NCLEX-RN®

Study Guide

Clinical judgment • priorities • pharmacology • labs • all 8 client-needs areas

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A visual, high-yield review for nursing graduates preparing for the NCLEX-RN. It follows the 2026 NCLEX-RN Test Plan, which took effect April 1, 2026, and focuses on how the exam thinks: safety first, priorities, and clinical judgment.

Inside this guide

- How the exam works and the 2026 test plan
- The clinical judgment model and NGN question types
- Prioritization frameworks and delegation
- High-yield content for all eight client-needs areas
- Lab values, drug classes and stem suffixes
- Maternity, pediatric and mental health essentials
- Test-taking strategies and 15 practice questions

★ HEADS UP

What changed in 2026? Very little. The category percentages, question count and format are the same as 2023. The main change is the name: “Safety and Infection Control” is now **“Safety and Infection Prevention and Control.”**

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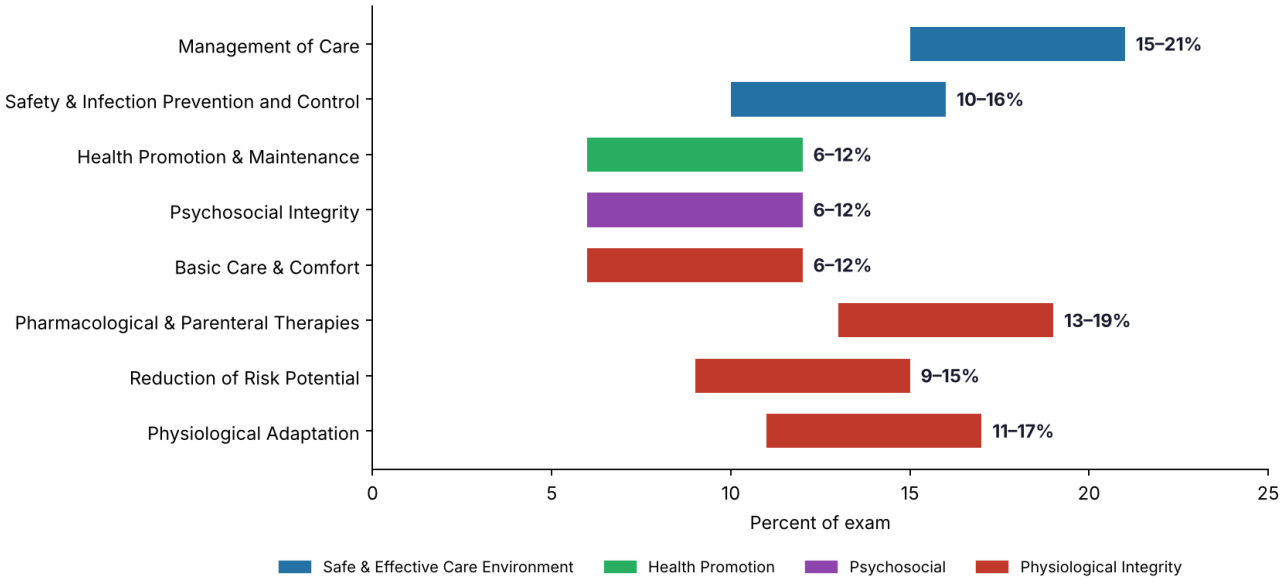
How the exam works

Feature	Details
Length	85 to 150 questions; up to 5 hours, including the tutorial and optional breaks
Format	Computerized adaptive testing (CAT): each answer changes the difficulty of the next question
Scored items	70–135; 15 unscored pretest items are mixed in and look the same
Case studies	3 scored case studies of 6 questions each (18 items), within the first 85
Scoring	Pass/fail against a standard — no percentage. Many NGN items give partial credit
Ending	Stops when the computer is 95% sure you are above or below the standard, or you reach 150 items or 5 hours

2026 test plan — client needs



Percent ranges from the NCSBN 2026 NCLEX-RN Test Plan (same ranges as 2023).

★ **MYTH BUSTER**

The exam ending early doesn't mean you failed. Shutting off at 85 questions happens to strong and weak test-takers. Don't read anything into the length — just answer each question as it comes.

Clinical judgment — the heart of NGN



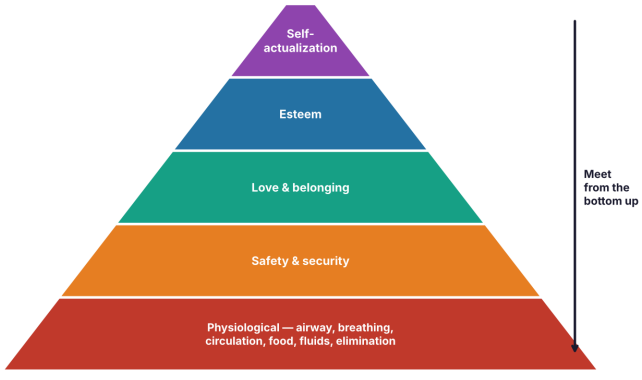
NGN questions follow NCSBN's clinical judgment model. Case studies walk through all six steps with one patient.

- **Recognize cues:** which findings matter?
- **Analyze cues:** what conditions fit?
- **Prioritize hypotheses:** which problem is most urgent?
- **Generate solutions:** what outcomes and actions?
- **Take action:** which interventions first?
- **Evaluate outcomes:** is the patient better, same or worse?

NGN question types

Type	What you do	Tip
Extended multiple response	Select all that apply from 5–10 options	Judge each option alone — true or false?
Matrix / grid	Check a box in each row (e.g., indicated / not indicated)	Each row is its own mini-question
Drop-down (cloze)	Pick words to complete a sentence or table	Read the whole sentence first
Drag-and-drop	Move options into blanks or put steps in order	For ordering, find the first and last steps
Highlight	Highlight relevant findings in notes or a table	Highlight only what's abnormal or relevant
Bowtie	Condition in the middle, 2 actions and 2 parameters to monitor	Pick the condition first; the rest follows
Trend	Review data over time (vital signs, labs, notes)	Look for the direction of change

Prioritization frameworks



- **ABCs:** airway → breathing → circulation (except CPR: compressions first)
- **Maslow:** physical needs before safety, then emotional needs
- **Acute before chronic;** unstable before stable; unexpected before expected
- **Actual problems before potential** ones
- **Safety:** the least restrictive option that keeps the patient safe
- **Assess before acting** — unless the patient is in danger now (e.g., stop a transfusion reaction first)

Delegation and assignment

RN	LPN / LVN	UAP / CNA
• Initial and ongoing assessment	• Stable, predictable patients	• Vital signs on stable patients
• Care planning and evaluation	• Data collection, reinforce teaching	• Bathing, feeding, toileting
• Teaching (new info)	• Oral, IM, subQ meds	• Ambulating, turning
• Unstable or unpredictable patients	• Tube feedings, suctioning	• Intake & output
• IV push meds, blood products	• Sterile dressing changes	• Obtaining weights
• Discharge teaching	• Urinary catheter insertion	• Report changes to the nurse

Five rights of delegation: right task, right circumstance, right person, right directions and communication, right supervision and evaluation. The RN stays accountable for delegated care. Remember: **you can't delegate assessment, teaching or evaluation**, and never delegate an unstable patient.

Safe and Effective Care Environment

MANAGEMENT OF CARE (15–21%)	
Consent	The provider explains the procedure; the nurse witnesses the signature and confirms understanding. Minors need a guardian unless emancipated.
Advance directives	Living will and health care power of attorney. Ask on admission; respect DNR orders (DNR ≠ do not treat).
Confidentiality	Share information only with the care team and people the patient authorizes. No photos, no social media.
Ethics	Autonomy, beneficence, nonmaleficence, justice, fidelity, veracity. Report unsafe practice through the chain of command.
Communication	SBAR for reports; read back verbal and phone orders; use qualified interpreters, never children.
Discharge	Start planning on admission; teach-back; arrange case management and home services.

SAFETY & INFECTION PREVENTION AND CONTROL (10–16%)	
Precautions	**Contact:** C. diff (soap and water), MRSA, VRE, scabies. **Droplet:** flu, pertussis, meningitis (N. meningitidis), mumps — surgical mask within 6 feet. **Airborne:** TB, measles, varicella — N95 and negative-pressure room.
Restraints	Last resort with an order; check every 15 minutes or per policy; release and reposition at least every 2 hours; tie to the bed frame with quick-release knots.
Falls	Bed low and locked, call light in reach, non-skid socks, hourly rounding, bed alarms.
Fire (RACE)	Rescue, Alarm, Contain, Extinguish. Extinguisher: PASS (pull, aim, squeeze, sweep).
ID and meds	Two identifiers; six rights of medication administration; report errors with an incident report (not mentioned in the chart).
Ergonomics	Wide base of support, bend at the knees, use lift equipment.

Health Promotion and Maintenance (6–12%)

- **Pregnancy:** Naegele's rule = first day of last period − 3 months + 7 days + 1 year
- Normal fetal HR **110–160**; late decelerations = placental problem → turn left side, stop oxytocin, give O_2, IV fluids, notify
- Early decels mirror contractions (head compression) — normal; variable decels = cord compression → change position
- **Rh-negative mother:** RhoGAM at 28 weeks and within 72 h after birth
- Postpartum: boggy uterus → massage fundus; check bladder
- **Newborn:** APGAR at 1 and 5 min; vitamin K and eye ointment
- **Milestones:** rolls over ~4–6 mo, sits ~6 mo, walks ~12 mo, 2-word phrases ~2 y
- **Erikson:** trust (infant), autonomy (toddler), initiative (preschool), industry (school age), identity (teen)
- **Screening:** follow current guidelines for blood pressure, cancer and other screenings
- **Live vaccines** (MMR, varicella): avoid in pregnancy and in people with weakened immune systems

Psychosocial Integrity (6–12%)

Topic	Key points
Therapeutic communication	Open-ended questions, reflection, silence. Avoid "why" questions, false reassurance and giving advice.
Suicide risk	Ask directly about a plan and means. Risk is high when mood suddenly lifts after depression. 1:1 observation; remove harmful objects.
Lithium	Level about 0.6–1.2 mEq/L; keep sodium and fluid intake steady; toxicity = vomiting, diarrhea, tremor, confusion.
Antipsychotics	Watch for extrapyramidal symptoms, tardive dyskinesia, and neuroleptic malignant syndrome (fever, rigidity, unstable vital signs).
Alcohol withdrawal	Starts 6–24 h after the last drink; seizures and delirium tremens possible. Benzodiazepines, thiamine, seizure precautions.
Abuse	Interview alone; document objectively; nurses are mandatory reporters for child and elder abuse.
Crisis and grief	Stay with the patient, be honest, support coping. Grief stages are not always in order.

Physiological Integrity

BASIC CARE & COMFORT (6–12%)	
Mobility	Crutches: 2–3 finger widths below the armpit, weight on hands. Cane: opposite the weak leg; "up with the good, down with the bad."
Nutrition	Check tube placement before feeds; head of bed 30–45°. Dysphagia: sit upright, thickened liquids as ordered, chin tuck.
Elimination	Catheter bag below the bladder; no routine irrigation; remove as soon as possible (CAUTI).
Comfort	Use pain scales (numeric, FACES, FLACC for infants/nonverbal); reassess 30–60 min after a dose.
Sleep	Reduce noise and light, cluster care, limit caffeine.

PHARMACOLOGICAL & PARENTERAL THERAPIES (13–19%)

Insulin	Rapid (lispro): onset 15 min — give with meals. Regular: only insulin given IV. NPH: cloudy, peak 4–12 h. Glargine: no peak; don't mix.
Anticoagulants	Heparin: aPTT, antidote protamine. Warfarin: INR 2–3, antidote vitamin K, steady vitamin K diet. Watch for bleeding.
Cardiac	Digoxin: hold if apical HR < 60; toxicity = nausea, yellow/green vision; low potassium raises risk. Beta-blockers: hold for low HR/BP.
Antibiotics	Get cultures first. Vancomycin: trough/AUC, infuse over at least 60 min. Aminoglycosides: kidney and hearing toxicity.
Blood	Verify with 2 nurses; 18–20 gauge IV; normal saline only; stay with the patient 15 min; stop for any reaction.
IV therapy	Infiltration: stop, elevate, cool or warm compress per drug. Phlebitis: stop, warm compress. TPN: glucose checks; don't stop suddenly.

Drug class suffixes

Suffix	Class	Example	Watch for
-pril	ACE inhibitor	lisinopril	Dry cough, angioedema, high potassium
-sartan	ARB	losartan	High potassium, dizziness
-olol	Beta-blocker	metoprolol	Low HR/BP; masks low-sugar signs
-dipine	Calcium channel blocker	amlodipine	Low BP, swelling of ankles
-statin	Cholesterol lowering	atorvastatin	Muscle pain, liver tests
-prazole	Proton pump inhibitor	pantoprazole	Take before breakfast
-azepam / -azolam	Benzodiazepine	lorazepam	Sedation; antidote flumazenil
-mycin / -micin	Aminoglycoside / macrolide	gentamicin	Kidney and hearing damage
-parin	Anticoagulant	enoxaparin	Bleeding; low platelets
-sone / -olone	Corticosteroid	prednisone	High glucose, infection; taper off

REDUCTION OF RISK POTENTIAL (9–15%)

Procedures	Cardiac cath: check pulses, keep leg straight, watch for bleeding. Contrast: check allergies and kidney function; hold metformin per policy.
Post-op	Watch for bleeding, low urine output, atelectasis (incentive spirometer 10×/hour), DVT (early walking, SCDs), and wound separation (cover with sterile saline gauze).
Lines and tubes	Chest tube: keep below the chest; continuous bubbling in water seal = air leak. NG tube: check placement and patency.
Vital signs	Report new changes from baseline: SpO_2 drop, new irregular heart rhythm, change in level of consciousness.

Lab values to know (typical adult ranges)

Lab	Normal	Lab	Normal
Sodium	135–145 mEq/L	Hemoglobin	M 14–18, F 12–16 g/dL
Potassium	3.5–5.0 mEq/L	Platelets	150,000–400,000
Calcium	8.5–10.5 mg/dL	WBC	5,000–10,000
Magnesium	1.5–2.5 mEq/L	INR (no warfarin)	0.8–1.2 (on warfarin 2–3)
Glucose (fasting)	70–100 mg/dL	aPTT	30–40 s (heparin 1.5–2.5×)
BUN	10–20 mg/dL	HbA1c	< 5.7% normal; diabetes ≥ 6.5%
Creatinine	0.6–1.2 mg/dL	ABG pH	7.35–7.45
Albumin	3.5–5.0 g/dL	$PaCO_2$ / HCO_3	35–45 mmHg / 22–26 mEq/L

Ranges vary slightly by lab — the NCLEX gives reference ranges when exact numbers matter.

PHYSIOLOGICAL ADAPTATION (11–17%)

Respiratory	COPD: SpO_2 88–92%, pursed-lip breathing. Asthma: silent chest is an emergency. PE: sudden dyspnea and chest pain → O_2, anticoagulation.
Cardiac	MI: aspirin, ECG within 10 min. Heart failure: daily weights (report 2–3 lb in a day or 5 lb in a week), low sodium, diuretics.
Neuro	Increased ICP: Cushing's triad (high BP with wide pulse pressure, low HR, irregular breathing); head of bed 30°. Stroke: last known well time, swallow screen.
Endocrine	DKA: insulin drip, fluids, watch potassium. Hypoglycemia: rule of 15. Thyroid storm vs myxedema coma.
Renal and fluids	AKI: watch potassium and fluid overload. Dialysis: no BP or IV in the fistula arm; feel the thrill, hear the bruit.
Shock and sepsis	Early signs: tachycardia, tachypnea, confusion. Sepsis: cultures, antibiotics, fluids within the first hour.

Test-taking strategies

- Read the **last line first** — what is the question really asking?
- Look for key words: **first, best, priority, needs further teaching**
- "Needs further teaching" = pick the **wrong** statement
- Assume you have the staff and supplies you need
- Choose the answer that helps the patient **now**, at the bedside
- Eliminate answers with "always" or "never"
- If two answers say the same thing, both are usually wrong
- Don't pick "call the provider" if a nursing action can come first
- SATA: treat each option as true or false
- Breathe, pace yourself, and take the optional breaks

Practice questions

1. Which patient should the nurse see first after report?
- **A.** A patient with COPD and SpO_2 90%
- **B.** A post-op patient with new restlessness and SpO_2 85%
- **C.** A patient asking for pain medication, pain 5/10
- **D.** A patient with diabetes and glucose 210

2. Which task can the RN delegate to a UAP?
- **A.** Assessing a new admission
- **B.** Evaluating response to pain medication
- **C.** Taking vital signs on a stable patient
- **D.** Teaching a patient about a new inhaler

3. A patient has measles. Which precautions are needed?
- **A.** Droplet
- **B.** Airborne
- **C.** Standard only
- **D.** Contact

4. A patient with C. difficile is in contact isolation. How should the nurse clean their hands after care?
- **A.** Chlorhexidine wipes
- **B.** Alcohol-based gel
- **C.** Soap and water
- **D.** Gloves only

5. The fetal heart tracing shows late decelerations. What is the first action?
- **A.** Turn the patient to her left side
- **B.** Increase the oxytocin
- **C.** Prepare for discharge
- **D.** Document and keep watching

6. A patient on lithium has vomiting, diarrhea and a coarse tremor. What should the nurse suspect?
- **A.** Serotonin syndrome
- **B.** Alcohol withdrawal
- **C.** Normal side effects
- **D.** Lithium toxicity

7. Before giving digoxin, the apical pulse is 54. What should the nurse do?
- **A.** Give half the dose
- **B.** Give the dose
- **C.** Hold the dose and notify the provider
- **D.** Recheck in 4 hours and give

8. Which potassium level should be reported right away?
- **A.** 4.2 mEq/L
- **B.** 4.8 mEq/L
- **C.** 3.8 mEq/L
- **D.** 6.1 mEq/L

9. A patient with heart failure gained 3 lb since yesterday. What does this suggest?
- **A.** Normal variation
- **B.** Dehydration
- **C.** Better nutrition
- **D.** Fluid retention

10. Which statement by a patient taking warfarin needs further teaching?
- **A.** “I’ll report blood in my urine.”
- **B.** “I’ll eat a lot more spinach starting this week.”
- **C.** “I’ll keep my INR appointments.”
- **D.** “I’ll use a soft toothbrush.”

11. A patient receiving blood develops chills and back pain. First action?
- **A.** Stop the transfusion
- **B.** Give acetaminophen
- **C.** Call the lab
- **D.** Slow the transfusion

12. Which is the best example of therapeutic communication?
- **A.** “Tell me more about how you’re feeling.”
- **B.** “If I were you, I’d have the surgery.”
- **C.** “Why did you stop taking your medicine?”
- **D.** “Don’t worry, everything will be fine.”

13. A patient using a cane has a weak right leg. Which hand should hold the cane?
- **A.** Left
- **B.** Both
- **C.** Right
- **D.** Either

14. A patient with a head injury has BP 186/60, HR 48 and irregular breathing. What do these findings suggest?
- **A.** Hypoglycemia
- **B.** Hypovolemic shock
- **C.** Sepsis
- **D.** Increased intracranial pressure

15. A client is 2 hours post-op and has urine output of 20 mL/h for 2 hours. Weight 80 kg. What should the nurse do?
- **A.** Restrict fluids
- **B.** Keep watching
- **C.** Assess and notify the provider
- **D.** Remove the catheter

Answers and rationales

#	Ans	Why
1	**B**	New restlessness with hypoxia is an airway/breathing problem — unstable.
2	**C**	Routine tasks for stable patients can be delegated; assessment, teaching and evaluation can't.
3	**B**	Measles, varicella and TB need airborne precautions with an N95 and negative-pressure room.
4	**C**	Alcohol doesn't kill C. diff spores; use soap and water.
5	**A**	Late decels mean poor placental blood flow: turn left, stop oxytocin, give O_2, IV fluids, notify.
6	**D**	GI upset and coarse tremor are signs of toxicity; hold the dose and check the level.
7	**C**	Hold digoxin for an adult apical HR under 60.
8	**D**	Normal is 3.5–5.0; 6.1 can cause dangerous rhythms.
9	**D**	A gain of 2–3 lb in a day suggests fluid retention — notify the provider.
10	**B**	Big changes in vitamin K intake change warfarin's effect; keep it steady.
11	**A**	Stop the transfusion first, then keep the line open with saline through new tubing and notify.
12	**A**	Open-ended statements invite the patient to share.
13	**A**	Hold the cane on the strong side (opposite the weak leg).
14	**D**	This is Cushing's triad, a late sign of increased ICP — an emergency.
15	**C**	Minimum is about 0.5 mL/kg/h (40 mL/h for 80 kg); check the bladder and catheter, then report.

★ ABOUT THE AUTHOR

Mary Veneman BSN RN CEN is a Certified Emergency Nurse (CEN®) and critical care nurse with experience in med-surg, ICU, and ER nursing. She shares that experience with nurses who want to deepen their knowledge and become certified.

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