NGN NCLEX-RN Cheat Sheet

The 6 NCJMM Cognitive Skills — with NCLEX examples for each step

1 RECOGNIZE CUES

Identify which patient data is clinically significant. Filter relevant from irrelevant.

Ask yourself:
- What info is provided? (vitals, labs, history, nurse notes)
- What is abnormal vs. within expected range?
- Which findings are time-sensitive or potentially life-threatening?

NCLEX Example:
ICU patient: BP 78/46, HR 128, SpO■ 93%, confused, no urine x 4h → ALL are significant cues

Format: Extended SATA or Hot Spot (Highlighting)

2 ANALYZE CUES

Connect the cues. What clinical picture do they form together?

Ask yourself:
- What body system(s) are affected?
- What is the underlying pathophysiology?
- What do the cues suggest is happening to this patient?

NCLEX Example:
BP 78/46 + HR 128 + altered LOC + oliguria + fever → septic shock / distributive shock pattern

Format: Cloze / Drop-Down

3 PRIORITIZE HYPOTHESES

Rank your clinical hypotheses. What is most likely? What is most dangerous if missed?

Ask yourself:
- What is the most likely explanation for the cue cluster?
- What is the most life-threatening possibility even if less likely?
- Rank: Confirmed > Suspected > Possible

NCLEX Example:
Most likely: Septic shock. Most dangerous if missed: cardiac tamponade. Rank septic shock #1.

Format: Drag & Drop (rank order) or Bow-Tie (left side)

4 GENERATE SOLUTIONS

Identify all possible nursing actions. What could be done for this patient?

Ask yourself:
- What are the independent nursing interventions?
- What requires a physician order (collaborative)?
- What are contraindicated actions for this condition?

NCLEX Example:
Septic shock options: IV fluids, oxygen, blood cultures, antibiotics (ordered), monitor MAP, foley catheter

Format: Matrix/Grid or Extended SATA

5 TAKE ACTIONS

Choose the single best / priority action. Apply NCLEX decision frameworks.

Ask yourself:
- ABCs first: Airway → Breathing → Circulation
- Assess BEFORE intervening (unless life-threatening)
- Least invasive first; independent before collaborative
- Safety first, then physiological, then psychosocial (Maslow)

NCLEX Example:
MAP 52, hypotensive: First action = notify provider + prepare IV fluid bolus. NOT morphine. NOT ambulate.

Format: Bow-Tie (Actions + Condition + Monitor)

6 EVALUATE OUTCOMES

Reassess. Did the intervention work? What does improvement look like?

Ask yourself:
- What are the expected outcomes if the intervention was effective?
- What findings indicate the patient is NOT improving?
- What requires a change in the care plan?

NCLEX Example:
After fluid bolus for septic shock: MAP >65, HR decreasing, urine >0.5 mL/kg/hr = improving. If not → reassess.

Format: Matrix/Grid (Effective / Ineffective / Unrelated)

NCLEX PRIORITY FRAMEWORK	ABCs (Airway > Breathing > Circulation) → Safety → Maslow (Physical > Psychosocial) → Assess before intervene → Least invasive first → Independent before collaborative

Practice all 6 steps with unlimited AI case studies at nurseiq.app

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