SAVANT NURSING ACADEMY

NCLEX-PN PRIORITY CHEAT SHEET

Who Do You See First? What Do You Do First?

THE CORE RULE

The goal is not to find the sickest patient. Identify the patient at greatest risk of immediate harm.

THE S.A.V.A.N.T.™ PRIORITY METHOD

S - SPOT THE PRIORITY - Identify what the question asks: **first, priority, immediate, most important, requires follow-up, needs intervention, see first.**

A - ASSESS THE CLUES - Look for what is **new, unexpected, unstable, worsening, or changed from baseline.**

V - VERIFY SAFETY - Ask who could suffer serious harm if care is delayed. Think **Airway** → **Breathing** → **Circulation** → **Neurological status** → **Safety.**

A - APPLY NURSING SCOPE - **RN:** unstable/new/complex/initial/teaching. **LPN/LVN:** generally stable, predictable, routine care and reinforcement within scope. **UAP:** routine, predictable tasks that do not require nursing judgment.

N - NARROW THE OPTIONS - Remove delayed, unsafe, out-of-scope, or routine answers that ignore an immediate threat.

T - TAKE ACTION - Choose the safest, highest-priority action supported by the cues. Do not change an answer without a specific clinical reason.

THE SAVANT PRIORITY LADDER™

1. AIRWAY - IMMEDIATE	Stridor; severe facial/tongue swelling; inability to maintain airway; obstruction; sudden inability to speak normally.
2. BREATHING	Severe respiratory distress; cyanosis; falling oxygenation; new severe wheezing; absent/decreased breath sounds with acute symptoms; respiratory depression.
3. CIRCULATION / PERFUSION	Uncontrolled bleeding; shock; symptomatic severe hypotension; unstable dysrhythmia; acute concerning chest pain; poor perfusion.
4. ACUTE NEUROLOGICAL CHANGE	New confusion; sudden weakness/facial droop; difficulty speaking; new seizure; sudden decreased level of consciousness.
5. IMMEDIATE SAFETY THREAT	Active suicidal intent; violent behavior creating danger; severe hypoglycemia; dangerous medication reaction; serious treatment complication.
6. URGENT BUT STABLE	Significant pain without instability; fever without deterioration; noncritical abnormal labs; stable postoperative concerns.
7. ROUTINE / EXPECTED	Scheduled medications; routine dressing changes; discharge questions; expected discomfort; stable chronic findings; hygiene/ADLs.

ABCs - BUT DON'T USE THEM BLINDLY

A - Airway: Can air move? **B - Breathing:** Is the patient ventilating and oxygenating? **C - Circulation:** Is blood circulating effectively?

NCLEX TIP

Compare the **actual findings**. A stable chronic respiratory patient may be lower priority than a postoperative patient who suddenly becomes confused and hypotensive.

UNSTABLE BEATS STABLE

Usually prioritize: Acute over chronic • Unexpected over expected • New over longstanding • Deteriorating over improving • Unstable over stable • Actual threat over potential threat

Example: Chronic COPD findings at established baseline vs. sudden postoperative shortness of breath and tachycardia → **see the postoperative patient first.** Sudden change + respiratory symptoms may signal an acute complication.

EXPECTED VS. UNEXPECTED

Ask: **“Is this expected for this patient's condition?”** Unexpected findings can indicate a complication, deterioration, medication reaction, or treatment failure.

High-alert words: Suddenly • New • Increasing • Decreasing • Restless • Confused • Unresponsive • Diaphoretic • Pale

ACUTE VS. CHRONIC

A chronic diagnosis does not automatically make a patient low priority. **A new change in a chronic condition can become the priority.** Example: chronic heart failure with mild baseline edema vs. new severe dyspnea and falling oxygenation.

MASLOW - AFTER PHYSIOLOGICAL THREATS

1. Physiological **2.** Safety **3.** Love/belonging **4.** Esteem **5.** Self-actualization

Oxygen > Education **Perfusion > Emotional comfort** **Severe hypoglycemia > Discharge planning**

SAVANT NURSING ACADEMY

PRIORITY DECISION RULES

ASSESS FIRST OR ACT FIRST?

Usually **assess before intervening**. Act immediately when the emergency is already clearly identified and delaying for unnecessary additional data could cause harm.

ASK YOURSELF

Do I already have enough information to know what is happening?
NO → Assess. YES + immediate danger → Act.

DO I CALL THE PROVIDER FIRST?

Usually not when an appropriate nursing action can safely be performed immediately. Think: **Recognize** → **Stabilize** → **Notify/Escalate.** Do not delay emergency response merely to call the provider.

PRIORITY LAB RED FLAGS

Potassium: rhythm risk • **Glucose:** neurological/safety risk • **Hgb/Hct:** bleeding/oxygen-carrying capacity • **Platelets:** bleeding risk • **Coagulation tests:** anticoagulation/bleeding • **Creatinine:** renal/medication concerns • **Sodium:** neurological complications • **Troponin:** myocardial injury

Remember: Interpret labs with symptoms, trends, and clinical context. The number alone may not determine priority.

PRIORITY MEDICATION WARNING SIGNS

Investigate immediately: respiratory depression after an opioid; symptomatic hypoglycemia after insulin; significant bleeding with anticoagulants; severe allergic reaction; new concerning dysrhythmia; signs of medication toxicity.

SAVANT RULE

Medication + dangerous symptom = investigate immediately.

DELEGATION QUICK GUIDE

RN	**UNSTABLE • NEW • COMPLEX • INITIAL • TEACH** Initial comprehensive assessments; unstable patients; new significant changes; complex judgment; initial teaching; evaluation of care.
LPN/LVN	**STABLE • PREDICTABLE • ROUTINE • REINFORCE** Stable/predictable patients; focused data collection; routine medications/treatments; dressing changes; reinforcement of established teaching, within jurisdiction and policy.
UAP	**ROUTINE • STANDARD • STABLE • NO NURSING JUDGMENT** Hygiene; feeding appropriate stable patients; ambulation; routine I&O; weights; routine vital signs on appropriate stable patients.

Never delegate: assessment • clinical judgment • nursing evaluation • initial teaching

10-SECOND PRIORITY TEST

1. Is there an AIRWAY threat?	6. Who is UNSTABLE?
2. Is there a BREATHING threat?	7. What is NEW or UNEXPECTED?
3. Is there a CIRCULATION/perfusion threat?	8. Is this ACTUAL or only POTENTIAL?
4. Is there an acute NEURO change?	9. Do I need to ASSESS, or is immediate ACTION already indicated?
5. Is there an immediate SAFETY threat?	10. Is this within the nurse's SCOPE?

PRIORITY WORDS TO CIRCLE

FIRST • BEST • IMMEDIATE • PRIORITY • MOST IMPORTANT • REQUIRES FOLLOW-UP • NEEDS INTERVENTION • SEE FIRST

These words change what the question is asking you to identify.

SAVANT RAPID-FIRE RULES

Airway before comfort. Unstable before stable. Acute before chronic unless chronic is acutely worsening. Unexpected before expected. Actual problems generally before potential problems.

New neurological changes demand attention. Safety before convenience. Assess before acting unless the emergency is already clear. Do what the nurse can safely do before unnecessarily delaying care. Never delegate nursing judgment.

FINAL SAVANT QUESTION

“Which patient is most likely to experience serious harm if I wait?”

S - Spot the priority **A** - Assess the clues **V** - Verify safety
A - Apply nursing scope **N** - Narrow the options **T** - Take action

DON'T JUST FIND THE RIGHT ANSWER.
FIND THE SAFEST ANSWER.™

Savant Nursing Academy
Created by nurses. Built for nursing students.

Educational Disclaimer: This resource is intended for educational and NCLEX-PN preparation purposes only. It does not replace clinical judgment, employer policies, state-specific scope-of-practice requirements, current clinical guidelines, or individualized medical advice.

© 2026 Savant Nursing Academy. All rights reserved.