NCLEX-RN 2026 · DAILY REVIEW · DAY 03

Client Rights, Advocacy, and *Refusal of Care*

Today you train the muscle that separates a safe entry-level RN from one who gets sued: knowing when a client gets to say no, when you must speak up, and when to escalate through the chain of command. Built on the 2026 NCLEX-RN Test Plan — Safe and Effective Care Environment / Management of Care — and the NGN Clinical Judgment Measurement Model.

SAFE & EFFECTIVE CARE ENV. | MANAGEMENT OF CARE | CJMM · 6 STEPS | APPLICATION-LEVEL+

01 High-Yield Overview

FOUNDATION

A **competent adult client has the absolute right to refuse** any treatment, medication, or procedure — even one that is life-saving — as long as they are *informed* and *have decisional capacity*. The NCLEX never asks you to talk a client into compliance. It asks you to **respect autonomy, verify understanding, document the refusal, and notify the provider**.

Advocacy on the NCLEX is not about being polite. It is about **action**: getting the interpreter, stopping the procedure when consent is invalid, reporting the impaired coworker, calling the rapid response team when the provider is unresponsive, and protecting the client against unbiased care — regardless of culture, ethnicity, sexual orientation, gender identity, or gender expression. The 2026 Test Plan explicitly lists unbiased and equal-access care as an advocacy activity.

The three foundational rights you must protect every shift: **autonomy** (self-determination), **informed consent** (voluntary, capable, informed), and **refusal** (the right to say no without coercion). Layered on top: privacy/dignity, access to care, end-of-life preferences, participation in decisions, and education about rights and responsibilities.

> **CORE NCLEX MINDSET**
> The right answer almost always supports the client's choice, secures understanding, or removes coercion. The wrong answer almost always pressures, manipulates, withholds information, or assumes on the client's behalf.

02 10 Must-Know Rules

MEMORIZE

01 **A competent adult may refuse any treatment**, including blood, dialysis, food, surgery, or resuscitation — even if refusal results in death. The nurse respects the choice; the nurse does not override it.

02 **The provider obtains informed consent. The nurse witnesses the signature and verifies understanding.** If the client cannot explain the procedure, risks, benefits, and alternatives in their own words — consent is incomplete and the nurse must *stop and notify the provider*.

03 **Refusal must be informed.** The nurse explains the consequences of refusal in language the client understands, offers an interpreter when needed, then honors the decision. The nurse does not threaten or guilt the client.

04 **An interpreter is required by law and policy** when the client has limited English proficiency or uses sign language. Family members — especially children — are *not* acceptable medical interpreters except in an immediate life-threat with no alternative.

05 **Emancipated and certain minors can consent.** Minors who are emancipated, married, pregnant, parents, or seeking care for STIs, substance use, or mental health (state-dependent) may consent for themselves. Otherwise, a parent or legal guardian consents.

06 **Emergency consent is implied** when life or limb is at immediate risk and the client cannot consent and no surrogate is reachable. Document the emergency.

07 **The right to refuse extends to nursing care** — turning, ambulating, bathing, IV starts, medications. Document, notify the provider when refusal affects the treatment plan, and offer again later.

08 **Advocate up the chain of command** when the client's rights are threatened: charge nurse → nursing supervisor → provider → ethics committee → facility administration → state board. Don't skip levels except in immediate danger (call rapid response or a code).

09 **Unbiased care is non-negotiable.** The 2026 Test Plan explicitly requires equal access regardless of culture, ethnicity, sexual orientation, gender identity, or gender expression. Address clients by their stated name and pronouns.

10 **Document refusal objectively**: what the client said (in quotes when possible), what was explained, what consequences were reviewed, who was notified, and that the client demonstrated understanding. Never document an opinion ("client was being difficult").

03 RN Safety Decision Table

ACTION VS. TRAP

SITUATION	BEST RN ACTION	WHY THIS IS SAFEST	COMMON NCLEX TRAP
Client about to sign consent says, "I don't really know what they're going to do."	**Stop the procedure.** Hold the consent form, notify the provider to return and re-explain.	Informed consent requires understanding. The nurse witnesses understanding, not just a signature.	Letting the nurse "explain the procedure herself" — that's the provider's role.
Adult Jehovah's Witness refuses blood for hemorrhage.	Respect the refusal, document, notify provider, discuss alternatives (cell saver, erythropoietin, IV iron).	Competent adults have absolute right to refuse, even life-saving therapy.	Calling the family to "talk sense" — that's coercion.
Client speaks only Mandarin; spouse offers to translate consent.	Decline the spouse. Use a **certified medical interpreter** (in-person or phone/video).	Family interpreters introduce bias, errors, and consent invalidity. Federal law requires qualified interpreters.	"It's faster to use the family member" — speed never beats consent integrity.
Confused, oriented x1 client refuses morning meds.	Assess capacity. If *not* capable, contact the surrogate/POA and provider. Do not force.	Refusal requires capacity. The nurse evaluates orientation, understanding of consequences, and consistency.	Assuming refusal automatically equals incompetence — and forcing meds.
Provider writes an order the nurse believes is unsafe.	Question the order with the provider. If unresolved, escalate: charge nurse → supervisor → chain of command. Do not carry out.	The nurse is legally accountable for every order carried out, even an MD's. Advocacy = refusing to harm.	"Just do it because the doctor said so" — that's negligence, not deference.
Adult client with a valid DNR codes; family screams "Do everything!"	Honor the DNR. The advance directive — not the family — governs care.	The client's prior expressed wishes prevail over family preference.	Starting CPR to "appease the family" — violates autonomy.
Transgender client is repeatedly misgendered by a coworker.	Speak privately to the coworker, model correct pronouns, escalate if continued. Document only clinically relevant facts.	Unbiased care is a 2026 Test Plan requirement. Misgendering harms therapeutic trust and is reportable as discriminatory.	Avoiding the conversation "to keep the peace."
Client refuses a leg amputation despite gangrene.	Verify capacity, ensure informed refusal, document, notify provider, offer palliative options. Respect the choice.	Even a "bad" decision is the client's to make.	Documenting "client is non-compliant" — that's judgmental and legally risky.
Family asks for the client's lab results in the hallway.	Verify the client gave permission. Discuss in a private space. Share only what the client has authorized.	HIPAA permits sharing only with client-designated parties and only minimum necessary information.	Sharing because "they seem like family."
Suspect a coworker is impaired (slurred speech, smells of alcohol).	Remove them from client care immediately, notify the charge nurse / supervisor, document facts. Report per state law if required.	Client safety overrides collegial loyalty. Most states mandate reporting impaired practice.	"Talking to them first" before removing them from care.

04 Delegation & Scope · Rights / Advocacy Tasks

RN VS LPN/VN VS UAP

Most rights-and-advocacy tasks **cannot** be delegated below the RN — they require assessment, teaching, or clinical judgment. Use this table to recognize the traps.

TASK	RN	LPN/VN	UAP	DELEGATE?	WHY / WHY NOT
Verify the client understands informed consent	✓	✗	✗	NO	Requires nursing judgment about comprehension — RN only.
Witness the client's signature on consent	✓	✓ (per facility)	✗	SOMETIMES	Witnessing the signature is clerical; verifying understanding is not.
Provide an interpreter for a non-English-speaking client	✓	✓	✗	YES	Coordinating a certified interpreter is a logistical task any licensed staff can arrange.
Translate medical information for a client (when bilingual UAP available)	✗	✗	✗	NO	Untrained bilingual staff are *not* medical interpreters. Use certified services.
Teach client about right to refuse	✓	✗	✗	NO	Teaching = RN scope. Application-level assessment of understanding required.
Reinforce previously taught information about client rights	✓	✓	✗	LPN/VN OK	Reinforcement of prior RN teaching is within LPN/VN scope.
Notify provider that client refused a treatment	✓	✓	✗	YES (LPN)	LPN can notify; RN remains accountable for follow-up assessment.
Document a refusal of care in the medical record	✓	✓	✗	RN preferred	RN should document the assessment of capacity and understanding.
Report suspected abuse to authorities	✓	✗	✗	NO	Mandatory reporting is the RN's professional/legal duty — not delegable.
Transport a stable client to private room for family discussion	✓	✓	✓	YES	Pure logistics — appropriate for UAP if client is stable.
Sit with a client who refuses leaving against medical advice	✓	✓	✓	YES (with direction)	UAP can stay with the client; RN must do the AMA discussion and documentation.
Advocate to the provider regarding an unsafe order	✓	✗	✗	NO	Critical thinking and clinical judgment — RN only.

5 RIGHTS OF DELEGATION RECAP

Right Task · Right Circumstance · Right Person · Right Direction/Communication · Right Supervision/Evaluation. If even one is missing — *do not delegate*.

05 Red-Flag Cues

RECOGNIZE · ACT · ESCALATE

IMMEDIATE ASSESSMENT BY THE RN

→ Client says "I don't understand" before signing consent.

→ Client becomes hesitant, tearful, or withdrawn after provider leaves the room.

→ Client asks, "Can I still change my mind?" — capacity and voluntariness check.

→ Family is answering questions for an oriented adult client.

→ Client suddenly refuses a treatment they previously accepted (new symptom? pain? confusion?).

NOTIFY THE PROVIDER

→ Client withdraws or refuses consent for an ordered procedure.

→ Client signs consent but cannot describe the procedure, risks, or alternatives.

→ Refusal of care affects the treatment plan (e.g., refuses dialysis, antibiotics, blood).

→ Discovery that the wrong surrogate decision-maker is being used.

→ Advance directive on chart conflicts with current orders.

RAPID RESPONSE / EMERGENCY TEAM

→ Client deteriorates after refusing a treatment (e.g., declines anticoagulant, develops PE symptoms).

→ DNR client suddenly distressed — confirm code status, treat comfort, manage symptoms.

→ Imminent harm and provider not reachable — escalate without waiting.

CHAIN OF COMMAND

→ Provider refuses to clarify or change an unsafe order.

→ Family insists on overriding a competent client's choice.

→ Coworker continues to provide biased or discriminatory care after coaching.

→ Facility policy is being violated and the manager has not acted.

MANDATORY REPORTING

→ Suspected child abuse, elder abuse, or vulnerable-adult neglect.

→ Intimate-partner violence with serious injury (state-dependent).

→ Communicable diseases per state public-health reporting list.

→ Impaired health-care worker (most states require board reporting).

→ Gunshot wounds, certain stab wounds, suspected criminal assault (state-dependent).

HOLD DELEGATION & REASSESS

→ UAP attempts to "convince" a refusing client to take meds.

→ UAP shares client information in a hallway or break room.

→ LPN/VN performs an admission assessment on an unstable client.

→ Staff member discusses a client on social media — even without names.

→ UAP is using their personal phone in the client's room.

06 Advanced NGN Practice Questions

10 ITEMS · MIXED TYPES

Q1 MULTIPLE CHOICE

A 78-year-old client scheduled for a hip replacement signs the consent form, then asks the nurse, "What did the surgeon say they were going to do to me again?" Which action by the nurse is the priority?

A. Explain the procedure to the client using the surgeon's notes.

B. Notify the surgeon to return and re-explain the procedure before the consent is valid.

C. Document that the client signed and proceed with pre-op preparation.

D. Ask the family member at the bedside to clarify what the surgeon said.

RATIONALE

Correct (B): Informed consent requires that the client demonstrate understanding. The signature is invalid without comprehension. The provider — not the nurse — explains the procedure, risks, benefits, and alternatives. The nurse must *stop* the process and notify the surgeon.

A is wrong: The nurse's role is to *verify* understanding, not *provide* the disclosure. Doing so is outside the RN scope for consent.

C is wrong: Proceeding with an invalid consent exposes the client to a procedure they did not knowingly agree to — a battery in legal terms.

D is wrong: Family cannot substitute for the provider's disclosure or the client's own understanding when the client has capacity.

Trap tested: Confusing the nurse's *witness* role with the provider's *disclosure* role.

CJMM · TAKE ACTION

Q2 SATA

The nurse is caring for an alert, oriented 56-year-old client with end-stage renal disease who states, "I'm done with dialysis. I just want to go home." Select **all** appropriate nursing actions.

A. Assess the client's understanding of the consequences of stopping dialysis.

B. Notify the nephrologist of the client's decision.

C. Offer a referral to palliative care and case management.

D. Contact the client's adult children to help change the client's mind.

E. Document the conversation using the client's own words.

F. Place the client on a 1:1 sitter for safety until the decision is reversed.

G. Verify whether the client has an existing advance directive on file.

RATIONALE

Correct (A, B, C, E, G): The RN must verify informed decision-making, communicate up the team, mobilize appropriate resources (palliative, case management), document objectively, and integrate the advance directive into the plan of care — all 2026 Test Plan activities.

D is wrong: Recruiting family to override a competent adult's refusal is coercion.

F is wrong: Refusal of treatment is not a reason for a 1:1 sitter. A sitter is not a tool to enforce compliance.

Trap tested: Substituting family persuasion for client autonomy.

CJMM · GENERATE SOLUTIONS

Q3 MATRIX / GRID

For each scenario, indicate whether the nurse should **Proceed**, **Stop & Notify Provider**, or **Escalate to Chain of Command**.

SCENARIO	PROCEED	STOP & NOTIFY PROVIDER	ESCALATE CHAIN OF COMMAND
1. Pre-op client signs consent and accurately describes the surgery, risks, and alternatives.	✓		
2. Client says, "I signed it but I'm not sure what artery they're operating on."		✓	
3. Provider writes an order for blood transfusion on a client whose chart lists a refusal of blood products.		✓	
4. Provider refuses to discontinue the blood order after the nurse points out the refusal.			✓
5. Adult client with capacity refuses pre-op antibiotics; client describes risks accurately.	✓		
6. Adult client with new-onset confusion refuses pre-op antibiotics and states "the lights are talking to me."		✓	
7. Bilingual UAP volunteers to translate consent because the certified interpreter has a 45-minute wait.			✓
8. Family demands resuscitation on a client with a valid DNR order in the chart.	✓ (honor DNR)		

RATIONALE

Proceed when the client's rights are intact and the action follows the advance directive (1, 5, 8).

Stop & notify when an order or signature is incomplete, contradicts the client's documented wishes, or when capacity is in question (2, 3, 6).

Escalate when a provider or coworker is creating ongoing risk after being informed (4, 7).

Trap tested: Treating "convenience" (item 7) as justification to use an unqualified interpreter — invalidates consent.

CJMM · ANALYZE CUES / PRIORITIZE HYPOTHESES

Q4 BOW-TIE

A nurse is caring for an alert, oriented adult Jehovah's Witness with active GI bleeding (Hgb 6.4 g/dL, BP 88/52, HR 122). The client refuses blood products. Complete the bow-tie:

Central condition: Symptomatic anemia with hemodynamic instability in a client refusing blood products.

Choose 2 priority actions (left side of bow-tie):

A. Initiate large-bore IV access and administer crystalloid fluid resuscitation per protocol.

B. Notify the provider and request alternatives (cell-saver, IV iron, erythropoietin, tranexamic acid).

C. Have the chaplain attempt to convince the client to accept blood.

D. Place a STAT type & crossmatch and have PRBCs at the bedside in case the client changes their mind.

E. Request a court order to override the refusal.

Choose 2 parameters to monitor (right side):

F. Hemodynamic status (HR, BP, MAP, mentation) every 15 minutes.

G. Hgb/Hct and lactate trend.

H. Daily weights.

I. Wound culture results.

RATIONALE

Correct actions (A, B): Respect the refusal but treat the underlying problem with all available *permissible* therapies. Volume resuscitation is not blood. Bloodless-medicine alternatives are standard and often acceptable.

Correct monitoring (F, G): Reflects active hemorrhage and end-organ perfusion.

C, D, E are wrong: Coercion, false hope to manipulate consent, and courts rarely override competent adult refusals — these violate autonomy.

Trap tested: Equating "respecting refusal" with "doing nothing." You still treat the patient — within their consented options.

CJMM · GENERATE SOLUTIONS / TAKE ACTION

Q5 ORDERED RESPONSE

A non-English-speaking client is about to sign a surgical consent. Place the nurse's actions in the **correct order**.

01 Stop the consent process; the form is not yet signed.

02 Contact a certified medical interpreter (in-person, phone, or video).

03 Have the provider re-explain the procedure with the interpreter present.

04 Verify the client's understanding by having the client describe the procedure in their own words (via interpreter).

05 Witness the client's signature on the consent form.

06 Document the interpreter used (name and ID) and the verification of understanding.

RATIONALE

The integrity of consent is built sequentially: *stop → interpreter → disclosure → verify → witness → document*. Skipping or reordering any step (e.g., having the interpreter translate while the provider is absent) invalidates consent.

Trap tested: Allowing the interpreter to deliver the disclosure on behalf of the provider — not permitted.

CJMM · TAKE ACTION

Q6 DROP-DOWN / CLOZE

Complete the documentation entry for a refusal of care:

SAMPLE ENTRY (correct fills shown in bold/italic):

0930. Client refused 0900 dose of metoprolol. Client stated, *"I feel fine and I don't want any more pills today."* Client is *alert and oriented x4*, able to verbalize the purpose of the medication and the risk of refusal (*uncontrolled blood pressure, increased cardiac workload*). Dr. Patel notified at 0925. New orders received: *recheck BP in 1 hour and reassess*. Will reoffer medication later this shift. — J. Lee, RN

Which 3 elements are essential in a refusal-of-care note?

A. The client's own words (in quotes).

B. Assessment of capacity / orientation.

C. Provider notification and any new orders.

D. Nurse's opinion on whether the refusal was reasonable.

E. Family members' opinions on the refusal.

RATIONALE

Correct (A, B, C): Objective, capacity-based, communication-documented. Per 2026 Test Plan: "Use approved terminology when documenting care."

D, E wrong: Subjective opinions are not nursing documentation. They invite legal liability.

Trap tested: Charting "client is non-compliant" — judgmental, vague, and indefensible.

CJMM · TAKE ACTION / EVALUATE OUTCOMES

Q7 PRIORITIZATION

The nurse on a med-surg unit has these four assignments. Which client should the nurse see **first**?

A. A 65-year-old who refused morning physical therapy and is watching TV.

B. A 72-year-old post-op day 2 with consent signed for chest tube insertion in 30 minutes who states, "I have no idea what they're putting in."

C. A 40-year-old waiting for an interpreter to discuss tomorrow's MRI consent.

D. A 58-year-old DNR client with new shortness of breath, RR 28, SpO_2 88%.

RATIONALE

Correct (D): ABCs trump ethical/legal issues when oxygenation is failing — even a DNR client gets *comfort and symptom management*. DNR does not mean "do not treat." Address breathing first.

B is the strong distractor: Critical, but the procedure isn't for 30 minutes — there is time after addressing the deteriorating client.

A, C: Stable; can wait.

Trap tested: Assuming DNR = ignore. DNR specifies no chest compressions / intubation; it does *not* withhold oxygen, suction, comfort, or assessment.

CJMM · PRIORITIZE HYPOTHESES

Q8 DELEGATION SCENARIO

The charge RN is making the day's assignments. Which task is most appropriate to delegate to an experienced UAP?

A. Reinforcing the discharge teaching about a new anticoagulant.

B. Assessing whether a confused client has the capacity to refuse a procedure.

C. Sitting with a client who is waiting for a family member before signing AMA paperwork.

D. Notifying the provider that a client has changed their code status.

RATIONALE

Correct (C): Companionship and observation of a stable client is within UAP scope. The RN still performs the AMA discussion and signs the legal forms.

A: Teaching = RN. *Reinforcement* of prior teaching can be LPN/VN, never UAP.

B: Capacity assessment = RN judgment.

D: Communicating critical status changes / code status is RN responsibility.

Trap tested: Mixing "watching a client" (delegable) with "assessing/teaching/communicating critical info" (not delegable).

CJMM · GENERATE SOLUTIONS

Q9 CASE STUDY (STANDALONE)

A 19-year-old college student presents to the ED with a fractured wrist after a fall. Parents arrive and demand to know the full medical history including a recent ED visit for emergency contraception. What is the nurse's best response?

A. "I'll give you a complete summary as soon as the doctor signs off."

B. "Your child is over 18, so I'll need their permission before I share any information."

C. "I can only share information that the parents are paying for through insurance."

D. "Let me check with the doctor to see what is okay to share."

RATIONALE

Correct (B): A client over the age of majority — even if on parents' insurance, even if a dependent — controls disclosure of their own protected health information. The nurse advocates by upholding HIPAA and the client's autonomy.

A, C: Insurance status and provider preference do not override the client's right to control disclosure.

D: The decision belongs to the client, not the provider.

Trap tested: Equating family relationship or financial relationship with legal access to medical information.

CJMM · RECOGNIZE CUES / TAKE ACTION

Q10 HANDOFF / SBAR SCENARIO

The off-going RN is giving SBAR handoff. Which element is **most important** to include when transferring a client who refused a treatment during the previous shift?

A. The nurse's personal opinion of why the client refused.

B. The client's stated reason, capacity assessment, provider notification, current plan, and what is to be reoffered or reassessed.

C. The family's reaction and which family members were upset.

D. Whether the client is likely to refuse again on the next shift.

RATIONALE

Correct (B): SBAR for a refusal must transfer the *facts*: what the client said, capacity verification, who was notified, current plan, and the trigger for reassessment. Per the 2026 Test Plan: "Provide and receive handoff of care (report) on assigned clients."

A, C, D: Opinions and predictions are not handoff content — they bias the oncoming nurse and may color the next interaction.

Trap tested: Inserting subjective interpretation into objective handoff.

CJMM · EVALUATE OUTCOMES / TAKE ACTION

07 Unfolding NGN Case Study

ALL 6 CJMM STEPS

NURSE'S NOTES — 0700

Mrs. R is a 74-year-old female admitted yesterday from a skilled nursing facility with a left hip fracture after a fall. Surgery (left hip ORIF) is scheduled for today at 1100. Client is alert, oriented x3, lives alone at her daughter's home, prefers to speak in Tagalog. Daughter is at the bedside translating. Client has a history of HTN, mild dementia (MMSE 24/30 on admission), atrial fibrillation on apixaban (held 48 h pre-op). DNR is documented in the chart, signed 6 months ago at the SNF. Client states (per daughter), "I want the surgery so I can walk again."

VITAL SIGNS — 0700

BP	HR	RR	SpO_2	TEMP	PAIN
142/86	88	18	96%	37.0°C	5/10

PROVIDER ORDERS

- → NPO since midnight
- → Cefazolin 2 g IV on call to OR
- → Surgical consent for left hip ORIF — to be signed pre-op
- → Resume apixaban 24 h post-op per surgical team
- → DVT prophylaxis: sequential compression devices pre-op

LABS (0500 DRAW)

Hgb 11.2 · Hct 33.8 · Platelets 240k · Cr 1.1 · K 4.0 · INR 1.2 · Type & screen completed

FAMILY / CLIENT STATEMENTS

At 0830, the daughter pulls the nurse aside in the hallway and says, *"My mother doesn't really understand what's happening. The surgeon came in and explained everything in English, and I translated what I could. She signed the form, but honestly, I don't think she got it. Also — about the DNR — if something happens during surgery, we want everything done. That paper was from before she got better."*

Step 1 · Recognize Cues

Which findings are concerning for unsafe consent and an unclear plan of care? **Select all that apply.**

- ✓ Surgeon explained the procedure only in English to a Tagalog-preferring client
- ✓ Daughter — not a certified interpreter — translated the disclosure
- ✓ Client may not have understood the procedure she signed for
- ✓ Family is requesting full resuscitation despite documented DNR
- ✓ Mild dementia — capacity must be reverified for today's decisions

✗ Hgb 11.2 (mild but expected post-fracture; not the priority)

✗ BP 142/86 (mildly elevated; not the priority)

Step 2 · Analyze Cues

Cluster the cues. The unifying problem is: **The consent obtained may not be valid (no certified interpreter, capacity uncertain), and there is a conflict between the existing DNR and the family's expressed wish.** Two distinct issues — they must be addressed separately and before the OR call.

Step 3 · Prioritize Hypotheses

Rank from highest to lowest priority:

01 **Invalid informed consent** — surgery cannot proceed; immediate risk of legal battery.

02 **Code-status conflict** — must be clarified before induction; clarify capacity for today's decision-making.

03 **Capacity reassessment** — affects both the consent and the DNR conversation.

04 Pre-op antibiotic timing and SCDs — routine; address after legal/ethical clarification.

Step 4 · Generate Solutions

→ Call the OR / surgeon — pause the case until consent is reverified.

→ Arrange a certified Tagalog interpreter (in-person, phone, or video).

→ Have the surgeon re-disclose the procedure with the interpreter present.

→ Perform a brief capacity check (client describes the surgery, risks, and her goal).

→ Convene a goals-of-care conversation with client, daughter, surgeon, and anesthesia — clarify the DNR for this surgical episode (some facilities allow "DNR suspended for OR," some require explicit reaffirmation).

→ Document everything — interpreter ID, capacity findings, code-status decision.

Step 5 · Take Action

The nurse:

01 Notifies the charge nurse and OR coordinator that the case may be delayed.

02 Pages the surgeon to return to the bedside.

03 Calls the interpreter service — confirms Tagalog availability.

04 Documents the daughter's statement, the recognition that consent integrity is in question, and the actions taken.

05 Once the interpreter is present, supports the surgeon's re-disclosure, then verifies the client's understanding in her own words.

06 Facilitates a separate conversation about code status for the OR; documents the client's choice (not the family's).

Step 6 · Evaluate Outcomes

Successful outcomes include:

→ Client (with interpreter) restates the procedure, risks, benefits, and alternatives in her own words.

→ Consent form re-signed (or addendum added per facility policy) with certified interpreter documented.

→ Code status for the OR episode explicitly addressed and documented — with the *client's* wishes governing.

→ Surgery proceeds without delay to client safety; no legal exposure for invalid consent.

→ Daughter is supported but understands that her mother's expressed wishes prevail.

EVALUATION ANCHOR

If the client cannot restate the procedure even after the interpreted re-disclosure, the case is paused indefinitely and a capacity evaluation is requested. The right answer is *never* "proceed because the OR is waiting."

08 "What Should the Nurse Do First?"

5 MINI-SCENARIOS

SCENARIO 1

A client about to be wheeled to the cath lab states, "I want to think about this more — can we wait?"

▸ **Stop transport. Notify the provider. The client may be withdrawing consent.**

Consent must be voluntary and ongoing. Any hesitation pauses the process. Document the statement verbatim.

SCENARIO 2

A new admit speaks only Vietnamese. The bilingual UAP offers to translate the admission paperwork.

▸ **Decline the UAP. Call a certified medical interpreter.**

Untrained bilingual staff are not interpreters under federal language-access law. Consent and admission rights teaching require a certified service.

SCENARIO 3

An oriented adult with terminal cancer refuses IV fluids. Family is upset and is asking the nurse to "just start the line anyway."

▸ **Honor the client's refusal. Document. Notify the provider. Offer palliative-care consult and family support.**

Family pressure does not override a competent client's choice.

SCENARIO 4

A nurse overhears two coworkers discussing a celebrity client's diagnosis in the elevator.

▸ **Interrupt the conversation, redirect them to a private area, and report the HIPAA breach to the charge nurse / privacy officer.**

Confidentiality breaches require immediate intervention and escalation. Even partial information in a public space is a breach.

SCENARIO 5

A previously alert client with a valid DNR becomes acutely short of breath, RR 30, SpO_2 84%.

▸ **Apply oxygen, sit the client upright, suction if needed, notify the provider — provide all non-resuscitative comfort and symptom management.**

DNR means no compressions/intubation; it does *not* mean "do nothing." Active symptom management is required.

09 "Can This Be Delegated?"

5 MINI-SCENARIOS

SCENARIO 1 · INTERPRETER COORDINATION

Calling the language line to arrange a Spanish interpreter for an upcoming consent.

▸ Delegate to UAP or unit clerk. RN performs the actual disclosure verification.

Logistics are delegable; clinical verification is not.

SCENARIO 2 · TEACHING ABOUT REFUSAL RIGHTS

A new admit asks, "Can I really refuse the IV?"

▸ RN only. This is teaching about client rights — application-level RN scope.

Reinforcement after the RN's teaching could be done by LPN/VN, never UAP.

SCENARIO 3 · WITNESSING CONSENT SIGNATURE

Standing in the room while a client signs a consent the surgeon has already discussed.

▸ RN preferred. LPN/VN may witness per facility policy. UAP — no.

The witness must be a licensed clinician who can attest the client was alert, oriented, and not coerced.

SCENARIO 4 · STAYING WITH AN AMA CLIENT

A client who has signed AMA paperwork is waiting for a ride. The unit is busy.

▸ UAP can sit with the stable client. RN remains accountable for the AMA discussion and follow-up documentation.

Companionship and observation = UAP scope.

SCENARIO 5 · REPORTING SUSPECTED ELDER ABUSE

A confused older adult has bruising in multiple stages of healing and flinches when family enters the room.

▸ RN — mandatory reporter. Must report to Adult Protective Services per state law. Do not delegate.

Mandatory reporting is the professional obligation of the licensed nurse. Document objective findings only.

10 "Who Should the Nurse Contact?"

5 REFERRAL / COLLABORATION SCENARIOS

SCENARIO 1

A client refuses dialysis and wants to spend their remaining time at home.

Palliative care + case management + social worker (hospice coordination).

Goals-of-care discussions and home-hospice arrangement are interdisciplinary.

SCENARIO 2

A client speaks limited English and consent is pending for a procedure tomorrow.

Certified medical interpreter (in-person if available, phone/video otherwise).

Family members and bilingual staff are not substitutes.

SCENARIO 3

A client's advance directive contradicts a provider's plan, and the provider has not responded to two pages.

Charge nurse → nursing supervisor → chief of service / on-call provider → ethics committee.

Chain of command preserves client wishes and prevents harm.

SCENARIO 4

A client expresses spiritual distress before refusing further treatment.

Chaplain / pastoral care + the client's own faith leader if requested.

Spiritual support is part of holistic advocacy and rights to dignity.

SCENARIO 5

A transgender client states they have been deadnamed repeatedly by the night shift.

Charge nurse → nursing manager → patient advocate / patient-experience office.

Unbiased care is a 2026 Test Plan activity; the system must respond, not just one nurse.

11 Legal & Ethical Traps

5 HIGH-RISK SCENARIOS

TRAP 1 · INVALID CONSENT

A 32-year-old presents to the ED in active labor in a language no one on staff speaks. Husband, who is fluent, offers to translate consent for emergency C-section.

Use the certified interpreter — even by phone — unless delay puts life at immediate risk. Document the situation and the interpreter used.

Emergency consent is implied *only* if life/limb is immediately threatened and no alternative exists.

TRAP 2 · REFUSAL OF TREATMENT

An alert client with sepsis refuses IV antibiotics, says, "I'd rather pray about it."

Verify capacity, ensure informed refusal, document, notify provider, offer chaplain. Honor the choice.

Religious or personal reasons are valid grounds for refusal in a competent adult.

TRAP 3 · CONFIDENTIALITY

A nurse's neighbor calls and asks how their elderly mother (the nurse's patient) is doing.

Do not confirm or deny that the person is a patient. Refer the caller to the client directly.

Even acknowledging admission is protected information under HIPAA.

TRAP 4 · MANDATORY REPORTING

During an admission assessment, a 14-year-old discloses ongoing sexual abuse by a stepparent and begs the nurse not to tell anyone.

The nurse must report to child protective services. The nurse cannot promise confidentiality on disclosures of abuse of a minor.

Mandatory reporting overrides the client's request. The nurse should explain this gently *before* the disclosure when possible.

TRAP 5 · END-OF-LIFE / DNR

A client with a valid DNR is admitted with a fall and altered mental status. The family says, "Forget the DNR — we want her resuscitated."

Honor the DNR. The client's prior directive governs. Notify the provider; engage palliative care to support the family.

Family preference does not override a valid advance directive from a competent client.

12 End-of-Day Quick Review

DRILL THE PATTERNS

10 ONE-LINE MUST-REMEMBER POINTS

01 The provider *discloses*; the nurse *verifies* understanding and *witnesses* the signature.

02 Competent adults can refuse anything, even life-saving care.

03 Capacity = orientation + understanding + appreciation of consequences + consistency.

04 Certified interpreters are required for limited English proficiency, ASL, or sensory impairment.

05 Family is never a substitute for a certified interpreter (except true emergency, no alternative).

06 DNR ≠ "do not treat" — comfort, suction, oxygen, symptom management continue.

07 Advance directives override family wishes when there is a conflict.

08 Mandatory reporting overrides the client's request for secrecy.

09 Document refusal in the client's own words, with capacity check and provider notification.

10 Unbiased care is a 2026 Test Plan activity — equal access regardless of culture, ethnicity, sexual orientation, gender identity, gender expression.

5 COMMON NCLEX TRAPS

→ Letting the nurse "explain the procedure" — that's the provider's job.

→ Using family or a bilingual UAP as an interpreter for consent.

→ Treating a DNR as a withdrawal of all care.

→ Charting "client was non-compliant" instead of "client declined; verbalized understanding of risks."

→ Recruiting family to convince a competent client to change their mind.

5 "NEVER DO THIS" RULES

→ Never proceed with a procedure when the client cannot describe what is being done.

→ Never coerce, guilt, or pressure a client out of a refusal.

→ Never share PHI in a hallway, elevator, social media, or with unauthorized family.

→ Never override a valid advance directive based on family preference.

→ Never delegate assessment, teaching, capacity evaluation, or first-time judgment calls below the RN.

5 SAFETY-FIRST PHRASES TO RECOGNIZE ON THE NCLEX

→ "Tell me what the doctor explained" — verifying understanding (correct).

→ "Let's get the interpreter on the line" — language access (correct).

→ "I will document your decision and notify the provider" — honoring refusal (correct).

→ "I need to clarify this order before I give the medication" — chain of command (correct).

→ "Your wishes are documented and will be followed" — autonomy / advance directive (correct).

SCREENSHOT · SAVE · DRILL

Day 3 — Rights · Advocacy · Refusal

THE CONSENT CHAIN

- Provider DISCLOSES
- Nurse VERIFIES understanding
- Client SIGNS voluntarily
- Nurse WITNESSES
- Nurse DOCUMENTS

If any step missing → STOP & notify provider

CAPACITY CHECK (QUICK)

- Oriented x3–x4
- Can restate the situation
- Understands consequences
- Decision is consistent
- Free from coercion

REFUSAL-OF-CARE ALGORITHM

- Assess capacity
- Confirm understanding
- Explain consequences
- Honor decision
- Notify provider
- Document in client's words
- Reoffer later

INTERPRETER RULES

- Certified medical interpreter required
- In-person / phone / video
- NOT family
- NOT children (ever)
- NOT bilingual UAP/staff
- Document interpreter name & ID

DNR QUICK TRUTHS

- No CPR, no intubation
- YES: O_2, suction, comfort, fluids, antibiotics, surgery (unless specified)
- Client wishes > family wishes
- Confirm before each new episode
- Some facilities suspend DNR for OR — confirm policy

DELEGATION SNAPSHOT

- Assess capacity → RN only
- Teach rights → RN only
- Reinforce teaching → LPN OK
- Witness signature → RN preferred / LPN per policy
- Coordinate interpreter → UAP / clerk
- Mandatory reporting → RN only

CHAIN OF COMMAND

- Charge nurse
- Nursing supervisor
- Provider / on-call
- Chief of service
- Ethics committee
- Risk management / Admin
- State board (last resort / impaired practice)

Imminent harm → SKIP to RRT / Code

MANDATORY REPORTING

- Child abuse / neglect
- Elder / vulnerable-adult abuse
- Communicable diseases (state list)
- Gunshot / certain stab wounds
- Impaired practice
- Sentinel events (facility)

UNBIASED CARE · 2026 TP

- Equal access regardless of culture/ethnicity
- Sexual orientation
- Gender identity
- Gender expression
- Disability / language / faith
- Address by stated name & pronouns

DOCUMENTATION ESSENTIALS

- Client's words in quotes
- Capacity findings
- Education provided
- Consequences reviewed
- Provider notified + new orders
- Interpreter used (if any)
- NO opinions, NO labels

RED-FLAG PHRASES ON NCLEX

- "I don't understand..." → STOP consent
- "I changed my mind" → Honor it
- "Don't tell anyone" → Mandatory report still applies
- "Just convince him..." → Coercion, refuse
- "Family wants everything done" → Check directive first

CJMM MAPPING FOR DAY 3

- Recognize → "I don't understand"
- Analyze → consent vs. capacity vs. DNR
- Prioritize → stop the risky action
- Generate → interpreter, palliative, chain
- Act → notify provider, document
- Evaluate → restated understanding, plan aligned

END OF DAY 3 · TOMORROW → DAY 4: INFORMED CONSENT & ADVANCE DIRECTIVES