2026 NCLEX-RN • MANAGEMENT OF CARE • DAY 5 OF 15

Confidentiality, HIPAA, Social Media *& Documentation.*

Learn to think like a safe entry-level RN who protects every word, every chart entry, and every conversation — because the boundary of a client's privacy is also the boundary of safe care.

TEST PLAN FOCUS: CONFIDENTIALITY / INFORMATION SECURITY · CONTINUITY OF CARE · INFORMATION TECHNOLOGY

CJMM STEPS: 1-6 (FULL LOOP)

01 — SETTING THE STAGE

High-Yield *Overview*

What you need to think about before you touch a chart, answer a phone, or open your mouth at the nurses' station.

HIPAA (Health Insurance Portability and Accountability Act) protects every form of **Protected Health Information (PHI)** — written, spoken, or electronic. "PHI" = the client's name (or any identifier) combined with any health-related information. Think: name, MRN, date of birth, address, room number, photo, diagnosis, treatment, lab values — alone or in combination.

Two rules govern almost every NCLEX confidentiality question:

1. Minimum necessary. Access only the information you need to do your job. Looking up a celebrity, a coworker, a neighbor, or your own family member's chart — out of curiosity, concern, or kindness — is a federal violation. Intent does not matter.

2. Need to know. Share PHI only with team members directly involved in the client's care. Family members, friends, employers, and even coworkers on the unit who are not assigned to the client are *not* automatically entitled to information. A competent client controls their own disclosure.

Social media is where new nurses lose licenses. There is no such thing as a "safe" client post — combinations of details (date, unit, age, diagnosis, location, even a background detail in a selfie) can identify a client. NCLEX expects you to recognize that "no name was used" is *not* a defense.

Documentation is the legal record of nursing care. Three words guide every charting decision: **objective, timely, factual.** Chart what you see, hear, measure, and what the client says — in quotes. Avoid labels ("non-compliant," "uncooperative," "appears anxious"). Use approved abbreviations. Correct errors with a single line, "error," initials, date — never white-out, never erase, never alter a prior entry. Document refusal of care fully: refusal + teaching + understanding + provider notification.

HIPAA does not block mandatory reporting. Abuse, neglect, communicable diseases, gunshot wounds, and impaired colleagues must still be reported per law. When you witness a breach, intervene immediately and report — silence is also a violation.

> *"If it isn't **charted**, it wasn't done. If it isn't **private**, it wasn't protected. If it isn't **objective**, it isn't defensible."*

02 — FOUNDATIONS

10 Must-Know *Rules*

If you remember nothing else from Day 5, remember these. Each one maps directly to high-frequency NCLEX item content.

01

Minimum necessary rule. Access only what you need for the client in your care. Curiosity-based access is a federal violation — even if you don't share what you saw.

02

Need-to-know basis. The care team gets PHI. Family, friends, coworkers not assigned to the client do not — unless a competent client authorizes disclosure.

03

Verify identity before any phone disclosure. Use callback numbers, security questions, or refer to the privacy officer. Never disclose to a caller you can't verify.

04

Social media is never safe for client content. No photos, no initials, no "memorable cases." Combinations of details (date + unit + age) can identify a client.

05

Log out of the EHR every time you walk away. Never share a login. Audit trails record every keystroke — and every coworker who used your credentials.

06

Conversations belong in private spaces. No client discussion in elevators, hallways, cafeterias, or open workspaces. If you witness it, intervene at the moment.

07

Document objectively. Record what you see, hear, measure, and what the client says (in quotes). Skip opinions, labels, blame, and assumptions.

08

Correct errors the legal way. Single line through the entry → write "error" → initial → date → enter the correct information. Never erase, white-out, or scribble.

09

Late entries are legal when labeled. Add the current date/time, write "late entry," and reference the original time. Never backdate or insert into a prior time slot.

10

Mandatory reporting overrides HIPAA. Suspected abuse, communicable disease, gunshot wounds, impaired colleagues — report them per state law. HIPAA does not protect a perpetrator.

03 — DECISION FRAMEWORK

RN Safety *Decision Table*

Real situations you will see on NCLEX — and exactly how to think through the safest action.

SITUATION	BEST RN ACTION	WHY THIS IS SAFEST	COMMON NCLEX TRAP
Coworker discusses a client by name in the elevator.	Discreetly stop the conversation in the moment, redirect to a private area, and report to the manager/privacy officer if it continues.	Intervening immediately stops the active breach. Reporting upholds the RN's duty to protect privacy.	`"IGNORE" OR "TELL MANAGER LATER"` — NCLEX rewards immediate intervention.
Client's adult son calls for lab results. Client is alert and competent.	Speak with the client first to confirm permission, then disclose only what the client authorizes.	Competent clients control disclosure. Family relationship ≠ automatic authorization.	`"FAMILY IS FINE"` — assuming family = right to information.
You post a breakroom selfie; a chart is visible in the background.	Take the post down immediately, notify the privacy officer, and document per policy.	Unintentional PHI exposure is still a breach. Audit trails and screenshots remain.	`"NO NAME WAS USED"` — visible identifiers are still PHI.
You realize you charted the wrong medication time in the paper chart.	Single line through the entry → write "error" → initial → date → enter the correction.	Preserves legal integrity; nothing is hidden or destroyed.	`"WHITE-OUT"` or scribbling over — never legally acceptable.
Provider asks you to chart that an IV "infiltrated because the client kept moving."	Chart only objective findings: what was seen, when, what was done. No blame, no opinion.	Documentation must be factual and free of conclusions assigned to others.	`"THE PROVIDER TOLD ME TO WRITE IT"` — orders do not override charting standards.
Coworker is looking up a celebrity client's chart "just to peek."	Stop the action; report to the privacy officer or manager per facility policy.	Curiosity access is a federal violation even with no disclosure.	`"SHE DIDN'T SHARE IT"` — access itself is the violation.
Client asks to see their own medical record.	Notify the provider/HIM department; follow policy to grant access. Clients have a legal right to their records.	Right of access is part of HIPAA; refusing it is a violation.	`"ONLY THE PROVIDER CAN SHOW IT"` — clients have direct rights.
You forgot to chart a medication given 2 hours ago.	Enter a "late entry" with the current date/time, referencing the actual time of administration.	Late entries are legally acceptable when labeled clearly.	`BACKDATING` into the original time slot — chart tampering.
Family overhears a hallway report.	Move the report to a private room; remind the team to use enclosed spaces.	Reports in open spaces violate the duty of privacy.	`"THEY'RE FAMILY"` — privacy applies regardless of relationship.
You make a medication error.	Chart objective findings + interventions in the medical record. File a *separate* incident report per facility policy.	Chart and incident report serve different legal purposes.	`"INCIDENT REPORT FILED"` charted in the medical record — never document this.

04 — SCOPE & DELEGATION

Delegation & Scope *for Confidentiality & Documentation*

Who can do what — and which tasks must stay with the RN. Apply the 5 Rights of Delegation (right task, circumstance, person, direction, supervision).

TASK	RN	LPN/VN	UAP	CAN DELEGATE?	WHY OR WHY NOT
Initial teaching about HIPAA rights to a newly admitted client.	YES	NO	NO	No	Initial client education is in RN scope.
Reinforcing previously taught rights/responsibilities.	YES	YES	NO	Yes — to LPN	Reinforcement is in LPN/VN scope; UAP cannot teach.
Witnessing a client signature on informed consent.	YES	SOMETIMES	NO	Limited	Verifying understanding = RN. Witnessing signature only may be permitted for LPN per facility policy.
Entering measured vital signs into the EHR.	YES	YES	YES	Yes — to UAP	UAP enters data. RN interprets and addresses abnormals.
Taking a verbal phone order from a provider.	YES	VARIES	NO	Not to UAP	Requires licensed scope and read-back. LPN per facility/state policy.
Disclosing client diagnosis to a family member (with consent).	YES	YES	NO	Not to UAP	Clinical disclosure is a licensed function.
Transporting a stable client to imaging.	YES	YES	YES	Yes — to UAP	Routine transport of stable clients is in UAP scope.
Evaluating client response to a new medication.	YES	NO	NO	No	Evaluation of response is RN scope.
Reviewing the discharge medication reconciliation list with the client.	YES	NO	NO	No	Med reconciliation and initial discharge teaching are RN scope.
Releasing the chart to a subpoena/legal request.	RN refers	NO	NO	No	Refer to risk management / privacy officer. RNs do not release records to legal requests independently.

05 — PATTERN RECOGNITION

Red-Flag *Cues*

Findings that demand action — categorized by the level of response NCLEX expects.

▸ IMMEDIATE INTERVENTION

- Staff member photographing a client (even "for the family")
- Coworker discussing a celebrity/high-profile client at the nurses' station
- Coworker logged into the EHR and walking away from the workstation
- Sharing of an EHR login, password, or badge
- Anyone (visitor, family) photographing a chart or screen
- Active client-identifying conversation in a hallway, elevator, or cafeteria

▸ PROVIDER NOTIFICATION

- Client requests to amend the medical record
- Client refuses care/treatment (after teaching)
- Discovery of a documentation discrepancy affecting orders
- Unreported adverse event surfacing in documentation
- Client wishes to access their own record

▸ CHAIN OF COMMAND

- Provider asks you to alter, delete, or falsify a chart entry
- Persistent staff breaches after intervention
- Supervisor instructs you to delete or backdate a chart entry
- Pattern of unauthorized access discovered on the unit
- Subpoena or legal request for client records arrives on the unit

▸ MANDATORY REPORTING

- Suspected abuse or neglect (child, elder, vulnerable adult)
- Communicable diseases per state law (e.g., TB, measles, certain STIs)
- Gunshot or stab wounds, certain injuries
- Impaired colleague (substance use, diversion)
- Sentinel events per facility policy

▸ HOLD DELEGATION & REASSESS

- UAP attempting to access a chart for a non-assigned client
- LPN about to provide initial teaching on a new complex diagnosis
- New staff unsure about facility EHR procedure or documentation policy
- Anyone asked to disclose information without verified authorization

06 — ACTIVE PRACTICE

NGN Practice *Questions (12)*

Application-level NGN items across mixed formats. Read the stem, answer first, then reveal the rationale.
Each answer maps to a step of the NGN Clinical Judgment Measurement Model.

MULTIPLE CHOICE · CJMM • TAKE ACTION

Question 01

A nurse in a busy ED learns that a well-known singer is being treated on the unit. Another RN says, "I'm going to take a quick peek at the singer's chart — I'm just curious." Which is the *most appropriate* action by the nurse?

A. Wait until later to discuss it privately with the curious nurse.

B. Tell the nurse not to access the chart and report the conversation to the charge nurse or privacy officer.

C. Ignore the conversation since the curious nurse has not yet accessed the chart.

D. Briefly look at the chart together since both nurses work on the unit.

SATA · CJMM • RECOGNIZE / ANALYZE CUES

Question 02

A nursing student reviews the facility's social media policy. Which of the following actions would constitute a HIPAA violation? *Select all that apply.*

A. Posting a selfie at work with a chart visible in the background.

B. Sharing a generic post about a difficult shift with no identifying information.

C. Posting a photo that shows a client's room number on Snapchat.

D. Sharing an inspirational quote about nursing.

E. Mentioning a "celebrity client" by initials in a private Facebook group.

F. Posting about a "memorable case" with the date, unit, and approximate age.

G. Discussing the day's challenges with a non-healthcare roommate, using the client's name.

Correct: A, C, E, F, G

A: A visible chart is direct PHI exposure.

C: Room number + facility = identifying combination.

E: "Celebrity" + initials + private group is identifiable.

F: Date + unit + age, combined, can identify a client.

G: Using the client's name with anyone outside the care team = breach. Social media platform is not required.

B and D are not violations when truly free of identifiers.

> ***Trap:*** *Thinking only a name counts. Combinations of identifiers count. "No name" is not a defense.*

MATRIX / GRID · CJMM • TAKE ACTION

Question 03

For each documentation action below, identify whether it is *Appropriate* or *Inappropriate.*

ACTION	APPROPRIATE	INAPPROPRIATE
"Client appears uncooperative and difficult."	–	✓
"Client refused 0900 metformin; states 'I never take it at home.' Teaching provided on purpose and risks of skipping; verbalized understanding. Dr. Lee notified 0915."	✓	–
Used white-out to correct a wrong entry.	–	✓
Late entry: "10/15 1430 – late entry for 10/15 0900: tolerated PT, ambulated 50 ft with walker, SpO2 96%."	✓	–
"Family member visited; I think they were upset about the diagnosis."	–	✓
Charted "incident report filed" in the medical record.	–	✓
"RR 28, accessory muscle use noted, lips dusky. O2 applied 4 L NC per protocol. Dr. Lee notified."	✓	–
"Client is non-compliant."	–	✓

Appropriate entries are *objective, factual, time-stamped,* and document teaching/notification when relevant.

Inappropriate entries use *labels* (uncooperative, non-compliant), *opinions* ("I think"), *destructive corrections* (white-out), or *reference incident reports* in the chart.

> ***Trap:*** *Words like "appears" and "seems" feel safe but are still subjective unless followed by what the nurse observed.*

BOW-TIE · CJMM • GENERATE SOLUTIONS / TAKE ACTION

Question 04

A staff nurse discovers a coworker has accessed the EHR of a former neighbor not assigned to her. The coworker says, "I just wanted to know if she was okay; she's a friend."

CENTER: HIPAA Privacy Violation (Unauthorized Chart Access)

Actions to take – choose 2:

A. Help the coworker chart on the neighbor's record to "fix" it.

B. Report the breach to the privacy officer per facility policy.

C. Stop the coworker from accessing the chart further.

D. Tell the client's family that someone accessed the chart.

E. Wait to see if the coworker accesses the chart again.

Parameters to monitor – choose 2:

A. Audit trail of the coworker's chart access.

B. Coworker's social media for any disclosures.

C. Client's chart for altered entries.

D. Other client charts the coworker may have accessed.

E. Coworker's friendship with the client.

Actions: B + C | Monitor: A + D

Actions: Stop further unauthorized access (C) and report to the privacy officer (B). Disclosure to the family is governed by facility/legal counsel — not the discovering RN.

Monitor: The audit trail (A) shows exactly what was accessed and when. Other charts (D) may also have been accessed — patterns matter.

> ***Trap:*** *"Wait and see if it happens again." NCLEX never rewards delay when a breach is in progress or has occurred.*

ORDERED RESPONSE · CJMM • TAKE ACTION

Question 05

Place the following steps in correct order when correcting a documentation error in a paper chart.

1. Identify the incorrect entry.
2. Draw a single line through the incorrect entry.
3. Write "error" near the line.
4. Initial and date the correction.
5. Document the correct information in a new entry.
6. Notify the provider if the error affected care.

Correct order: 1 → 2 → 3 → 4 → 5 → 6

The original entry must remain visible (single line, never scribbled), labeled (error), authenticated (initial + date), and followed by the correct entry. Provider notification follows only if the error affected care decisions.

> ***Trap:*** *Putting "Notify provider" first. Notification is meaningful only after the record is corrected and the impact known.*

DROP-DOWN / CLOZE · CJMM • GENERATE SOLUTIONS

Question 06

Complete the statement by choosing the correct option in each bracket.

"A nurse is preparing to release information about a client to a family member who has called the unit. The nurse should first **[verify the family member's identity / confirm the client's permission to share]** and then **[share the lab results / refer to written authorization or speak with the client]**. If the client is competent, **[the family has the right to all information / the client controls disclosure]**."

Correct: confirm client's permission | refer to written authorization or speak with the client | the client controls disclosure

Authority to disclose flows from the competent client, not from the family relationship. Identity verification is necessary but secondary to authorization.

> ***Trap:*** *"Verify identity first" — identity matters, but without authorization to share, identity is irrelevant.*

MULTIPLE CHOICE · CJMM • TAKE ACTION

Question 07

A 78-year-old client is alert, oriented, and competent. The client's adult son calls and asks for the most recent lab results. Which response by the nurse is *best*?

A. "I'll fax them to you right now."

B. "I'm sorry, but family members are never given lab results."

C. "Let me speak with your father first to confirm he wants me to share that information with you."

D. "Only the provider can release that information."

Correct: C

C is correct. Honors client autonomy and verifies authorization. The client controls disclosure.

A: Unauthorized release = breach.

B: Inaccurate — competent clients may authorize family disclosure.

D: Inaccurate — RNs disclose within scope when authorized.

> ***Trap:*** *All-or-nothing answers ("never," "only"). Real-world disclosure is governed by the client's permission.*

MULTIPLE CHOICE • DOCUMENTATION CJMM • TAKE ACTION

Question 08

A client refuses a scheduled CT scan. Which documentation by the nurse is *most appropriate*?

A. "Client refused the CT scan; was uncooperative."

B. "Client states, 'I don't want any more tests. I just want to go home.' Purpose of scan and risks of refusal explained. Client verbalized understanding. Dr. Patel notified at 1015. No further intervention requested at this time."

C. "Client refused scan because they are tired of being in the hospital."

D. "Client refused, but I'm sure they'll change their mind by tomorrow."

Correct: B

B is objective, time-stamped, documents teaching, verifies understanding, and shows provider notification — the full refusal documentation set.

A: Labeling ("uncooperative").

C: Assumes the reason without quoting the client.

D: Opinion / prediction.

> ***Trap:*** *"Refusal documented" is incomplete — refusal + teaching + understanding + provider notification = the legal record.*

DELEGATION SCENARIO CJMM • GENERATE SOLUTIONS

Question 09

The charge RN is making assignments. Which task is *most appropriate* to delegate to a UAP?

A. Initial teaching about a new home oxygen setup.

B. Transporting a stable client to the radiology department for an MRI.

C. Documenting the client's response to a new pain medication.

D. Reviewing the medication reconciliation list with the client at discharge.

Correct: B

B is within UAP scope — stable client, routine transport.

A: Initial teaching = RN.

C: Evaluating response = RN.

D: Med reconciliation/discharge teaching = RN.

> ***Trap:*** *"Documenting" sounds delegable, but documenting a response requires nursing evaluation — that's the RN's job.*

HANDOFF / SBAR CJMM • TAKE ACTION

Question 10

A nurse is giving a transfer report to the receiving unit. Which statement is *most appropriate* to include in the SBAR?

A. "She's been really annoying – keeps calling out for things."

B. "S: 68-year-old admitted with pneumonia. B: PMH HTN, DM2; on home insulin. A: SpO2 91% on 2L NC, RR 22, last antibiotic at 0900. R: Continue antibiotics, monitor respiratory status, glucose checks before meals. Code status: Full. Allergies: PCN."

C. "She's basically fine, you don't need to do much."

D. "I'll just send the chart so you can read it yourself."

Correct: B

B is structured (SBAR), objective, and includes the must-have safety items – code status, allergies, pending issues.

A: Subjective + labeling.

C: Vague, unsafe, no critical information.

D: Sending the chart is not handoff.

> ***Trap:*** *A complete handoff requires code status, allergies, lines/tubes/drains, pending labs, and unresolved concerns – even when the client is stable.*

PRIORITIZATION CJMM • PRIORITIZE HYPOTHESES

Question 11

A nurse is starting a shift. Which of the following situations requires the *most immediate* action?

A. A client requests pain medication.

B. A UAP is overheard discussing a client's HIV status in the hallway.

C. A scheduled IV antibiotic is due in 15 minutes.

D. A family member is upset about the meal tray.

Correct: B

B is an active legal violation in progress, which must be stopped *now.* The information being disclosed is also particularly sensitive (HIV status), heightening the harm.

A, C: Important, but neither is an active breach.

D: Service concern; can be addressed shortly.

> ***Trap:*** *Medication and pain feel "urgent," but an in-progress breach is a now action – confidentiality is a safety issue.*

SATA • DOCUMENTATION CJMM • TAKE ACTION

Question 12

Which of the following actions support legally defensible documentation? *Select all that apply.*

A. Charting in real time when possible.

B. Using only facility-approved abbreviations.

C. Charting opinions about the client's emotional state.

D. Documenting refusal of care, teaching provided, and provider notification.

E. Leaving blank spaces in the EHR for "future" entries.

F. Using objective descriptions of what was seen, heard, and measured.

G. Documenting "client appears non-compliant."

H. Drawing a single line through paper-chart errors and labeling them.

I. Sharing your EHR login with a trusted coworker so they can chart faster.

J. Charting "Dr. Smith paged at 1430; returned call 1445; new order received."

Correct: A, B, D, F, H, J

C: Opinions are not objective.

E: Blank spaces invite tampering and are not legally defensible.

G: "Non-compliant" is a label.

I: Sharing a login violates EHR and HIPAA policies.

> ***Trap:*** *"Trusted coworker" doesn't matter – every key under your login is legally yours.*

07 — UNFOLDING CASE STUDY

NGN Case Study: *Mrs. R., Day 2 Pneumonia*

A full Clinical Judgment Measurement Model loop — Recognize, Analyze, Prioritize, Generate, Take Action, Evaluate. Confidentiality and documentation enter the case during the clinical deterioration.

CLIENT PROFILE

62-year-old female, hospital day 2 for community-acquired pneumonia. PMH: hypertension, type 2 diabetes, stage 3 CKD. Allergies: **PCN (rash)**. Code status: **Full code**. Daughter at bedside.

NURSE'S NOTES — DAY 2, 0700

Client awake, alert, oriented ×3. C/o fatigue. Lung sounds with scattered crackles bilaterally. Skin warm, dry. Ambulated to chair with minimal assist. Tolerated breakfast 50%. IV access patent left forearm. Daughter at bedside. Call light within reach.

VITAL SIGNS TREND

TIME	T (°F)	HR	BP	RR	SPO₂	O₂
0700	100.2	92	138/82	22	93%	2L NC
1100	100.6	96	134/80	22	94%	2L NC
1500	101.8	110	110/68	26	90%	2L NC

PROVIDER ORDERS

Ceftriaxone 1 g IV q24h · Azithromycin 500 mg PO daily · Acetaminophen 650 mg PO q6h PRN fever · O2 to maintain SpO2 > 92% · Daily CBC + BMP · VS q4h, more frequent if unstable.

LAB RESULTS — RETURNED 1430

WBC **18,500/mm³** (high) · Lactate **3.2 mmol/L** (high) · BUN **38 mg/dL** (high) · Creatinine **1.9 mg/dL** (baseline 1.4).

DAUGHTER'S STATEMENT — 1500

"She's confused all of a sudden. She didn't recognize me when I walked in. And earlier I overheard the nurse in the hallway telling the other nurse that mom had a 'bad UTI' — I'd like to know what's going on."

HEALTH CARE TEAM NOTES

Charge nurse: "Pull labs from earlier — this looks like sepsis developing."
Respiratory therapist: "Will reassess oxygenation now."

Q1 — Recognize Cues

Which findings are concerning? *Select all that apply.*

A. T 101.8°F (rising)

B. HR 110 (up from 92)

C. BP 110/68 (down from 138/82)

D. RR 26

E. SpO2 90% on 2L

F. New confusion

G. WBC 18,500

H. Lactate 3.2

I. Creatinine 1.9 (up from 1.4)

J. Nurse discussing case in hallway

`All of A–J are concerning.`

A–I together = SIRS/sepsis criteria with new organ dysfunction (acute kidney injury + altered mental status). J is a confidentiality breach overheard by family — relevant but addressed after stabilization.

Q2 — Analyze Cues

The client is most likely developing which condition?

A. Pulmonary embolism

B. Sepsis with possible acute kidney injury

C. Acute heart failure exacerbation

D. Hypoglycemia

`Correct: B`

Fever, tachycardia, hypotension, tachypnea, hypoxia, leukocytosis, elevated lactate, and rising creatinine in a client with infection = sepsis with developing AKI.

Q3 — Prioritize Hypotheses (Cloze)

The client's clinical picture is most consistent with **[sepsis / pulmonary embolism / heart failure]**. The most concerning physiologic alteration is **[decreased perfusion and oxygen delivery / hyperglycemia / electrolyte imbalance]**. The priority intervention is **[call rapid response / administer PRN acetaminophen / contact dietitian]**.

`Correct: sepsis | decreased perfusion and oxygen delivery | call rapid response`

Falling BP + rising HR + new confusion + rising lactate = perfusion problem. Rapid response activation is the most time-critical action.

Q4 — Generate Solutions

Choose the 4 most appropriate immediate interventions.

A. Call rapid response team

B. Increase O2 per protocol to maintain SpO2 > 92%

C. Notify provider; request orders per sepsis protocol

D. Obtain blood cultures and lactate per sepsis bundle (per orders)

E. Wait one hour and recheck

F. Restrict family visitation

G. Address the hallway breach with the involved nurse

H. Give only the scheduled azithromycin

Correct: A, B, C, D

RRT, O_2 titration, provider notification, and sepsis bundle initiation are all time-critical. The breach (G) is real — but addressed after the client is stable, not in place of resuscitation.

Q5 — Take Action: Which Client to See First?

The nurse has four assigned clients. Who is seen first?

A. Mrs. R. (deteriorating septic client described above)

B. Stable POD#2 cholecystectomy client requesting PRN pain medication

C. Client awaiting discharge teaching

D. Client requesting a meal tray substitution

Correct: A

Unstable, deteriorating, new confusion + perfusion compromise — ABCs + change in condition + safety risk.

Q6 — Evaluate Outcomes

After interventions, the client's status: HR 98 · BP 118/72 · RR 20 · SpO_2 95% on 4L NC · T 100.4 · Oriented ×3.

For each finding, indicate whether the expected outcome was *Met / Partially Met / Not Met.*

GOAL	STATUS
Improved perfusion (BP up, HR down)	✓ Met
Improved oxygenation (SpO_2 > 92%)	✓ Met
Resolution of confusion	✓ Met
Resolution of fever	~ Partially Met
Hemodynamic stabilization	✓ Met

Q7 — Confidentiality Follow-Up

Now that the client is stabilized, what should the nurse do about the daughter's report of the hallway conversation?

A. Ignore it — it wasn't a real breach.

B. Apologize to the daughter, address the breach with the involved nurse, and report to the privacy officer per facility policy.

C. Tell the daughter she shouldn't have been listening.

D. Document the daughter's comment in the chart but take no other action.

Correct: B

Acknowledge the family, address the staff behavior, and follow facility policy on breach reporting. NCLEX never rewards silence about a witnessed breach.

08 — PRIORITIZATION DRILL

"What Should the Nurse *Do First?*"

Five mini-scenarios. Pick the first action; then read the rationale.

01

A new RN is overheard discussing a client's diagnosis in the cafeteria.

First action: Discreetly approach the nurse and ask to move the conversation to a private area. Then follow up with the manager or privacy officer per policy. *Intervene at the moment — silence is participation.*

02

A nurse finds a printout of a client's labs left at the unit printer.

First action: Retrieve the document immediately and dispose of it in the designated PHI shred bin. Document/report per facility policy if appropriate. *Containment first; reporting second.*

03

A family member asks for the client's medication list while the competent client is asleep.

First action: Politely defer until the client awakens so authorization can be obtained directly. *Sleeping ≠ incapacitated. The client still controls disclosure.*

04

A nurse logs into the EHR and is then called urgently to a patient's room.

First action: Log out before leaving the workstation. If the call is truly emergent, use the rapid-lock/timeout, then return only briefly. *Logged-in workstations are open chart access.*

05

A nurse realizes she forgot to chart a medication given 2 hours ago.

First action: Enter a "late entry" in the EHR with the current date/time, referencing the actual time of administration. *Never insert into a prior time slot.*

09 — DELEGATION DRILL

"Can This Be *Delegated?*"

Five scenarios. Identify the correct team member and the rationale.

01

Transport of a stable, ambulatory client to the radiology department for an X-ray.

UAP **Yes — delegate.** Routine transport of a stable client is in UAP scope.

02

Initial education for a newly diagnosed heart failure client about home self-monitoring.

RN **No — RN only.** Initial teaching on a new diagnosis is RN scope.

03

Entering measured vital signs into the EHR.

UAP **Yes — delegate.** UAP enters values. RN interprets and addresses abnormals.

04

Telling a calling spouse the client's new diagnosis.

NO **Not delegable to UAP.** Disclosure of clinical information requires licensed scope and verified authorization from the competent client.

05

Reinforcing previously taught HIPAA rights with a client preparing for discharge.

LPN/VN **Yes — delegate.** Reinforcement is in LPN/VN scope; initial teaching remains with the RN.

10 — REFERRAL & COLLABORATION

"Who Should the Nurse *Contact?*"

Five scenarios. Identify the right team member.

01

A nurse discovers a coworker has accessed a former neighbor's chart.

Contact: Privacy Officer / Compliance Officer + Nurse Manager. Document the facts; follow facility breach procedure.

02

A nurse suspects a coworker is falsifying documentation to cover a medication error.

Contact: Nurse Manager → Nursing Supervisor (chain of command). May ultimately involve risk management and the State Board of Nursing.

03

A provider asks the nurse to delete a chart entry that documents a medication error.

Contact: *Refuse first.* Then escalate up the chain of command – charge nurse → manager → nursing supervisor → risk management. Document the conversation per facility policy.

04

A client wants to file a formal complaint about how their information was handled.

Contact: Patient Advocate / Ombudsman + Privacy Officer.

05

A client speaks only Vietnamese, and the family wants to interpret a complex informed-consent discussion.

Contact: Professional medical interpreter (in-person or phone) + provider for re-consent. Family should not interpret for consent or sensitive disclosures.

11 — LEGAL / ETHICAL TRAP DRILL

Legal & *Ethical Traps*

High-frequency NCLEX traps involving consent, refusal, confidentiality, mandatory reporting, and end-of-life care.

01

A subpoena arrives on the unit requesting a client's chart.

Action: Notify risk management / legal services and the privacy officer. The nurse does *not* release records independently. HIPAA permits disclosure per court order, but facility process governs the release.

02

A competent adult client tells the nurse, "Don't tell my husband I'm pregnant."

Action: Honor the request. Document the client's instructions. Do not disclose to the spouse. Competent clients control their own disclosure.

03

The mother of a 16-year-old asks for the teen's STI screening results. State law permits minors to consent to STI care confidentially.

Action: Refer to state law and facility policy. In many states, the minor's disclosure rights protect this information from parents. Do not automatically disclose.

04

A nurse discovers another nurse accessed her own grandmother's chart "to help with care decisions."

Action: Even with good intent, family-member access without need-to-know is a HIPAA violation. Report per facility policy. Good intent does not authorize access.

05

A client is end-of-life with a documented DNR. The family asks the nurse not to chart the DNR conversation because "we don't want to think about it."

Action: Document accurately. The legal record must reflect the conversation and the client's directive. Educate the family about why the advance directive must be visible to every clinician involved.

12 — END-OF-DAY QUICK REVIEW

End-of-Day *Quick Review*

Four panels. Read them, screenshot them, recall them tomorrow.

10 MUST-REMEMBER POINTS

1. Minimum necessary = access only what you need for your client.
2. PHI = name + any health info; combinations of identifiers count.
3. Verify identity before disclosing anything by phone.
4. Curiosity access is a federal HIPAA violation.
5. Log out of the EHR every time you walk away.
6. Document objectively — what you see, hear, measure, quote.
7. Refusal documentation = refusal + teaching + understanding + provider notification.
8. Late entries are legal when labeled (current time + original time).
9. Never document "incident report filed" in the medical record.
10. Mandatory reporting (abuse, communicable disease) overrides HIPAA.

5 COMMON NCLEX TRAPS

1. "Family = automatic right to info." *False.* Competent client controls disclosure.
2. "I didn't share it, so it isn't a breach." *False.* Access itself is the violation.
3. Charting "non-compliant" / "uncooperative" / "appears anxious." Labeling.
4. Using white-out, scribbling, or deleting prior entries. Never legal.
5. Delaying intervention when witnessing a breach. NCLEX = act now.

5 "NEVER DO THIS" RULES

1. NEVER share your EHR login or password.
2. NEVER post about a client on social media — not even "without names."
3. NEVER access a chart for a client not in your care.
4. NEVER chart opinions, labels, or assumptions.
5. NEVER alter, backdate, or delete a prior chart entry.

5 SAFETY-FIRST PHRASES TO RECOGNIZE

1. "Notify the privacy officer..."
2. "Document objectively..."
3. "Verify authorization before disclosure..."
4. "Log out of the EHR..."
5. "Report per facility policy..."

13 — ONE-PAGE VISUAL SUMMARY

Day 5 *Infographic*

Screenshot this. Re-read it tomorrow morning. The whole day, on one page.

▸ THE CORE RULE

- **Minimum necessary + need to know**
- Access only what serves your client
- Share only with the care team
- Competent client controls disclosure

▸ WHAT COUNTS AS PHI

- Name · MRN · DOB · address
- Room number · photo · diagnosis
- Treatment · lab values
- Combinations of identifiers count

▸ SOCIAL MEDIA: ALWAYS UNSAFE

- No photos · no initials · no "memorable cases"
- Background details in selfies count
- Private groups still count
- "No name used" is NOT a defense

▸ EHR DISCIPLINE

- Log out every time
- Never share a login
- Audit trails track every keystroke
- Privacy screens facing away from public

▸ DOCUMENTATION FLOW

OBSERVE → MEASURE → QUOTE THE CLIENT → RECORD ACTION → NOTIFY PROVIDER → DOCUMENT RESPONSE

- Objective · Timely · Factual · Approved abbreviations
- No labels · no opinions · no blame
- Refusal = refusal + teaching + understanding + notification

▸ ERROR CORRECTION (PAPER)

- ① Single line through entry
- ② Write "error"
- ③ Initial + date
- ④ Enter correct information
- ⑤ Notify provider if care was affected

▸ LATE ENTRY RULES

- Use current date/time stamp
- Label "late entry"
- Reference the original time
- Never backdate into a prior slot

▸ HIPAA EXCEPTIONS (REPORT ANYWAY)

- Suspected abuse / neglect
- Communicable diseases (per state)
- Gunshot / stab wounds
- Impaired colleague / diversion
- Court order / subpoena (via legal)

▸ WHEN YOU WITNESS A BREACH

STOP IT → REDIRECT → REPORT → DOCUMENT

- Privacy officer / nurse manager
- Silence = participation

▸ DELEGATION SNAPSHOT

- **RN:** Initial teaching · evaluation · disclosure with authorization
- **LPN:** Reinforcement · verbal orders (varies)
- **UAP:** Transport (stable) · enter VS data

▸ THE 5-ITEM HANDOFF FLOOR

- ① Code status
- ② Allergies
- ③ Lines / tubes / drains
- ④ Pending labs / studies
- ⑤ Unresolved concerns

▸ CJMM LOOP FOR TODAY

RECOGNIZE → ANALYZE → PRIORITIZE → GENERATE → ACT → EVALUATE

- Every confidentiality / documentation question maps here.