NCLEX-RN · 2026 | MANAGEMENT OF CARE DAILY REVIEW DAY 08 · VOL. I

Collaboration with the *Interprofessional* Team

Knowing who to call, when to call them, and what to say — because the RN sits at the hub of every plan of care.

FRAMEWORK: **2026 NCLEX-RN TEST PLAN** CATEGORY: **SAFE & EFFECTIVE CARE ENVIRONMENT** MODEL: **NGN CLINICAL JUDGMENT MEASUREMENT MODEL**

LEVEL: **APPLICATION & HIGHER**

§ 01 High-Yield *Overview*

The interprofessional team is the coordinated set of licensed and credentialed disciplines that together meet the client's biological, psychological, social, and spiritual needs. The RN sits at the **hub** of that team — assessing, identifying who is needed, securing an order when required, communicating significant findings, coordinating the plan, and evaluating outcomes.

On NCLEX, collaboration is **not** the same as delegation. Delegation moves a task to someone with a *narrower* scope (LPN/VN, UAP). Collaboration partners the RN with another *licensed/credentialed expert* (PT, OT, SLP, RT, RD, pharmacist, social worker, case manager, chaplain, wound nurse, mental-health team, rapid response team, provider) to optimize a part of the plan of care that requires their specialized scope.

Three NCLEX truths anchor this day:

ANCHOR 1 · THE RN COORDINATES; THE PROVIDER AUTHORIZES

Most referrals, diagnostics, medications, treatments, and discipline-specific consults require a **provider order**. The RN *identifies the need*, secures the order, then coordinates and follows up. Social work and case management may be RN-initiated per facility policy.

ANCHOR 2 · ASSESS BEFORE YOU REFER

The NCLEX-correct nurse **assesses first**. "Notify provider," "consult dietitian," and "call the wound nurse" are almost never the first action when assessment data is incomplete. Recognize and analyze cues *before* you generate solutions.

ANCHOR 3 · USE THE RIGHT LADDER OF URGENCY

Subtle change → call provider with SBAR. Trending downward but not yet coding → **Rapid Response Team**. Pulseless / apneic → **Code Blue**. Unsafe order or non-responsive provider → **chain of command** (charge nurse → nursing supervisor → medical director).

§ 02 10 *Must-Know* Rules

01 **Assess first, refer second.** Always recognize and analyze cues before calling another team member. Incomplete data → wrong specialist or wasted call.

02 **Use SBAR every time.** Situation → Background → Assessment → Recommendation. Closed-loop with read-back of any verbal orders and critical results.

03 **Most consults need a provider order** — PT, OT, SLP, RD, RT, wound nurse, hospice, palliative care, home health. Social work and case management are often RN-initiated per policy.

04 **SLP evaluates swallowing first** after stroke, prolonged intubation, head/neck surgery, or any new dysphagia cue — *before* any PO intake (including water and oral meds).

05 **Dietitian after the swallow is cleared** — for diet texture, malnutrition, enteral/parenteral planning, dysphagia diets, diabetic teaching, renal/cardiac/liver diets.

06 **Respiratory therapist owns the airway equipment** — vent settings, ABG draws (per policy), suctioning trouble, NIV (CPAP/BiPAP) management, neb delivery, oxygen titration teaching.

07 **Pharmacist for medication safety** — drug interactions, dose verification (especially high-alert: insulin, heparin, opioids, chemo, K^+), reconciliation discrepancies, IV compatibility, affordability/coupon programs.

08 **Social worker vs. case manager** — SW addresses psychosocial barriers (abuse, mental health, housing, food, finances, end-of-life support). CM coordinates the *logistics* of safe transitions (home health, DME, rehab, insurance authorizations, follow-up).

09 **Rapid Response = deteriorating, not yet coding.** Activate for new hypotension, hypoxia, mental status change, chest pain, "I just feel weird," new arrhythmia, or RN gut-feeling. Call Code Blue for pulseless/apneic.

10 **Chaplain on request — never assume.** Offer spiritual support; let the client identify their tradition or decline. Same for ethics committee: convene for value conflicts that cannot be resolved at the bedside.

§ 03 RN Safety *Decision* Table

SITUATION	BEST RN ACTION	WHY THIS IS THE SAFEST ACTION	COMMON NCLEX TRAP
Post-CVA client coughs on first sip of water at breakfast	Hold all PO intake; consult **SLP** for bedside swallow evaluation; notify provider	Prevents aspiration pneumonia — the leading cause of post-stroke death	Choosing dietitian first (texture decisions follow the swallow eval)
Newly intubated client; vent showing high-pressure alarm	Assess the client (DOPE — Displacement, Obstruction, Pneumothorax, Equipment), then call **RT**; manual ventilate if needed	Airway is ABC priority; RT troubleshoots vent within scope	Calling the provider before assessing the client and bag-mask ventilating
Client refuses to take new $480/month inhaler at discharge	Coordinate with **pharmacist** (formulary alternative) and **social worker / case manager** (patient-assistance programs)	Adherence is a safety issue; affordability barriers are SW/CM/Rx territory	Documenting "non-compliant" without addressing the root cause
Family describes recent bruising on an older client; client says nothing	Assess privately; report suspicion to **provider, social worker, and adult protective services** per state law	Mandatory reporters report suspicion — not proof; SW initiates APS pathway	Waiting for "evidence" before reporting; calling family for clarification
Post-op day 1 client suddenly SOB, HR 118, SpO2 88% on 2L	Stay with client, apply O2, raise HOB, **activate Rapid Response**, notify provider	Cue cluster fits PE; RRT brings advanced assessment to the bedside before arrest	Calling the provider first and waiting for a callback
Client with stage 3 sacral pressure injury on admission	Obtain order for **wound care nurse** consult; coordinate with **dietitian** (protein/calorie needs) and turning schedule	Wound healing is multidisciplinary — local care + nutrition + offloading	Treating it as "just a dressing change" the UAP can do
Provider gives a verbal order over the phone for IV potassium 40 mEq bolus	**Read back**, clarify, refuse to administer as bolus — IV K^+ is never bolused; escalate per chain of command if provider insists	Bolus K^+ → fatal dysrhythmia; verbal read-back is mandatory safety practice	Administering because "the provider ordered it"
Client tearfully asks "Am I going to die from this cancer?"	Sit, use therapeutic communication, then offer **chaplain**, **social worker**, and **palliative care** consult per client preference	Spiritual/psychosocial distress needs a team response, not a one-line answer	Calling chaplain immediately without exploring what the client wants
Client unable to feed self or button shirt 4 days post-stroke	Obtain order for **OT** consult to evaluate ADLs and adaptive equipment	OT scope = fine motor, ADLs, adaptive devices; PT scope = gait/mobility	Confusing OT (occupation = activities of daily living) with PT (physical movement)
Pre-op consent signed but client now says "I don't really get what they're doing to me"	**Stop the process**; notify the provider; do not transport to OR until provider re-explains and consent is verified	Informed consent requires understanding; the nurse witnesses understanding, not just the signature	Re-explaining the procedure yourself and proceeding

§ 04 Collaboration *Scope* Table — Who Owns What

When collaboration is the focus, the question on NCLEX is rarely "RN vs LPN vs UAP" — it's "*which discipline* matches this problem?" The grid below shows whether the RN can initiate the consult independently or must secure a provider order, and what each team member uniquely contributes.

TEAM MEMBER	WHAT THEY UNIQUELY DO	RN MAY INITIATE?	ORDER NEEDED?	COMMON NCLEX TRIGGER
Provider (MD/DO/NP/PA)	Diagnose, prescribe, order treatments, change code status	Yes — must notify	N/A (writes the orders)	Change in condition, abnormal labs, new symptom
Pharmacist	Med reconciliation, interactions, dosing, IV compatibility, affordability, anticoag/insulin management	Yes	No	High-alert med, polypharmacy, "looks-alike/sounds-alike"
Respiratory Therapist (RT)	Vents, NIV (CPAP/BiPAP), nebs, suctioning, ABG, O_2 titration, peak-flow teaching	Often per protocol	Sometimes — for new vent/NIV settings	Mechanical ventilation, asthma/COPD, post-extubation
Physical Therapist (PT)	Gait, strength, transfers, assistive devices (walker, crutches), gross motor rehab	No	Yes	Post-op joint, CVA mobility, fall, deconditioning
Occupational Therapist (OT)	ADLs (bathing/dressing/feeding/grooming), fine motor, adaptive equipment, home safety, splinting	No	Yes	Post-CVA self-care, hand surgery, dementia ADL decline
Speech-Language Pathologist (SLP)	Swallow evaluation, dysphagia diet recs, aphasia therapy, communication strategies	No	Yes	Post-CVA, post-extubation, head/neck CA, new dysphagia
Registered Dietitian (RD)	Diet planning, malnutrition assessment, enteral/parenteral formulas, diabetic/renal/cardiac counseling	No	Yes	Unintended weight loss, NPO > 5 days, new diabetes, dysphagia diet
Social Worker (SW)	Psychosocial barriers — abuse, mental health, housing, food, finances, IPV, addiction, end-of-life support	Yes (per policy)	Often no	Homelessness, suspected abuse, family crisis, no support
Case Manager (CM)	Discharge logistics — home health, DME, rehab placement, insurance, follow-up appointments	Yes (per policy)	Often no	Complex discharge, new oxygen, needs SNF, equipment
Chaplain / Spiritual Care	Spiritual distress, ritual/sacrament needs, presence at end-of-life, ethical conversations	Yes — on request	No	Terminal diagnosis, spiritual distress, withdrawal of care
Wound Care Nurse / CWOCN	Complex wound staging, dressing selection, ostomy/incontinence, NPWT troubleshooting	No (consult)	Yes	Stage 3/4 PI, dehisced wound, new ostomy, fistula
Mental Health / Psych Team	Risk assessment, crisis intervention, capacity evaluation, psych meds, involuntary hold	Yes for risk assessment	Yes for psych consult	Suicidal ideation, psychosis, delirium, capacity question
Rapid Response Team (RRT)	Bedside critical-care assessment for deteriorating but not-yet-arrested clients	Yes — any RN can activate	No	New hypotension, hypoxia, mental status change, RN gut feeling
Code Blue Team	Full advanced cardiac/respiratory resuscitation	Yes — any RN	No	Pulseless and/or apneic
Ethics Committee	Mediates value/principle conflicts (e.g., family vs. advance directive, futility, refusal of life-saving care for a minor)	Yes — via chain of command	No	Family overriding written advance directive; unresolved moral distress

§ 05 Red-Flag *Cues*

IMMEDIATE ASSESSMENT

- New change in level of consciousness
- SpO_2 drop > 4% from baseline
- New chest pain, dyspnea, or palpitations
- New unilateral calf swelling/pain post-op
- Unexpected vital sign trend (HR ↑, BP ↓, RR ↑)
- Client / family says "Something is different"

PROVIDER NOTIFICATION

- Critical lab value (K^+, glucose, INR, troponin, etc.)
- New cardiac arrhythmia
- Post-procedure bleeding above expected
- Failed swallow screen pre-PO med
- Refused treatment of a life-sustaining nature
- New skin breakdown identified on assessment

RAPID RESPONSE

- HR < 40 or > 130 sustained
- SBP < 90 or > 200, or MAP < 65
- RR < 8 or > 28
- SpO_2 < 90% despite supplemental O_2
- New, sustained mental status change
- New, severe pain unrelieved by usual measures
- RN's professional concern — "they don't look right"

CHAIN OF COMMAND

- Provider gives an unsafe order and won't clarify
- Provider has not returned page for a deteriorating client
- Coworker appears impaired
- Refused to follow facility policy on a critical issue
- Family overriding a written advance directive
- Order to skip required safety checks

MANDATORY REPORTING

- Suspected child, elder, or vulnerable adult abuse/neglect
- Suspected intimate partner violence (varies by state)
- Reportable communicable disease (TB, measles, pertussis, STIs, COVID-19, etc.)
- Gunshot, stab, or burn injuries (varies by state)
- Impaired colleague (board of nursing)
- Sentinel events (internal QI + sometimes external)

HOLD DELEGATION / REASSESS

- Client just had a fall — RN reassesses, doesn't delegate
- Unstable vitals — RN owns the next set
- New blood transfusion — first 15 minutes are RN-only
- New tube feeding initiation — RN verifies placement
- Acute pain crisis or new behavioral escalation
- End-of-life imminent — RN at bedside

§ 06 Advanced NGN *Practice* Questions

Q1 MULTIPLE CHOICE GENERATE SOLUTIONS

A nurse is caring for a 72-year-old client on day 2 after an ischemic stroke. The client coughs and clears their throat with the first sip of water at breakfast. Which team member should the nurse contact **first**?

A Registered dietitian

B Speech-language pathologist

C Physical therapist

D Respiratory therapist

RATIONALE

CORRECT · B Coughing on PO intake post-CVA is a textbook dysphagia cue. The **SLP** performs the bedside swallow evaluation that determines whether the client can have anything by mouth — including water and oral medications.

A · NO The dietitian sets the diet *texture* (mechanical-soft, nectar-thick, etc.) *after* the SLP clears the swallow. Calling RD first risks aspiration.

C · NO PT addresses gait, transfers, and mobility — not swallowing.

D · NO RT manages airway equipment and oxygen, not swallow function, unless aspiration has already compromised the airway.

Trap: Choosing the dietitian because of the "food" context.

Clinical Judgment Step: Generate Solutions — picking the right intervention for the right cue.

Q2 SATA GENERATE SOLUTIONS

A nurse is planning care for a 68-year-old client newly admitted with hemorrhagic stroke. The client has dysphagia, right-sided hemiparesis, expressive aphasia, and a new stage 2 pressure injury on the sacrum. Which team members should the RN coordinate with? **Select all that apply.**

A Speech-language pathologist

B Physical therapist

C Occupational therapist

D Wound care nurse

E Registered dietitian

F Respiratory therapist

G Chaplain

RATIONALE

CORRECT · A, B, C, D, E

SLP → dysphagia + expressive aphasia. PT → hemiparesis/mobility. OT → ADLs (feeding/dressing/grooming on the affected side). Wound care nurse → pressure injury staging and dressing plan. Dietitian → protein/calorie support for wound healing and dysphagia-appropriate textures (after SLP).

F · NO RT is consulted for airway/ventilation problems. No cue suggests respiratory compromise here.

G · NO Chaplain is offered *on request*; the cues do not indicate spiritual distress. Choosing it without a cue assumes the client's beliefs.

Trap: "Pick everyone to be safe." NCLEX rewards picking the right ones for the cues, not the most.

Clinical Judgment Step: Generate Solutions — matching specialists to discrete cues.

Q3 MATRIX / GRID ANALYZE CUES + GENERATE SOLUTIONS

For each client finding, indicate the team member the RN should contact **first**.

FINDING	RT	OT	SW / CM	WOUND RN	SLP	PHARMACIST
New BiPAP order for COPD exacerbation	✓					
Cannot button shirt or feed self after stroke		✓				
Cannot afford new $480 inhaler at discharge			✓			also
Stage 3 sacral injury with foul-smelling drainage				✓		
Drools and pockets food after extubation					✓	
Heparin order in mg, not units — looks unsafe						✓

RATIONALE

Match the cue to the scope. NIV equipment → **RT**. ADLs/fine motor → **OT**. Affordability → **SW/CM** (pharmacist can also help with patient-assistance programs and formulary alternatives). Complex wound → **wound care nurse**. Pocketing food = dysphagia → **SLP**. Medication safety/clarification → **pharmacist**, plus chain of command if order is unsafe.

Trap: Defaulting to "call the provider" for everything. The interprofessional team exists so the provider isn't the only escalation pathway.

Clinical Judgment Step: Analyze Cues + Generate Solutions.

Q4 BOW-TIE PRIORITIZE HYPOTHESES + TAKE ACTION + EVALUATE

A 78-year-old client is on post-operative day 1 after total hip arthroplasty. Complete the bow-tie: identify the most likely complication, two priority actions to coordinate with the team, and two parameters to monitor.

ACTIONS TO TAKE

- Coordinate with **PT** for early ambulation as ordered
- Verify **SCDs in place** and confirm pharmacologic prophylaxis (enoxaparin) is ordered with pharmacy/provider

Venous Thromboembolism (DVT/PE)

PARAMETERS TO MONITOR

- Unilateral **calf pain, warmth, swelling**, asymmetry
- Sudden **dyspnea, tachypnea, SpO_2 drop**, pleuritic chest pain

RATIONALE

Orthopedic surgery + immobility + age = highest risk for VTE. The interprofessional plan combines mechanical (SCDs + ambulation by PT) and pharmacologic (anticoagulant verified by pharmacist/provider) prophylaxis. Monitoring spans both the limb (DVT) and the chest (PE).

Trap: Picking infection or hemorrhage as the priority. Both are real risks, but VTE is the leading preventable cause of post-op morbidity/mortality in joint replacement.

Clinical Judgment Step: Prioritize Hypotheses → Take Action → Evaluate Outcomes.

Q5 ORDERED RESPONSE TAKE ACTION — SBAR

A nurse is calling the on-call provider about a client with worsening dyspnea. Place the SBAR statements in the correct order.

A "I recommend obtaining a stat chest X-ray, ABG, and considering escalation to a higher level of care."

B "Mr. Allen in 412 is becoming increasingly short of breath."

C "He is a 64-year-old admitted 2 days ago with CHF exacerbation; baseline SpO_2 was 95% on 2L."

D "His RR is now 32, SpO_2 is 86% on 4L, lungs have crackles to the scapula, BP 178/96, HR 118."

RATIONALE

CORRECT ORDER · B → C → D → A Situation (B) → Background (C) → Assessment (D) → Recommendation (A). SBAR provides a structured, predictable framework so providers can act on the most clinically relevant data within seconds.

Trap: Starting with assessment data ("RR is 32...") instead of orienting the listener with the situation.

Clinical Judgment Step: Take Action — communicate effectively with the team.

Q6 DROP-DOWN / CLOZE GENERATE SOLUTIONS

A nurse is reviewing the plan of care during an interdisciplinary conference. The client has been NPO for 5 days following bowel resection and weighs 18% less than their admission weight. The nurse should first consult **[Dropdown 1]** to evaluate the need for **[Dropdown 2]**, and consult **[Dropdown 3]** to coordinate logistics if long-term nutrition support is needed at home.

DROPDOWN	OPTIONS	CORRECT
Dropdown 1	respiratory therapist · **dietitian** · physical therapist · chaplain	dietitian
Dropdown 2	fall precautions · swallow evaluation · **enteral or parenteral nutrition** · oxygen therapy	enteral or parenteral nutrition
Dropdown 3	physical therapist · **case manager** · chaplain · respiratory therapist	case manager

RATIONALE

An 18% unintended weight loss with 5+ days NPO is severe malnutrition risk. The **dietitian** evaluates and recommends the nutrition route. If home enteral/parenteral nutrition becomes the plan, the **case manager** coordinates the home infusion company, DME (pumps), supplies, and home-health follow-up.

Trap: Choosing SLP for "nutrition." SLP evaluates swallowing, not metabolic nutrition status.

Clinical Judgment Step: Generate Solutions — matching the discipline to the problem.

Q7 PRIORITIZATION PRIORITIZE HYPOTHESES

A charge nurse is reviewing four assigned clients. Which client should the RN see **first**?

A. A post-op day 2 hip-replacement client awaiting PT consult for ambulation

B. A newly admitted client requesting a chaplain visit

C. A client with COPD whose SpO_2 has dropped from 94% to 86% on 2L nasal cannula

D. A client on TPN whose family is questioning the discharge plan with the case manager

RATIONALE

CORRECT · C An 8-point SpO_2 drop in a COPD client is an ABC priority — possible mucus plug, pneumothorax, PE, or worsening exacerbation. The RN assesses, escalates O_2 cautiously (avoid blunting hypoxic drive), and likely calls RT and provider; consider RRT.

A · NO Stable; PT consult is not time-critical.

B · NO Important and addressable, but spiritual support is not the acute physiologic priority.

D · NO Psychosocial/logistic — CM is already involved.

Trap: Picking the client with the "loudest" complaint (D) over the silently deteriorating one (C).

Clinical Judgment Step: Prioritize Hypotheses — ABCs over psychosocial.

Q8 CASE-STUDY SATA GENERATE SOLUTIONS

A 55-year-old client is admitted with crushing chest pain and a new diagnosis of NSTEMI. History: type 2 diabetes, hypertension, smoker. The family discloses the client has not been taking maintenance medications "because they cost too much" and lives alone in a third-floor walk-up. Which team members should the RN coordinate with for discharge planning? **Select all that apply.**

A. Pharmacist (formulary alternatives, patient-assistance programs)

B. Social worker (psychosocial support, financial barriers)

C. Case manager (cardiac rehab placement, home health, follow-up)

D. Speech-language pathologist

E. Dietitian (cardiac/diabetic diet education)

F. Physical therapist (activity progression and conditioning)

G. Wound care nurse

RATIONALE

CORRECT · A, B, C, E, F The whole team is needed because the barriers are simultaneously clinical and social: **pharmacist** for affordability, **SW** for psychosocial/financial barriers and assistance applications, **CM** for cardiac rehab and follow-up logistics, **RD** for dual cardiac/diabetic teaching, **PT** for activity progression and the 3-flight stair concern.

D · NO No swallow or communication cue.

G · NO No wound cue.

Trap: Limiting yourself to one "obvious" referral when the cues point to multiple barriers.

Clinical Judgment Step: Generate Solutions — holistic, multidisciplinary planning.

Q9 COLLABORATION SCENARIO TAKE ACTION

A nurse is preparing to discharge a client post-CABG with a sternal wound infection requiring sterile daily packing for 3 weeks. The client lives alone and has Medicare. To ensure safe transition home, which team member should the RN contact **first**?

A Physical therapist

B Case manager

C Wound care nurse

D Chaplain

RATIONALE

CORRECT · B The clinical issue (wound care expertise) has been or will be addressed by the wound care nurse during admission, but **safe transition home** requires the **case manager** to arrange home health nursing for sterile dressing changes, DME (supplies), Medicare authorization, and follow-up appointments.

C · CLOSE The wound care nurse provides expert recommendations on the dressing technique and supplies; they do not arrange home health.

A · NO Activity is one piece, but not the limiting factor for discharge.

D · NO No cue for spiritual distress.

Trap: Choosing the discipline that "fits the wound" instead of the one that fits the transition.

Clinical Judgment Step: Take Action — match the referral to the goal of the moment.

Q10 HANDOFF / SBAR SCENARIO RECOGNIZE CUES + TAKE ACTION

At morning huddle, the night nurse reports on a 76-year-old client with worsening pneumonia who is now on 6L nasal cannula with SpO_2 88–91%, RR 28, mild new confusion. Which response by the oncoming day nurse demonstrates appropriate use of the interprofessional team?

A "I'll just monitor and notify the provider in a few hours if it gets worse."

B "I'll page respiratory therapy now and also call the provider to assess for escalation of care; if I see further decline, I'll activate the rapid response team."

C "Let's wait until the providers round at 10 AM."

D "I'll ask the UAP to recheck vitals in 2 hours and call me if anything changes."

RATIONALE

CORRECT · B The client is already at the threshold for RRT — SpO_2 trending low on high-flow nasal cannula, tachypnea, and new mental status change all signal failure of current therapy. Activating **RT + provider** now, and being prepared to escalate to **RRT**, uses the whole team appropriately.

A, C, D · NO All delay assessment and intervention. Waiting "to see" with these vitals is unsafe; delegating only vitals to a UAP ignores the trending decline.

Trap: Equating "stable for now" with "safe." Trend matters more than a single number.

Clinical Judgment Step: Recognize Cues → Take Action.

§ 07

Unfolding *NGN Case Study*

Mr. R. Garcia · 68 · POD 2 L-TKA

ORTHOPEDIC FLOOR · 0930

NURSE'S NOTES

0700 handoff: Client awake, alert × 4. Pain 4/10 with oxycodone 5 mg q4h PRN. *Refused* to ambulate with PT yesterday afternoon — "too tired." Has not voided in 8 hours (Foley d/c'd POD 1). Lung sounds clear. SpO_2 96% on room air. Wife at bedside: "He seems quieter than usual."

0930: Client reports left calf "achy and tight." Calf circumference 2 cm greater than right. Mild redness and warmth to left calf. Pedal pulses 2+ bilateral. Skin pale, slightly diaphoretic. Anxious affect.

VITAL SIGNS — TREND

0700 · T	0700 · HR	0700 · RR	0700 · BP	0700 · SPO_2	0700 · PAIN
99.2°F (37.3°C)	96	18	138/82	96% RA	4/10
0930 · T	**0930 · HR**	**0930 · RR**	**0930 · BP**	**0930 · SPO_2**	**0930 · PAIN**
99.0°F	108 ↑	24 ↑	132/78	92% RA ↓	5/10

PROVIDER ORDERS

Regular diet · VS q4h · **Enoxaparin 40 mg SC daily** · Acetaminophen 650 mg q6h scheduled · Oxycodone 5 mg q4h PRN · Ambulate with PT BID · SCDs while in bed · I/O q shift · Foley discontinued POD 1 · CBC, BMP daily.

TODAY'S LABS

WBC 11.2 · Hgb 10.4 (admission 11.8) · Plt 188 · BUN 22 · Cr 1.0 · Na 138 · K 4.0 · Glucose 124. *D-dimer not yet ordered.*

CLIENT & FAMILY STATEMENT

Client: "I just want to rest. My leg feels weird today, and I get short of breath when I sit up." Wife: "He doesn't seem like himself this morning."

TEAM NOTES

PT: Refused therapy yesterday PM; will attempt this AM. **Case Management:** Discharge planned POD 4 — home with home-health PT/OT. **Pharmacy:** Enoxaparin order verified, appropriate dose for VTE prophylaxis.

CS · 1 SATA RECOGNIZE CUES

Which findings at 0930 are **concerning** and require further analysis? *Select all that apply.*

- A Left calf "achy and tight," 2 cm larger than right
- B HR 108, RR 24, SpO_2 92% on room air
- C Mild redness and warmth to left calf
- D Client refused PT yesterday
- E Wife: "He doesn't seem like himself"
- F Pain rated 5/10
- G Diaphoresis, pallor, anxious affect

RATIONALE

CORRECT · A, B, C, D, E, G All of these are cues consistent with VTE (DVT + possible PE). The refused PT is a contributing risk factor (immobility), and the wife's statement is a sensitive early indicator of subtle decompensation. Pain 5/10 is mildly elevated but expected post-op and not, by itself, a red flag.

Clinical Judgment Step: Recognize Cues.

CS · 2 DRAG & DROP ANALYZE CUES

Match each cue to whether it supports **DVT**, **PE**, or **either**.

CUE	DVT	PE	EITHER / BOTH
Unilateral calf swelling and warmth	✓		
SpO_2 92% on room air with new dyspnea		✓	
HR 108, RR 24			✓
Refused early ambulation			✓
Anxious affect, pallor, diaphoresis		✓	

RATIONALE

Local signs (swelling/warmth) localize to the DVT; systemic respiratory and adrenergic findings (hypoxia, tachypnea, anxiety, diaphoresis) point upstream to PE. Tachycardia and immobility are nonspecific risk indicators for both.

Clinical Judgment Step: Analyze Cues.

CS · 3 MULTIPLE CHOICE PRIORITIZE HYPOTHESES

Based on the cues, the nurse identifies the **priority hypothesis** as:

A Postoperative anemia

B Pulmonary embolism with deep vein thrombosis

C Surgical site infection

D Urinary retention

RATIONALE

CORRECT · B The cue cluster (unilateral calf signs + new hypoxia + tachycardia + tachypnea + anxiety) most strongly fits VTE with possible PE — the most *life-threatening* and *time-sensitive* hypothesis. Other hypotheses are possible but not the priority.

Clinical Judgment Step: Prioritize Hypotheses — urgency + likelihood + risk.

CS · 4 SATA GENERATE SOLUTIONS

Which of the following should the RN include in the plan of care **now**? *Select all that apply.*

A Notify the provider immediately using SBAR

B Place the client on bedrest pending evaluation

C Apply supplemental O_2 to maintain $SpO_2 \geq 94\%$

D Anticipate orders for D-dimer, lower-extremity duplex US, and CTA chest

E Have the client ambulate with PT to "work it out"

F Massage the left calf to improve circulation

G Initiate continuous SpO_2 and cardiac monitoring

H Coordinate with pharmacy on possible therapeutic anticoagulation

RATIONALE

CORRECT · A, B, C, D, G, H All support the priority hypothesis. E · NO Ambulating with a suspected DVT can dislodge a clot. F · NO Calf massage is contraindicated and can also dislodge a clot.

Trap: "Ambulation is always good." Not when VTE is suspected.

Clinical Judgment Step: Generate Solutions.

CS · 5 ORDERED RESPONSE TAKE ACTION

Place the RN's actions in the correct order, from **first to last**.

A Apply supplemental O_2 at 2 L NC, titrate to $SpO_2 \geq 94\%$

B Place the client on bedrest; raise HOB; keep calf still

C Notify the provider using SBAR

D Anticipate and prepare for stat diagnostics; start continuous monitoring

E Document assessment, intervention, and provider notification

RATIONALE

CORRECT ORDER · A → B → C → D → E ABCs first (oxygen). Then prevent clot dislodgement (bedrest). Then communicate with the provider using SBAR. Then prepare diagnostics and continuous monitoring while awaiting orders. Document last — but document everything, including the time of notification.

Clinical Judgment Step: Take Action.

CS · 6 SATA EVALUATE OUTCOMES

Two hours later, the nurse reassesses. Which findings indicate an **improving** outcome? *Select all that apply.*

A HR 84, RR 16, SpO_2 97% on 2L NC

B Therapeutic anticoagulation initiated per protocol; aPTT pending

C Left calf circumference stable, no extension of swelling

D Client reports "I can breathe easier"

E Hgb 9.4 (down from 10.4)

F Wife: "He looks more like himself"

G New petechiae and gum bleeding noted

RATIONALE

CORRECT · A, B, C, D, F Vital sign trend, subjective relief, stable limb exam, and the wife's observation all suggest improvement. Initiating anticoagulation per protocol is a positive process measure.

E · NO Declining Hgb is worsening; could reflect bleeding from anticoagulation — notify provider.

G · NO New petechiae/gum bleeding suggest a bleeding complication of anticoagulation — escalate immediately.

Trap: Assuming therapy started = outcome improved. Re-evaluate continuously.

Clinical Judgment Step: Evaluate Outcomes.

§ 08 "What Should the Nurse Do *First?*"

SCENARIO 1

A nurse is monitoring four post-op clients. One client has new chest pain and SpO_2 87% on 2L; another is awaiting PT consult; another asks for a chaplain; another is being discharged with case management.

First action: Go to the client with chest pain and hypoxia. ABCs override all other tasks. Apply O_2, assess, prepare to call provider and possibly activate RRT.

SCENARIO 2

A post-CVA client just finished a bedside SLP swallow eval that failed. The dietitian is on the way. The AM medication pass is due.

First action: Hold all PO meds. Notify provider to obtain alternate routes (IV/NG/SL) before the next dose. Do not give PO until SLP clears the swallow.

SCENARIO 3

An older client is admitted with bruising in multiple stages of healing. The adult daughter says her mother "falls a lot." The client looks down and won't make eye contact.

First action: Interview the client privately and assess for safety. Then report suspicion to provider and social work; mandatory reporting follows state law regardless of "proof."

SCENARIO 4

A nurse receives a verbal phone order: "Give 40 mEq potassium IV bolus over 5 minutes."

First action: Do not administer. IV potassium is *never* bolused. Read-back the order, request clarification, and escalate via chain of command if the provider insists.

SCENARIO 5

A client on PCA opioids becomes lethargic with RR 8 and SpO_2 84%.

First action: Stop the PCA. Stimulate the client, support airway, apply O_2, prepare naloxone, call RRT and provider. Notify pharmacy after stabilization for review of dose/parameters.

§ 09 "Can This Be *Delegated?*"

SCENARIO 1

The RN needs the swallow-screening tool completed on a newly admitted post-stroke client before any oral meds.

RN. Initial swallow screening is an RN responsibility per most facility policies; the SLP performs the formal eval if screening fails. Do *not* delegate to UAP.

SCENARIO 2

A post-op client with stable vitals needs assistance with morning hygiene and ambulating to the bathroom with a walker.

UAP. Stable client, predictable task, within UAP scope. RN reinforces ambulation precautions and is notified of any change.

SCENARIO 3

Discharge teaching is needed on a new diagnosis of heart failure including medications, sodium, and weight monitoring.

RN. Initial teaching and evaluation of understanding cannot be delegated. The dietitian can supplement diet teaching; the pharmacist can clarify meds; the RN owns the overall education.

SCENARIO 4

The first 15 minutes of a new packed-red-cell transfusion need monitoring.

RN. The first 15 minutes are RN-only for assessment of transfusion reaction. After stability, vitals collection may be delegated per policy, with RN review of trends.

SCENARIO 5

A stable client with a NG tube needs routine documented intake recording every 4 hours.

UAP may record measured intake/output for a stable client. The RN *verifies placement and administers* the feeding and reviews the totals.

§ 10 "Who Should the Nurse *Contact?*"

SCENARIO 1

A client with new ileostomy is anxious about pouch changes at home and cannot describe what to do if the stoma color changes.

Wound, Ostomy, and Continence Nurse (WOCN). Specialty teaching, supply selection, troubleshooting. Coordinate with case manager for home-health follow-up.

SCENARIO 2

A client with end-stage cancer is asking if "all the tubes" are really necessary and tearfully says they "just want to go home."

Palliative care + chaplain + social worker, with provider involvement to discuss goals of care. The RN may also recommend an ethics consultation if conflicts arise.

SCENARIO 3

A new mother is being discharged but has no transportation, no food at home, and reports her partner "controls everything."

Social worker for safety screening (IPV) and resource navigation; **case manager** for discharge logistics; **provider** notified for documentation and safety planning. Follow mandated-reporting laws as applicable.

SCENARIO 4

A client with COPD is being discharged on home oxygen for the first time.

Respiratory therapist for home-O_2 teaching (safety, flow rates, equipment), **case manager** for DME vendor and Medicare paperwork. RN coordinates education sign-off.

SCENARIO 5

A client's INR is 6.8 on warfarin; they had a clinic visit yesterday and started a new antibiotic.

Provider (immediate notification — critical lab) and **pharmacist** (drug-drug interaction review and dosing recommendations). Hold warfarin per protocol/order; assess for bleeding.

§ 11 Legal / Ethical *Traps*

TRAP 1 · INFORMED CONSENT

The surgical consent is signed, but in pre-op the client says, "I'm not really sure what they're cutting out today."

Stop the process. Informed consent requires understanding. Notify the surgeon to re-explain; the nurse witnesses understanding, not just the signature. Do not transport to OR.

TRAP 2 · REFUSAL OF CARE

A capable adult Jehovah's Witness refuses a life-saving blood transfusion. The family demands the nurse "just give it."

Honor the refusal. Document client's capacity and understanding. Notify provider and chaplain; involve ethics if needed. Family wishes do not override a capable adult's informed refusal.

TRAP 3 · CONFIDENTIALITY

A client's adult son calls and asks for the lab results. He says, "I'm a nurse and I'm her power of attorney."

Do not disclose without verifying he is the documented health-care proxy *and* that the client has authorized disclosure. Refer to social work / medical records for verification.

TRAP 4 · MANDATORY REPORTING

A new mother quietly tells the RN her partner "shoves her" but begs her not to tell anyone. The client is competent and refuses help.

IPV reporting laws vary by state. Many states do *not* mandate reporting of IPV between competent adults; some do. Always offer safety planning, document, involve SW, and provide hotline information. Mandated reporting for children, elders, and vulnerable adults is non-negotiable.

TRAP 5 · END-OF-LIFE / ADVANCE DIRECTIVE

A client has a written DNR. During cardiac arrest, the daughter screams, "Save him!"

Honor the written DNR. The advance directive expresses the capable client's wishes. Family distress is addressed by chaplain and SW; the directive is followed. Document and escalate to chain of command if there is pressure to override.

§ 12 End-of-Day *Quick Review*

A. 10 Must-Remember Points

1. Assess *before* you refer.
2. SBAR every call to the provider.
3. SLP before PO post-stroke or post-extubation.
4. RD *after* swallow clearance.
5. RT owns the airway equipment and NIV.
6. Pharmacist for med interactions, dosing, affordability.
7. SW for psychosocial barriers; CM for logistics.
8. RRT for deterioration, Code Blue for arrest.
9. Chaplain on request, not by assumption.
10. Most consults need a provider order; verify policy.

B. 5 Common NCLEX Traps

1. Choosing the dietitian before the SLP.
2. Confusing OT (ADLs) with PT (mobility).
3. Defaulting to "call the provider" instead of using the right specialist.
4. Picking the wound nurse for discharge logistics (use the case manager).
5. Selecting "everyone" on a SATA instead of matching the cues.

C. 5 "Never Do This" Rules

1. Never give PO meds before swallow clearance after stroke or extubation.
2. Never massage or ambulate a suspected DVT.
3. Never bolus IV potassium.
4. Never accept a verbal order without read-back.
5. Never disclose protected health information without verifying authorization.

D. 5 Safety-First Phrases on NCLEX

1. "Notify the provider using SBAR"
2. "Activate the rapid response team"
3. "Hold the medication / treatment pending clarification"
4. "Escalate via chain of command"
5. "Document assessment, intervention, and time of notification"

DAY 08 · STANDALONE SUMMARY · SCREENSHOT-READY

Collaboration with the *Interprofessional Team*

RN'S HUB ROLE

- → Assess
- → Identify need
- → Obtain order (if required)
- → Coordinate care
- → Communicate findings (SBAR)
- → Evaluate outcomes

SPECIALIST QUICK MATCH

- **Swallow** → SLP
- **Diet / nutrition** → RD
- **ADLs / fine motor** → OT
- **Mobility / gait** → PT
- **Vent / O_2 / NIV** → RT
- **Meds / interactions** → Pharmacist
- **Wound complexity** → Wound RN

SOCIAL WORKERS VS. CASE MANAGERS

- **SW** → psychosocial barriers (abuse, finances, mental health, end-of-life support)
- **CM** → logistics (home health, DME, rehab, insurance, follow-up)
- Both often RN-initiated per facility policy

ESCALATION LADDER

- Change in condition → SBAR to provider
- Deteriorating → Rapid Response
- Pulseless / apneic → Code Blue
- Unsafe order → Chain of command
- Value conflict → Ethics committee

SBAR STRUCTURE

- **S** — Situation: who, where, what's happening
- **B** — Background: relevant history
- **A** — Assessment: vitals + your interpretation
- **R** — Recommendation: what you need from them

MANDATORY REPORTING

- Child abuse / neglect
- Elder / vulnerable adult abuse
- Reportable communicable diseases
- Gunshot / stab (state-specific)
- Impaired colleague → Board of Nursing

ORDER REQUIRED? · AT-A-GLANCE

CONSULT	ORDER NEEDED?
Physical Therapy	Yes
Occupational Therapy	Yes
Speech-Language Pathology	Yes
Registered Dietitian	Yes
Wound Care Nurse	Yes
Respiratory Therapy (new settings)	Yes
Pharmacist	No
Social Worker	Usually no (per policy)
Case Manager	Usually no (per policy)
Chaplain	No — on request
Rapid Response Team	No — any RN activates
Code Blue Team	No — any RN activates
Ethics Committee	No — via chain of command