

DIANE'S NGN NCLEX 2026 VISUAL STUDY LIBRARY

Emergency Assessment

Rapid, systematic evaluation when seconds save lives

CRITICAL CARE

FUNDAMENTALS

CLINICAL JUDGMENT



Source disclosure: This topic was not in your uploaded reference notes. Content drawn from standard NGN NCLEX 2026 references: *Saunders Comprehensive Review for NCLEX-RN*, ATI Adult Medical-Surgical Nursing, Emergency Nurses Association (ENA) TNCC framework, AHA BLS/ACLS 2025 guidelines, and current ENPC standards.



Definition & Overview

WHAT IT IS & WHY IT MATTERS

Emergency assessment is the rapid, systematic evaluation of a client experiencing actual or potential life-threatening conditions. It is the foundation of all emergency, trauma, code, and rapid-response nursing care.

- **Primary survey** (ABCDE) — identifies and treats *immediate* threats to life in ≤ 60 seconds.
- **Secondary survey** (head-to-toe + history) — uncovers injuries or conditions missed during primary.
- **Goal:** Recognize cues, prioritize hypotheses, intervene *before* deterioration. Assessment & intervention happen *simultaneously* in emergencies — unlike routine care.



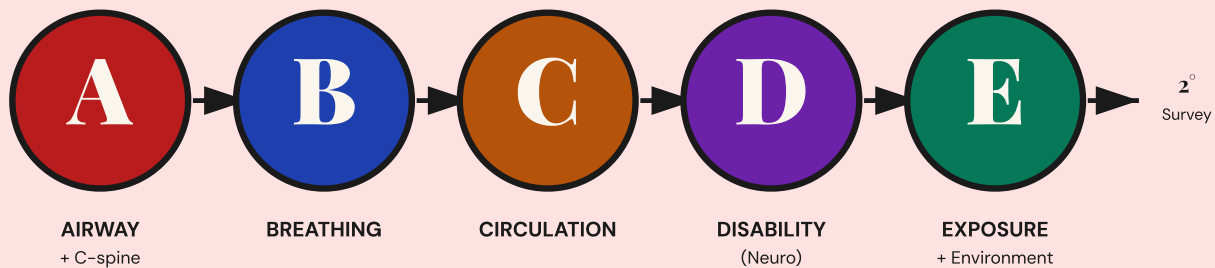
NCLEX PRIORITY FRAMEWORKS

ABCs → Maslow → Safety → Acute over Chronic → Unstable over Stable. When in doubt, the **airway** always wins. Use the ABCDE primary survey before ANY focused assessment.

2 Primary Survey: ABCDE

STEP-BY-STEP MECHANISM & SEQUENCE

The ABCDE sequence is **non-negotiable**. Each step must be evaluated *and* stabilized before moving to the next. If you find a problem at "A," you fix "A" before assessing "B."



A

AIRWAY + C-SPINE

- Look, listen, feel for air movement
- Open airway: **jaw-thrust** (trauma) or head-tilt/chin-lift (medical)
- Suction blood/secretions
- Insert OPA (unconscious) or NPA (conscious)
- Maintain manual C-spine immobilization until cleared

B

BREATHING

- Rate, depth, symmetry, effort
- Auscultate bilaterally — apex & bases
- SpO₂ capnography (EtCO₂)
- Apply **high-flow O₂** via NRB (100%) if unstable
- Assist with BVM at 10–12 breaths/min if apneic

C

CIRCULATION

- Pulse (rate, quality, regularity), cap refill, skin color/temp
- BP — both arms if dissection suspected
- Control external hemorrhage — **direct pressure** → **tourniquet**
- Two **large-bore (16–18 gauge) IVs**
- Cardiac monitor + 12-lead if chest pain

D

DISABILITY (NEURO)

- **AVPU**: Alert / Verbal / Pain / Unresponsive
- Glasgow Coma Scale (GCS) — eye, verbal, motor
- Pupils — size, equality, reactivity (PERRLA)

E

EXPOSURE + ENVIRONMENT

- Fully undress to inspect for hidden injuries, rashes, bleeding
- Log-roll to assess back (with C-spine)

- Check **blood glucose** (rule out hypoglycemia)
- Note posturing: decorticate vs. decerebrate

- **Prevent hypothermia** — warm blankets, warm IV fluids
- Maintain dignity — cover after exam

3

Signs & Symptoms

COMPENSATED VS. DECOMPENSATED CUES

⚠ Early / Compensated

The body is still fighting — INTERVENE NOW.

- **Restlessness, anxiety, agitation** (#1 sign of hypoxia)
- **Tachycardia** (first compensation for shock)
- Tachypnea, mild SpO₂ drop (90–94%)
- Cool, pale, slightly clammy skin
- Capillary refill 2–3 seconds
- Narrowing pulse pressure
- Decreased urine output (0.5–1 mL/kg/hr)
- Mild confusion, irritability

SOS Late / Decompensated

Compensation has failed — IMMINENT ARREST.

- **Bradycardia** (ominous in adults & peds)
- **Hypotension** (LATE sign — don't wait for it)
- SpO₂ < 90%, gasping, agonal respirations
- Cyanosis — central (lips, tongue)
- Cold, mottled, dusky skin
- Capillary refill > 3 seconds
- Anuria (< 0.5 mL/kg/hr or none)
- Unresponsiveness, GCS < 8 (intubate!)

🚩 Red Flag Findings — Call Rapid Response NOW



Airway: Stridor, gurgling, snoring, drooling, inability to speak in full sentences, "tripod" positioning.



Breathing: RR < 10 or > 30, accessory muscle use, paradoxical chest movement, absent breath sounds (pneumothorax).



Circulation: SBP < 90, HR > 130 or < 50, no palpable pulse, jugular vein distention with hypotension (tamponade).



Disability: Sudden Δ in LOC, GCS drop ≥ 2, unequal/fixed pupils, seizure, posturing, "worst headache of my life."



Exposure: Hypothermia (< 35°C / 95°F), uncontrolled bleeding, distended/rigid abdomen,

expanding hematoma.

4

Priority Nursing Interventions

ABC FRAMEWORK — WHAT TO DO, IN ORDER

⚡ GOLDEN RULE

In emergencies, **assessment IS intervention**. You do not "assess then call HCP" — you assess, treat, and call simultaneously. **Open the airway → start O₂ → call for help.**

A — Airway First

- **Open** airway: jaw-thrust if trauma suspected; head-tilt/chin-lift otherwise
- **Suction** visible secretions, blood, vomit (max 10–15 sec per pass)
- **Insert** OPA (unconscious, no gag) or NPA (conscious, intact gag)
- **Prepare** for intubation if GCS ≤ 8, apnea, or unable to protect airway

B — Breathing

- **Administer** 100% O₂ via NRB (15 L/min) for any unstable patient — concerns about CO₂ retention come *after* stabilization
- **Ventilate** with BVM at 10–12 breaths/min if RR < 10 or apneic; 1 breath every 6 seconds during CPR with advanced airway
- **Decompress** tension pneumothorax: large-bore needle, 2nd ICS midclavicular line (or 4th–5th ICS anterior axillary per current ATLS)
- **Apply** 3-sided occlusive dressing for sucking chest wound

C — Circulation

- **Control** hemorrhage: direct pressure → pressure dressing → tourniquet (2–3 inches above wound, note time)
- **Establish** two large-bore (16–18 g) IVs in antecubital fossae; IO access if no IV within 90 seconds in arrest
- **Initiate** warmed isotonic fluid bolus (NS or LR) — 30 mL/kg for septic/hypovolemic shock
- **Begin** CPR at 100–120 compressions/min, depth 2–2.4 inches (adult) if pulseless
- **Defibrillate** shockable rhythms (V-fib, pulseless V-tach) — minimize interruptions

D — Disability

- **Check** blood glucose on every altered LOC — hypoglycemia mimics stroke/shock
- **Administer** naloxone 0.4–2 mg IV/IM/IN for suspected opioid overdose (titrate to respiration, not LOC)
- **Position** HOB 30° if increased ICP suspected (no Trendelenburg)

- **Protect** from injury during seizure — do NOT restrain or place objects in mouth

E — Exposure / Safety

- **Remove** all clothing for full inspection — cut, don't pull
- **Warm** patient: blankets, warm fluids, room temp $\geq 75^{\circ}\text{F}$ — hypothermia worsens coagulopathy
- **Preserve** evidence in suspected assault/abuse — paper bags, do not wash
- **Document** findings, times, interventions, and responses

START Triage (Mass Casualty)

RED Immediate Life-threatening but survivable with rapid intervention. Treat first.	YELLOW Delayed Serious but stable; can wait 30 min – 2 hr for definitive care.	GREEN Minor "Walking wounded." Ambulatory, minor injuries. Treat last.	BLACK Expectant Deceased or non-survivable. Comfort care only — do not divert resources.
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5

Emergency Pharmacology

CODE & RESUSCITATION DRUGS AT A GLANCE

DRUG	INDICATION	DOSE (ADULT)	NURSING WATCH-FORS
Epinephrine <i>α & β agonist</i>	Cardiac arrest; anaphylaxis	1 mg IV/IO q3–5 min (arrest) 0.3–0.5 mg IM (anaphylaxis)	Tachycardia, HTN, tremor; flush line with 20 mL NS & elevate extremity post-dose
Atropine <i>Anticholinergic</i>	Symptomatic bradycardia	1 mg IV q3–5 min, max 3 mg	Will NOT work in 2nd-degree type II or 3rd-degree block; dry mouth, blurred vision, tachycardia
Amiodarone <i>Class III antiarrhythmic</i>	V-fib, pulseless V-tach	300 mg IV/IO push, then 150 mg	Hypotension, pulmonary toxicity, hepatotoxicity, blue-gray skin (long-term)
Adenosine <i>AV node blocker</i>	SVT (stable, narrow-complex)	6 mg rapid IVP, then 12 mg $\times$ 2	Brief asystole expected (3–10 sec) — warn patient! Push fast with NS flush; AC vein
Naloxone (Narcan) <i>Opioid antagonist</i>	Opioid overdose / resp. depression	0.4–2 mg IV/IM/IN q2–3 min	Titrate to respirations (not LOC); short half-life — may need repeat doses; acute withdrawal in dependence
Dextrose 50% (D50)	Hypoglycemia (< 70 mg/dL + symptoms)	25 g (50 mL) IV push	Confirm IV patency — extravasation = tissue necrosis; recheck BG in 15 min
Sodium Bicarbonate	Severe metabolic acidosis; hyperkalemia; TCA OD	1 mEq/kg IV	NOT compatible with most drugs — flush line; monitor ABGs; risk of alkalosis
Calcium Gluconate	Hyperkalemia with EKG changes; Ca-channel blocker OD	1 g (10 mL of 10%) IV	Cardiac monitoring; tissue necrosis if extravasated; do NOT mix with bicarb
Magnesium Sulfate	Torsades de pointes; eclampsia	1–2 g IV over 5–60 min	Watch reflexes, RR, urine output — toxicity = absent DTRs, RR < 12; antidote = Ca gluconate
Vasopressin / Norepinephrine	Septic / distributive shock	Titrated infusion	Central line preferred; extravasation = necrosis; monitor MAP $\geq$ 65 mmHg

6

NCLEX Test Traps

WHERE STUDENTS LOSE POINTS

**Distracted by the obvious injury**

A bleeding open femur fracture LOOKS urgent — but if the airway is gurgling, airway wins. Always run ABCDE in order.

✗ WRONG

Apply pressure to the bleeding leg first.

✓ RIGHT

Suction the airway and position to maintain patency, THEN address bleeding.

**"Assess first" vs. emergency intervention**

The classic NCLEX rule "always assess before intervening" does **not** apply when the patient is in arrest, unresponsive, or has no airway. In codes, you act.

✗ WRONG

Take vital signs on an unresponsive, pulseless patient.

✓ RIGHT

Begin CPR immediately and call a code.

**Waiting for hypotension to call shock**

Hypotension is a **late** sign. By the time BP drops, the body has already lost 30–40% of blood volume. Tachycardia, restlessness, narrowed pulse pressure come first.

✗ WRONG

"BP is still 110/70 — I'll keep monitoring."

✓ RIGHT

HR 128, restless, cool skin → call Rapid Response, bolus NS.

**Head-tilt on a trauma patient**

If trauma is suspected (MVA, fall > standing height, diving injury), **never** hyperextend the neck. Use the **jaw-thrust** maneuver to open the airway without moving the C-spine.

✗ WRONG

Head-tilt/chin-lift on an MVA victim.

✓ RIGHT

Manual in-line stabilization + jaw-thrust.



Forgetting to check blood glucose

Hypoglycemia mimics stroke, intoxication, psychosis, and seizure. **Every** altered LOC gets a finger-stick — it's fast, cheap, and reversible.

✗ WRONG

Order a CT scan first for confusion.

✓ RIGHT

Check BG, then proceed with workup.



"Stable" green-tag is not always lowest priority

In mass casualty, you treat **RED first, then YELLOW, then GREEN, then BLACK**. A "walking wounded" patient with a broken arm is lower priority than an unconscious head injury — even if it feels counterintuitive.



Withholding O₂ from a COPD patient in respiratory failure

The "2 L max for COPD" rule applies to **chronic, stable** patients. In acute emergencies — hypoxia kills first. Give the O₂ they need, then titrate down.

✗ WRONG

"He has COPD — I can't go above 2 L."

✓ RIGHT

SpO₂ 78% → high-flow O₂, prepare for BiPAP/intubation.



Patient & Family Education

BEFORE, DURING, AND AFTER THE EMERGENCY

Pre-Emergency (Prevention & Preparedness)

- Teach **recognition of warning signs** for stroke (BE FAST), heart attack (chest pressure, SOB, jaw pain, nausea), anaphylaxis (hives + airway swelling), and sepsis (fever + AMS).
- Encourage **medical alert bracelets** for chronic conditions: diabetes, seizure disorder, anticoagulation, severe allergies.
- Verify **advance directives**, POLST/MOLST forms, and healthcare proxy are completed and accessible.
- Teach families to **call 911 first** — do not drive to the ER if cardiac arrest or stroke is suspected.
- Recommend BLS/CPR + AED certification for family members of high-risk patients.

During the Emergency

- **Communicate clearly and calmly** — fear escalates panic. Use short sentences, give one direction at a time.
- Explain each procedure briefly *as you do it* (e.g., "I'm putting this oxygen mask on you to help you breathe").
- Offer family a **liaison** (chaplain, social worker, nurse) — they want updates, not technical details.
- Support **family presence during resuscitation** when feasible — evidence supports better grief outcomes.

Post-Emergency

- Review **discharge instructions** in plain language; teach-back is mandatory for high-risk teaching.
- Identify **red flag symptoms** that require return to ED (fever, worsening pain, neurologic changes, bleeding).
- Connect with **community resources**: outpatient follow-up, social work, mental health, support groups (especially after trauma, code, loss).
- Acknowledge **psychological impact** — PTSD risk is high after MI, code, ICU stay; screen and refer.



Memory Mnemonics

PATTERN RECOGNITION FOR EXAM DAY

PRIMARY SURVEY

ABCDE

- A** — Airway + C-spine
- B** — Breathing
- C** — Circulation
- D** — Disability (Neuro)
- E** — Exposure

QUICK LOC CHECK

AVPU

- A** — Alert
- V** — responds to Verbal
- P** — responds to Pain
- U** — Unresponsive

FOCUSED HISTORY

SAMPLE

- S** — Signs/Symptoms
- A** — Allergies
- M** — Medications
- P** — Past medical hx
- L** — Last meal
- E** — Events leading up

PAIN ASSESSMENT

OPQRST

- O** — Onset
- P** — Provokes/Palliates
- Q** — Quality
- R** — Region/Radiation
- S** — Severity (0–10)
- T** — Time/duration

STROKE RECOGNITION

BE FAST

- B** — Balance loss
- E** — Eyes (vision Δ)
- F** — Face droop

TRAUMA CAUSES (D-CODES)

5 H's & 5 T's

- H** — Hypoxia, Hypovolemia, Hypo/Hyperkalemia, H+ (acidosis), Hypothermia
- T** — Tension PTX, Tamponade, Toxins, Thrombosis (PE), Thrombosis (MI)

A — Arm weakness

S — Speech slurred

T — Time to call 911

 QUICK PATTERN TIP

Restless + Tachycardic = Hypoxia until proven otherwise. These two cues together are the #1 most-tested early shock pattern on NCLEX. Don't wait for hypotension.

CLINICAL JUDGMENT PRACTICE

NCJMM Six-Step Scenario

Next-Generation Clinical Judgment Measurement Model

SCENARIO: A 58-year-old man is brought to the ED by EMS after being found unresponsive in a parking lot following a motor vehicle crash 20 minutes ago. On arrival he has obvious head trauma with bleeding from the scalp, his breathing is noisy and irregular, and there is a visible deformity of the right thigh. EMS placed a cervical collar and a non-rebreather mask at 15 L. Vitals: HR 132, BP 88/54, RR 28 (irregular, gurgling), SpO₂ 89%, T 35.6°C (96.1°F), GCS 7 (E2 V2 M3). Right pupil 5 mm sluggish, left 3 mm reactive.



Recognize Cues

Relevant findings: Gurgling/irregular respirations (airway compromise), SpO₂ 89% on high-flow O₂ (hypoxia despite intervention), HR 132 + BP 88/54 (compensated shock progressing), GCS 7 (severe TBI — cannot protect airway), unequal pupils with sluggish right (possible herniation), hypothermia 35.6°C, obvious femur deformity (potential 1–1.5 L blood loss).

Irrelevant for now: Scalp bleeding (cosmetic; rarely life-threatening unless arterial), time elapsed since crash.



Analyze Cues

The clinical picture is consistent with **severe traumatic brain injury** (GCS 7, unequal pupils → possible uncal herniation) *plus* **hemorrhagic shock** (tachycardia, hypotension, hypothermia, femur fracture). Gurgling respirations + GCS < 8 = **cannot protect airway**. Hypoxia despite NRB suggests inadequate ventilation, not just oxygenation. The combination of TBI + shock dramatically increases mortality — hypotension and hypoxia each independently double mortality in TBI.



Prioritize Hypotheses

1. **#1 Airway compromise + impending respiratory failure** (highest priority — GCS < 8, gurgling, hypoxia)
2. **#2 Hemorrhagic shock** (active blood loss from femur ± internal bleeding)

3. **#3 Increased ICP / herniation** (unequal pupils, GCS drop)
4. **#4 Hypothermia** (worsens coagulopathy in the "lethal triad")
5. **#5 Stabilize femur fracture** (after life threats addressed)

STEP
4

Generate Solutions

- Suction airway and prepare for **rapid sequence intubation** — maintain inline C-spine immobilization.
- Establish **two large-bore IVs (16–18 g)**; initiate warmed isotonic fluids and prepare for massive transfusion protocol.
- Maintain **SBP $\geq$ 110 mmHg** in TBI (per current Brain Trauma Foundation guidelines — avoid even brief hypotension).
- Elevate HOB to 30°, midline neck position (after C-spine cleared or with collar in place) to optimize cerebral venous drainage.
- Apply **traction splint** to femur to reduce bleeding and pain.
- Use warmed blankets / forced-air warmer; warm all IV fluids and blood products.
- Obtain stat labs: type & cross, CBC, coags, lactate, ABG, ETOH/drug screen.
- Prepare for emergent CT head + chest/abdomen/pelvis after airway secured.

STEP
5

Take Action

1. **Suction** visible secretions/blood while maintaining manual C-spine stabilization.
2. **Assist with RSI** — preoxygenate with BVM, prepare etomidate + rocuronium, suction ready, confirm placement with EtCO₂ + bilateral breath sounds.
3. **Insert** two 16-gauge IVs; initiate 1 L warmed LR bolus while activating massive transfusion protocol (1:1:1 ratio PRBC:FFP:platelets).
4. **Apply** traction splint to right femur; reassess distal pulses, color, sensation.
5. **Cover** with warmed blankets; verify temperature q5 min.
6. **Notify** trauma surgery, neurosurgery, blood bank; prepare for OR/CT.
7. **Document** all interventions with times and patient responses.

STEP
6

Evaluate Outcomes

Expected within 15–30 minutes:

- ☒ **Airway secured** — ETT confirmed, SpO₂ $\geq$ 94%, EtCO₂ 35–40 mmHg

-  **Hemodynamics improving** — SBP $\geq$ 110, HR trending down toward 100, urine output $\geq$ 0.5 mL/kg/hr
-  **Temperature $\geq$ 36°C** with active rewarming
-  **Distal pulses intact** in right leg after splinting
-  Patient en route to **CT or OR** for definitive care

If outcomes NOT met: Reassess ABCDE in order — re-suction airway, verify ETT placement, escalate fluids/blood, consider vasopressors (norepinephrine for MAP $<$ 65), call neurosurgery for emergent decompression if pupils worsen or GCS drops further.

Diane's NGN NCLEX 2026 Visual Study Library

Emergency Assessment · Critical Care & Fundamentals Cluster

Content drawn from Saunders, ATI, ENA TNCC, Brain Trauma Foundation, AHA BLS/ACLS 2025, current NGN NCLEX 2026 test plan