

CLINICALJUDGE™ • MASTER STUDY GUIDE

MEDICAL EMERGENCIES & NURSING INTERVENTIONS

The rapid-recognition, priority-action reference for every high-yield emergency on the 2026 Next-Generation NCLEX-RN. Organized by body system with pathophysiology, hallmark cues, priority ladders, antidotes, and the traps that sink test-takers.

2026 NGN BLUEPRINT

PHYSIOLOGICAL ADAPTATION

REDUCTION OF RISK POTENTIAL

MANAGEMENT OF CARE • PRIORITIZATION

~40 EMERGENCIES

ABC / MASLOW / SAFETY

RED
CRITICAL / ACT NOW

BLUE
PATHOPHYSIOLOGY

GREEN
SAFE / EXPECTED

ORANGE
COMPLICATIONS

YELLOW
NCLEX TRAPS

PURPLE
MEDICATIONS

TEAL
PT. EDUCATION



UNIVERSAL FIRST MOVE

Unstable + undifferentiated? → **Airway • Breathing • Circulation**, then assess. The "first action" answer is almost always the least invasive assessment OR the intervention that protects ABCs — not calling the provider.

01

CARDIOVASCULAR EMERGENCIES

PERFUSION • CARDIAC OUTPUT • RHYTHM

CARDIAC ARREST (VF / PULSELESS VT / ASYSTOLE / PEA)

NO PULSE • NO EFFECTIVE OUTPUT

PATHO

Lethal rhythm → loss of cardiac output → no perfusion → brain/organ death in minutes

PRIORITY LADDER

- 1 Confirm unresponsive + no pulse / no breathing (≤ 10 sec)
- 2 Start **high-quality CPR** 30:2 (100–120/min, 2 in. depth)
- 3 Attach AED/defibrillator — shock VF/pulseless VT ASAP
- 4 Epinephrine 1 mg IV q3–5 min; amiodarone for shockable
- 5 Treat reversible causes (H's & T's); minimize interruptions

TRAP

Do NOT shock asystole or PEA — they are non-shockable. Shock only VF and pulseless VT. CPR is never interrupted >10 sec.

ACUTE CORONARY SYNDROME / STEMI

PLAQUE RUPTURE • CORONARY OCCLUSION

PATHO

Atherosclerotic rupture → thrombus → ↓coronary flow → myocardial ischemia/infarct

CUES

STABLE/EXPECTED

- › Relief with rest/nitro
- › Troponin trending down

CRITICAL

- › Crushing chest pain → jaw/arm
- › ST-elevation, ↑troponin
- › Diaphoresis, dyspnea, N/V

PRIORITY LADDER (MONA-B)

- 1 12-lead ECG + continuous monitor; O₂ if SpO₂ <90%
- 2 **Aspirin** chewed 162–325 mg (first drug)
- 3 Nitroglycerin SL (hold if SBP <90 / RV infarct / PDE-5 use)
- 4 Morphine for refractory pain; beta-blocker if stable
- 5 STEMI → PCI <90 min (door-to-balloon) or fibrinolytics

TRAP

Aspirin before morphine. Give nitro before morphine. Never give nitro if Viagra/sildenafil within 24–48h → profound hypotension.

CARDIOGENIC SHOCK

PUMP FAILURE • ↓CO DESPITE VOLUME

PATHO

Myocardial damage → ↓contractility → ↓CO → backward congestion + forward hypoperfusion

CUES

Hypotension, cool clammy skin, crackles, ↑JVD, ↓urine, weak pulses, altered LOC — **pump is failing, lungs are wet.**

PRIORITY

- 1 Support ABCs, high-flow O₂ / ventilation
- 2 Inotropes (dobutamine), cautious diuresis
- 3 Vasopressors only if pressure fails; reduce preload/afterload
- 4 Mechanical support (IABP) / revascularization

TRAP

Don't bolus fluids hard — the failing pump can't handle volume; you'll worsen pulmonary edema. Unlike hypovolemic shock, the answer is NOT a fluid challenge.

CARDIAC TAMPONADE

PERICARDIAL FLUID • COMPRESSION

PATHO

Fluid in pericardial sac → compresses heart → ↓filling → ↓CO

CUES — BECK'S TRIAD

① Hypotension ② muffled/distant heart sounds ③ JVD. Also **pulsus paradoxus** (SBP drop >10 mmHg on inspiration), narrowed pulse pressure.

PRIORITY

- 1 Notify provider STAT, prep for **pericardiocentesis**
- 2 O₂, IV fluids to temporize filling, monitor
- 3 Anticipate echo; have emergency equipment ready

TRAP

Muffled sounds + JVD + hypotension = tamponade, not just "shock." Definitive fix is pericardiocentesis — not more fluids alone.

HYPERTENSIVE CRISIS / EMERGENCY

SBP >180 / DBP >120 + ORGAN DAMAGE

CUES

Severe headache, blurred vision, chest pain, dyspnea, confusion, seizures — signs of **end-organ damage** (brain, heart, kidney, eyes).

PRIORITY

- 1 Continuous BP + cardiac/neuro monitoring
- 2 IV antihypertensive titrated (nicardipine, labetalol, nitroprusside)
- 3 Lower MAP **≤25% in first hour** — gradual, not abrupt
- 4 Quiet environment, seizure precautions

TRAP

Do NOT drop BP too fast — abrupt reduction → cerebral/renal ischemia/stroke. Controlled, gradual lowering only.

PULMONARY EMBOLISM

CLOT IN PULMONARY VASCULATURE

PATHO

DVT/clot dislodges → lodges in lung → V/Q mismatch → hypoxia + RV strain

CUES

Sudden dyspnea, pleuritic chest pain, tachycardia, tachypnea, hypoxia, anxiety/sense of doom, possible hemoptysis.

PRIORITY

- 1 High-Fowler's, O₂, continuous SpO₂/cardiac monitor
- 2 IV access; anticipate **anticoagulation** (heparin)
- 3 Massive PE → thrombolytics / embolectomy
- 4 Do not massage legs; ongoing VTE prophylaxis after

TRAP

Sudden onset dyspnea + chest pain + tachycardia post-op/immobile = PE until proven otherwise. Position upright, not flat.

02

RESPIRATORY EMERGENCIES

OXYGENATION • VENTILATION • AIRWAY

ACUTE RESPIRATORY FAILURE / ARDS

REFRACTORY HYPOXEMIA • ↓COMPLIANCE

PATHO

Alveolar-capillary injury → non-cardiac pulmonary edema → ↓gas exchange → hypoxemia refractory to O₂

CUES

Severe dyspnea, ↓SpO₂ despite high O₂, bilateral infiltrates ("white-out"), tachypnea, restlessness → lethargy. PaO₂/FiO₂ ratio low.

PRIORITY

- 1 Maintain airway; escalate O₂ / prep for intubation
- 2 **Low tidal volume** lung-protective ventilation + PEEP
- 3 Prone positioning, treat underlying cause (sepsis, aspiration)
- 4 Monitor ABGs, sedation, hemodynamics

TRAP

Hallmark = hypoxemia that does NOT improve with supplemental O₂. Rising PaCO₂ + falling LOC signals fatigue → intubate, don't wait.

TENSION PNEUMOTHORAX

AIR TRAPPED • MEDIASTINAL SHIFT

PATHO

One-way air leak → pressure builds → lung collapse + mediastinal shift → ↓venous return → shock

CUES

Tracheal deviation (away from affected side), absent breath sounds, ↓SpO₂, JVD, hypotension, sudden severe dyspnea, asymmetric chest.

PRIORITY

- 1 STAT provider notification — life-threatening
- 2 Emergent **needle decompression** (2nd ICS, midclavicular)
- 3 Chest tube placement to water-seal drainage
- 4 High-flow O₂ monitor for re-expansion

TRAP

Tracheal deviation = emergency, needs immediate decompression — not "monitor and reassess." For chest-tube: continuous bubbling in water-seal = air leak; report it.

STATUS ASTHMATICUS

SEVERE REFRACTORY BRONCHOSPASM

CUES

Severe dyspnea, accessory muscle use, prolonged expiration. **Silent chest + ↓wheezing = worsening** (no air movement), rising CO₂, exhaustion.

PRIORITY

- 1 High-Fowler's, O₂, continuous monitoring
- 2 Short-acting beta-2 agonist (albuterol) nebulized
- 3 IV/systemic corticosteroids; ipratropium, IV magnesium
- 4 Prepare for intubation if failing

TRAP

A quieting chest is bad, not good. Diminished/absent wheezing + ↓breath sounds means airway is closing — escalate immediately.

AIRWAY OBSTRUCTION (CHOKING)

FBAO • ASPIRATION

CUES

Partial: coughing, stridor, can still move air. **Complete:** universal choking sign, no air movement, no speech, cyanosis.

PRIORITY

- 1 Partial + effective cough → **encourage coughing**, don't intervene
- 2 Complete + conscious adult → abdominal thrusts (Heimlich)
- 3 Becomes unconscious → start CPR, look in mouth before breaths
- 4 Infant → 5 back blows + 5 chest thrusts (no abdominal thrusts)

TRAP

If they can cough/speak, do NOT do thrusts — let them clear it. Blind finger sweeps are contraindicated (may push it deeper).

03 NEUROLOGIC EMERGENCIES

PERFUSION • INTRACRANIAL PRESSURE • CORD

ACUTE STROKE (CVA)

ISCHEMIC (87%) VS HEMORRHAGIC

CUES — BE-FAST

Balance, **Eyes**, **Face** droop, **Arm** drift, **Speech** slurred, **Time**. Sudden weakness/numbness one-sided, aphasia, "worst headache" (hemorrhagic).

PRIORITY

- 1 Note/establish **last known well time** — drives treatment window
- 2 STAT non-contrast CT to rule out bleed before any tPA
- 3 Ischemic: **tPA within 3–4.5 h** if no contraindications
- 4 Maintain airway, swallow screen before any PO, BP management

TRAP

CT before tPA, always. tPA is contraindicated in hemorrhagic stroke. NPO until dysphagia screen passed → aspiration risk.

STATUS EPILEPTICUS

SEIZURE >5 MIN OR NO RECOVERY BETWEEN

PRIORITY

- 1 Protect airway, turn to side, O₂ suction; do NOT restrain
- 2 Nothing in mouth; pad/clear environment
- 3 IV **benzodiazepine** (lorazepam/diazepam) first-line
- 4 Then load antiepileptic (levetiracetam, phenytoin/fosphenytoin)
- 5 Monitor glucose, check for reversible causes

MEDS

Lorazepam IV Diazepam Levetiracetam Fosphenytoin

TRAP

Never force anything into the mouth or restrain limbs. Priority during a seizure is airway protection + safety, not stopping movement.

INCREASED INTRACRANIAL PRESSURE

MASS EFFECT • HERNIATION RISK

CUES

Earliest = **↓LOC / restlessness**. Late = **Cushing's triad**: ↑SBP with widening pulse pressure, bradycardia, irregular respirations. Fixed/dilated pupils, posturing, projectile vomiting.

PRIORITY

- 1 HOB elevated 30°, head **midline/neutral** (promote venous drainage)
- 2 Maintain airway/oxygenation; avoid hypercapnia
- 3 Osmotic therapy (mannitol, hypertonic saline)
- 4 Limit suctioning/clustering care; prevent ↑intrathoracic pressure

TRAP

Cushing's triad is a LATE, ominous sign. Earliest change is a subtle drop in LOC — act then. Avoid neck flexion, hip flexion, and prolonged suctioning.

AUTONOMIC DYSREFLEXIA

SCI AT/ABOVE T6 • SYMPATHETIC SURGE

PATHO

Noxious stimulus below injury (full bladder/bowel) → massive sympathetic discharge → severe HTN

CUES

Sudden severe pounding headache, dangerously high BP, bradycardia, flushing/sweating above injury, nasal congestion, "doom."

PRIORITY

- 1 **Sit patient upright** immediately (lowers BP)
- 2 Find & remove trigger — check for full bladder/kinked catheter first, then impacted stool, tight clothing
- 3 Monitor BP q2–5 min; antihypertensive if persists

TRAP

Sit up + find the cause FIRST (usually a distended bladder). Don't lay them flat — that raises cerebral pressure. This is a true emergency (stroke risk).

04

ENDOCRINE & METABOLIC EMERGENCIES

GLUCOSE • ELECTROLYTES • HORMONES

DIABETIC KETOACIDOSIS (DKA)

TYPE 1 • HYPERGLYCEMIA + KETOSIS + ACIDOSIS

CUES

Glucose >250, **Kussmaul respirations**, fruity/acetone breath, ketones, metabolic acidosis (pH <7.3), polyuria → dehydration, abdominal pain, ↓LOC.

PRIORITY LADDER

- 1 **IV fluids first** — 0.9% NS to restore volume
- 2 IV regular insulin infusion (lowers glucose + stops ketosis)
- 3 Replace **potassium** before/with insulin once K is not high & urine output present
- 4 Add dextrose when glucose ~200; monitor K, ABG, neuro

TRAP

Fluids before insulin. Insulin drives K⁺ into cells → watch for hypokalemia (dysrhythmias). Don't lower glucose too fast → cerebral edema.

HYPEROSMOLAR HYPERGLYCEMIC STATE (HHS)

TYPE 2 • EXTREME HYPERGLYCEMIA, NO KETOSIS

CUES

Glucose often >600, profound dehydration, **severe neuro changes** (more than DKA), no significant ketones/acidosis, high serum osmolality.

PRIORITY

- 1 Aggressive **IV fluid** resuscitation (mainstay — even more than DKA)
- 2 IV insulin, potassium monitoring/replacement
- 3 Slow correction; watch neuro status closely

TRAP

HHS = no ketones, no Kussmaul, no fruity breath (that's DKA). HHS has higher glucose, worse dehydration, and more neuro involvement.

HYPOGLYCEMIA

GLUCOSE <70 MG/DL

CUES

Shaky, diaphoretic, tachycardic, anxious, hungry → confusion, slurred speech, seizures, coma. **"Cold & clammy = need candy."**

PRIORITY — RULE OF 15

- 1 **Conscious**: 15 g fast carbs (juice, glucose tabs) → recheck in 15 min
- 2 Repeat until >70, then complex carb + protein snack
- 3 **Unconscious / NPO**: IV D50 (dextrose) or IM glucagon

TRAP

Never give oral glucose to an unconscious patient (aspiration). Treat hypoglycemia before hyperglycemia — it kills faster.

THYROID STORM (THYROTOXIC CRISIS)

SEVERE HYPERTHYROIDISM

CUES

Hyperthermia (fever to 105°F), severe tachycardia/dysrhythmia, hypertension, agitation/delirium, vomiting/diarrhea — everything "sped up."

PRIORITY

- 1 Cooling measures, cardiac monitoring, O₂, IV fluids
- 2 **Beta-blocker (propranolol)** for tachycardia/symptoms
- 3 Antithyroid drugs (PTU/methimazole), iodine, corticosteroids
- 4 Treat fever (acetaminophen — NOT aspirin)

TRAP

Avoid aspirin — it displaces thyroid hormone and worsens the storm. Use acetaminophen for fever.

MYXEDEMA COMA

SEVERE HYPOTHYROIDISM • "EVERYTHING SLOWED"

CUES

Hypothermia, bradycardia, hypotension, hypoventilation, profound lethargy → coma, hyponatremia, hypoglycemia.

PRIORITY

- 1 Airway/ventilation support, passive rewarming
- 2 IV **levothyroxine**, IV glucocorticoids
- 3 Correct hyponatremia/hypoglycemia cautiously, monitor cardiac

TRAP

Mirror image of thyroid storm — **everything is LOW and slow**. Rewarm passively (active rewarming → vasodilation + shock).

ADRENAL (ADDISONIAN) CRISIS

ACUTE CORTISOL DEFICIENCY

CUES

Profound hypotension/shock, hyponatremia, **hyperkalemia**, hypoglycemia, severe weakness, N/V, abdominal pain — often after stress/steroid withdrawal.

PRIORITY

- 1 IV **hydrocortisone** STAT (life-saving)
- 2 Aggressive IV fluids (D5NS) — volume + glucose + sodium
- 3 Treat hyperkalemia, monitor cardiac/BP closely

TRAP

Never abruptly stop chronic steroids → precipitates crisis. During illness/surgery, steroid doses must be increased ("stress dose").

05 SHOCK STATES & ANAPHYLAXIS

PERFUSION FAILURE • DISTRIBUTIVE • HYPOVOLEMIC

ANAPHYLAXIS

TYPE I HYPERSENSITIVITY • DISTRIBUTIVE SHOCK

PATHO

Allergen → massive histamine release → bronchoconstriction + vasodilation + capillary leak → airway + shock

CUES

Stridor, wheeze, throat tightness, swelling lips/tongue (angioedema), urticaria, hypotension, GI cramps, sense of doom — **rapid onset**.

PRIORITY LADDER

- 1 **Epinephrine IM** (anterolateral thigh) — FIRST and immediate
- 2 Stop the trigger; maintain airway, high-flow O₂
- 3 IV fluids for hypotension; positioning supine + legs up
- 4 Adjuncts: antihistamines, corticosteroids, bronchodilators

TRAP

Epinephrine first — not Benadryl, not steroids. Those are adjuncts; epi is the only drug that reverses airway/shock immediately.

SEPSIS / SEPTIC SHOCK

DYSREGULATED RESPONSE TO INFECTION

CUES

Fever or hypothermia, tachycardia, tachypnea, hypotension, altered LOC, ↑lactate, **warm flushed skin** early → cold/mottled late. ↑WBC.

PRIORITY — HOUR-1 BUNDLE

- 1 Measure **lactate**; obtain blood cultures **before** antibiotics
- 2 Broad-spectrum **antibiotics within 1 hour**
- 3 Rapid **crystalloid 30 mL/kg** for hypotension/↑lactate
- 4 Vasopressors (norepinephrine) if MAP <65 after fluids

TRAP

Cultures BEFORE antibiotics — but never delay antibiotics waiting on them. Early warm skin can mask a deteriorating patient.

HYPVOLEMIC SHOCK

BLOOD / FLUID VOLUME LOSS

CUES

Tachycardia (early), hypotension (late), cool clammy skin, ↓urine <30 mL/h, weak thready pulse, ↑cap refill, restlessness → ↓LOC, narrowed pulse pressure.

PRIORITY

- 1 Identify & **control the source** of loss (hold pressure on bleed)
- 2 2 large-bore IVs; rapid isotonic crystalloid / blood products
- 3 O₂, monitor, modified Trendelenburg/legs up, keep warm

TRAP

Tachycardia is the earliest sign — hypotension is late (compensation fails). For active bleeding, control the source first, then resuscitate.

NEUROGENIC SHOCK

SCI • LOSS OF SYMPATHETIC TONE

CUES

Hypotension WITH bradycardia + warm, dry, flushed skin (the giveaway). Seen with spinal cord injury — distinguishes it from other shocks.

PRIORITY

- 1 Spinal immobilization, airway/ventilation
- 2 IV fluids; **vasopressors** for vascular tone
- 3 Atropine for symptomatic bradycardia; keep warm

TRAP

Bradycardia + warm dry skin sets neurogenic shock apart — every other shock causes tachycardia + cool clammy skin.

06 HEMATOLOGIC, RENAL & GI EMERGENCIES

ELECTROLYTES • CLOTTING • BLEEDING

HYPERKALEMIA

K⁺ >5.0 • CARDIAC INSTABILITY

CUES

Peaked T waves → widened QRS → sine wave → cardiac arrest. Muscle weakness, paresthesia, ↑bowel sounds/cramping. Renal failure is #1 cause.

PRIORITY

- 1 **Calcium gluconate** — stabilizes the myocardium (first if ECG changes)
- 2 Shift K into cells: **insulin + dextrose**, beta-agonist, bicarb
- 3 Remove K: loop diuretics, sodium polystyrene/patiromer, dialysis

TRAP

Calcium stabilizes the heart but does NOT lower K. Insulin shifts it temporarily; only dialysis/excretion removes it. Peaked T = act now.

DISSEMINATED INTRAVASCULAR COAGULATION

SIMULTANEOUS CLOTTING + BLEEDING

PATHO

Trigger (sepsis, OB, trauma) → **widespread microclots** → **consumes platelets/factors** → **uncontrolled bleeding**

CUES

Oozing from IV sites/gums, petechiae, ecchymosis, hematuria + organ ischemia. **↑PT/PTT, ↑D-dimer, ↓platelets, ↓fibrinogen.**

PRIORITY

- 1 **Treat the underlying cause** (the only true fix)
- 2 Replace components: platelets, FFP, cryoprecipitate
- 3 Support perfusion/oxygenation; monitor for bleeding/thrombosis

TRAP

The paradox: clotting AND bleeding at once. Fixing DIC means fixing the trigger — product replacement is supportive only.

ACUTE HEMOLYTIC TRANSFUSION REACTION

ABO INCOMPATIBILITY

CUES

Within minutes: **fever, chills, flank/back pain**, hypotension, tachycardia, dark/red urine (hemoglobinuria), sense of doom, DIC.

PRIORITY LADDER

- 1 **STOP the transfusion immediately** (first action)
- 2 Keep IV open with **0.9% NS via new tubing**
- 3 Notify provider + blood bank; recheck patient/unit ID
- 4 Treat hypotension, support kidneys, return blood/tubing to lab

TRAP

Stop the blood first, THEN saline via new line — do not run the saline through the same tubing as the blood. Prevention = two-RN verification.

GI HEMORRHAGE / ESOPHAGEAL VARICES

UPPER / LOWER GI BLEED

CUES

Hematemesis ("coffee-ground" or bright red), melena, hematochezia, hypotension, tachycardia, ↓Hgb/Hct, signs of hypovolemic shock.

PRIORITY

- 1 ABCs; 2 large-bore IVs, fluids/blood products, O₂
- 2 NPO, monitor VS/output; type & crossmatch
- 3 Varices: octreotide, endoscopy/banding; consider balloon tamponade
- 4 PPIs for ulcers; correct coagulopathy

TRAP

Stabilize circulation before diagnostics. A patient with varices + cirrhosis can exsanguinate fast — airway protection if altered (aspiration of blood).

07

MATERNAL / OB EMERGENCIES

HEMORRHAGE • ECLAMPSIA • FETAL

POSTPARTUM HEMORRHAGE (PPH)

>500 ML VAGINAL / >1000 ML C-SECTION

CUES

Boggy uterus (uterine atony = #1 cause), saturating >1 pad/hour, bright red bleeding, ↑HR, ↓BP, ↓LOC. Causes = 4 T's: Tone, Trauma, Tissue, Thrombin.

PRIORITY LADDER

- 1 **Firm fundal massage** first (atony is most common cause)
- 2 Ensure bladder empty; IV fluids, monitor VS & blood loss
- 3 Uterotonics: oxytocin, methylergonovine, carboprost, misoprostol
- 4 Blood products; surgical intervention if refractory

TRAP

Massage the boggy fundus first. Hold **methylergonovine** if hypertensive; avoid **carboprost** in asthma (bronchospasm).

PREECLAMPSIA → ECLAMPSIA

HTN + PROTEINURIA → SEIZURES

CUES

BP ≥140/90, severe headache, visual changes, RUQ pain, hyperreflexia/clonus, edema → **seizure = eclampsia**. HELLP = hemolysis, ↑LFTs, ↓platelets.

PRIORITY

- 1 **Magnesium sulfate** IV for seizure prophylaxis/treatment
- 2 Seizure precautions, quiet/dim environment, side-lying
- 3 Antihypertensives (labetalol, hydralazine); monitor mom + fetus
- 4 Definitive treatment = delivery of the baby

TRAP

Mag toxicity = loss of DTRs → resp depression → cardiac arrest. Antidote is **calcium gluconate**. Hold mag if RR <12, absent reflexes, or urine <30 mL/h.

PLACENTAL ABRUPTION

PREMATURE PLACENTAL SEPARATION

CUES

Painful dark-red bleeding (may be concealed), **rigid/board-like tender uterus**, fetal distress, signs of shock. (Vs. placenta previa = painless bright-red bleeding.)

PRIORITY

- 1 Continuous fetal + maternal monitoring; left lateral position
- 2 O₂, large-bore IV, fluids/blood, treat for shock
- 3 Prepare for emergent delivery (often C-section); watch for DIC

TRAP

Abruption = PAINFUL + rigid uterus; previa = PAINLESS. Never perform a vaginal exam with suspected previa — can trigger massive hemorrhage.

UMBILICAL CORD PROLAPSE

CORD SLIPS AHEAD OF PRESENTING PART

CUES

Visible/palpable cord, **sudden variable/prolonged fetal decelerations** or bradycardia, often after membrane rupture.

PRIORITY LADDER

- 1 **Relieve cord pressure** — gloved hand lifts presenting part off cord
- 2 Reposition mom: **knee-chest or Trendelenburg**
- 3 O₂, call for help, prep for emergent C-section; keep cord moist, don't push it back

TRAP

Don't leave to "call" first. The nurse's hand stays in place lifting the presenting part off the cord until delivery — call for help simultaneously.

08 ENVIRONMENTAL, TOXICOLOGIC & PROCEDURAL

TEMPERATURE • OVERDOSE • ANESTHESIA

MALIGNANT HYPERTHERMIA

ANESTHESIA REACTION • HYPERMETABOLIC

CUES

Earliest = ↑end-tidal CO₂ + masseter (jaw) rigidity after volatile anesthetics/succinylcholine. Later: rapidly rising temp, muscle rigidity, tachycardia, dysrhythmias.

PRIORITY

- 1 Stop triggering agent; 100% O₂; call for help
- 2 **Dantrolene** IV — the antidote (mix rapidly)
- 3 Active cooling, treat hyperkalemia/dysrhythmias, monitor for DIC

TRAP

Rising temp is a LATE sign — the first clue is ↑ETCO₂ + jaw rigidity. **Dantrolene** is the life-saving drug. Genetic → screen family history.

OPIOID OVERDOSE

CNS + RESPIRATORY DEPRESSION

CUES

Triad: ↓RR/respiratory depression, **pinpoint pupils**, ↓LOC/coma. Hypotension, cyanosis, ↓bowel sounds.

PRIORITY

- 1 Support airway/ventilation **FIRST** (the killer is hypoventilation)
- 2 **Naloxone (Narcan)** — antidote; titrate to respirations
- 3 Monitor for re-sedation (naloxone shorter-acting than opioid)

TRAP

Pinpoint pupils + ↓RR = opioids. Naloxone may need repeat dosing; watch for acute withdrawal & rebound respiratory depression.

ACETAMINOPHEN TOXICITY

HEPATOTOXIC OVERDOSE

CUES

Early: N/V, malaise (often deceptively mild). Later: **RUQ pain, jaundice, rising LFTs**, hepatic failure, coagulopathy.

PRIORITY

- 1 Obtain acetaminophen level + time of ingestion (Rumack-Matthew)
- 2 **N-acetylcysteine (NAC)** — antidote; most effective <8–10 h
- 3 Activated charcoal if very recent; monitor liver function

TRAP

Early symptoms are mild/absent — don't be reassured. NAC works best given early, so don't wait for liver damage to appear.

HEAT STROKE & SEVERE HYPOTHERMIA

THERMOREGULATORY FAILURE

CUES

Heat stroke: core >40°C, hot dry skin, AMS, no sweating. **Hypothermia:** <35°C, shivering → absent, bradycardia, ↓LOC, J/Osborn wave.

PRIORITY

- 1 ABCs; heat stroke → rapid active **cooling**, IV fluids
- 2 Hypothermia → gradual **rewarming**, handle gently, warm IV fluids
- 3 Continuous cardiac monitoring; correct electrolytes

TRAP

Severe hypothermia: handle gently & rewarm slowly — rough movement or rapid rewarming can trigger lethal dysrhythmias (VF). "Not dead until warm and dead."

MAJOR BURNS — EMERGENT PHASE

FIRST 24–48 H • FLUID SHIFT

CUES

Airway risk (facial burns, singed nares, hoarse, soot, stridor), massive fluid shifts → hypovolemia, risk of **hyperkalemia** early then hypokalemia.

PRIORITY

- Airway first** — inhalation injury/edema can occlude; early intubation
- Large-bore IV; **Parkland formula** LR fluid resuscitation
- Titrate to urine output (0.5–1 mL/kg/h); pain control, wound care

TRAP

Airway before the burn itself. Carbon monoxide poisoning → 100% O₂; a normal SpO₂ can be falsely reassuring with CO. Circumferential burns → compartment syndrome.

ACUTE COMPARTMENT SYNDROME

↑PRESSURE IN FASCIAL COMPARTMENT

CUES — 6 P'S

Pain out of proportion + on passive stretch (earliest), Paresthesia, Pallor, Pulselessness (late), Paralysis, Poikilothermia.

PRIORITY

- Notify provider STAT; **do not elevate above heart** (keep at heart level)
- Loosen/remove constrictive casts/dressings
- Prepare for emergent **fasciotomy**; assess neurovascular q hour

TRAP

Pain unrelieved by opioids + pain on passive stretch = earliest sign. Pulselessness is LATE. Do NOT elevate the limb above heart level — it worsens perfusion.

09 HIGH-YIELD CRITICAL LABS & VALUES

RECOGNIZE THE DANGER NUMBER

LAB / VALUE	NORMAL RANGE	EMERGENCY CONTEXT	NCLEX SIGNIFICANCE
Potassium (K ⁺)	3.5–5.0 mEq/L	Hyperkalemia / DKA / renal failure	Peaked T waves → fatal dysrhythmias; calcium stabilizes heart
Sodium (Na ⁺)	135–145 mEq/L	Adrenal crisis, SIADH, HHS	Rapid correction → cerebral edema or osmotic demyelination
Glucose	70–110 mg/dL	DKA >250 / HHS >600 / hypo <70	<70 treat first; correct slowly to avoid cerebral edema
Arterial pH	7.35–7.45	DKA, resp failure, shock	<7.35 acidosis (DKA, sepsis); guides ventilation
PaO ₂ / SpO ₂	80–100 / ≥95%	ARDS, PE, resp failure	Refractory hypoxemia = ARDS hallmark; CO masks true SpO ₂
Troponin	<0.04 ng/mL	ACS / MI	Most specific cardiac marker; rises with infarct
Lactate	0.5–2.2 mmol/L	Sepsis / shock	>2 signals hypoperfusion; trend guides resuscitation
Platelets	150–400 k/μL	DIC, HELLP, ITP	↓ in DIC/HELLP → bleeding risk; <20k = spontaneous bleed
INR / PT / PTT	INR ~1.0	DIC, anticoagulation, GI bleed	↑ in DIC; warfarin reversal = vit K; heparin = protamine
Magnesium	1.3–2.1 mEq/L	Eclampsia (therapeutic 4–7)	Toxicity → loss of DTRs, resp depression; antidote = Ca gluconate
Ammonia	15–45 mcg/dL	Hepatic encephalopathy / GI bleed	↑ → confusion/coma; lactulose lowers it
ETCO ₂ (capno)	35–45 mmHg	Malignant hyperthermia, resp status	Sudden ↑ETCO ₂ = earliest MH clue; confirms ET tube placement

10 IF → THEN DECISION RULES

FAST-MAPPING THE "FIRST ACTION"

IF unresponsive + no pulse

THEN start CPR before anything else; defibrillate VF/pulseless VT only.

IF suspected stroke

THEN establish last-known-well + CT before tPA; NPO until swallow screen.

IF anaphylaxis (airway/shock)

THEN IM epinephrine immediately — before antihistamines/steroids.

IF boggy uterus + heavy postpartum bleeding

THEN firm fundal massage first → uterotonics.

IF tracheal deviation + absent breath sounds + JVD

THEN tension pneumothorax → emergent needle decompression.

IF active transfusion + fever/chills/back pain

THEN STOP transfusion first → NS via new tubing → notify.

IF SCI ≥T6 + pounding headache + spiking BP

THEN sit upright + check/empty bladder (autonomic dysreflexia).

IF DKA

THEN isotonic fluids first → insulin → replace K⁺.

IF cord prolapse / visible cord

THEN gloved hand lifts presenting part off cord + knee-chest position.

IF hyperkalemia with ECG changes

THEN calcium gluconate first to protect heart → then shift/remove K⁺.

IF mag sulfate + RR<12 / absent DTRs

THEN stop mag + give calcium gluconate (antidote).

IF ↑ETCO₂ + jaw rigidity under anesthesia

THEN malignant hyperthermia → stop agent + dantrolene.

11 THE 8 CLASSIC NCLEX TRAPS

WHERE TEST-TAKERS LOSE POINTS

01

CALLING THE PROVIDER AS "FIRST ACTION"

The first nursing action is usually to **assess** or **protect ABCs**, not to notify the provider — unless the intervention requires an order you can't initiate.

FIX Do the independent nursing action first; notify after stabilizing.

02

TREATING THE LATE SIGN INSTEAD OF THE EARLY ONE

Cushing's triad (ICP), pulselessness (compartment), hypotension (shock) are all **LATE**. Tachycardia, restlessness, ↓LOC come first.

FIX Act on the earliest subtle change — that's the testable moment.

03

FLUIDS FOR CARDIOGENIC SHOCK

Fluid boluses help **hypovolemic** shock but drown the failing pump in **cardiogenic** shock.

FIX Match the intervention to the shock type — not all shock = give fluids.

04

DIPHENHYDRAMINE/STEROIDS BEFORE EPINEPHRINE

In anaphylaxis, epinephrine is the only agent that reverses airway compromise + shock. Antihistamines are adjuncts.

FIX Epinephrine IM is always the first drug in anaphylaxis.

05

INSULIN BEFORE FLUIDS/POTASSIUM IN DKA

Insulin drives K⁺ intracellularly → dangerous hypokalemia. Fluids restore perfusion first.

FIX Fluids → insulin → monitor & replace potassium.

06

THE "QUIET CHEST" REASSURANCE

In status asthmaticus, diminishing wheezes/breath sounds = airway closing. NOT improvement.

FIX Silent chest = escalate/prepare to intubate, never relax.

07

LAYING THE PATIENT FLAT UNIVERSALLY

Autonomic dysreflexia, increased ICP, PE, and respiratory distress all need the patient **upright**, not supine.

FIX Position to the physiology — upright for ICP/AD/respiratory.

08

CONFUSING LOOK-ALIKE CONDITIONS

DKA vs HHS, abruption vs previa, neurogenic vs hypovolemic shock, mag toxicity vs eclampsia.

FIX Anchor on the single distinguishing cue (ketones? pain? skin temp? DTRs?).

12 NGN QUESTION PATTERNS TO EXPECT

HOW EMERGENCIES ARE TESTED IN 2026

RECOGNIZE CUES

Highlight which findings in a chart are abnormal/relevant to the emerging emergency.

"Which 4 assessment findings require immediate follow-up?"

ANALYZE CUES

Link clusters of findings to the most likely complication or condition.

"The client is most likely experiencing ____ as evidenced by ____."

PRIORITIZE HYPOTHESES

Rank which condition is the greatest/most urgent threat.

"Which condition is the priority to address?"

GENERATE SOLUTIONS

Select the interventions expected to manage the prioritized problem.

"Which 3 interventions should the nurse anticipate?"

TAKE ACTION

Choose the first/best nursing action and its correct sequence.

"Which action should the nurse take first?"

EVALUATE OUTCOMES

Decide whether the patient is improving, unchanged, or worsening.

"Which findings indicate the treatment was effective?"

13 NGN BOW-TIE — WORKED EXAMPLE

SEPTIC SHOCK • CLINICAL JUDGMENT IN ONE FRAME

ACTIONS TO TAKE

Obtain blood cultures, then give broad-spectrum antibiotics within 1 hour

Bolus 30 mL/kg isotonic crystalloid

Start norepinephrine if MAP <65 after fluids

SEPTIC SHOCK

Infection + hypotension + ↑lactate refractory to fluids

PARAMETERS TO MONITOR

MAP ≥65 mmHg & urine output ≥0.5 mL/kg/h

Serum lactate clearance / trend

Mental status, temperature, SpO₂

CONDITION MOST LIKELY EXPERIENCING

RISK IF UNTREATED

Distributive (septic) shock — widespread vasodilation and capillary leak from a dysregulated host response to infection.

Multi-organ dysfunction, DIC, refractory hypotension, and death — early recognition + the Hour-1 bundle change outcomes.

14

PATIENT & CAREGIVER EDUCATION CHECKLIST

PREVENTION • EARLY RECOGNITION • WHEN TO CALL 911

TEACH BEFORE DISCHARGE ✓

- | | |
|--|---|
| ✓ Recognize chest pain / stroke (BE-FAST) signs → call 911 immediately, don't drive self | ✓ Carry & correctly use an epinephrine auto-injector; replace before expiry |
| ✓ Diabetics: treat lows with 15 g fast carbs; carry glucose source & ID | ✓ Never abruptly stop corticosteroids; carry medical-alert ID |
| ✓ SCI patients/caregivers: recognize autonomic dysreflexia & sit upright | ✓ Seizure first aid: protect head, turn to side, time it, nothing in mouth |
| ✓ Anticoagulant safety: bleeding precautions & signs to report | ✓ Asthma action plan; seek help if rescue inhaler isn't working |
| ✓ Postpartum: report soaking >1 pad/hour or large clots | ✓ Acetaminophen: stay under max daily dose; watch combo products |
| ✓ Heat/cold safety: hydration, layering, recognize early heat illness | ✓ Medication reconciliation & allergy band accuracy at every transition |

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