation: Situation · Background · Assessment · Recommendation.
10. Safety overrides every tie — suicide, abuse, falls, restraints.

5 Common NCLEX Traps

- Picking the "most vocal" client (loud pain) over the silent unstable one.
- Choosing "notify provider" as the first action when you haven't assessed.
- Choosing "document" in an emergency.
- Confusing "urgent" (loud, dramatic) with "priority" (lethal).
- Selecting an order out of habit instead of by clinical judgment.

5 "Never Do This" Rules

- **Never** delegate the initial assessment, teaching, or evaluation.
- **Never** leave a suicidal or actively unstable client alone.
- **Never** delay antibiotics in septic shock to wait for cultures.
- **Never** coerce a client into accepting refused treatment.
- **Never** ignore a UAP's report — verify at the bedside.

5 Safety-First Phrases to Recognize on NCLEX

- *"New onset" / "sudden" / "abrupt change" — almost always the right answer to see first.*
- *"Stridor / drooling / inability to speak in full sentences" — airway emergency.*
- *"Altered level of consciousness" — never ignore, never delegate.*
- *"Specific plan" (suicide / violence) — imminent safety; stay with the client.*
- *"Doesn't look right" (from any team member) — assess at the bedside now.*

SECTION 13

Standalone Infographic Summary

Screenshot-ready. Everything from Day 1 on one canvas.

DAY 01 · PRIORITIZATION & ESTABLISHING PRIORITIES

Think Like a Safe RN

in 8 layers.

Each prioritization question can be solved by walking these frameworks until one answer survives.

ABC → STABLE? → ACUTE? → ACTUAL? → UNEXPECTED? → MASLOW → NURSING PROCESS → SAFETY

See First — Red-Flag Cues

- Stridor, drooling, tongue swelling
- SpO_2 drop on supplemental O_2
- New confusion / altered LOC
- BP < 90 with HR > 120
- New chest pain, FAST-positive
- Suicidal ideation with plan

Delegation Cheat Sheet

- **RN only:** assess, teach, evaluate, unstable, IV push narcotics
- **LPN/VN:** stable PO/IM meds, reinforce teaching, routine wound care
- **UAP:** ADLs, VS on stable client, ambulation (after 1st), I/O
- Right task · circumstance · person · direction · supervision

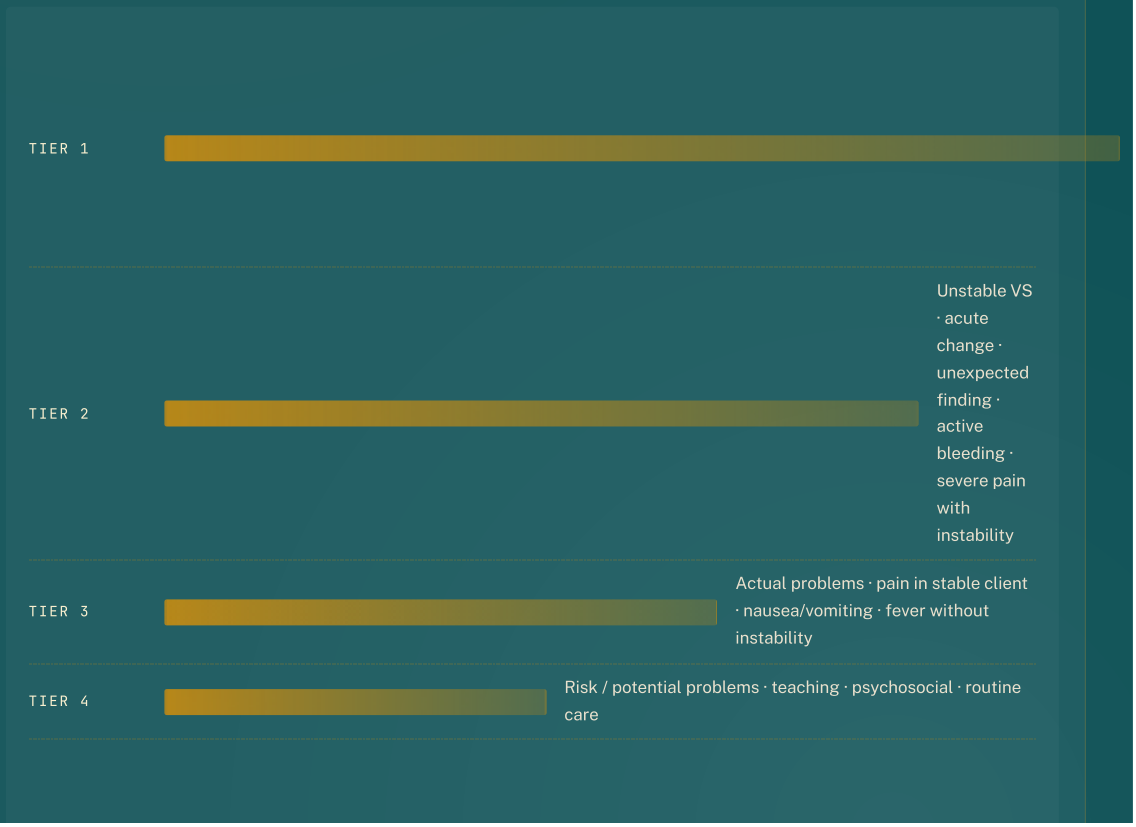
When "First" Is NOT "Notify Provider"

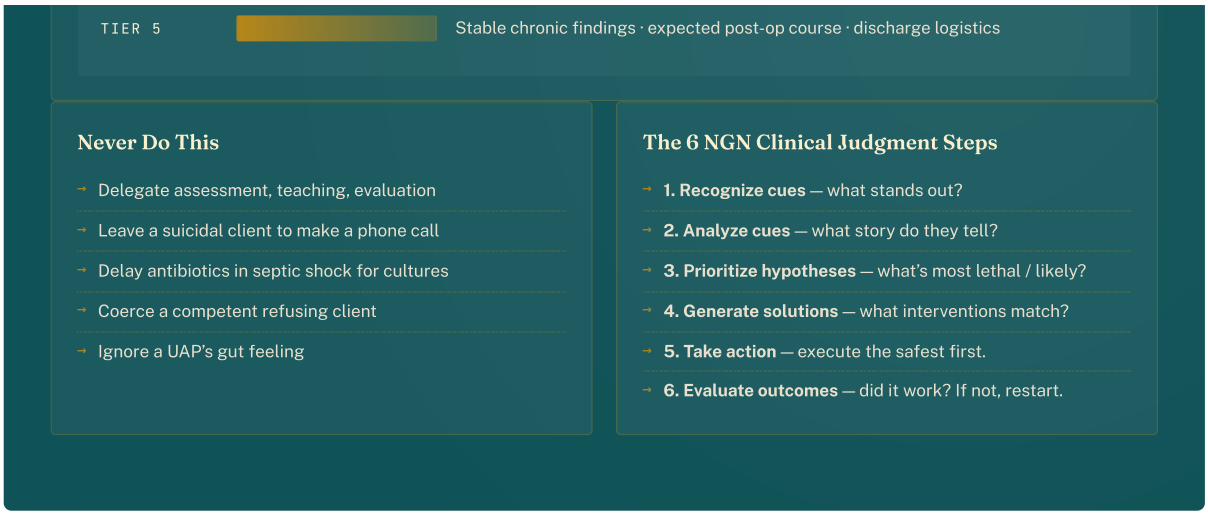
- You haven't laid eyes on the client yet
- You have no vitals or assessment data
- You have not stabilized airway / bleeding
- You can intervene under existing orders or standards

SBAR in 4 Lines

- **S:** Who you are · who the client is · what's happening
- **B:** Why they're here / pertinent history
- **A:** Vitals · trend · your nursing impression
- **R:** What you need from the listener (specific!)

Priority Pyramid — Always Falls This Way





"Priority is not what feels urgent. Priority is what becomes irreversible if you don't act first."

Day 01 of 15 · Management of Care · 2026 NCLEX-RN NGN Review
Next up: **Day 02 — Delegation, Assignment, & Supervision**.