2026 NGN NCLEX-RN · MANAGEMENT OF CARE · DAY 10 OF 15

Ethical Practice & End-of-Life Decision-Making

How a safe entry-level RN protects autonomy, prevents harm, and navigates moral distress when life is ending.

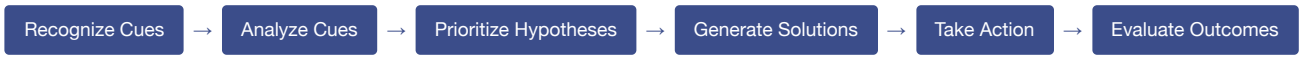
Autonomy | Beneficence | Nonmaleficence | Justice | Fidelity | Veracity | Moral Distress | Hospice / Palliative | NGN Clinical Judgment

1 High-Yield Overview

Ethical practice is the lens you put on top of every clinical decision. The NCLEX-RN expects you to apply the **nurses' code of ethics** consistently, recognize an **ethical dilemma** when you see one, and act in a way that protects the client's **self-determination** — especially at the end of life when the client cannot always speak for themselves.

The 2026 Test Plan is explicit: under Management of Care you must *"Recognize and report ethical dilemmas," "Practice in a manner consistent with the nurses' code of ethics," "Integrate advance directives into client plan of care,"* and *"Inform client and staff members of ethical issues affecting client care."* Under Psychosocial Integrity you must *"Provide end-of-life care and education to clients."*

On the test, an ethics item rarely says "this is an ethics question." It looks like a fight between the family and the client, a DNR that nobody can find, a nurse who knows the order is wrong, or a dying client who is asking for the truth. Your job is to **follow the client's voice first**, document, and escalate through the chain of command — not pick sides, not argue, not lie.



THE SIX ETHICAL PRINCIPLES (MEMORIZE THESE — THEY'RE THE BACKBONE OF EVERY RATIONALE)

Autonomy
The client's right to make their own decision, even a "bad" one. Refusing dialysis, refusing blood, signing out AMA — all autonomy.

Beneficence
Doing *good*. Acting in the client's best interest. Pain control at end of life, comfort care.

Nonmaleficence
"Do no harm." Not giving a medication that's clearly wrong. Pulling the IV antibiotic that is now harming a dying client.

Justice
Fair, equal, unbiased care — regardless of culture, ethnicity, sexual orientation, gender identity, gender expression, ability to pay, or behavior.

Fidelity
Keeping promises. "I'll be back at 10 with your pain medication" — and you actually come back.

Veracity
Truth-telling. Not hiding a diagnosis because the family asked you to.

END-OF-LIFE CARE QUICK MAP

TERM	WHAT IT MEANS	NCLEX PEARL
Palliative care	Symptom & comfort care at ANY stage of illness; can be given alongside curative treatment.	Not the same as hospice. A client on chemo can also get palliative care.
Hospice	Comfort-focused care when life expectancy is ≤ 6 months and curative treatment is stopped.	Requires a physician/NP certification of terminal prognosis. Care can occur at home, inpatient hospice, or LTC.
DNR / DNAR	"Do Not Resuscitate" — no CPR, no intubation, no defibrillation at the moment of cardiopulmonary arrest.	DNR ≠ "do not treat." You still give meds, fluids, comfort care, antibiotics if ordered.

Allow Natural Death (AND)	Newer language for DNR, focused on what you *will* do, not what you won't.	Same intent as DNR — just a softer, family-friendly framing.
POLST / MOLST	Physician/Medical Orders for Life-Sustaining Treatment. An actual order set that travels with the client.	POLST is an order. A living will is only a wish until a provider writes orders.
Living will	Written document stating what treatments the client wants/refuses if incapacitated.	Activates only when the client cannot make decisions.
Durable POA for Health Care / Health Care Proxy	A person legally chosen to make decisions when the client cannot.	Activates only when the client is decisionally incapable. Different from financial POA.
Withholding vs. withdrawing	Withholding = never starting. Withdrawing = stopping what was started.	Ethically and legally *equivalent* — both are acceptable when consistent with client wishes.
Principle of Double Effect	Giving opioids/sedatives to relieve pain at end of life, even if it may shorten life, is ethical when intent is comfort.	Pain control is **not** euthanasia. Titrate to comfort, document intent.
Brain death	Irreversible cessation of all brain function, including brainstem. Legally = death.	Family does not "consent" to withdraw life support after brain death — the person is already legally deceased.

2 10 Must-Know Rules

1. **The competent client's wishes always come first** — even over the family, the provider, your own personal beliefs, or religious values.
2. **You may refuse to participate** in care that violates your personal/religious conscience (e.g., elective abortion) — but you must ensure another nurse continues safe care. You can *never* abandon a client.
3. **DNR is not "do not treat."** Comfort, pain, oxygen, repositioning, mouth care, IV fluids if ordered, dignity — all continue.
4. **An advance directive is not in effect** until the client is decisionally incapable. A conscious, oriented client speaks for themselves every time.
5. **The health care proxy speaks the client's voice**, not their own preference. Family conflict that overrides the client's documented wishes is escalated to the **ethics committee**.
6. **Pain medication at end of life is appropriate** even if it may shorten life — this is the **principle of double effect**, not euthanasia.
7. **Truth-telling (veracity) is non-negotiable.** When family says "Don't tell Mom she has cancer," the nurse *explores* the family's fear but does not lie to a competent client.
8. **Brain death = legal death.** Withdrawal of mechanical support after brain death is not "ending a life." Organ donation is offered by a trained requester from the OPO, not the bedside nurse.
9. **Recognize → Report.** Ethical dilemmas are escalated up the chain of command: charge nurse → nursing supervisor → ethics committee. You do not solve them alone.
10. **Moral distress is real and must be named.** Use the ethics committee, debriefs, EAP, and chain of command — never quietly comply with care you believe is unethical.

3 RN Safety Decision Table

SITUATION	BEST RN ACTION	WHY THIS IS THE SAFEST ACTION	COMMON NCLEX TRAP
A competent client with metastatic cancer says, "I'm done. Stop the chemo."	Notify the provider and document the client's verbatim statement. Honor the refusal.	Autonomy. A competent adult has an absolute right to refuse — even life-prolonging — care.	Calling the family to "talk him out of it." That violates autonomy and confidentiality.
Adult son insists the nurse not tell the client her diagnosis is terminal.	Explore the son's fears, then explain the nurse cannot withhold information from a competent client.	Veracity. Truth-telling and informed decision-making belong to the client.	"I'll talk to the doctor about not telling her." Collusion is still deception.
Client has a valid out-of-hospital DNR; new admitting provider writes "Full code."	Clarify the discrepancy with the provider immediately; protect the client's directive until reconciled.	Self-determination and the directive prevail. The order does not override the legal document.	Doing nothing because "the doctor wrote it." Quiet compliance with an unsafe/incorrect order is negligence.
Dying client is moaning; family refuses morphine because "it will kill him."	Educate on principle of double effect, titrate to comfort per orders, document.	Beneficence + nonmaleficence. Under-treating pain causes harm.	Withholding pain medication because the family is upset.

Husband (POA) wants tube feeding continued; the client's living will refuses artificial nutrition.	Notify provider; bring to ethics committee. The written client wish controls.	The proxy speaks the client's voice, not their own preference.	"The husband is POA, so do what he says." A proxy cannot override a competent prior statement.
Client declared brain dead; family asks to "give him more time."	Provide grief support, involve chaplain/social work; brain death = legal death and is explained by the provider.	Veracity + compassion. Compassion does not require lying about the diagnosis.	Leaving the ventilator on indefinitely to avoid conflict.
Coworker says, "I don't believe in this hospice stuff, I'm going to keep pushing PT."	Address peer; if unresolved, notify the charge nurse / nursing supervisor.	Fidelity to the plan of care + nonmaleficence. Care must align with client wishes.	Avoiding confrontation and "minding your own business." Silence is complicity.
Pediatric Jehovah's Witness parent refuses life-saving blood for a 6-year-old.	Notify provider, social work, risk management. Court order may be obtained to protect the child.	Parents cannot refuse life-saving care for a minor. Justice + nonmaleficence + state law.	Treating this like an adult autonomy decision. A minor has no decisional capacity.
Nurse feels strong moral distress caring for a client whose family insists on continued aggressive interventions.	Request an ethics consult; use chain of command; document concerns.	Moral distress is a recognized professional issue. The system has resources.	Quietly resigning the shift or refusing to come back. Avoidance does not resolve the dilemma.
Client newly intubated and sedated; no advance directive on chart.	Identify legal next of kin / surrogate per state law; document. Notify social work.	Without a proxy, surrogate hierarchy (spouse → adult child → parent → adult sibling) usually applies.	Asking the friend at the bedside to sign. Friends are not legal surrogates.

4 Delegation / Scope Table — Ethical & End-of-Life Tasks

TASK	RN	LPN/VN	UAP	CAN DELEGATE?	WHY OR WHY NOT?
Discuss advance directive options & obtain initial education on goals of care	✓	✗	✗	**No — RN only**	Requires nursing assessment, judgment, and teaching — RN scope (matches "Provide client with information about advance directives" in the test plan).
Witness a client's signature on a consent or advance directive	✓	✓	✗	**Limited**	Witnessing signature ≠ obtaining consent. RN preferred; check facility policy. UAP cannot witness clinical documents.
Reinforce previously taught hospice/comfort education	✓	✓	✗	**Yes (to LPN)**	LPN can reinforce — initial teaching is RN.
Post-mortem care after expected death	✓	✓	✓	**Yes**	Standard, predictable, no nursing judgment required after pronouncement.
Mouth care, repositioning, bathing of a dying client	✓	✓	✓	**Yes**	Comfort care basics — clearly UAP scope.

Administer scheduled IV morphine drip on hospice client	✓	✗*	✗	**No**	IV opioid administration is RN in most jurisdictions; check state Nurse Practice Act.
Notify provider of new ethical concern (family refusing to honor DNR)	✓	✗	✗	**No**	Requires assessment, synthesis, escalation — RN.
Initiate ethics committee consult	✓	✗	✗	**No**	RN role; coordinates with charge / supervisor / provider.
Sit with a grieving family member, offer tissues, get water	✓	✓	✓	**Yes**	Presence and basic comfort are not nursing-only.
Pronouncement of death (where state allows RN)	✓ **(varies)**	✗	✗	**No**	Some states allow RN pronouncement on hospice/LTC; otherwise provider. Never LPN/UAP.
Approach family about organ donation	✗	✗	✗	**No**	By federal law (CMS) only a trained Organ Procurement Organization (OPO) requester or designated trained staff approaches family. The RN *refers* the case.

5 Red-Flag Cues

IMMEDIATE ASSESSMENT

- Client tearfully says, "I don't want any more treatment."
- Family yelling at staff in front of dying client.
- Confused new admission with no documented advance directive and no surrogate present.
- Sudden change in mental status during goals-of-care discussion (may invalidate consent capacity).

PROVIDER NOTIFICATION

- Conflict between living will and current admission orders.
- Family requesting CPR be performed despite a valid DNR.
- Client withdraws consent for treatment.
- Inadequate pain control at end of life.

RAPID RESPONSE

- Full-code client without a DNR who is rapidly deteriorating — even if hospice was being discussed.
- Acute respiratory distress in a client whose code status has not yet been clarified.

CHAIN OF COMMAND

- Provider refuses to write comfort orders for a clearly dying client.
- Coworker overriding a DNR.
- Unresolved family-vs-client conflict.
- Pressure to participate in care you believe is unethical (moral distress).

MANDATORY REPORTING

- Suspected withholding of food/fluids or pain relief by a caregiver in a dependent adult — possible elder neglect.
- Impaired colleague diverting end-of-life opioids.
- Provider giving lethal medication outside of legal medical-aid-in-dying frameworks.

HOLD DELEGATION & REASSESS

- UAP says, "The family doesn't want her turned because it 'hurts her.'" Reassess pain, comfort, plan.
- LPN reports the family stopped the oxygen on a comfort-care client without an order.
- UAP is uncomfortable with post-mortem care — assign someone else.

6 Advanced NGN Practice Questions

QUESTION 1

Multiple Choice

A 78-year-old client with end-stage COPD says to the nurse, "If my breathing gets worse, I don't want to be put on a machine." The client is alert and oriented and has no advance directive on file. Which action should the nurse take **first**?

A. Document the statement in the medical record.

B. Notify the health care provider of the client's wishes.

C. Sit with the client and clarify what "a machine" means to them.

D. Ask the client's daughter to come to the bedside.

▼ Show rationale

Correct: C. NGN step = **Recognize Cues**. Before documenting, calling the provider, or involving family, the RN must clarify the client's actual meaning — does "machine" mean intubation? BiPAP? Any oxygen? Without clarity you cannot accurately document or advocate.

A. Documentation will happen, but you cannot document what you have not yet clarified.

B. Notification follows assessment.

D. Bringing family in *before* exploring the client's voice violates autonomy and confidentiality.

Trap: "Notify the provider" looks safe — but skipping assessment is the trap.

QUESTION 2 Select All That Apply

A client with a valid DNR order is admitted to the medical unit. Which interventions remain appropriate? **Select all that apply.**

A. Administering ordered IV antibiotics for pneumonia.

B. Repositioning every 2 hours for skin integrity.

C. Withholding all pain medication.

D. Providing supplemental oxygen for comfort.

E. Discontinuing all blood draws automatically.

F. Offering food, fluids, and mouth care.

G. Calling a code if the client stops breathing.

▼ Show rationale

Correct: A, B, D, F. NGN step = **Generate Solutions / Take Action**.

A. DNR ≠ "do not treat" — antibiotics, fluids, and ordered treatments continue.

B, D, F. Comfort care, repositioning, oxygen for dyspnea, and basic needs always continue.

C. Withholding pain meds violates beneficence and nonmaleficence.

E. Labs are not automatically stopped — only the provider can adjust ordered care.

G. A code violates the DNR.

Trap: Students assume DNR means stop everything. It means no CPR/intubation/defib at arrest.

QUESTION 3 Matrix / Grid

For each ethical situation below, indicate the **primary ethical principle** being upheld or violated.

SITUATION	AUTONOMY	BENEFICENCE	NONMALEFICENCE	JUSTICE	VERACITY
The nurse honors a client's refusal of dialysis.	✔				
The nurse tells a client her cancer has returned despite the family asking the nurse not to.					✔
The nurse holds a medication that has caused a previous allergic reaction.			✔		
The nurse advocates for equal pain management for an undocumented client.				✔	
The nurse stays after shift to make sure a dying client is comfortable.		✔			

▼ **Show rationale**

NGN step = **Analyze Cues**. Each row maps to its single best-fit principle:

- **Refusal of dialysis** = Autonomy (self-determination).
- **Truth-telling against family pressure** = Veracity.
- **Avoiding known-harm drug** = Nonmaleficence ("do no harm").
- **Equal access regardless of status** = Justice.
- **Going above and beyond to do good** = Beneficence.

Trap: Many scenarios touch multiple principles. Pick the one most directly involved.

QUESTION 4

Bow-Tie

An 82-year-old hospice client at home has worsening dyspnea and air-hunger. The family is at the bedside. The nurse arrives for a routine visit.

Center action (1): _____

Cues to support the action (2): _____ _____

Outcomes to monitor (2): _____ _____

WORD BANK

Begin chest compressions | Administer sublingual morphine per comfort protocol | Call 911 | Air hunger / accessory muscle use | Client on home hospice with DNR | Respiratory rate | Family anxiety level | Capillary refill | Blood pressure trend

▼ Show rationale

Center action: Administer sublingual morphine per comfort protocol.

Supporting cues: Air hunger / accessory muscle use | Client on home hospice with DNR.

Outcomes to monitor: Respiratory rate | Family anxiety level.

NGN steps tested = **Generate Solutions, Take Action, Evaluate Outcomes.**

Chest compressions or 911 transfer to ED contradicts the hospice plan of care and the DNR. Morphine relieves dyspnea and air hunger and is standard hospice comfort care; the *principle of double effect* supports it.

Trap: "Call 911" looks like the cautious choice but actively violates the client's documented plan.

QUESTION 5

Ordered Response

The nurse is caring for a client whose family is demanding that staff perform CPR if the client arrests, despite a valid signed DNR. Place the nurse's actions in the **correct order**.

1. Notify the health care provider and charge nurse of the conflict.
2. Sit with the family and explore their fears and the meaning of the DNR.
3. Document the conversation and notifications in the medical record.
4. Verify the DNR document is current and on the chart.
5. Request an ethics committee consult if the conflict is unresolved.

▼ Show answer & rationale

Correct order: 4 → 2 → 1 → 5 → 3 (document throughout).

1. **Verify the DNR** — you must confirm the document exists and is current before acting.
2. **Explore family fears** — most conflict comes from misunderstanding the DNR; therapeutic communication first.
3. **Notify provider/charge** — unresolved conflict needs interdisciplinary input.
4. **Ethics committee** — escalate when conflict cannot be resolved at the unit level.
5. **Documentation** — every step must be documented; it is concurrent, but written documentation of the final resolution is the final formal step.

NGN step = **Take Action.** Trap: jumping straight to "call ethics" without first verifying and communicating.

QUESTION 6

Drop-Down / Cloze

Complete the statement with the most appropriate term.

A nurse who repeatedly cares for clients receiving aggressive treatment that the nurse believes is causing more suffering than benefit may experience [moral distress ✓]. The nurse should request a(n) [ethics committee consult ✓] and document concerns using the [chain of command ✓].

▼ Show rationale

NGN step = **Recognize Cues / Analyze Cues**.

Moral distress is the specific term for knowing the right action but being constrained from taking it. It differs from burnout (overall depletion) or compassion fatigue (secondary trauma).

The **ethics committee** exists for exactly this purpose, and concerns are formally escalated through the **chain of command**.

Trap: Confusing moral distress with compassion fatigue.

QUESTION 7

Prioritization

A nurse on a med-surg floor has four assigned clients. Which client should the nurse see **first**?

A. A client with a DNR who is moaning and has not received the scheduled comfort medication.

B. A client requesting to speak to the chaplain.

C. A client newly admitted who has not yet completed the advance-directive form.

D. A family member who is upset that visiting hours have changed.

▼ Show rationale

Correct: A. NGN step = **Prioritize Hypotheses**.

A dying client with uncontrolled pain is an immediate beneficence + nonmaleficence concern. Comfort is a clinical priority and the most acute unmet need.

B. Important psychosocially but not as urgent.

C. Important and required, but not acutely time-sensitive.

D. Service-recovery issue — delegate or address after acute needs.

Trap: Picking the "newly admitted" client because of an admission reflex. Pain at end of life beats paperwork.

QUESTION 8 Delegation Scenario

The charge nurse is assigning staff to care for end-of-life clients. Which task is **most appropriate** to delegate to the UAP?

A. Discussing the meaning of a living will with a newly admitted client.

B. Performing post-mortem care after an expected death.

C. Witnessing the signature of a client signing an advance directive.

D. Administering ordered IV morphine to a dying client.

▼ Show rationale

Correct: B. NGN step = **Take Action**.

Post-mortem care after an *expected* death is a standard, predictable, unchanging task — perfectly within UAP scope.

A. Teaching = RN.

C. Witnessing legal signatures = licensed nurse per policy, not UAP.

D. IV opioid administration = RN.

Trap: Confusing post-mortem care (UAP-appropriate) with pronouncement (provider or qualified RN).

QUESTION 9 Handoff / SBAR Scenario

A nurse is giving handoff on a hospice transfer to a long-term care facility. Which piece of information is **most essential** to include in the SBAR?

A. The family's preferred florist for funeral flowers.

B. The client's code status and active comfort orders.

C. The names of grandchildren who visit on weekends.

D. The previous month's hemoglobin trend.

▼ Show rationale

Correct: B. NGN step = **Take Action (Continuity of Care).**

Code status + active comfort orders are essential safety information. The receiving nurse needs to know — instantly — whether to call a code and what comfort interventions are authorized.

A, C. Nice but not safety-critical handoff content.

D. Past lab trends are not immediate handoff priorities for a comfort-focused client.

Trap: Drowning the handoff in non-actionable detail and burying the code status.

QUESTION 10 Case-Style Multiple Choice

A 90-year-old client with advanced dementia is admitted from a nursing home with aspiration pneumonia. The client has a valid living will refusing artificial nutrition and mechanical ventilation. The adult daughter (health care proxy) is at the bedside and tearfully says, "I can't lose her. Please put in the feeding tube and intubate her if she gets worse." Which response by the nurse is **most appropriate**?

A. "I understand. I will let the physician know to insert the feeding tube."

B. "Your mother's wishes are clearly stated in her living will. Let's talk together about what she wanted and how we can support her — and you — through this."

C. "Your mother is incompetent now, so what she wrote no longer applies."

D. "You are her proxy, so we will follow whatever you decide."

▼ Show rationale

Correct: B. NGN step = **Take Action.**

The proxy's role is to *voice* the client's prior expressed wishes, not to substitute her own preference. The living will is binding when the client lacks capacity. The nurse uses therapeutic communication and acknowledges grief while protecting client autonomy.

A. Bypasses the directive — and the provider — without conversation.

C. Factually wrong; the directive is most relevant precisely *because* the client cannot speak.

D. The proxy cannot override a clearly stated prior wish.

Trap: Treating the proxy like a free agent.

QUESTION 11 Select All That Apply

Which scenarios **require escalation** to the ethics committee? **Select all that apply.**

A. Family demanding aggressive treatment that contradicts a competent client's clearly stated wishes.

B. Disagreement among providers about appropriate goals of care for a client with a poor prognosis.

C. A nurse experiencing repeated moral distress on a unit.

D. A client refusing pain medication because of personal preference.

E. A surrogate making decisions that appear to be in the surrogate's interest, not the client's.

F. A standard admission of a client to hospice.

▼ Show rationale

Correct: A, B, C, E.

Ethics committees exist for unresolved value conflicts: client-vs-family, provider-vs-provider, distress in staff, and concerns about surrogate motivation.

D. A competent client refusing care = autonomy, not an ethical conflict requiring committee.

F. Routine hospice admission is not an ethical conflict.

Trap: Thinking the ethics committee solves *all* uncomfortable situations.

QUESTION 12

Matrix — Action Indicated / Not Indicated

For a hospice client at home with rising air hunger and a family that is "afraid morphine will kill him," indicate whether each nursing action is **Indicated** or **Not Indicated**.

ACTION	INDICATED	NOT INDICATED
Withhold the prescribed morphine until the family agrees.		✔
Educate the family on the principle of double effect.	✔	
Administer the morphine as ordered to relieve dyspnea.	✔	
Tell the family they are wrong and they need to step out.		✔
Document the family's concerns and the teaching provided.	✔	
Cancel the morphine order and call for an ED transfer.		✔

▼ Show rationale

NGN step = **Generate Solutions / Take Action.**

The plan of care is comfort. Withholding pain medication causes harm. Education and documentation respect both the client (beneficence/nonmaleficence) and the family (compassion + therapeutic communication).

Trap: Letting family anxiety override the clinical plan of care.

7 Unfolding NGN Case Study

SETTING

Medical-surgical unit. Time: 0700 handoff.

NURSE'S NOTES — 0700

72-year-old client admitted yesterday from home with sepsis secondary to pneumonia. PMH: stage IV pancreatic cancer (diagnosed 8 months ago, declined further chemotherapy), CKD stage 3, mild dementia. Client is awake, oriented to person and place. The client's spouse and adult daughter are at the bedside. Daughter is tearful; spouse is quiet. The client has a **signed living will refusing intubation, mechanical ventilation, CPR, and artificial nutrition**, but the admitting hospitalist wrote **"Full code"** on admission. No POLST/MOLST on file.

VITAL SIGNS

PARAMETER	0700 TODAY	TREND (24H)
HR	118	↑
BP	92/54	↓
RR	28, labored	↑
SpO_2	87% on 4 L NC	↓
Temp	38.9 °C	↑
Mental status	A&O ×2, mildly drowsy	Worse

PROVIDER ORDERS

- IV ceftriaxone & azithromycin q24h
- IV fluids — NS 100 mL/h
- O_2 titrate to $SpO_2 \geq 92\%$
- Acetaminophen 650 mg PO q4h PRN for fever
- Morphine 2 mg IV q2h PRN dyspnea/pain
- Code status: **Full code**

LAB / DIAGNOSTIC DATA

- WBC 22.4 (↑), Lactate 4.2 (↑↑)
- CXR: bilateral lower-lobe consolidation
- Cr 2.1 (↑ from 1.6 baseline)

FAMILY / CLIENT STATEMENTS

- **Client** (slowly, between breaths): "I told them already… I don't want a tube… let me rest."
- **Daughter**: "Please do everything. He's confused — he doesn't mean it."
- **Spouse**: "He signed the paper himself. I was with him."

HEALTH CARE TEAM NOTES

- Case manager: Hospice consult was discussed at last clinic visit; pending.
- Social work: Living will reviewed at admission — copy on chart.

CASE STUDY QUESTIONS

Q-CASE 1 — RECOGNIZE CUES

SATA

Which findings are **most relevant** to the ethical and clinical situation? Select all that apply.

A. Living will refusing intubation/CPR/artificial nutrition.

B. Admitting order reads "Full code."

C. Client states "I don't want a tube."

D. Daughter says "He's confused — he doesn't mean it."

E. Lactate 4.2 with SpO_2 87%.

F. Client is awake and oriented to person and place.

G. Spouse confirms the client signed the living will himself.

▼ Show rationale

Correct: A, B, C, D, E, F, G — all relevant. NGN step = **Recognize Cues**. This is a classic NGN trick: every cue matters. The discrepancy between the living will (A) and the order (B), combined with the client's current statement (C, F) and the daughter's distress (D), and the deteriorating clinical picture (E), all set up the ethical decision. The spouse (G) corroborates capacity at the time of the directive.

Q-CASE 2 — ANALYZE CUES

Cloze

Complete the analysis:

The client is currently [decisionally capable ✓ ⌄], which means the [client's current verbal statement ✓ ⌄] takes priority. The nurse identifies an ethical dilemma involving primarily [autonomy and veracity ✓ ⌄].

▼ Show rationale

NGN step = **Analyze Cues**. A&O × 2 with coherent speech that aligns with prior written wishes = decisionally capable. A capable client's contemporaneous voice always controls. Autonomy (self-determination) and veracity (truth-telling about diagnosis/prognosis) are the most directly engaged principles.

Q-CASE 3 — PRIORITIZE HYPOTHESES

Multiple Choice

Which is the nurse's **highest priority** concern at this moment?

A. Resolving the family conflict.

B. Reconciling the code-status discrepancy before the client deteriorates further.

C. Documenting the living will.

D. Calling hospice immediately.

▼ Show rationale

Correct: B. NGN step = **Prioritize Hypotheses.** Vital signs and lactate show this client is rapidly heading toward respiratory failure / arrest. If the code-status discrepancy is not reconciled NOW, the client will be intubated against his expressed wishes — a violation of autonomy and a legal issue. Family discussion (A) and hospice call (D) follow.

Q-CASE 4 — GENERATE SOLUTIONS

SATA

Which actions should the nurse plan? Select all that apply.

A. Call the hospitalist immediately to reconcile code status.

B. Notify the charge nurse.

C. Sit with the family briefly, acknowledge their grief, and explain the directive.

D. Request a palliative care / ethics consult.

E. Override the order and tell the family CPR will not be performed.

F. Document the client's statement verbatim.

▼ Show rationale

Correct: A, B, C, D, F. NGN step = **Generate Solutions.** The nurse coordinates a rapid response involving the provider and the team. Option E is wrong because the nurse does not unilaterally change a code-status order — the provider rewrites it after reconciliation.

Q-CASE 5 — TAKE ACTION

Ordered Response

Place the actions in the order the nurse should perform them.

1. Document the client's verbatim statement and all notifications.
2. Page the hospitalist with SBAR: directive vs. order conflict, deteriorating status.
3. Use therapeutic communication with the family at the bedside.
4. Notify the charge nurse.
5. Reassess vital signs and apply comfort measures (positioning, O_2, PRN morphine for dyspnea per order).

▼ Show answer

Correct order: 5 → 2 → 4 → 3 → 1.
Comfort/oxygen first (immediate safety + nonmaleficence), then page provider (reconcile order), notify charge (chain of command + resources), therapeutic communication with the family, and document throughout — with formal documentation as the final closing step.

Q-CASE 6 — EVALUATE OUTCOMES

Matrix

Two hours later, the hospitalist has rewritten the orders as DNR/DNI with comfort-focused care; morphine is titrated. Indicate whether each finding shows the plan is **Effective** or **Needs Reassessment**.

FINDING	EFFECTIVE	NEEDS REASSESSMENT
Respirations 18, no accessory muscle use, eyes closed, calm.	✔	
Daughter at bedside holding client's hand, crying quietly.	✔	
Client moaning, brow furrowed, gripping the bedrail.		✔
Code status now reads "DNR/DNI, comfort care."	✔	
UAP starting suctioning and frequent vital signs q15min.		✔
Family asks chaplain to come.	✔	

▼ Show rationale

NGN step = **Evaluate Outcomes.** Calm respirations and family presence are positive indicators of comfort and emotional support. Continued moaning suggests pain not yet controlled — needs reassessment and titration. Aggressive suctioning and frequent vitals are inconsistent with comfort care and should be reassessed/discontinued.

8 "What Should the Nurse Do *First*?" 5 Mini-Scenarios

1. **A dying client cries out in pain; the family blocks the door and says, "Don't give him any more drugs."**
   First action: Acknowledge the family briefly, then administer the prescribed comfort medication and educate after. **Why:** Beneficence and nonmaleficence — pain control cannot be held hostage by family preference.
2. **A new admission has a living will, but it is not yet on the chart and the client is now confused.**
   First action: Call the family/POA, request the document be brought immediately, and clarify code status with the provider. **Why:** Until reconciled, treat as full code, but reconcile urgently.
3. **A client withdraws consent for chemotherapy mid-infusion.**
   First action: Stop the infusion. **Why:** Withdrawal of consent at any time must be honored; continuing is battery.
4. **A 17-year-old emancipated minor wants to refuse a blood transfusion.**
   First action: Verify legal emancipation documentation. **Why:** Emancipated minors hold adult decisional authority; documentation matters legally.
5. **A nurse witnesses a colleague photographing a deceased client.**
   First action: Intervene directly and immediately, then report to the nursing supervisor. **Why:** HIPAA + dignity violation; this is also potentially mandatory-reportable misconduct.

9 "Can This Be Delegated?" 5 Mini-Scenarios

1. **Bathing and repositioning a comfort-care client.** → UAP ✓ Routine, predictable, no judgment required.
2. **Initial advance-directive education for an alert client.** → RN only Requires teaching + assessment.
3. **Calling the family of a deceased client to inform them of the death.** → RN or provider Not appropriate for UAP; sensitivity, judgment, possible questions.
4. **Reinforcing what hospice means for a client previously taught by the RN.** → LPN ✓ Reinforcement, not initial teaching.
5. **Performing post-mortem care.** → UAP / LPN ✓ Standard procedure following pronouncement.

10 "Who Should the Nurse Contact?" 5 Referral / Collaboration Scenarios

1. **Family with no insurance, dying client, no end-of-life plan in place.** → Social work + case manager — community resources, hospice intake, financial assistance.
2. **Client expressing spiritual distress about the meaning of death.** → Chaplaincy / spiritual care
3. **Disagreement among providers about appropriate goals of care.** → Ethics committee + palliative care consult
4. **Brain death has been declared; family considering organ donation.** → Organ Procurement Organization (OPO) — by federal law the OPO requester approaches the family, not the bedside RN.
5. **Family at home cannot manage symptom burden for a hospice client.** → Home hospice RN, on-call hospice provider

11 Legal / Ethical Traps 5 Scenarios

1. **The provider tells the nurse to "just sign as the witness" on a consent form for a client the nurse has not assessed.** → Stop. The nurse witnesses the *signature* of a client who has been informed by the provider; verify the client understands and is signing voluntarily. Document. Do not sign blind.
2. **A 14-year-old asks for confidentiality regarding her STI testing.** → State-specific. Most states allow minors confidential STI care; verify state law and facility policy. Do not promise absolute confidentiality regarding mandatory reporting items (e.g., abuse, threats of harm).
3. **The family asks the nurse not to tell the client his cancer is terminal.** → Veracity. Acknowledge family fear; explain the nurse cannot withhold information from a competent client; coordinate with the provider for a unified, compassionate disclosure.
4. **A nurse caring for a Jehovah's Witness client refuses to give a unit of blood the client is now in distress over.** → Conscience clause & safety. The nurse may refuse to administer if there's a conscience conflict, but must arrange for another nurse to provide care and never abandon the client. If the client themself is refusing — that's autonomy, not nurse conscience.
5. **A hospice client is found with bruises in different stages, and the home caregiver becomes evasive.** → Mandatory report. Suspected elder abuse/neglect must be reported to adult protective services per state law — regardless of hospice status.

12 End-of-Day Quick Review

10 ONE-LINE MUST-REMEMBER POINTS

1. Autonomy > family wishes > provider preference, when the client is competent.
2. DNR ≠ "do not treat" — comfort, fluids, meds, oxygen continue.

5 COMMON NCLEX TRAPS

1. Treating "DNR" as "do nothing." → Wrong.
2. Letting the proxy override a clearly stated prior wish. → Wrong.

3. Living will activates only when client lacks capacity.
4. Health care proxy voices the client's wishes, not their own.
5. Double effect: comfort medication at end of life is ethical.
6. Brain death = legal death.
7. Veracity > family secrecy.
8. You may refuse on conscience but cannot abandon.
9. Ethics committee for value conflicts; chain of command for safety conflicts.
10. Document the client's voice verbatim.

3. Holding pain meds because family is upset. → Wrong.
4. Treating a 17-year-old like an adult without verifying emancipation. → Wrong.
5. Asking the bedside RN to approach family about organ donation. → Wrong (OPO does this).

5 "NEVER DO THIS" RULES

1. Never lie to a competent client about diagnosis or prognosis.
2. Never abandon a client because of personal/religious objection.
3. Never administer or withhold care unilaterally to override an order — escalate.
4. Never let family direct care for a competent client without the client's voice.
5. Never sign as a witness on a consent the client doesn't understand.

5 SAFETY-FIRST PHRASES TO RECOGNIZE ON NCLEX

1. "The client is alert and oriented and states..." → Autonomy controls.
2. "There is a valid signed living will..." → Honor when client lacks capacity.
3. "The family is demanding..." → Therapeutic communication + chain of command.
4. "The nurse is experiencing moral distress..." → Ethics committee.
5. "Comfort care orders are in place..." → Continue dignity, pain control; stop aggressive treatments.

📌 Day 10 Infographic Summary

Screenshot-ready. Everything you need to remember about ethics & end-of-life on one page.

THE 6 ETHICAL PRINCIPLES

- **Autonomy** — client decides.
- **Beneficence** — do good.
- **Nonmaleficence** — do no harm.
- **Justice** — fair, equal care.
- **Fidelity** — keep promises.
- **Veracity** — tell the truth.

END-OF-LIFE DOCUMENTS

- **Living will** — wishes (activates when incapacitated).
- **POA / Proxy** — person to speak for client.
- **POLST/MOLST** — actual provider order.
- **DNR** — no CPR/intubation at arrest.
- **AND** — Allow Natural Death (same as DNR).

HIERARCHY OF VOICE

DNR = NO CPR ONLY

DOUBLE EFFECT

Client (if competent) → Living will / POLST → Health Care Proxy → Surrogate hierarchy (spouse → adult child → parent → adult sibling)

✓ Antibiotics
✓ Pain meds
✓ Oxygen
✓ Fluids
✗ CPR / Intubation / Defib at arrest

Opioids that relieve pain at end-of-life are ethical even if they may shorten life. Intent = comfort, not death.

ESCALATION PATH

Bedside RN → Charge Nurse → Nursing Supervisor → Provider → **Ethics Committee** → Risk Management / Legal

RED FLAGS = STOP & ESCALATE

- Order contradicts directive
- Family overriding competent client
- Proxy acting against client's prior wishes
- Inadequate pain control at EOL
- Moral distress in staff

NGN CLINICAL JUDGMENT — ETHICAL LENS

STEP	WHAT YOU ASK
Recognize Cues	What does the client say? What does the document say? Are they aligned?
Analyze Cues	Is the client capable? Which principle is in play?
Prioritize Hypotheses	What's the biggest threat to autonomy/safety RIGHT now?
Generate Solutions	Therapeutic communication, provider notification, ethics consult, comfort orders.
Take Action	Address safety first, then communicate, then escalate, then document.
Evaluate Outcomes	Is the client comfortable? Are the directives now being followed? Is the family supported?

The competent client's voice wins. Comfort is never optional. Document everything.