Basic Care and Comfort

National Council Licensure Examination for Registered Nurses (NCLEX-RN)

6 to 12% of the exam · 16 activity statements · 2026 NCLEX-RN Test Plan

Basic Care and Comfort covers the everyday physical care that keeps a client comfortable, nourished, mobile and safe: hygiene and ADLs, nutrition and tube feeding, elimination, skin, mobility devices, sleep, pain and comfort measures. NCLEX items test the correct, safe way to perform this care, what to assess before and after, and when a finding means the care must stop or be escalated.

You should be able to: After this guide you should be able to carry out and evaluate basic physical care safely, from feeding tubes and irrigations to skin, mobility, elimination, sleep and pain, and recognize when a finding means you must stop and escalate.

Every activity statement: the key point and the trap

1. Assess how the client manages daily self care and help as needed

ADLs are bathing, dressing, toileting, transferring, continence and feeding; instrumental ADLs include shopping, cooking, managing money and medications.

Trap: Completing the whole task for the client to save time, which undermines independence and rehabilitation.

2. Feed the client through a feeding tube

Confirm initial placement of a blind-inserted feeding tube by X-ray before the first feeding or medication.

Trap: Relying on hearing air in the stomach to confirm tube placement, or giving a feeding to a client lying flat.

3. Give care to the body after death

Confirm that death has been pronounced per agency policy and law, and check for organ or tissue donation requirements and whether the case goes to the medical examiner or coroner.

Trap: Removing all tubes and lines from a client whose death must be reviewed by the medical examiner or coroner.

4. Carry out irrigations, for example of the eye, ear or bladder

Eye irrigation: tilt the head toward the affected side and flow the solution from the inner canthus to the outer canthus so it drains away from the other eye and the tear duct; for a chemical splash, irrigate **immediately** with large volumes.

Trap: Counting the whole drainage bag as urine output instead of subtracting the irrigant infused.

5. Help the client offset a physical or sensory deficit, for example with aids

Cane: hold it on the stronger side and advance it with the weaker leg.

Trap: Teaching the client to hold the cane on the weak side, which reduces stability.

6. Assess the skin and act to keep skin and tissue intact

Assess skin on admission and regularly with a risk scale such as the Braden Scale; a lower Braden score means higher risk.

Trap: Massaging a reddened bony prominence, which damages tissue, or calling a healing Stage 3 injury a Stage 2.

7. Assess and manage problems with bowel or bladder function

Assess bowel and bladder patterns, intake, mobility and medications that affect elimination (opioids, anticholinergics, diuretics).

Trap: Asking a client with suspected retention to drink more fluid, instead of assessing bladder volume first.

8. Put on, look after or take off orthopaedic devices

Check neurovascular status distal to a cast, splint or traction: color, warmth, capillary refill, pulses, sensation, movement and pain.

Trap: Giving more pain medication and elevating the limb higher when the findings point to compartment syndrome.

9. Protect the client's dignity and privacy during care

Knock, introduce yourself and explain care before you begin.

Trap: Starting care with the curtain open, or discussing the client's condition at the nurses' station where others can hear.

10. Use comfort measures that do not involve medication

Nonpharmacological measures include positioning, heat or cold, massage, relaxation and breathing, guided imagery, music and distraction; they add to analgesics but do not replace them for moderate or severe pain.

Trap: Applying a heating pad without a barrier or time limit for a client with reduced sensation.

11. Assess how well nourished the client is and act as needed

Weight change over time is one of the most useful signs of nutritional status; weigh at the same time on the same scale.

Trap: Giving thin water to a client who coughs while swallowing because it seems harmless.

12. Assess how the client sleeps and rests and act as needed

Ask about usual sleep times, quality, daytime sleepiness, snoring and pauses in breathing, and medications or substances that affect sleep.

Trap: Requesting a sleeping pill for an older adult before trying to fix the environment and routine.

13. Assess fluid intake and output and act as needed

Intake includes oral fluids, tube feeding, IV fluids and flushes; output includes urine, vomit, liquid stool, drainage and suction.

Trap: Relying on intake and output totals alone when daily weight is the more reliable measure of fluid balance.

14. Promote blood flow through movement, range of motion and positioning

Active range of motion is done by the client; passive range of motion is done by the caregiver for a client who cannot move a joint, moving each joint gently only to the point of resistance or pain.

Trap: Continuing range of motion or massage on a leg with signs of a deep vein thrombosis.

15. Assess the client's pain and act on it

Pain is what the client says it is; the client's self-report is the most reliable measure.

Trap: Doubting the client's report of pain because the client is laughing with visitors or vital signs are normal.

16. Know complementary therapies, their possible benefits and when to avoid them

Ask every client about herbs, supplements, oils and other therapies, because clients often do not mention them unless asked.

Trap: Assuming a natural product is harmless and not reporting it when the client takes an interacting medication.

Key terms

Activities of daily living (ADLs): Basic self-care tasks: bathing, dressing, toileting, transferring, continence and feeding.

Braden Scale: A pressure injury risk scale; lower scores mean higher risk.

Deep tissue pressure injury: Persistent, nonblanchable deep red, maroon or purple discoloration from pressure damage to underlying tissue.

Unstageable pressure injury: Full-thickness tissue loss whose depth is hidden by slough or eschar.

Shear: Force from skin and underlying tissue sliding in opposite directions, such as when a client slides down in bed.

Compartment syndrome: Rising pressure in a muscle compartment that cuts off blood flow and threatens the limb.

Neurovascular check: Assessment of color, warmth, pulses, capillary refill, sensation, movement and pain distal to an injury or device.

Continuous bladder irrigation: Constant flow of sterile solution through a three-way catheter to prevent clots after urologic surgery.

Dysphagia: Difficulty swallowing, which raises the risk of aspiration.

Refeeding syndrome: Dangerous shifts in phosphate, potassium and magnesium when nutrition restarts after starvation.

Orthostatic hypotension: A drop in blood pressure on standing that causes dizziness and falls.

FLACC: A behavioral pain scale (face, legs, activity, cry, consolability) for children or clients who cannot self-report.

PAINAD: A behavioral pain scale for clients with advanced dementia.

Postmortem care: Care of the body after death, with respect for the family and legal requirements.

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