Reduction of Risk Potential

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

9 to 15% of the exam · 19 activity statements · 2026 NCLEX-RN Test Plan

Reduction of Risk Potential covers how the nurse lowers the chance that a client develops a complication from a condition, a test, a procedure or a treatment. NCLEX items test whether you notice a trend in vital signs, assessment findings or results, monitor correctly around procedures and sedation, collect specimens and manage tubes, lines and devices safely, and act **first** on the finding that threatens the client most.

You should be able to: After this guide you should be able to recognize dangerous trends in vital signs, assessments and results with their reference ranges, care for a client before, during and after procedures and moderate sedation, collect specimens correctly, and manage tubes, catheters, IV lines and compression devices so that complications are prevented or caught early.

Every activity statement: the key point and the trap

1. Assess and act on changes and patterns in vital signs

Typical adult ranges: heart rate 60 to 100/min, respiratory rate 12 to 20/min, SpO2 95 to 100% (lower targets for some clients with chronic lung disease, as prescribed), blood pressure below 120/80 mm Hg, temperature about 97.8 to 99.1 F (36.5 to 37.3 C).

Trap: Waiting for hypotension before acting, when tachycardia is the earlier sign of blood loss.

2. Carry out focused assessments

A focused assessment looks closely at the body system linked to the client's problem or complaint, after a quick check of airway, breathing and circulation.

Trap: Palpating the abdomen before auscultating, or treating increasing pain under a cast with more analgesic without a neurovascular check.

3. Spot patterns and changes in the client's condition and act on them

Restlessness, anxiety and new confusion can be the **first** signs of hypoxia or shock; assess oxygenation before giving a sedative.

Trap: Assuming new confusion in an older client is dementia or sundowning and giving a sedative before checking oxygenation.

4. Follow diagnostic test results and act on them

Typical adult reference ranges (vary by laboratory): sodium 135 to 145 mEq/L, potassium 3.5 to 5.0 mEq/L, fasting glucose 70 to 99 mg/dL, BUN 10 to 20 mg/dL, creatinine 0.6 to 1.2 mg/dL.

Trap: Reporting only values outside the range while missing a large drop that is still inside it, or a value that trends toward danger.

5. Do tests within your scope, such as an ECG or bedside testing

For a 12-lead ECG, place V1 in the fourth intercostal space right of the sternum, V2 at the same level left of the sternum, and V4 at the fifth intercostal space in the midclavicular line; ask the client to lie still.

Trap: Mistaking late decelerations for early ones, or increasing oxytocin when the fetal pattern is not reassuring.

6. Assess how the client responds to treatments and procedures

Know the expected result of each procedure and its most likely complication, and assess for both afterward.

Trap: Clamping a chest tube to transport the client or for an air leak, instead of following the prescription and checking the system.

7. Teach the client before and after surgery

Teach before surgery what the client will do after it: deep breathing, coughing with a pillow splinting the incision, turning and leg exercises.

Trap: Teaching the client to blow into the incentive spirometer, or teaching breathing exercises only after surgery when pain makes learning harder.

8. Give care before surgery

Informed consent: the provider doing the procedure explains it, its risks, benefits and alternatives; the nurse witnesses the signature and checks that the client understands and agrees.

Trap: Having the nurse explain surgical risks to obtain consent, or giving a sedative before the consent is signed.

9. Manage the client during a procedure under moderate sedation

Under moderate sedation the client breathes without help and responds purposefully to voice or light touch; it can deepen unexpectedly.

Trap: Assigning the monitoring nurse a second task during the procedure, or waiting for a low SpO2 instead of acting on decreased responsiveness.

10. Draw blood samples from the client

Identify the client with two identifiers before the draw, and label the tubes at the bedside in the client's presence, never ahead of time.

Trap: Starting the antibiotic before drawing blood cultures, or drawing blood above a running IV infusion.

11. Take precautions against injury or complications from a procedure or diagnosis

Fall precautions: bed low and locked, call light in reach, nonslip footwear, scheduled toileting and a bed alarm when needed.

Trap: Putting a padded tongue blade or anything else into the mouth during a seizure, or letting a client after posterior hip surgery sit in a low chair.

12. Teach the client about treatments and procedures

Explain what will happen, why, how long it will take, what the client will feel, and what to do before and after.

Trap: Sending a client to MRI without screening for implanted devices or metal.

13. Collect non-blood samples for diagnostic tests

Clean-catch midstream urine: clean the area front to back, begin voiding into the toilet, then collect the middle of the stream in the sterile cup.

Trap: Taking a urine specimen from the drainage bag, or continuing a 24-hour collection after urine was discarded.

14. Insert, care for or remove a nasogastric or orogastric tube

Measure the tube from the tip of the nose to the earlobe to the xiphoid process, mark it, place the client in high Fowler's position, and have the client tilt the chin down and swallow as it advances.

Trap: Relying on the sound of an air bolus to confirm tube placement instead of an x-ray and pH checks.

15. Insert, care for or remove a urinary catheter

Insert a urinary catheter only when there is a clear indication, use sterile technique, and remove it as soon as it is no longer needed (nurse-driven removal protocols help).

Trap: Placing the drainage bag on the bed or the floor, or leaving a catheter in for convenience.

16. Insert, care for or remove a peripheral IV

Choose a vein in the forearm, starting distally on the nondominant arm; avoid areas of flexion, veins in the legs in adults, and arms with a fistula or on the side of lymph node removal.

Trap: Starting an IV in an arm with an arteriovenous fistula or on the side of a mastectomy with lymph node removal.

17. Apply or maintain devices that help venous return, such as compression stockings

Measure the legs to choose the correct size of antiembolism stockings, and apply them while the legs are least swollen, ideally before the client gets up.

Trap: Applying compression to a leg with signs of deep vein thrombosis, or letting stockings roll down into a tight band.

18. Manage the client after a procedure under moderate sedation

Monitor vital signs, SpO2 and level of consciousness at the intervals policy sets until the client returns to baseline, often using a recovery score.

Trap: Giving fluids before the gag reflex returns, or letting a sedated client leave alone or drive home.

19. Look after a percutaneous feeding tube

Check the external length mark at the skin before each use and each shift; a change suggests the tube has moved.

Trap: Reinserting a dislodged new gastrostomy tube at the bedside, or feeding a client lying flat.

Key terms

Trend: The direction of change across several readings, compared with the client's baseline.

Pulse pressure: Systolic minus diastolic pressure; narrows in early shock and widens with rising intracranial pressure.

Cushing triad: Rising systolic pressure with widened pulse pressure, bradycardia and irregular respirations, signs of increased intracranial pressure.

Critical value: A result far enough outside the reference range to need prompt reporting to the provider.

Late deceleration: A fetal heart rate drop that starts after the peak of a contraction, linked to reduced placental blood flow.

Informed consent: Agreement to a procedure after the provider explains its risks, benefits and alternatives; the nurse witnesses the signature.

Moderate sedation: Drug-induced depressed consciousness in which the client breathes unaided and responds purposefully to voice or touch.

Time out: A pause by the whole team right before a procedure to confirm the client, procedure and site.

Incentive spirometer: A device that encourages slow, deep inhalation to keep the alveoli open after surgery.

Clean-catch specimen: A midstream urine sample collected after cleaning, to reduce contamination.

CAUTI: Catheter-associated urinary tract infection, prevented mainly by avoiding and promptly removing indwelling catheters.

Tidaling: The expected rise and fall of water in a chest tube's water seal chamber with breathing.

Compartment syndrome: Rising pressure inside a muscle compartment that cuts off blood flow, with pain out of proportion and pain on passive stretch.

Sequential compression device: Leg sleeves that inflate in turn to push venous blood upward and prevent clots.

Gastrostomy tube: A feeding tube placed through the abdominal wall into the stomach, often endoscopically.

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