Reduction of Risk Potential

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

9 to 15% of the exam · 22 activity statements · 2026 NCLEX-PN Test Plan

Reduction of Risk Potential covers how the practical nurse lowers the chance that a client's condition, a diagnostic test or a procedure leads to harm: collecting specimens and vital signs, monitoring laboratory and diagnostic results, caring for tubes, catheters and IV lines, helping before and after procedures and surgery, and watching for early complications. NCLEX-PN items test whether you take measurements and specimens correctly, recognize a result or a change that matters and report what is outside your scope to the RN or provider.

You should be able to: After this guide you should be able to reduce a client's risk from conditions, tests and procedures as a practical nurse: take measurements and specimens correctly, care for tubes and lines within your scope, recognize an early complication and report what belongs to the RN or provider.

Every activity statement: the key point and the trap

1. Spot client risks and act to reduce them

Collect data that identifies risk: fall history, confusion, weakness, sensory loss, new or multiple medications, invasive lines, and the client's own report.

Trap: Waiting until after a fall to act on risks that were already visible on admission.

2. Look for urine retention using a bladder scan, ultrasound or palpation

Suspect urinary retention when a client has not voided in several hours, voids small frequent amounts, or has lower abdominal fullness and discomfort, especially after surgery or anesthesia.

Trap: Recording a client as continent because small amounts are passing, when frequent small voids with a full bladder signal overflow from retention.

3. Collect blood, urine, stool or sputum samples for testing

Confirm the correct container, label at the bedside with two identifiers, and follow any timing, such as a first-morning or a 24-hour collection.

Trap: Starting the antibiotic before the ordered cultures are collected, which lowers the chance of identifying the organism.

4. Monitor nasogastric suction, whether continuous or intermittent

A nasogastric tube to suction removes stomach contents to decompress the stomach or rest the bowel; keep the ordered setting (continuous or intermittent, low or high).

Trap: Raising the suction to high because drainage stopped, instead of first checking placement, kinks and patency.

5. Monitor results of diagnostic and lab tests

Compare each result with its reference range and with the client's own trend; a value drifting toward danger matters even inside the range.

Trap: Filing a critical potassium result to mention on rounds later instead of reporting it right away.

6. Recognize signs of possible complications in pregnancy

Report signs of a prenatal complication promptly: vaginal bleeding, a severe or persistent headache, blurred vision, epigastric pain, marked swelling of the face and hands, and reduced fetal movement.

Trap: Treating a late-pregnancy headache and swelling as normal discomfort instead of reporting possible preeclampsia.

7. Do bedside tests such as pregnancy tests, troponin and urine dipsticks

Point-of-care tests give a result at the bedside: capillary blood glucose, urine dipstick, urine pregnancy test, rapid strep, and troponin or others where policy allows.

Trap: Recording a point-of-care glucose without acting on a hypoglycemic value while the client is symptomatic.

8. Check and interpret vital signs such as oxygen saturation and blood pressure

Measure vital signs accurately: the right cuff size, an apical pulse for a full minute when it is irregular or for cardiac drugs, and respirations counted without the client's awareness.

Trap: Reporting or acting on a low oxygen saturation from a cold finger or a poor waveform without first checking the probe.

9. Take steps to prevent harm or complications linked to a procedure or condition

Match the precaution to the procedure or diagnosis: aspiration precautions for a swallowing problem, bleeding precautions for a low platelet count or anticoagulation, seizure precautions for a client at risk.

Trap: Letting a client eat or drink right after an endoscopy before the gag reflex has returned, which risks aspiration.

10. Do an ECG

An ECG records the heart's electrical activity; the practical nurse performs the recording where policy allows and ensures a clear tracing.

Trap: Delaying the ECG or the report while a client has active chest pain, instead of obtaining it and reporting the symptom immediately.

11. Help with diagnostic or invasive procedures

Confirm informed consent, the correct client, site and procedure, allergies and any needed NPO status before assisting.

Trap: Leaving the bedside during an invasive procedure instead of staying to monitor the client's breathing and comfort.

12. Draw blood by venipuncture

Confirm the test, the client with two identifiers, and any special requirements such as fasting before drawing blood.

Trap: Drawing blood from the arm with the dialysis access or from above a running IV, which can harm the access or give a diluted result.

13. Apply compression stockings or SCDs and check they are used correctly

Graduated compression stockings and sequential compression devices help prevent deep vein thrombosis in clients with limited mobility.

Trap: Rolling a stocking down to the ankle, which creates a tight band that can cut off circulation, or applying a device to a leg with a suspected clot.

14. Help care for clients before and after surgery

Before surgery, confirm consent, allergies, NPO status, the site mark, removal of jewelry, dentures and nail polish, and that the ordered preparation is done.

Trap: Letting a postoperative client stay still and skip deep breathing, which raises the risk of pneumonia and clots.

15. Insert, look after and remove urinary catheters

Insert a urinary catheter with sterile technique: correct size, cleaning the meatus, inflating the balloon only after urine returns, and securing the catheter.

Trap: Hanging the drainage bag at or above bladder level, which lets urine flow back and raises infection risk.

16. Insert, look after and remove nasogastric tubes

Measure the tube from the nose to the earlobe to the xiphoid process to estimate the length, and lubricate the tip with a water-soluble gel.

Trap: Continuing to advance a nasogastric tube while the client coughs and desaturates, instead of withdrawing it at once.

17. Check blood glucose

Check blood glucose at the times ordered: before meals and at bedtime, before insulin, or when hypoglycemia or hyperglycemia is suspected.

Trap: Giving the scheduled mealtime insulin when the pre-meal glucose is already low, instead of treating the hypoglycemia first.

18. Look after central venous catheters

A central venous catheter ends in a large central vein; maintenance follows strict policy because infection and air embolism are serious risks.

Trap: Leaving a central line open to air during a cap or tubing change, which can let air enter the central circulation.

19. Look after and remove peripheral IV lines

Check a peripheral IV site each shift and before use for infiltration (cool, swollen, pale), phlebitis (red, warm, tender along the vein) and patency.

Trap: Flushing harder to push past resistance in an IV site that is actually infiltrated, which forces fluid into the tissue.

20. Do focused data collection suited to the client's condition, such as neuro or circulation checks

Focused data collection targets the client's current problem: a neurological check for a head injury or stroke, a circulation check for a cast or vascular concern.

Trap: Checking only the casted side without comparing it to the other limb, missing a developing circulation problem.

21. Monitor how the client reacts to treatments and procedures

Monitor how the client responds during and after a treatment or procedure: vital signs, comfort, breathing, bleeding and level of consciousness.

Trap: Assuming a treatment worked and moving on without rechecking the client's actual response.

22. Reinforce teaching on procedures, treatments and equipment

Reinforce teaching the RN or provider began about a procedure, treatment or piece of equipment, in plain language the client understands.

Trap: Telling a client how to use new equipment without a return demonstration, so a mistake goes unnoticed until home.

Key terms

Urinary retention: The bladder does not empty; signs include a full, firm lower abdomen and small frequent voids.

Bladder scan: A noninvasive ultrasound that measures the volume of urine left in the bladder.

Critical value: A laboratory or point-of-care result dangerous enough to require prompt reporting.

Preeclampsia: A pregnancy disorder with high blood pressure, protein in the urine and symptoms such as headache and swelling.

Infiltration: IV fluid leaking into tissue; the site is cool, swollen and pale.

Phlebitis: Inflammation of a vein, often from an IV; the site is red, warm and tender along the vein.

Air embolism: Air entering the venous system, a risk with central lines; treated by clamping, left side head-down position and oxygen.

Neurovascular check: A circulation and nerve check of a limb: color, temperature, capillary refill, pulses, movement and sensation.

Glasgow Coma Scale: A scale that scores eye opening, verbal response and motor response to measure level of consciousness.

Sequential compression device: Inflatable leg sleeves that squeeze and release to help prevent deep vein thrombosis.

Clean-catch midstream urine: A urine sample collected after cleaning and starting the stream, to reduce contamination.

Hemolysis: Breakdown of red cells in a blood sample, which can give false results and require a redraw.

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