Physiological Adaptation

National Council Licensure Examination for Practical Nurses (NCLEX-PN)

7 to 13% of the exam · 17 activity statements · 2026 NCLEX-PN Test Plan

Physiological Adaptation covers how the practical nurse cares for clients with acute and chronic physical conditions: wounds and drains, temperature, respiratory and cardiac needs, tracheostomy and ventilator care, ostomy care, fluid and electrolyte imbalance, dialysis and medical emergencies. NCLEX-PN items test whether you carry out this care correctly, recognize the signs that a condition is worsening, respond to an emergency in the right order and report changes outside your scope to the RN or provider.

You should be able to: After this guide you should be able to care for clients with acute and chronic physical conditions as a practical nurse, recognize the signs that a condition is worsening, respond to an emergency in the right order and report changes that belong to the RN or provider.

Every activity statement: the key point and the trap

1. Reinforce teaching about the client's care and condition

Reinforce the teaching the RN or provider began about the client's condition, its care and warning signs, in plain language.

Trap: Giving a client a new explanation of a diagnosis the provider has not yet discussed, which is outside the practical nurse's role.

2. Look after drainage devices such as wound drains and chest tubes

Keep a wound drain (such as a Jackson-Pratt or Hemovac) compressed to maintain gentle suction, and secure it so it does not pull on the insertion site.

Trap: Leaving a wound drain bulb expanded after emptying, which loses the suction that pulls fluid from the wound.

3. Help remove a client's wound drain

A wound drain is removed when drainage has dropped to the level the provider sets, with an order; the practical nurse assists.

Trap: Pulling against resistance when a drain does not slide out, instead of stopping and reporting it.

4. Use cooling or warming measures to bring body temperature back to normal

For a fever, follow the plan: antipyretics if prescribed, light covers, a comfortable room, fluids if allowed, and find and report the likely cause.

Trap: Rewarming or cooling a client too quickly, causing shivering or stressing a cold, irritable heart.

5. Care for wounds and change dressings

Match technique to the wound: clean technique for many chronic wounds at home, sterile technique for a fresh surgical wound per policy.

Trap: Pushing protruding tissue back in or leaving an evisceration uncovered instead of covering it with sterile saline gauze and calling for help.

6. Act fast in a life-threatening emergency, for example by starting CPR

In a life-threatening emergency, check responsiveness, call for help and activate the emergency response, and start care without delay.

Trap: Leaving the client to go find help or equipment first, instead of calling out, activating the code and starting compressions.

7. Act to improve breathing, for example with breathing treatments, suctioning or repositioning

Position the client to ease breathing: upright or high Fowler's, leaning forward on a table for severe shortness of breath.

Trap: Suctioning routinely on a schedule rather than only when secretions are present, which can lower oxygen and irritate the airway.

8. Look after a client who has a tracheostomy

Keep the airway patent: humidified oxygen as ordered, suction secretions when needed, and keep the stoma clean and dry.

Trap: Removing the old ties before the new ones are secure, which can let the tracheostomy tube come out.

9. Take out sutures or staples

Suture or staple removal needs an order and confirmation that the wound edges are well approximated and healing.

Trap: Removing all sutures or staples at once before checking that the wound edges hold, risking dehiscence.

10. Look after a client on a ventilator

A ventilator supports breathing; the practical nurse assists with care under the RN's direction, with set limits on scope.

Trap: Silencing a ventilator alarm to stop the noise without first checking the client and the cause.

11. Help care for clients who have a pacemaker or other pacing device

A pacing device helps the heart maintain an adequate rate; the client may have a permanent pacemaker or temporary pacing.

Trap: Dismissing a pulse below the pacemaker's set rate as not important, when it can mean the device is failing to pace.

12. Spot and report basic abnormal findings on a cardiac rhythm strip

The practical nurse recognizes and reports basic rhythm findings; interpretation and treatment belong to the RN and provider.

Trap: Reacting to an alarm from a loose lead without checking the client, or ignoring a flat line without confirming the pulse.

13. Look after a client with a colostomy, ileostomy, urostomy or other ostomy

An ostomy diverts stool or urine to a stoma; a healthy stoma is pink to red and moist, and reddish color is expected while a pale, dusky or black stoma is reported at once.

Trap: Mistaking a normal reddish, moist stoma for a problem, or missing a true dusky, black stoma that signals poor blood supply.

14. Recognize signs of illness, whether sudden or long term

Collect data on symptoms of acute and chronic illness and compare them with the client's baseline: pain, breathing, intake, output, weight, skin and mental status.

Trap: Waiting to see whether sudden stroke-like symptoms pass instead of reporting them immediately.

15. Notice and report changes in the client's condition

Compare the client with the earlier shift and the baseline; a change is often the first sign of a serious problem.

Trap: Charting each abnormal value without connecting the trend and reporting that the client is getting worse.

16. Look after clients whose fluid or electrolyte balance is off

Recognize dehydration (dry mucous membranes, poor skin turgor, low blood pressure, fast pulse, concentrated urine, falling weight) and fluid overload (edema, crackles, distended neck veins, rising weight, high blood pressure).

Trap: Treating weakness and an irregular pulse in a client on diuretics as fatigue instead of a possible potassium imbalance to report.

17. Look after a client having hemodialysis or peritoneal dialysis

Hemodialysis filters the blood through a machine using vascular access (a fistula, graft or catheter); protect the access and the client.

Trap: Taking a blood pressure or drawing blood from the arm with a dialysis fistula, which can damage the access.

Key terms

Jackson-Pratt drain: A bulb wound drain kept compressed to provide gentle suction that pulls fluid from a wound.

Chest tube: A tube that drains air or fluid from the pleural space so the lung can re-expand.

Dehiscence: Separation of the edges of a surgical wound.

Evisceration: Protrusion of internal organs through an open wound, a surgical emergency.

Stoma: The opening of an ostomy on the abdomen; a healthy stoma is pink to red and moist.

Peritonitis: Infection of the abdominal lining; in peritoneal dialysis it shows as cloudy drainage, fever and abdominal pain.

Fistula (dialysis): A surgically joined artery and vein used for hemodialysis access; protect the arm and check the thrill and bruit.

Thrill and bruit: The buzz felt and the sound heard over a working dialysis access; their loss is reported.

Tracheostomy: A surgical opening into the trachea with a tube, kept clean and patent.

Ventilator-associated pneumonia: A lung infection linked to a ventilator, reduced by raising the head of the bed and frequent oral care.

SBAR: Situation, background, assessment and recommendation: a structured way to report a change to the RN or provider.

Asystole: No electrical activity in the heart, seen as a flat line; confirm the pulse and begin emergency response.

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