

NCLEX BOOTCAMP · STUDY SMARTER, NOT HARDER

The NCLEX BootCamp White Paper

The mindset, the method, and the exact game-plan to pass the NCLEX-RN — from a nurse practitioner who coaches students through it.

Inside: the question-attack frameworks, a worked question bank, a 6-week plan — and how a single 1-on-1 session with Brian can fix what self-study can't.

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Nurse Practitioner · NCLEX Coach

ABOUT THIS GUIDE

Why this is different

There are a hundred courses that'll re-teach you content. This isn't one of them. I wrote this to fix the part that actually trips people up: how to *study* so it sticks, and how to *think* the way this test wants you to think. Almost nobody teaches that well.

Here's what I've seen again and again. People don't fail the NCLEX because they don't know enough nursing. They fail because nobody ever showed them how the exam is built, how it really decides whether you pass, or what to do the second a question backs them into a corner. That's the whole reason this guide exists. Keep it on your desk and lean on it through your entire prep.

85–150

questions on the adaptive RN
exam

3,000+

practice questions to target
before test day

1

coaching session that often
changes the outcome



Brian Weinstein, MS, APN, NP-C, RN

Brian is a board-certified Nurse Practitioner (MS, APN, NP-C) and registered nurse — but he wasn't a natural. He struggled through nursing school, reading chapters three times and still freezing on test day, and with ADHD and dyslexia working against him he had to teach himself, from scratch, how to actually study. That's when he learned the hard way what nursing exams really reward: how you *think* under pressure, not how much you memorize. He rebuilt his entire approach, passed, and has spent the years since coaching students through NCLEX prep with that exact method. This guide distills his BootCamp framework — the same one he uses in his 1-on-1 sessions — combined with current research on the exam's structure and scoring.

IMPORTANT — PLEASE READ

This guide is educational and reflects the author's coaching experience plus publicly available information about the NCLEX. It is **not** affiliated with or endorsed by the NCSBN, Kaplan, or any testing body, and is not medical, legal, or guaranteed exam advice. Test plans and percentages change — always confirm the current **NCSBN NCLEX-RN Test Plan** at [ncsbn.org](https://www.ncsbn.org). Nothing here is medical advice; any mention of anxiety or medication is a conversation for your own licensed clinician.

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HOW TO USE THIS GUIDE

Read Parts 1–6 once, cover to cover, *before* you start heavy practice. Then keep Parts 4, 5, 8, and 13 open beside you every time you do questions. The frameworks only stick when you apply them live — which is exactly what a coaching session accelerates (Part 12).

01 Understand the Machine

You can't beat a test you don't understand. So before you touch a single practice question, let's get clear on what the NCLEX actually is: how it's put together, how it shifts under you in real time, and how it makes the pass-or-fail call.

It is a test of *minimum competency*

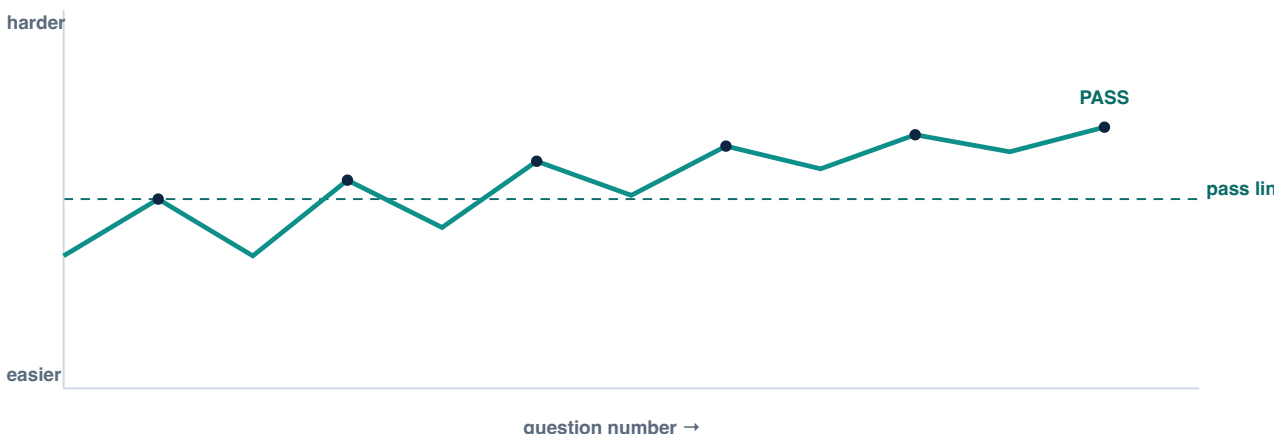
The NCLEX has one job: decide whether you are **safe enough** to practice as an entry-level nurse. It is not looking for the best nurse in your class — it is looking for the line between "safe to practice" and "not yet." That single idea changes how you answer: when two options both look right, the exam wants the **safest, most fundamental** action, not the most advanced one.

THE MANTRA

"**Minimum competency.**" Say it before every practice block. The NCLEX rewards safe, foundational nursing judgment — not cleverness.

Computerized Adaptive Testing (CAT)

The NCLEX-RN is delivered by **Computerized Adaptive Testing**. The test continuously estimates your ability. Answer correctly and the next item is a little harder; miss one and the next is a little easier. It keeps adjusting until it is statistically confident you are clearly above — or clearly below — the passing standard.



CAT hones in on your true ability; once it's 95% sure you're above the line, it stops.

- **Length is variable.** Since the Next Generation NCLEX (NGN) launched in April 2023, the RN exam ranges from roughly **85 to 150 questions**, with up to **5 hours** including breaks.
- **Some questions don't count.** Unscored *pretest* items are mixed in — you can't tell which, so treat every question as if it counts.
- **You can't go back.** Each answer locks before the next item is chosen. There is no review screen. Commit, then move on.

How the computer decides: the three rules

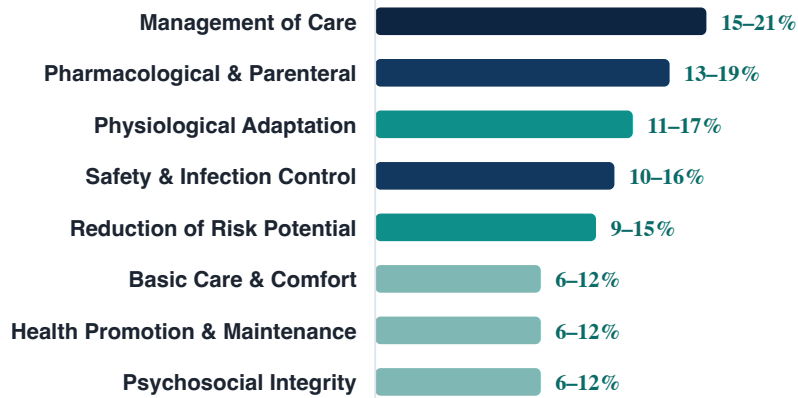
Rule	What it means for you
95% Confidence	The test stops as soon as it's 95% sure you're above (pass) or below (fail) the standard. Most candidates finish here.
Maximum-Length	If you hover at the borderline, the test runs to its maximum number of items and judges your final ability estimate.
Run-Out-of-Time	If time expires, your last ability estimate is used (a minimum number of questions is required).

REFRAMING "THE LAST QUESTIONS MATTER MOST"

The accurate, useful version: if you are **near the borderline**, the test keeps going precisely because it isn't sure about you — so every late question genuinely nudges your final estimate over the line. The lesson isn't magic about "the last five." It's this: **never mentally check out at the end.** Candidates who relax in the final stretch talk themselves out of a pass.

The blueprint: four Client Needs categories

Every NCLEX item maps to one of four **Client Needs** categories (two are split into subcategories). The weighting tells you where your study hours pay off most.



Approximate NCLEX-RN Client Needs weighting (NGN test plan). Confirm current figures at [ncsbn.org](https://www.ncsbn.org).

Read it strategically. Together, *Management of Care + Pharmacological & Parenteral Therapies* can be ~28–40% of your exam. Prioritization/delegation (Part 8) and medications (Part 7) are where points concentrate — so weight your practice there.

The Clinical Judgment Model (the NGN backbone)

Next Gen NCLEX measures how you *think* using a six-step clinical-judgment cycle. Every new item type maps to one or more of these steps:



The Clinical Judgment Measurement Model — the thinking the NGN case studies are built to score.

Cutting across every category are the **Integrated Processes**: the Nursing Process (assess → analyze → plan → implement → evaluate — the engine behind Part 4), Caring, Communication & Documentation, Teaching/Learning, and Culture & Spirituality.

02 The Mindset

Passing is more about how you behave and what you believe than about raw facts. The people I've watched pass started acting like nurses long before they ever walked into the test center.

Think it, then become it

This sounds soft; it is not. Your brain moves toward whatever you rehearse. Spend weeks telling yourself "I'm going to fail" and you prime hesitation, second-guessing, and panic — the exact behaviors that sink borderline candidates. Flip it on purpose:

- **Speak in the positive.** "I made it through nursing school. I can do this." Repeat it daily — out loud.
- **Picture the outcome.** You already cleared the hardest part: school. The NCLEX is the formality that confirms it.

The Vision Board

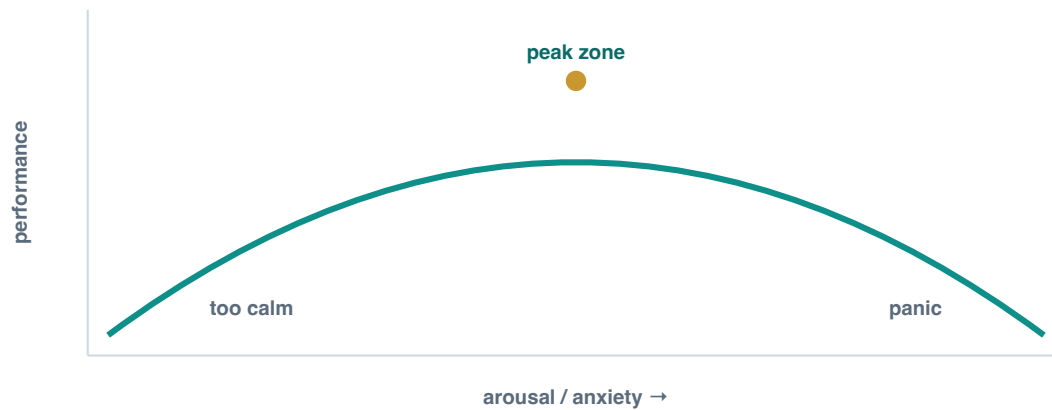
Make your goal physical and unavoidable. Build a board — digital or on your wall — with an image of **you as a nurse** (badge, scrubs, your name with "RN" after it). Look at it every morning before you study. It re-anchors months of work to a concrete identity, not an abstract test.

DAILY 60-SECOND RITUAL

Morning: look at the vision board → say your affirmation → name one thing you'll master today. Evening: cross off the flash cards you now know cold. Tiny, repeated, identity-level wins.

The anxiety sweet spot

Some nerves sharpen you; too many wreck recall. Your job isn't zero anxiety — it's the productive middle. Build that control like a skill:



Aim for the middle: alert and focused, not flat and not panicking.

- **Practice under real conditions.** Timed blocks, no phone, no notes. Familiarity is the best anti-anxiety tool there is.
- **Box breathing.** Inhale 4, hold 4, exhale 4, hold 4. Two cycles reset a racing mind mid-exam.
- **Sleep and fuel.** Memory consolidates in sleep. An all-nighter before the test is self-sabotage (Part 10).

A CAREFUL WORD ON MEDICATION

If test anxiety is genuinely impairing — panic, freezing, physical symptoms — that's worth a conversation with **your own physician or licensed prescriber**. This guide does not recommend, dose, or endorse any medication. Never take a prescription that isn't yours, and never try a new medication for the first time on test day.

03 Build the Base

You can't reason your way past a word you don't know. Lock in the vocabulary and the high-yield facts first — then the frameworks have something to work with.

Vocabulary wins quiet points

Many questions hinge on a single medical term. Miss the term and the whole stem collapses — you'll pick a wrong answer to a question you actually understood. Memorize the common terms cold:

Term	Means	Term	Means
Erythema	Redness	Dysuria	Painful/burning urination
Hematuria	Blood in urine	Dyspnea	Difficulty breathing
Tachycardia	Fast heart rate	Bradycardia	Slow heart rate
Diaphoresis	Sweating	Syncope	Fainting
Paresthesia	Numbness/tingling	Dysphagia	Difficulty swallowing
Orthopnea	Breathless lying flat	Cyanosis	Bluish skin (low O ₂)

A fuller term + lab-value reference is in the Appendix (Part 13).

Flash cards — your highest-ROI tool

You cannot learn everything in nursing school; the gaps are exactly where the NCLEX corners you. Flash cards are the most efficient way to close those gaps and move facts from short-term to long-term memory.

Flash-card etiquette (do it this way)

- **Draw on them.** Sketch a quick image linking front to back — your brain remembers pictures far better than text.
- **Highlight** the one word that matters.
- **Don't bury a missed card at the back.** Put it ~10 cards back so you see it again soon — that spacing is what converts short-term to long-term memory.

- **Retire what you know.** When a card is automatic, mark it with an X (you'll use this on test eve, Part 10).

Miss it → move it ~10 cards back (see it again soon)



Know it cold →



retire (X)

Spaced repetition in practice — the cheapest memory upgrade you'll ever make.

WHAT TO MEMORIZE (DON'T TRY TO MEMORIZE EVERYTHING)

Lab value ranges · normal vital signs by age · common drug classes + suffixes + key side effects · antidotes · isolation precautions · the medical vocabulary above · therapeutic-communication phrases. These recur constantly. Most disease minutiae do not — reason those out with Part 4.

04 Master the Question

This is the part I care about most. Once these frameworks are in your hands, you'll beat plenty of people who, on paper, know more nursing than you do. I've watched it happen too many times to call it luck.

First, don't beat yourself

- **Never read into the question.** Don't invent details ("but what if the patient also..."). Answer the patient in front of you, as written.
- **Watch for grammar cues.** Singular/plural and "a/an" can quietly point at the intended answer.
- **If the patient is in distress, giving a medication is rarely the first action.** Stabilize and assess airway/breathing/circulation first.

Framework 1 — Assessment vs. Implementation

The single most powerful filter on the NCLEX. Decide what the question is asking you to *do*, then delete the answers that don't match.

ASSESSMENT

You gather data — history or physical exam. *Ask the patient · auscultate lungs · listen to the heart · check the chart · perform a med reconciliation.*

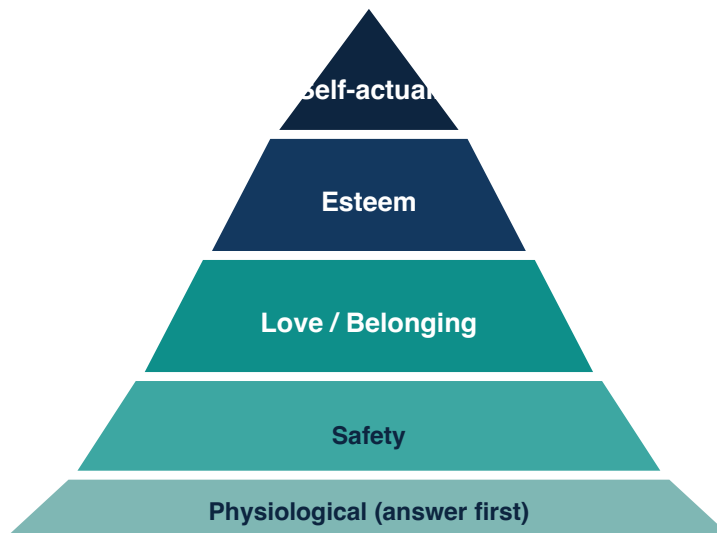
IMPLEMENTATION

You act on the patient. *Administer a drug · reposition · apply oxygen · start an IV · teach.*

The rule: if the stem asks you to **ASSESS**, eliminate every implementation answer. If it asks you to **IMPLEMENT**, eliminate every assessment answer. Often that alone leaves one or two options.

Framework 2 — Maslow

When answers mix physical and psychosocial needs, **physiological needs come first**, then safety, then love/belonging, then esteem, then self-actualization. Pick the physical need before the emotional one — unless the question is clearly about communication or coping.



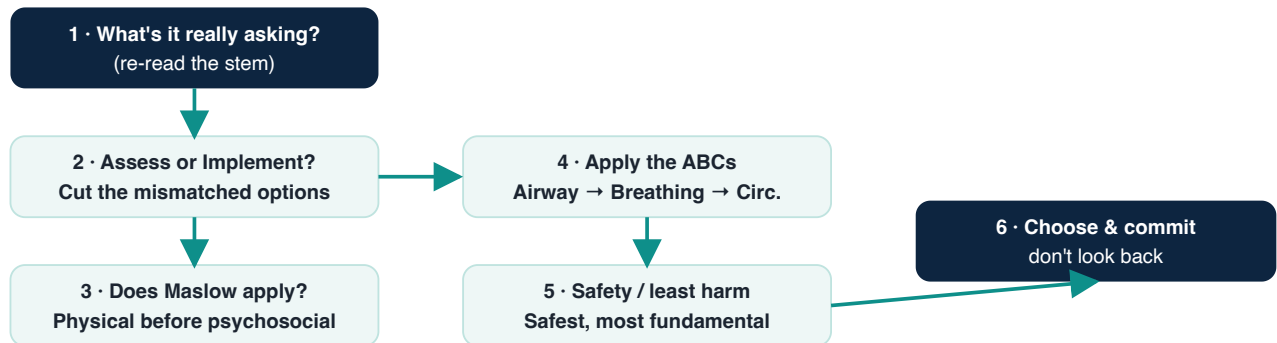
Maslow's hierarchy — physiological needs are prioritized first on the NCLEX.

Framework 3 — The ABCs

For "which patient/action first" priority questions: **Airway** → **Breathing** → **Circulation**. A patent airway beats everything; breathing beats circulation. This resolves most "first action" items in seconds.

Framework 4 — The Decision Tree

Stack the frameworks into one repeatable flow you run on every priority question:



The BootCamp decision tree — run it on every prioritization question until it's automatic.

Worked example

What is the first INTERVENTION for a patient having chest pain with a pulse oximetry of 86%?

- a. Listen to the patient's breath sounds
- b. Administer oxygen
- c. Obtain a full history
- d. Administer nitroglycerin

Walk the tree. *Step 1* — it asks the first **intervention** (implementation). *Step 2* — eliminate the assessments: (a) breath sounds and (c) history are assessments. Gone. *Step 4* — between (b) oxygen and (d) nitroglycerin, oxygen addresses **Breathing** (SpO₂ 86% is hypoxemia) and comes before a medication for a patient in distress. **Answer: B.** Notice: two frameworks, not memorized cardiology, got you there.

These frameworks are simple to read and hard to do under pressure.

That's the gap a coach closes. In a 1-on-1 session, Brian watches you work real questions live, catches the exact moment your reasoning slips, and drills the fix until it's automatic. Most students feel the difference in one hour.

[Book a 1-on-1 session →](#)

Details & how it works in Part 12.

05 The Question Bank

Ten questions, worked the way I'd work them with you. Don't just check whether you got the right letter. Cover my reasoning, try it yourself first, then see whether your *thinking* matched mine. That's the part that carries over to test day.

1. A client is admitted with an acute asthma exacerbation. Which assessment finding requires immediate intervention?

- a. Wheezing on expiration
- b. Respiratory rate of 28
- c. A suddenly *silent* chest
- d. Anxiety and sitting upright

C. ABCs — a silent chest in asthma means air isn't moving (impending respiratory failure), far more ominous than audible wheezing. Wheezing actually means air is still moving. Classic "worst-sounding isn't worst" trap.

2. Which client should the nurse assess first?

- a. Post-op day 1 reporting incisional pain 6/10
- b. A client with new-onset confusion and SpO₂ 88%
- c. A client awaiting discharge teaching
- d. A client requesting a PRN laxative

B. Airway/Breathing + a change in mental status = highest priority. Pain, teaching, and comfort needs are real but lower on Maslow/ABCs.

3. A client takes furosemide. Which lab value must the nurse report immediately?

- a. Potassium 3.1 mEq/L
- b. Sodium 140 mEq/L
- c. Glucose 105 mg/dL
- d. Calcium 9.2 mg/dL

A. Loop diuretics waste potassium; 3.1 is hypokalemia → risk of dysrhythmias. The others are normal. (This is why the lab table in Part 13 is worth memorizing.)

4. The nurse is teaching about warfarin. Which statement shows correct understanding?

- a. "I'll eat lots more leafy greens for health."
- b. "I'll use a soft toothbrush and electric razor."
- c. "I'll take ibuprofen for headaches."
- d. "I can skip my INR checks once I feel fine."

B. Bleeding precautions are correct. Big swings in vitamin K (greens) destabilize INR; NSAIDs increase bleeding; INR monitoring is ongoing. Teaching/Learning + safety.

5. A client with a chest tube has continuous bubbling in the *water-seal* chamber. The nurse should first:

- a. Clamp the chest tube
- b. Assess the system for an air leak
- c. Notify the provider
- d. Increase wall suction

B. Assess before you act or escalate (Nursing Process). Continuous water-seal bubbling suggests an air leak — check connections/insertion site first. Never routinely clamp a chest tube.

6. Which client can the RN safely delegate to unlicensed assistive personnel (UAP)?

- a. Assess a new admission's lung sounds
- b. Teach a diabetic about insulin
- c. Assist a stable client with a bed bath
- d. Evaluate response to a new pain med

C. UAP do stable, routine, predictable tasks. Assessment, teaching, and evaluation are RN-only (Part 8).

7. A post-partum client has a boggy uterus and heavy bleeding. The first action is to:

- a. Call the provider
- b. Massage the fundus
- c. Start oxytocin
- d. Document the finding

B. Fundal massage is the immediate independent nursing action for uterine atony (Circulation — stop the bleed). It often works before pharmacologic steps; escalate if it doesn't.

8. A client says, "I don't think I'll ever get better." The best response is:

- a. "Of course you will — stay positive!"
- b. "Why would you say that?"
- c. "You sound discouraged. Tell me more."
- d. "Most people in your situation recover."

C. Therapeutic communication: reflect the feeling and invite the client to expand. (a) gives false reassurance, (b) "why" sounds accusatory, (d) dismisses the feeling.

9. Which client requires airborne precautions?

- a. Influenza
- b. Active tuberculosis
- c. MRSA wound
- d. Pertussis

B. TB (also measles, varicella) → airborne, negative-pressure room + N95. Flu/pertussis are droplet; MRSA is contact. Memorize the precautions grid (Part 13).

10. A nurse finds an unresponsive client. After confirming unresponsiveness, the next step is to:

- a. Begin chest compressions
- b. Check a pulse for up to 10 seconds
- c. Call for help / activate the code
- d. Open the airway

C. Activate emergency response / get help (and a defibrillator) before beginning CPR — you need the team and the AED on the way. Then assess pulse/breathing and start compressions.

More practice — Pharmacology

11. A client takes digoxin. Which finding should the nurse report before the next dose?

- a. Apical pulse 78
- b. Potassium 3.0 mEq/L
- c. Reports mild nausea last week
- d. Blood pressure 128/76

B. Hypokalemia potentiates digoxin toxicity → dangerous dysrhythmias. Low K^+ is the must-report finding; a pulse of 78 is fine (hold if <60).

12. Which is an early sign of lithium toxicity the nurse should teach the client to watch for?

- a. Increased appetite
- b. Coarse hand tremor, diarrhea, and confusion
- c. Dry skin
- d. Weight loss

B. A *fine* tremor can be expected, but a *coarse* tremor with GI upset and confusion signals rising levels. Lithium has a narrow therapeutic range; hold and check a level.

13. A client on an MAOI must avoid which food to prevent hypertensive crisis?

- a. Fresh apples
- b. White rice
- c. Aged cheese and cured meats
- d. Skim milk

C. Tyramine-rich foods (aged cheese, cured/smoked meats, draft beer) + MAOIs → hypertensive crisis. A classic memorize-it item.

More practice — Safety & Infection Control

14. The most effective action to prevent transmission of *Clostridioides difficile* is:

- a. Alcohol-based hand rub
- b. Hand washing with soap and water
- c. Wearing a surgical mask
- d. Double-gloving

B. Alcohol gel does *not* kill *C. diff* spores — soap, water, and friction do. Contact precautions + handwashing.

15. During a small fire in a client's room, the nurse's first action (RACE) is to:

- a. Activate the alarm
- b. Rescue/remove anyone in immediate danger
- c. Confine the fire by closing doors
- d. Extinguish the fire

B. Rescue first (people before property), then Alarm, Confine, Extinguish.

More practice – Maternal-Newborn & Pediatrics

16. The fetal monitor shows late decelerations. The nurse's first action is to:

- a. Document and continue monitoring
- b. Reposition the mother to her side and apply O₂
- c. Increase the oxytocin
- d. Prepare for immediate delivery

B. Late decels = uteroplacental insufficiency. Reposition (left side), stop oxytocin, give O₂, IV fluids, notify provider. Intrauterine resuscitation first.

17. A preeclamptic client on magnesium sulfate has absent deep tendon reflexes and RR of 10. The nurse should:

- a. Increase the magnesium
- b. Stop the magnesium and prepare calcium gluconate
- c. Reassess in 30 minutes
- d. Give a PRN sedative

B. Absent DTRs + respiratory depression = magnesium toxicity. Stop the infusion; the antidote is calcium gluconate.

18. A child with suspected epiglottitis arrives drooling and tripod-sitting. The nurse should avoid:

- a. Keeping the child calm with the parent
- b. Examining the throat with a tongue depressor
- c. Having emergency airway equipment ready
- d. Allowing a position of comfort

B. Never inspect the throat in suspected epiglottitis — it can trigger complete airway obstruction. Keep the child calm; airway protection is everything.

More practice — Mental Health

19. A client says, "I just can't go on anymore." The nurse's priority is to:

- a. Notify the family
- b. Ask directly whether the client is thinking of suicide
- c. Reassure the client things will improve
- d. Document the statement

B. Assess safety first — ask directly about suicidal ideation and a plan. Asking does not "plant the idea"; it's the priority intervention.

20. Which client is at highest risk for alcohol-withdrawal delirium needing close monitoring 48–72 hrs after the last drink?

- a. A client with stable vitals on day 1
- b. A client with rising BP, HR, tremors, and confusion
- c. A client requesting more food
- d. A client sleeping soundly

B. Autonomic hyperactivity + confusion signals delirium tremens (a medical emergency). Peak risk is ~48–72 hours after the last drink.

More practice — Cardiac, Respiratory & Labs

21. A client with COPD and chronic CO₂ retention has SpO₂ of 84% and severe dyspnea. The nurse should:

- a. Withhold oxygen to protect the respiratory drive
- b. Apply oxygen, titrated, and monitor closely
- c. Wait for an ABG before acting
- d. Place the client flat

B. Never withhold O₂ from a severely hypoxic patient. Give it, titrate to the target, and monitor. Hypoxia kills faster than the theoretical drive concern.

22. Which ECG/finding with a potassium of 6.8 mEq/L requires immediate action?

- a. Peaked T waves
- b. Occasional yawning
- c. Pink, warm skin
- d. Soft bowel sounds

A. Hyperkalemia → peaked T waves and risk of lethal dysrhythmia. This is an emergency (calcium gluconate to protect the heart, then shift/remove K⁺).

23. A post-op client's BP drops to 86/50, HR rises to 118, and urine output falls. The first nursing action is to:

- a. Document the trend
- b. Increase IV fluids per protocol and notify the provider
- c. Give the scheduled antihypertensive
- d. Encourage ambulation

B. Hypotension + tachycardia + low output = early hypovolemic shock (Circulation). Restore volume and escalate. Never give an antihypertensive to a hypotensive client.

24. A client reports numbness around the mouth and muscle twitching after a thyroidectomy. The nurse suspects:

- a. Hyperkalemia
- b. Hypocalcemia (parathyroid injury)
- c. Hypernatremia
- d. Hypoglycemia

B. Perioral numbness + twitching (positive Chvostek/Trousseau) = hypocalcemia from parathyroid disruption — a known post-thyroidectomy complication. Have calcium ready.

25. A client receiving a unit of packed red cells develops chills, fever, and low-back pain 15 minutes in. The nurse's first action is to:

- a. Slow the transfusion and reassess
- b. Stop the transfusion and keep the line open with normal saline
- c. Give an antipyretic and continue
- d. Notify the blood bank, then reassess in 30 minutes

B. Suspected transfusion reaction → stop the blood immediately and maintain IV access with saline (new tubing). Patient safety first; notify provider/blood bank after the client is protected.

26. A client with a chest tube has continuous bubbling in the water-seal chamber. The nurse should first:

- a. Clamp the chest tube
- b. Assess the system for an air leak (loose connection)
- c. Milk the tubing vigorously
- d. Remove the dressing

B. Continuous water-seal bubbling suggests an air leak — check connections from chest to drain first. Routine clamping is avoided (risk of tension pneumothorax).

27. A toddler is admitted with suspected epiglottitis. Which action is contraindicated?

- a. Keeping the child calm with the parent
- b. Examining the throat with a tongue depressor
- c. Having emergency airway equipment ready
- d. Allowing a position of comfort

B. Never inspect the throat in suspected epiglottitis — it can trigger total airway obstruction. Keep the child calm and have airway equipment nearby.

28. A client on lithium reports vomiting, coarse tremor, and confusion. The nurse should:

- a. Reassure the client these are expected
- b. Hold the next dose and obtain a lithium level; notify the provider
- c. Increase fluids and give the next dose early
- d. Restrict all sodium

B. These are lithium toxicity signs (therapeutic 0.6–1.2 mEq/L). Hold the dose, draw a level, and notify. Low sodium actually *raises* lithium levels — don't restrict it.

29. A client with a spinal cord injury at T4 suddenly has a pounding headache, BP 210/110, flushing, and sweating above the injury. The nurse should first:

- a. Lay the client flat and elevate the legs
- b. Raise the head of the bed and check for a full bladder/kinked catheter
- c. Give an antipyretic
- d. Apply warm blankets

B. Autonomic dysreflexia is an emergency. Sit the client up (helps lower BP) and remove the trigger — most often a distended bladder. Then notify and treat the BP.

30. A nurse is caring for four clients. Which should be assessed first?

- a. A stable client awaiting discharge teaching
- b. A client with new-onset shortness of breath and chest tightness
- c. A client requesting pain medication for a 4/10 headache
- d. A client whose IV needs to be restarted

B. Apply ABCs and "unstable before stable." New respiratory + cardiac symptoms are potentially life-threatening and outrank teaching, mild pain, or a routine IV restart.

How many of these did you get for the *right reason*?

Getting the answer isn't the goal — getting it by the method is. If your reasoning wobbled on even two of these, a focused session turns those wobbles into reflexes. Brian will run a live set with you and rebuild the thinking behind every miss.

[Reserve your session →](#)

06 When You Get "Cornered"

Everyone hits a question that freezes them. Panicking burns time and points. Run this rescue protocol instead — make it a reflex.



The "cornered" rescue protocol — physically writing the stem out re-engages your reasoning.

Then add the answer-side discipline from the BootCamp:

1. **Don't look at the answer choices first.** Seeing them too early biases you toward a wrong one. Read the *stem*, decide what you'd do, *then* look.
2. **Cover the options** while you read the stem twice.
3. **Run the decision tree** (Part 4): assess vs. implement → Maslow → ABCs → safest action.
4. **Commit.** You can't go back, and your first reasoned answer is usually right. Don't talk yourself out of it.

07 Pharmacology Survival

Pharm + Parenteral Therapies is 13–19% of the exam, and you can't reason your way to a drug you've never heard of. You don't need every drug — you need the **patterns**: suffixes, classes, and the handful of high-alert meds and antidotes that show up again and again.

Learn the suffixes, unlock the classes

Most drug names telegraph their class. Memorize the suffix and you can place a never-seen drug instantly.

Suffix	Class	Watch for
-pril	ACE inhibitors	Dry cough, hyperkalemia, angioedema
-sartan	ARBs	Hyperkalemia (no cough)
-olol	Beta-blockers	Bradycardia, hold if HR low; don't stop abruptly
-dipine	Calcium channel blockers	Hypotension, edema
-statin	Statins	Muscle pain (rhabdo), liver enzymes
-pam / -lam	Benzodiazepines	Sedation, respiratory depression
-cillin	Penicillins	Allergy/anaphylaxis
-mycin / -micin	Aminoglycosides	Oto- & nephrotoxicity; trough levels
-prazole	Proton pump inhibitors	Long-term: B12, Mg, fracture risk
-tidine	H2 blockers	Take before meals

High-alert antidotes (know these cold)

Drug / toxin	Antidote	Drug / toxin	Antidote
Heparin	Protamine sulfate	Warfarin	Vitamin K
Opioids	Naloxone	Benzodiazepines	Flumazenil
Acetaminophen	Acetylcysteine	Magnesium	Calcium gluconate
Digoxin	Digoxin immune Fab	Iron	Deferoxamine

THE RIGHTS – EVERY SINGLE MED PASS

Right **patient, drug, dose, route, time** — plus documentation, reason, and response. On the NCLEX, if a med order looks wrong, the safe answer is usually to *clarify/verify* before giving it, not to give it and watch.

08 Prioritization & Delegation

Management of Care is the single biggest slice of the exam (15–21%). Two skills dominate it: deciding **who to see first** and deciding **who can do what**. Master both and you move the needle more than any content review.

Who do I see first? Stack these filters

ABCs	Airway → Breathing → Circulation beats everything.
Acute > chronic	A new, sudden problem outranks a stable long-standing one.
Unstable > stable	Abnormal vitals / changing status first.
Unexpected > expected	A finding that <i>shouldn't</i> be happening for the diagnosis is the red flag.
Maslow	Physiological before psychosocial when all else is equal.

Who can do what — scope of practice

RN ONLY

Assess · Analyze · Plan · Teach · Evaluate · the *unstable or unpredictable* client · first dose / IV push / blood.

LPN / LVN

Stable clients with expected outcomes · reinforce teaching · most meds (per state) · routine procedures · ongoing data collection.

UAP

Stable, routine, predictable: ADLs, bathing, vitals, I&O, ambulation, feeding (no swallowing risk). **No** assessing, teaching, evaluating.

THE 5 RIGHTS OF DELEGATION

Right **task**, right **circumstance**, right **person**, right **direction/communication**, right **supervision**. If a task involves nursing judgment (assess/teach/evaluate) or an unstable patient — it stays with the RN.

Prioritization questions are where good students lose passable exams.

They're nuanced, they're everywhere, and they're hard to self-correct — you don't know *why* you keep picking second-best. That's the highest-value hour you can spend with a coach: Brian runs prioritization sets with you and rewires the instinct in real time.

[Work on this 1-on-1 →](#)

09 The Study Plan

Practice is the engine. The best predictor of passing is the **volume** and **quality** of practice questions you work — with rationales — before test day.

THE NUMBER

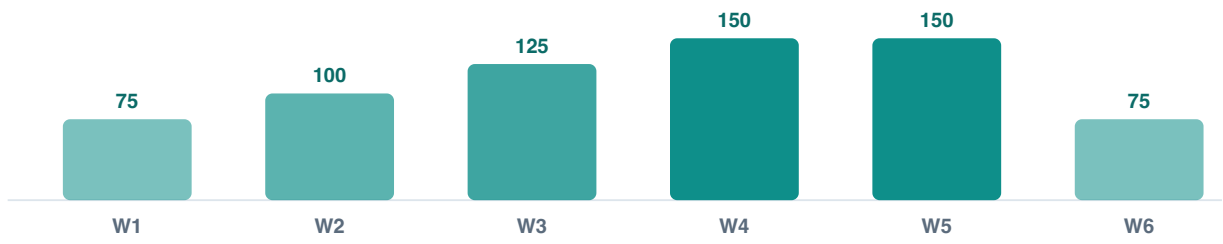
Plan to work **3,000–5,000 practice questions**. The point isn't the count — it's that by question 3,000 the *format* is second nature and the Part 4 frameworks fire automatically.

Quality beats quantity (do both)

- **Read every rationale** — for right answers too. You're learning the test's logic.
- **Keep an error log.** One line per miss: topic + *why* (knowledge gap? misread? wrong framework?). Patterns appear fast.
- **Turn every miss into a flash card.** That's how a wrong answer becomes a permanent gain.
- **Practice in the real format** — on a screen, timed, no notes.

A sample 6-week calendar

Week	Focus	Daily Qs	Also
1	Learn the format; baseline test	~75	Build flash-card deck; read this guide
2	High-yield: Mgmt of Care, Pharm	~100	Start error log; vocab daily
3	Your weakest 2 categories	~125	Rework missed questions
4	Mixed + NGN case studies	~150	Timed blocks
5	Simulate: full-length, timed, no notes	~150	Retire mastered cards
6	Taper + review error log	~75	Confidence + rest (Part 10)



Ramp up, peak with full-length simulation, then taper into test day. (Six weeks at this pace clears 3,000+ questions.)

10 Test Countdown

How you spend the final 48 hours can add or cost you points. The instinct to cram is wrong.

The day before — do NOT do questions

- **No practice questions.** A bad score the day before only rattles you; a good one means nothing new. Stop.
- **Light flash-card review in the morning only.** Take a marker and **X out every card you know by heart** — watch the "unknown" pile shrink to almost nothing. That visual is pure confidence fuel.
- **Then live your life.** Movie, massage, good meal, early bed. Let your brain consolidate.

TEST-DAY CHECKLIST

- Two acceptable IDs (names matching your ATT exactly).
- Authorization to Test (ATT) + test-center address; arrive ~30 min early.
- Protein breakfast; water for breaks.
- Layers — test centers run cold.
- Do your vision-board ritual before you walk in.

During the exam

- **Pace, don't race.** You have time; rushing causes misreads. But don't agonize — commit and move.
- **Take the breaks.** Tired brains misread stems.
- **Don't try to count questions or guess if you're "passing."** It's unknowable mid-exam and only distracts you.
- **Finish strong** (Part 1): if the test is still going, it isn't sure yet — every late question counts.

11 Special Situations

If you've taken the NCLEX before

A retake is information, not a verdict. Diagnose honestly before you re-study:

- **Was it content?** Use your Candidate Performance Report (CPR) to find the categories where you were "below" and rebuild those first.
- **Was it nerves?** If you knew the material but froze, your work is in Parts 2, 6, and 10 — anxiety control and the cornered protocol — more than content.
- **Was it pacing/format?** Then it's pure reps (Part 9) until the format is invisible.

THIS IS THE #1 REASON PEOPLE BOOK A SESSION

Most repeat test-takers can't diagnose their own failure — they study harder on the wrong thing and fail again. A single session to read your CPR *with* Brian and build a targeted plan is the highest-leverage move a retaker can make. (Part 12.)

Learning disabilities & accommodations

With documentation, you may qualify for testing accommodations through your nursing regulatory body / NCSBN — commonly **extended (e.g., double) time** and a **private testing room**. These must be requested and approved *before* you register, and require documentation — so start early.

1. Gather documentation of your diagnosis (from the provider/school that diagnosed you).
2. Request accommodations through your regulatory body / NCSBN *before* registering.
3. Allow extra lead time — approval isn't instant.

12 Work With Brian

This guide is the map. A session with me is having someone walk the trail next to you, spot the exact place you keep getting lost, and get you to the other side.

Who a 1-on-1 session is for

- You're **scoring in the 50s–60s** on practice and can't figure out why.
- You **know the content** but keep picking the second-best answer.
- You're a **repeat test-taker** and refuse to fail a third time.
- Your **test date is close** and you need a focused plan, fast.
- Anxiety is wrecking exams you should pass.

How a session works

BEFORE

You send your latest practice scores / CPR. Brian spots the pattern before you even meet.

DURING (LIVE, BY VIDEO)

You work real questions out loud while Brian watches your reasoning, stops you at the exact slip, and drills the fix with the frameworks in this guide.

AFTER

You leave with a written, personalized plan: what to drill, in what order, for the days you have left.

YOUR EDGE

A nurse practitioner in your corner who has done this many times — not a video you watch alone.

The math nobody mentions

I get it — a session feels like money you'd rather not spend. But here's what people miss: the expensive thing isn't the session. It's failing. There's the retake fee, sure, but the real hit is the **weeks (sometimes months) of an RN paycheck you're not earning** while you wait to sit it again.

1 coaching session

\$250

NCLEX retake fee

~\$200+

One month of delayed RN pay

~\$4,000–6,000+

A session is a rounding error against the cost of one more month not working as a nurse.

The asymmetry is the whole point: small, fixed investment vs. a large, recurring cost of delay.

Packages

FIRST SESSION · WHITE PAPER FREE

\$250 / 90 minutes, via Zoom

A comprehensive review plus a full assessment of your strengths and weak spots — then we build your plan. Your copy of this white paper is included free.

ADDITIONAL SESSIONS

\$150 / hour

Book as many follow-ups as you want — to drill the fixes and keep your momentum into test day.

You've read the method. Now get it installed.

Add a coaching session at checkout, then pick your time on Brian's calendar. Bring your hardest questions — we'll fix the thinking behind them together.

[Book your session at checkout →](#)

13 Quick-Reference Appendix

Lab values to know cold

Lab	Normal (approx.)	Lab	Normal (approx.)
Sodium (Na ⁺)	135–145 mEq/L	Potassium (K ⁺)	3.5–5.0 mEq/L
Calcium	9.0–10.5 mg/dL	Magnesium	1.5–2.5 mEq/L
Glucose (fasting)	70–100 mg/dL	BUN	10–20 mg/dL
Creatinine	0.6–1.2 mg/dL	Hemoglobin	12–18 g/dL
Hematocrit	36–52%	Platelets	150–400 k/ μ L
WBC	5,000–10,000/ μ L	INR (on warfarin)	2.0–3.0

Ranges vary slightly by source/lab — use your program's reference values.

Isolation precautions

Type	PPE	Examples (mnemonic)
Airborne	N95 + negative-pressure room	M-T-V : Measles, TB, Varicella
Droplet	Surgical mask	Influenza, pertussis, meningitis, mumps
Contact	Gown + gloves	MRSA, VRE, C. diff (soap & water!), RSV

Therapeutic communication — do & don't

DO

Reflect feelings · open-ended invites ("Tell me more") · silence · acknowledge · stay with the client's emotion.

AVOID

False reassurance ("You'll be fine") · "Why...?" · giving advice · changing the subject · closed yes/no questions.

The one-page mental checklist

1. Read the **stem** first — cover the answers.
2. Read it **twice**; don't read in anything extra.
3. **Assess** or **implement**? Cut the mismatches.
4. Mix of physical & psychosocial? **Maslow** — physical first.
5. "First/priority"? **ABCs**.
6. Still stuck? Pick the **safest, most fundamental** action.
7. **Commit** — don't look back.

Recommended tools

- **Visual learners:** Picmonic (picmonic.com) — mnemonic images that match the flash-card method here.
- **Flash cards:** NursingLabs flash cards + a solid NCLEX-RN cram sheet for daily review.
- **Question bank:** any reputable bank with thorough rationales — you need 3,000–5,000 questions, so pick one you'll use daily.
- **Official source of truth:** the NCSBN NCLEX-RN Test Plan + candidate bulletin at [ncsbn.org](https://www.ncsbn.org).

Critical ("call now") values

Lab	Panic value	Lab	Panic value
Potassium	< 2.5 or > 6.5 mEq/L	Sodium	< 120 or > 160 mEq/L
Glucose	< 50 or > 400 mg/dL	Calcium	< 6 or > 13 mg/dL
Platelets	< 50,000/ μ L	Hemoglobin	< 7 g/dL
INR (on warfarin)	> 5	pH	< 7.2 or > 7.6

High-alert drug watch

Drug / class	Watch for & key action
Opioids	Respiratory depression — hold if RR < 12; antidote naloxone
Anticoagulants	Bleeding — monitor labs; heparin→aPTT, warfarin→INR
Insulin	Hypoglycemia — know onset/peak; treat with fast carbs
Corticosteroids	↑ glucose, immunosuppression, don't stop abruptly (taper)
Chemotherapy	Neutropenia — infection precautions; monitor counts
Vancomycin / aminoglycosides	Oto/nephrotoxicity; trough levels; infuse vanc slowly

Erikson's psychosocial stages

Stage	Conflict	Stage	Conflict
Infant	Trust vs. Mistrust	School-age	Industry vs. Inferiority
Toddler	Autonomy vs. Shame	Adolescent	Identity vs. Role confusion
Preschool	Initiative vs. Guilt	Young adult	Intimacy vs. Isolation
Middle adult	Generativity vs. Stagnation	Older adult	Integrity vs. Despair

Rapid-fire: 20 facts to know cold

1. Hold **digoxin** if apical pulse < 60.
2. Hold a **beta-blocker** if HR < 60 or BP low; never stop abruptly.
3. Therapeutic **INR** on warfarin = 2–3; **lithium** level 0.6–1.2.
4. Heparin antidote = **protamine**; monitor aPTT. Warfarin antidote = **vitamin K**.
5. Check **trough** levels right before the next dose.
6. **Air embolism** → left side, head down (Trendelenburg).
7. ↑ **ICP** → HOB 30°, head midline; avoid prolonged suctioning.
8. **Compartment syndrome** → unrelenting pain + pain on passive stretch = emergency.
9. **Preeclampsia** → magnesium sulfate; toxicity antidote = calcium gluconate.
10. Give **IV fluids before insulin** in DKA; watch potassium closely.
11. **Addisonian crisis** → hypotension; give fluids + steroids. Cushing's → opposite.
12. **TPN** → monitor glucose; central line; never stop abruptly (rebound hypoglycemia).
13. Keep the **obturator** (and spare trach) at the bedside for a new tracheostomy.

14. Live vaccines are contraindicated in **pregnancy** and immunocompromise.
15. **Sickle cell crisis** → hydration, oxygen, pain control.
16. Newborn should void within **24 hours**; pass meconium within 48.
17. For **autonomic dysreflexia**, sit the client up and find the trigger (often a full bladder).
18. Clarify any med order that looks wrong **before** giving it.
19. On a tie, choose the answer that is **least invasive** and **safest**.
20. If the client is unstable, **act**; if stable, **assess** first.

Normal lab values to memorize

Lab	Normal range	Lab	Normal range
Sodium	135–145 mEq/L	Potassium	3.5–5.0 mEq/L
Calcium	9–10.5 mg/dL	Magnesium	1.5–2.5 mEq/L
Glucose (fasting)	70–110 mg/dL	BUN	10–20 mg/dL
Creatinine	0.6–1.2 mg/dL	Hemoglobin	12–18 g/dL
Hematocrit	37–52%	Platelets	150–400k/ μ L
WBC	5,000–10,000/ μ L	INR (no warfarin)	~1.0
pH	7.35–7.45	PaCO ₂	35–45 mmHg
HCO ₃	22–26 mEq/L	PaO ₂	80–100 mmHg
Digoxin	0.5–2.0 ng/mL	Lithium	0.6–1.2 mEq/L

Normal vital signs by age

Age	Heart rate (bpm)	Respirations
Newborn	100–160	30–60
Infant	90–150	25–40
Toddler / preschool	80–120	20–30
School-age	70–110	18–25
Adolescent / adult	60–100	12–20

14 High-Yield Must-Knows

This isn't a content course — but a handful of facts show up on almost every exam. Here's the hit list. If you can recite these cold, you've covered a surprising amount of the test.

Electrolytes — high vs. low at a glance

Electrolyte	Too HIGH	Too LOW
Potassium (K ⁺)	Peaked T waves, weakness, dysrhythmia (emergency)	Flat T / U wave, weakness, ↑ dig toxicity
Sodium (Na ⁺)	Thirst, dry mucosa, neuro changes	Confusion, headache, seizures
Calcium (Ca ²⁺)	"Bones, stones, groans, moans," weakness	Chvostek/Trousseau, tetany, tingling
Magnesium (Mg ²⁺)	↓ DTRs, respiratory depression, hypotension	↑ DTRs, tremor, torsades de pointes

Acid–base in one picture (ROME)

Respiratory = **O**pposite (pH and CO₂ move opposite ways). **M**etabolic = **E**qual (pH and HCO₃ move the same way).



Normal: pH 7.35–7.45 · CO₂ 35–45 · HCO₃ 22–26

Use ROME to classify any ABG in seconds, then check for compensation.

Positioning — condition → position

Situation	Position
Increased ICP	HOB 30°, head midline/neutral
Tube feeding / aspiration risk	HOB ≥ 30–45°
Air embolism	Left side, head down (Trendelenburg)
Autonomic dysreflexia	High Fowler's (sit up) + find the trigger
Post total hip replacement	Abduction pillow; don't cross legs / flex > 90°
Unconscious / post-seizure	Side-lying (recovery) to protect airway

Diets — condition → diet

Condition	Diet	Condition	Diet
Chronic kidney disease	Low K ⁺ , Na ⁺ , phosphorus; fluid limit	Heart failure / HTN	Low sodium
Celiac disease	Gluten-free	Gout	Low purine
Warfarin	Consistent vitamin K	Addison's	↑ sodium

Defense mechanisms

Mechanism	Quick definition
Denial	Refusing to accept reality
Projection	Attributing your feelings to someone else
Displacement	Shifting feelings onto a safer target
Regression	Reverting to earlier behavior under stress
Rationalization	Justifying with logical-sounding excuses
Sublimation	Channeling urges into acceptable outlets

OB & Peds quick facts

Newborn vitals HR 110–160 · RR 30–60 · temp ~36.5–37.5°C

APGAR Scored at 1 & 5 min: Appearance, Pulse, Grimace, Activity, Respiration (0–2 each)

Milestones Sit ~6 mo · crawl ~9 mo · first words/walk ~12 mo

Safety Rear-facing car seat to age 2; no honey under 1 yr; "back to sleep"

COMMON NCLEX TRAPS

- **"Worst sounding ≠ worst."** A silent chest beats loud wheezing; no bowel sounds beats hyperactive.
- **Assess before you act** — unless the patient is unstable/ABC-threatened, then act.
- **Never delegate** assessment, teaching, evaluation, or the unstable patient.
- **"Notify the provider" is rarely the first answer** — do the independent nursing action first, then escalate.
- **The NCLEX wants the safest answer**, not the most advanced one.

Memorizing these is step one. Applying them under pressure is the test.

That jump — from "I know it" to "I can do it on a timed adaptive exam" — is exactly what a session is for. Bring your weak topics; we'll turn knowing into doing.

[Book your session →](#)

15 NGN Case Studies, Worked

The Next Gen case studies scare people because they're new — an unfolding patient with six linked questions that track the clinical-judgment cycle from Part 1. Once you see two worked end to end, they stop being scary. Here are two, the way I'd walk them with you.

The NGN item types you'll meet

- | | |
|--------------------------|---|
| Matrix / grid | Mark each row (e.g., "expected / unexpected" or "indicated / contraindicated"). |
| Drop-down (cloze) | Fill a sentence from menus to complete clinical reasoning. |
| Highlight | Click the findings in a note that are concerning. |
| Bow-tie | Center = the condition; left = actions to take; right = parameters to monitor. |
| Drag-and-drop | Order or sort interventions. |

TWO NGN RULES THAT WIN POINTS

Most NGN items use **partial credit** — answer every part; a blank scores zero, a reasoned attempt can score. And many penalize **over-selecting**, so don't check everything "to be safe."

Case 1 — The deteriorating post-op client

Nurses' note (0800): Post-op day 1, abdominal surgery. T 38.9°C, HR 118, RR 24, BP 98/56, SpO₂ 93% on room air. Restless, says "I just don't feel right." Urine output 20 mL over 2 hours. Incision clean/dry/intact.

Recognize cues (highlight). Concerning: fever, tachycardia, tachypnea, falling BP, low SpO₂, low urine output, restlessness. Reassuring: the incision.

Analyze / prioritize hypothesis (drop-down). "The client is most likely experiencing **early sepsis** as evidenced by **fever + tachycardia + hypotension + low urine output.**" (Not hemorrhage — incision is intact, no overt bleeding.)

Take action (bow-tie). Left (do now): notify provider/rapid response, obtain cultures before antibiotics, give ordered IV fluids, apply O₂. Right (monitor): BP/MAP, urine output, lactate, mental status.

Evaluate outcomes. Improving = BP up, HR down, urine output ≥ 30 mL/hr, SpO₂ up, more alert. Worsening = rising lactate, falling MAP.

Case 2 — The client in a hyperglycemic crisis

ED note: Type 1 diabetic, 2 days of vomiting. Glucose 480 mg/dL, deep rapid breathing (Kussmaul), fruity breath, K⁺ 5.6, pH 7.21, HCO₃⁻ 14, drowsy, dry mucosa.

Recognize cues. Hyperglycemia, Kussmaul respirations, fruity breath, acidosis (low pH/HCO₃⁻), dehydration, altered mental status → **DKA**.

Analyze (matrix — indicated / not indicated). Indicated: IV isotonic fluids first, then insulin infusion, cardiac monitoring, hourly glucose & K⁺. Not indicated: oral fluids (drowsy), SubQ sliding-scale alone, withholding fluids.

Take action — order it (drag-and-drop). 1) IV fluids (NS), 2) start insulin drip, 3) monitor K⁺ closely (it will *fall* as insulin drives K⁺ into cells — replace before it bottoms out), 4) add dextrose when glucose ~200 to avoid hypoglycemia.

Evaluate. Improving = closing anion gap, normalizing pH, glucose trending down ~50–75/hr, clearing sensorium. Watch for **hypokalemia** and cerebral edema (don't drop glucose too fast).

Case 3 — The client with a suspected stroke

Triage note: 68-year-old, sudden right-sided weakness and slurred speech that started 45 minutes ago per spouse. BP 188/96, glucose 140, alert but anxious. Facial droop on the right. No trauma.

Recognize cues (highlight). Sudden unilateral weakness, slurred speech, facial droop, known last-known-well time → acute stroke until proven otherwise. The BP is high but not the first priority.

Analyze / prioritize (drop-down). "The priority is to **confirm time of onset and obtain a non-contrast CT** to determine eligibility for **thrombolytics**." Time is brain.

Take action (bow-tie). Left: keep NPO until swallow screen, protect airway, establish IV, stat CT, neuro checks. Right (monitor): LOC/NIH stroke scale, BP, glucose, time window.

Evaluate. Improving = stable/clearing deficits, airway protected, CT and time confirmed in time for treatment. Worsening = declining LOC, new deficits, aspiration. **Nothing by mouth** until swallowing is cleared.

Case studies reward thinking out loud — which is exactly how I coach.

In a session we take a live unfolding case and I have you narrate each step: what's the cue, what's your hypothesis, what do you do, how do you know it worked. That's the muscle the NGN scores — and it's hard to build alone.

[Drill NGN cases with me →](#)

16 System-by-System High-Yield

Not a textbook — a hit list. For each system: the conditions that show up most, the findings that should make you move, and the priority action. Skim it weekly; drill anything that feels fuzzy.

Cardiovascular

See most MI/ACS, heart failure, dysrhythmias, hypertension, DVT/PE.

Move when Chest pain, new dysrhythmia, BP/MAP dropping, sudden dyspnea (PE), unilateral leg swelling.

Priority MI: O₂, aspirin, position, 12-lead, pain control, monitor. HF: daily weights, low Na, watch for fluid overload.

Red flag New chest pain + diaphoresis; potassium extremes → lethal rhythms.

Respiratory

See most COPD, asthma, pneumonia, PE, chest tubes, ARDS.

Move when Silent chest, falling SpO₂, accessory muscle use, tracheal deviation (tension pneumo).

Priority Position upright, O₂ (titrate in COPD but never withhold for severe hypoxia), suction PRN, never clamp a chest tube routinely.

Red flag Silent chest in asthma = impending failure.

Neurological

See most Stroke, seizures, ↑ ICP, head injury, meningitis, spinal cord injury.

Move when Declining LOC, unequal/fixed pupils, Cushing's triad (↑BP, ↓HR, irregular resp), new focal deficit.

Priority Stroke: time is brain — note onset, get CT, swallow screen before anything PO. ↑ICP: HOB 30°, midline, calm, avoid spikes.

Red flag "Worst headache of my life," sudden one-sided weakness/slurring.

Endocrine

- See most** Diabetes (DKA/HHS/hypoglycemia), thyroid (hyper/hypo), adrenal (Addison/Cushing), SIADH/DI.
- Move when** Glucose extremes, Kussmaul breathing, thyroid storm (fever/tachy), adrenal crisis (hypotension).
- Priority** Hypoglycemia first if unsure (treat fast carbs); DKA: fluids → insulin → watch K⁺.
- Red flag** Altered mental status + abnormal glucose.

Gastrointestinal

- See most** GI bleed, bowel obstruction, pancreatitis, liver failure/cirrhosis, appendicitis.
- Move when** Hematemesis/melena, rigid abdomen, no bowel sounds, rising ammonia + confusion (hepatic encephalopathy).
- Priority** Bleed: large-bore IV, fluids/blood, monitor H&H. Liver: protect from bleeding; low-protein when encephalopathic.
- Red flag** Rigid, board-like abdomen = peritonitis.

Renal / Genitourinary

- See most** AKI/CKD, dialysis, UTI/pyelonephritis, retention, kidney stones.
- Move when** Urine output < 30 mL/hr, hyperkalemia, fluid overload, dialysis-access bruit absent.
- Priority** Protect the AV fistula (no BP/sticks in that arm; feel for thrill). Watch K⁺ and fluid balance.
- Red flag** Hyperkalemia in renal failure → cardiac arrest risk.

Hematology / Immune

- See most** Anemias, sickle cell, leukemia/neutropenia, thrombocytopenia, HIV, transfusion reactions.
- Move when** Fever in neutropenia (emergency), bleeding with low platelets, transfusion reaction signs (fever, chills, back pain).
- Priority** Transfusion reaction → **stop the blood**, keep the line open with saline, then assess/notify.
- Red flag** Neutropenic fever = treat now.

Musculoskeletal & Integumentary / Burns

- See most** Fractures, hip/knee replacement, compartment syndrome, pressure injuries, burns.
- Move when** Unrelenting pain + pain on passive stretch (compartment), neurovascular changes distal to injury, airway involvement in burns.
- Priority** Burns: airway first (singled nares, soot), then fluids (large volumes early). Post-hip: abduction, no leg crossing.
- Red flag** Facial/inhalation burns → airway can close fast.

That's a lot to hold in your head — and the exam tests it under a clock.

If one or two systems still feel shaky, that's the perfect thing to bring to a session. We'll pick your weakest system, run questions on it, and lock down the priorities so they're automatic on test day.

[Book a focused session →](#)

YOUR NEXT STEP

Don't gamble your license on guesswork.

You've got the method now. If you want it aimed straight at *your* weak spots, with me watching every question right alongside you, book a session.

\$250 · first 90-min session (white paper free) | \$150 · each additional hour

Book it at checkout, then choose your time on Brian's calendar.

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