DAY 11

NCLEX-RN 2026 · MANAGEMENT OF CARE · 15-DAY SERIES

Chain of Command, Unsafe Orders & Escalation

Today you'll learn to think like a safe entry-level RN who knows exactly when to escalate, who to call next, and how to refuse an unsafe order without abandoning the client. We'll layer the NCSBN Clinical Judgment Measurement Model onto every scenario.

SAFE & EFFECTIVE CARE ENVIRONMENT | MANAGEMENT OF CARE | APPLICATION-LEVEL NGN

INSIDE TODAY'S LESSON

01 HIGH-YIELD OVERVIEW

Chain of command is the structured path the RN uses when a clinical concern cannot be solved at the current level — for example, an unsafe order, a deteriorating client, an impaired coworker, or an unresolved ethical concern. The NCLEX expects you to escalate in *order*, but never delay urgent care while you escalate.

The two big buckets to recognize on test day:

1. **Administrative chain** — staffing, conflicts, policy, unsafe practice → Charge nurse → Nursing supervisor → Manager → Director → CNO.
2. **Clinical chain** — unsafe order, ineffective treatment, status change → Provider who wrote the order → Provider's supervisor/attending → Medical director → Risk management or Ethics committee.

THE ESCALATION LADDER (MEMORIZE THE ORDER)

1. **BEDSIDE RN**
   Assess, intervene, document. Try to resolve first.
2. **CHARGE NURSE**
   Staffing, peer conflict, unit-level resource issues.
3. **PROVIDER WHO WROTE THE ORDER**
   Clinical/order concerns — clarify first.
4. **NURSING SUPERVISOR / HOUSE SUPERVISOR**
   After hours, multi-unit, urgent escalation.
5. **NURSE MANAGER → DIRECTOR → CNO**
   Policy, repeated unsafe practice, formal complaints.
6. **RISK MANAGEMENT / ETHICS COMMITTEE / BOARD OF NURSING**
   Sentinel events, ethical impasse, license-level issues.

THREE "SKIP-THE-LADDER" EMERGENCIES

If any of these are present, do **NOT** stop to escalate hierarchically — act first, escalate while acting.

- **Code Blue** — no pulse, not breathing. Start CPR, push the code button.
- **Rapid Response** — clinical deterioration (↓SpO_2, ↓BP, ↑RR, ↓LOC, chest pain, new arrhythmia) before arrest. Stay at bedside, call RRT.
- **Active threat / mandatory reporting situation** — suspected abuse, communicable disease, threat of violence. Notify per facility policy + legally mandated agency.

THE SIX STEPS OF THE NCSBN CLINICAL JUDGMENT MODEL (APPLIED TO ESCALATION)

STEP	WHAT THE RN DOES IN AN ESCALATION SCENARIO
Recognize cues	Notice the abnormal finding, unsafe order, impaired coworker, or unresolved family concern.
Analyze cues	Determine if the cue is expected, unexpected, urgent, or chronic. Compare to baseline.
Prioritize hypotheses	Rank what is most life-threatening and most likely.
Generate solutions	Identify possible RN actions: stay at bedside, clarify order, hold order, call RRT, notify supervisor.
Take action	Use SBAR, follow chain of command, document objectively, advocate for client.
Evaluate outcomes	Reassess the client and the response from the chain of command. Re-escalate if unresolved.

02 10 MUST-KNOW RULES

1. **The RN is legally responsible for any order carried out** — even if a provider wrote it. "I was just following orders" is not a legal defense.
2. **Clarify before refusing.** If an order seems unsafe, contact the provider first and read back the order. Most "unsafe" orders are actually unclear orders.
3. **Hold the order, not the client's care.** If you cannot safely carry out an order, hold that single order, document the rationale, and continue all other safe care.
4. **Stay with the deteriorating client.** Send *someone else* to call the provider or RRT. Never abandon the bedside during decompensation.
5. **SBAR every escalation.** Situation, Background, Assessment, Recommendation — every time you call up the chain.
6. **Charge nurse is your first call for unit-level issues** (staffing, peer conflict, room assignment, equipment). Provider is first for clinical/order issues.
7. **Don't skip steps unless it's an emergency.** Going straight to the CNO over a staffing concern without speaking to the charge nurse is a trap answer.
8. **Rapid Response is for "not yet arrested but heading there."** Code is for arrest. Both are RN-activated and do not need a provider order.
9. **Document objectively.** Chart the order, your concern, who you notified, the time, the response, and the client's status. Never chart "provider was rude" or "I disagreed."
10. **Mandatory reports go outside the facility.** Suspected abuse, neglect, certain communicable diseases, gunshot wounds, and impaired licensed staff have legally required external reports — chain of command does not replace them.

03 RN SAFETY DECISION TABLE

SITUATION	BEST RN ACTION	WHY IT'S SAFEST	COMMON NCLEX TRAP
Provider orders a heparin drip dose that is 10× the usual range	Hold the order. Contact the prescribing provider, read back the order, request clarification.	RN is responsible for every order carried out; clarifying prevents harm without abandoning the client.	*"Give the dose and document concerns later" — never give a clearly unsafe medication.*
Charge nurse assigns 7 acute clients to a new RN	Speak directly to the charge nurse first; if unresolved, escalate to nursing supervisor.	Conflict resolution begins at the lowest effective level. Skipping is unprofessional and not therapeutic.	*"Refuse the assignment and leave" — abandonment risk; "Call the CNO" — skips chain.*
Postop client's SpO_2 drops to 84%, BP 88/52, RR 28; provider not answering pages	Activate **Rapid Response Team** immediately, stay at bedside, apply O_2, reassess.	RRT exists precisely for this — clinical decline + delayed provider response.	*"Keep paging the provider" — delays life-saving intervention.*
RN smells alcohol on a coworker who is about to administer insulin	Remove the coworker from client care immediately and notify the nursing supervisor.	Client safety first; impaired practice requires immediate intervention and mandatory reporting.	*"Talk to the coworker after shift" — delays protection of clients.*
Family insists on full code; client has a valid DNR on the chart	Honor the legal DNR. Notify provider; involve social work, chaplain, and ethics committee for family support.	Client self-determination is legally binding; family wishes do not override an executed advance directive.	*"Initiate CPR to satisfy family" — violates client autonomy and law.*
Provider gives a verbal order during a non-emergency	Politely ask provider to enter the order; if a verbal must be taken, write it down, read it back, and have provider co-sign within facility timeframe.	Verbal orders are limited to emergencies; read-back is a National Patient Safety Goal.	*"Take it without read-back to save time" — error-prone, against policy.*
Provider verbally berates an RN in the hallway in front of clients	Disengage, document the incident factually, report to the nurse manager and through facility's disruptive-behavior policy.	Maintains professionalism, uses chain of command, creates a paper trail without retaliation.	*"Argue back to defend yourself" — escalates conflict and violates professional conduct.*
RN suspects child abuse based on an infant's pattern of bruising	Notify the provider, document objectively, and report directly to Child Protective Services as a mandated reporter.	Mandatory reporting is required by law regardless of chain of command.	*"Report only to the charge nurse and wait" — fails the legal mandatory-reporting duty.*

04 DELEGATION / SCOPE TABLE

Escalation tasks have very specific scope. The RN cannot hand off the responsibility for clinical judgment, but can delegate *parts* of the response.

TASK	RN	LPN/VN	UAP	CAN DELEGATE?	WHY OR WHY NOT
Activate the Rapid Response Team	✓	✓	✓	**Yes — any staff**	RRT activation is a safety net; any team member can call. The *response* is led by RN/provider.
Clarify an unsafe medication order with the provider	✓	✗	✗	**No**	Requires RN clinical judgment and accountability for the order.
Refuse to carry out an unsafe order	✓	✓	✗	**Within scope only**	Licensed nurses must refuse unsafe orders within their scope. UAP doesn't carry orders.
Take vital signs every 15 min on a decompensating client	✓	✓	✗	**No (unstable)**	UAP can take VS on *stable* clients. An unstable client requires licensed assessment.
Report suspected impaired coworker to nursing supervisor	✓	✓	✓	**Yes — anyone witnessing**	All staff have duty to report; the RN/charge then escalates and removes from care.
Document the chain-of-command notification in the EHR	✓	✗	✗	**No**	RN documents own assessments and notifications; not delegated.
Witness a client refusing treatment / signing AMA	✓	✓	✗	**Licensed nurse**	UAP cannot witness clinical/legal forms requiring assessment of understanding.
Stay with a deteriorating client while RRT is called	✓	✓	✓	**Yes (presence)**	Any team member can stay at bedside; the RN directs the clinical response.
Call the on-call provider with SBAR for a status change	✓	✓ **(limited)**	✗	**RN preferred**	RN owns the assessment in SBAR. LPN may notify under RN direction in some states.
Report suspected abuse to CPS / APS	✓	✓	✓	**Yes — mandated**	All health care staff are mandated reporters; reporting is not a delegated act.

05 RED-FLAG CUES

IMMEDIATE ASSESSMENT

SUDDEN ↓ LOC

New confusion, lethargy, or unresponsiveness in a previously alert client.

ACUTE CHEST PAIN

Especially with diaphoresis, dyspnea, or radiation.

SPO_2 < 90% ON ROOM AIR

Or any 4-point drop from baseline.

NEW ONSET BLEEDING

Surgical site saturation, hematemesis, hematuria, melena.

PROVIDER NOTIFICATION

SIGNIFICANT VITAL SIGN CHANGE

BP < 90/60 or > 180/110, HR < 50 or > 130, T > 38.3 °C in immunocompromised.

UNRELIEVED PAIN

Post-medication pain unchanged or worsening.

LAB VALUE OUTSIDE CRITICAL LIMIT

K^+ < 3 or > 5.5, glucose < 70 or > 400, INR > 5.

ORDER DISCREPANCY OR ALLERGY CONFLICT

Drug-drug, drug-allergy, dose 10× normal.

RAPID RESPONSE (ACTIVATE NOW)

PRE-CODE DECLINE

Worried, "something is wrong" — RRT is for staff intuition + objective decline.

RR > 28 OR < 8

With altered mental status.

SUSTAINED SBP < 90

Despite intervention.

NEW STROKE SYMPTOMS

Facial droop, slurred speech, unilateral weakness.

CHAIN OF COMMAND

PROVIDER WON'T ADDRESS CONCERN

UNSAFE STAFFING

Assignment beyond scope or unsafe ratio.

DISRUPTIVE BEHAVIOR

Repeated unprofessional conduct.

Unsafe order stands after clarification.

POLICY VIOLATION

Pattern of unsafe practice.

MANDATORY REPORTING (OUTSIDE THE FACILITY)

SUSPECTED ABUSE/NEGLECT

Child, elder, dependent adult, intimate partner (varies by state).

REPORTABLE COMMUNICABLE DISEASE

TB, measles, pertussis, STIs, COVID-19 per state list.

GUNSHOT / KNIFE WOUND

Law enforcement notification per state.

IMPAIRED LICENSED PRACTITIONER

Report to the Board of Nursing/Medical Board after facility report.

HOLD DELEGATION & REASSESS

CLIENT JUST BECAME UNSTABLE

Pull task back from UAP; reassess yourself.

DELEGATE REPORTS UNEXPECTED FINDING

"His BP is 84/50" → RN goes to bedside.

SKILL OUTSIDE COMPETENCY

UAP unfamiliar with a device or task.

FAMILY/CLIENT REFUSES

RN reassesses the refusal and educates.

06 ADVANCED NGN PRACTICE QUESTIONS

Q1 MULTIPLE CHOICE

A provider writes an order for "morphine 10 mg IV push every 2 hours PRN pain" for an opioid-naïve 78-year-old client weighing 52 kg, postoperative day 1. What is the priority action of the RN?

A. Administer the medication as ordered and monitor respiratory status

B. Hold the dose, contact the prescribing provider to clarify the order, and document

C. Call the nursing supervisor to report an unsafe prescription

D. Administer half the dose and reassess in 30 minutes

Correct: B. The dose is excessive for an elderly, opioid-naïve, low-weight client. The RN must hold the dose and clarify with the prescriber first — this is the lowest effective step in the chain.
A — Administering a clearly unsafe order makes the RN legally accountable.
C — Skipping the prescriber violates chain-of-command order; supervisors are escalated to only if the prescriber refuses to adjust.
D — RNs cannot independently alter prescribed doses.

NCLEX trap: Choosing the supervisor before the prescriber. Step: Take Action

Q2 SELECT ALL THAT APPLY

Which findings would lead the RN to activate the Rapid Response Team? Select all that apply.

A. New onset of slurred speech and right facial droop

B. SpO_2 86% on 2 L nasal cannula, RR 30, accessory muscle use

C. Client is asleep with regular respirations and SpO_2 96%

D. Sustained SBP 84/52 after a 500 mL fluid bolus

E. "Something just isn't right" gut feeling with subtle confusion

F. Client without pulse or respirations

Correct: A, B, D, E. RRT is for pre-code clinical deterioration. Stroke symptoms, respiratory failure, refractory hypotension, and intuitive worsening all qualify.
C — Normal sleep.
F — Pulseless = Code Blue, not RRT.

NCLEX trap: Confusing arrest with pre-arrest; both are urgent but the team activated differs. Step: Analyze Cues

Q3 MATRIX / GRID

For each situation, indicate which level of the chain of command the RN should contact *first*.

SITUATION	CHARGE NURSE	PROVIDER	NURSING SUPERVISOR	ETHICS COMMITTEE
Disagreement with another RN about a room assignment	✓			
New onset of paradoxical breathing in a postop client		✓		
Night shift: two staff calls out and no replacement is found			✓	
Family insists on continuing aggressive care that conflicts with client's living will				✓
Provider repeatedly refuses to clarify an unclear order			✓	

Rationale: Unit-level peer conflict → charge nurse. Clinical decline → provider. Staffing crises after-hours → supervisor. Ethical impasse → ethics committee. Provider refusing to address an unsafe order → escalate up the medical chain via the nursing supervisor.
NCLEX trap: Going to the supervisor for things the charge nurse can resolve, or to the ethics committee for things the provider can resolve. Step: Generate Solutions

Q4 BOW-TIE

A 64-year-old postop client has just developed crackles to mid-lobes, SpO_2 87%, BP 168/92, HR 118, and frothy pink sputum. Drag the condition the nurse should prioritize, the two actions to take first, and the two parameters to monitor.

Most likely condition: Acute pulmonary edema

Two actions to take first:

- Place client in high-Fowler's position with feet dependent
- Activate Rapid Response and notify the provider via SBAR

Two parameters to monitor:

- SpO_2 and respiratory effort
- Blood pressure and urine output

Rationale: Acute pulmonary edema is life-threatening and requires immediate positioning, oxygen, and RRT activation while preparing for diuretics, morphine, and possibly NIPPV. Monitoring oxygenation and perfusion (BP, UOP) drives the next interventions.

Trap: Holding the call to the provider until lab work returns. Step: Prioritize Hypotheses + Take Action

Q5 ORDERED RESPONSE

The RN finds a client unresponsive with no pulse and no respirations. Place the following actions in the correct order.

1. Confirm unresponsiveness and shout for help
2. Activate the code blue / call rapid response per facility policy
3. Begin chest compressions at 100–120/min
4. Open the airway and provide ventilations once an AED/BVM is available
5. Continue CPR until the code team arrives and assumes care
6. Document the event objectively

Rationale: BLS sequence after recognition: shout for help → call code → compressions → ventilations → continue until relieved → document. RNs initiate CPR before defibrillation when AED is not immediately on the unit.

Trap: Stopping CPR to call the provider; the code team comes via the code button. Step: Take Action

Q6 DROP-DOWN / CLOZE

Complete the SBAR escalation statement.

"Dr. Lin, this is RN Patel on 4 South calling about Mr. Reyes, postop day 1 from an open cholecystectomy. He has become **[anxious and confused]**, with a respiratory rate of 30 and SpO_2 of 86% on 2 L. His skin is **[mottled and diaphoretic]**. I am concerned about **[respiratory failure / sepsis]**. I am requesting **[immediate evaluation, ABG, lactate, and consideration of higher level of care]**."

Rationale: The Situation (who, where, why calling) — Background — Assessment (objective + concern) — Recommendation (what you need) format is the gold standard. NCLEX likes the Recommendation that names what the nurse *needs* from the provider, not just "please come see the client."

Trap: Skipping the recommendation. Step: Take Action (Communicate)

Q7 PRIORITIZATION

A charge nurse is supervising four RNs. Which assignment most urgently requires direct charge-nurse involvement?

A. An RN reports that a client is refusing all morning medications

B. An RN reports she smells alcohol on the breath of a coworker reporting to the unit

C. An RN asks for help with a complex dressing change

D. An RN reports a family member is upset about a long wait for discharge paperwork

Correct: B. Impaired practice is an *immediate* safety threat to every client on the unit. The charge nurse removes the coworker from care and notifies the nursing supervisor; mandatory reporting to the Board of Nursing follows.

A, C, D are real but lower-acuity issues that can be addressed after the impaired-practice situation is contained.

Trap: Treating refusal of meds or upset family as more urgent than imminent client harm. Step: Prioritize Hypotheses

Q8 CASE-STUDY STYLE

An RN is caring for a client with sepsis. The provider has ordered "ceftriaxone 1 g IV now." The MAR notes an allergy to penicillin with prior anaphylaxis. The RN's first action?

A. Administer the antibiotic and have epinephrine at the bedside

B. Hold the dose and contact the prescribing provider to discuss cross-reactivity risk and possible alternative

C. Skip the dose and document on the MAR

D. Ask the pharmacist to change the order

Correct: B. Cephalosporin/penicillin cross-reactivity is real, especially with prior anaphylaxis. The RN holds the dose and clarifies with the prescriber.
A — Bypasses safety. **C** — Skipping without clarification compromises sepsis treatment. **D** — Pharmacists do not change orders without the provider's authorization.

Trap: Picking the pharmacist as a substitute for the prescriber. Step: Take Action

Q9 DELEGATION SCENARIO

During a Code Blue, which task is most appropriate for the RN to delegate to a UAP?

A. Pushing IV epinephrine

B. Recording compression cycles and timing on the code sheet

C. Interpreting the cardiac rhythm

D. Performing chest compressions if trained and competent

Correct: D. Trained UAP may perform compressions during a code. **B** is also acceptable when the UAP has been trained as a recorder; however, performing compressions has higher impact and is the most clinically appropriate delegation here.
A and C require licensed scope.
Trap: Forgetting that physical, repetitive, non-judgment tasks (compressions) are appropriate for trained UAP.

Step: Generate Solutions

Q10 HANDOFF / SBAR

An RN is escalating to the nursing supervisor about an unsafe staffing assignment. Which statement reflects the *Recommendation* component of SBAR?

A. "I have eight clients including two on isolation and one immediately postop."

B. "The unit has been short-staffed for the entire week."

C. "I'm worried something will get missed because the workload is unsafe."

D. "I am requesting either an additional nurse, a reassignment of one of the postop clients, or a documented acceptance of risk by you."

Correct: D. Recommendation is what the nurse needs from the person being called. A clear, specific ask drives action and creates documentation of escalation.
A is Situation/Background. **B** is Background. **C** is Assessment.

Trap: Stopping at "Assessment" without making a specific request. Step: Take Action (Communicate)

Q11 MULTIPLE CHOICE (ETHICAL)

An RN believes a surgeon has consented a client for surgery without ensuring full understanding — the client tells the RN "I don't know what they're going to do to me." What is the RN's best next action?

A. Reinforce the consent and have the client sign again

B. Notify the surgeon that the client has questions and request the surgeon return to clarify before the procedure

C. Cancel the surgery

D. Call the ethics committee

Correct: B. Informed consent is the *provider's* responsibility. The RN's role is to witness signature and to ensure the client understood — if they didn't, the RN advocates by stopping the process and recalling the surgeon.
A — RNs cannot obtain or reinforce surgical consent. **C** — Not within RN scope. **D** — Premature; provider hasn't been engaged yet.

Trap: Jumping to ethics committee before exhausting the chain. Step: Take Action (Advocate)

Q12 SELECT ALL THAT APPLY

Which situations require mandatory *external* reporting in addition to chain of command? Select all that apply.

A. An RN observes bruises in different stages of healing on a 4-year-old

B. A client is diagnosed with active pulmonary tuberculosis

C. A client reports she fell at home and refuses help

D. An RN diverts opioids and the facility verifies the diversion

E. An elderly client's home health aide is found pocketing money from the client's wallet

F. A client says, "I'm so frustrated I could scream"

Correct: A, B, D, E.

A — Suspected child abuse → CPS.

B — Reportable communicable disease → Public Health.

D — Impaired/diverting nurse → Board of Nursing.

E — Suspected elder financial exploitation → APS.

C — A capable adult refusing help is not abuse. **F** — Verbal frustration alone is not a threat.

Trap: Treating mandatory reports as optional or thinking the facility report substitutes for the legal report.

Step: Take Action (Legal Duty)

07 UNFOLDING NGN CASE STUDY

NURSE'S NOTES — 0700

62-year-old male, postop day 1 from open abdominal aortic aneurysm repair. Awake, oriented ×3. Pain 4/10. Lungs clear, abdomen soft, dressing dry and intact. Foley draining clear yellow urine 60 mL/hr. Bilateral pedal pulses 2+. Plan: advance diet, ambulate with PT, transition to PO pain meds.

VITAL SIGNS — 0700 → 1000 → 1300

PARAMETER	0700	1000	1300
Temp (°C)	37.0	37.4	38.6
HR	78	96	122
BP (mm Hg)	132/76	118/68	92/54
RR	16	20	28
SpO_2 (RA)	97%	94%	88%
UOP last hour	60 mL	30 mL	15 mL
LOC	A&O ×3	A&O ×3, restless	A&O ×2, lethargic

PROVIDER ORDERS (CURRENT)

- Diet: clears, advance as tolerated
- Morphine 4 mg IV q4h PRN pain
- Ambulate TID with PT
- Foley to gravity drainage
- Routine VS q4h
- Notify provider for SBP < 100, HR > 110, T > 38.3 °C, UOP < 30 mL/hr

FAMILY STATEMENT — 1305

"He keeps saying his belly feels really tight. He was joking with me an hour ago, but now he keeps drifting off."

HEALTH CARE TEAM NOTE — 1310

RN pages provider twice. No response after 12 minutes.

QUESTION 1 — RECOGNIZE CUES

Highlight the cues that require immediate follow-up.

Cues to recognize: Temp rising to 38.6 °C, HR 122, BP 92/54, RR 28, SpO_2 88% on RA, UOP dropped to 15 mL/hr, decreased LOC, "tight belly," provider unresponsive after 12 minutes.

Why: All except baseline 0700 values represent significant deterioration consistent with sepsis or possible internal hemorrhage post-AAA repair.

QUESTION 2 — ANALYZE CUES

The cues are most consistent with which two complications?

1. Septic shock (fever, tachycardia, hypotension, tachypnea, ↓UOP, altered LOC).
2. Intra-abdominal hemorrhage / graft leak (tight abdomen, hypotension, tachycardia, ↓UOP, ↓LOC).

Both are life-threatening and overlap. The RN must act before identifying the precise cause.

QUESTION 3 — PRIORITIZE HYPOTHESES

Which is the priority hypothesis to drive the next 5 minutes of care?

Priority: Hemodynamic collapse from either sepsis or hemorrhage. Both demand immediate resuscitation and surgical evaluation; perfusion is failing now.

QUESTION 4 — GENERATE SOLUTIONS

Select all interventions the RN should prepare for.

- ✅ Activate **Rapid Response Team** immediately.
- ✅ Stay at bedside; delegate a UAP to call the on-call surgeon and the nursing supervisor (provider unresponsive after 12 min).
- ✅ Apply high-flow O_2, raise head of bed to comfort, prepare for possible intubation.
- ✅ Establish second large-bore IV, prepare for fluid resuscitation per protocol.
- ✅ Anticipate STAT labs: CBC, lactate, blood cultures ×2, BMP, type & crossmatch, ABG, coags.
- ✅ Recheck dressing for bleeding, palpate abdomen for distention.

- ✅ Notify charge nurse; document escalation timeline.

QUESTION 5 — TAKE ACTION

Write the SBAR to the surgeon (escalation):

Situation: "Dr. Marquez, this is RN Patel on 4 South. I am calling about Mr. Reyes — POD #1 open AAA repair. He has decompensated over the last six hours. I was unable to reach the resident after two pages."
Background: "Stable this morning, now febrile to 38.6, HR 122, BP 92/54, RR 28, SpO2 88% RA, UOP 15 mL/hr, LOC declining, abdomen tight."
Assessment: "I am concerned about possible septic shock or postoperative hemorrhage."
Recommendation: "I have activated Rapid Response and need you at the bedside immediately for surgical evaluation. I will have STAT labs, type and cross, and a second IV ready."

QUESTION 6 — EVALUATE OUTCOMES

30 minutes later — which findings indicate the interventions are effective?

FINDING	EFFECTIVE	INEFFECTIVE	UNRELATED
BP 108/68 after fluid bolus and norepinephrine	✓		
SpO2 96% on 50% non-rebreather	✓		
UOP 40 mL/hr	✓		
HR remains 130; lactate 6.2 mmol/L		✓	
Client requests glasses			✓
LOC improving — oriented ×3	✓		

Persistent tachycardia and rising lactate indicate inadequate perfusion despite intervention — re-escalate.

08 "WHAT SHOULD THE NURSE DO FIRST?"

Scenario 1: The provider gives a verbal order in the hallway for a high-alert IV potassium drip during a non-emergent situation.

First Action: Politely ask the provider to enter the order into the EHR. Do not accept a non-emergent verbal order for a high-alert medication. *Why:* Verbal orders for high-alert drugs are a sentinel-event risk.

Scenario 2: The RN is in the middle of a sterile dressing change when the unit secretary announces a Code Blue in the next room.

First Action: Quickly cover the wound with a sterile dressing and respond to the Code; another nurse can complete the dressing change. *Why:* Life-threatening emergency outranks routine care; do not abandon sterile field uncovered.

Scenario 3: A new graduate RN calls the charge nurse saying she "doesn't feel comfortable" giving a chemo dose she has never administered.

First Action: Charge nurse reassigns the chemo to a chemo-certified RN and provides supervised learning later. *Why:* Competency and certification must precede high-risk administration.

Scenario 4: A client whispers to the RN, "My husband hits me at home." The husband is in the room.

First Action: Separate the client from the spouse in a non-suspicious way ("I need to take her to imaging"), then assess and report per mandatory reporting laws. *Why:* Safety first, private assessment, mandated reporting.

Scenario 5: The pharmacy delivers a medication that looks similar to a high-alert drug the RN was expecting, but the label name is different.

First Action: Stop, do not administer, and contact the pharmacist to verify. *Why:* Look-alike/sound-alike errors are a leading cause of medication harm; verify before administering.

09 "CAN THIS BE DELEGATED?"

Scenario 1: Reporting an impaired coworker to the supervisor.

Answer: Any staff member who witnesses impairment must report — but the licensed RN/charge nurse must remove the coworker from client care and document. *Delegation:* "Witnessing and reporting" is everyone's duty; clinical action is RN-led.

Scenario 2: Documenting that the RN notified the provider of a change in condition.

Answer: Cannot be delegated. The RN who performed the assessment and the call documents the note.

Scenario 3: Taking VS every 5 minutes on a hemodynamically unstable client awaiting transfer to ICU.

Answer: Cannot be delegated to UAP because the client is unstable. RN/LPN performs and interprets.

Scenario 4: Performing chest compressions on a client in cardiac arrest.

Answer: Yes — a trained UAP may perform compressions. The RN/provider directs the code.

Scenario 5: Witnessing a client's refusal of treatment / AMA form.

Answer: Licensed nurse — typically the RN — witnesses, because the witness must assess understanding. UAP cannot witness.

10 "WHO SHOULD THE NURSE CONTACT?"

Scenario 1: The client's living will conflicts with the family's wishes at end of life, and the team is unsure how to proceed.

Contact: Ethics committee (after notifying provider and charge nurse). *Why:* Ethical impasse, particularly around autonomy and end-of-life.

Scenario 2: A discharged client cannot afford insulin and pump supplies.

Contact: Case manager / social worker. *Why:* Coordinates community resources and financial support.

Scenario 3: A client with a stage 4 pressure injury requires complex wound care planning.

Contact: Wound/ostomy/continence nurse (WOC). *Why:* Specialty expertise in wound staging and treatment plan.

Scenario 4: The night-shift charge nurse cannot find coverage after two RNs call out sick.

Contact: Nursing supervisor. *Why:* After-hours operations and staffing escalation.

Scenario 5: A postop client failed a swallow screen and is at high risk of aspiration.

Contact: Speech-language pathologist (after notifying provider for orders). *Why:* SLP completes the formal swallow evaluation and recommends diet modification.

11 LEGAL / ETHICAL TRAP SCENARIOS

Scenario 1 — Consent: The surgeon asks the RN to "just have the client sign the consent" because the surgeon is running late.

Answer: The RN cannot obtain the consent. RN role is limited to witnessing the signature after the provider has explained risks, benefits, and alternatives. The RN must respectfully tell the surgeon the consent discussion must happen first.

Scenario 2 — Refusal: An alert, oriented adult client refuses dialysis and wants to leave AMA.

Answer: Honor autonomy. Confirm understanding, document, notify provider, offer follow-up resources, and have the client sign the AMA form. Do not block the door.

Scenario 3 — Confidentiality: A family member calls asking for an update; the client has not given permission.

Answer: The RN cannot release information. State that confidentiality prevents confirming the client is even present without permission.

Scenario 4 — Mandatory Reporting: An RN suspects an elderly client's caregiver is withholding food.

Answer: Notify provider, document objectively, and file an Adult Protective Services report — mandated by law. Facility chain of command does not replace the legal report.

Scenario 5 — End of Life: A client with a valid DNR begins to deteriorate. The family at the bedside screams "Do something!"

Answer: Provide comfort care per the DNR; do not initiate CPR. Stay with the family, offer chaplain and social work support, notify provider, and document the client's expressed wishes and the family's response. The legal order stands.

12 END-OF-DAY QUICK REVIEW

10 ONE-LINE MUST-REMEMBER POINTS

1. The RN is legally accountable for any order they carry out.
2. Clarify unsafe orders with the prescriber *first*.
3. Rapid Response Team = decline. Code Blue = arrest.
4. Stay with the deteriorating client; send someone else to call.
5. Charge nurse for unit issues. Provider for clinical/order issues.
6. Do not skip steps unless the situation is emergent.
7. SBAR every escalation: Situation, Background, Assessment, Recommendation.
8. Mandatory reporting (abuse, communicable disease, impaired practice) is a *legal* duty.
9. Document objectively: what, when, who, response, client status.
10. Client's living will/DNR overrides family wishes.

5 COMMON NCLEX TRAPS

1. Choosing the supervisor or CNO before the charge nurse for a unit-level concern.
2. Picking the pharmacist as a substitute for the prescribing provider.
3. Confusing Rapid Response with Code Blue.
4. "Reinforcing consent" — the RN cannot obtain surgical consent.
5. Treating chain of command as a replacement for mandatory external reporting.

5 "NEVER DO THIS" RULES

1. Never administer a clearly unsafe medication "just this once."
2. Never abandon a deteriorating client at the bedside.
3. Never accept a non-emergent verbal order for a high-alert drug.
4. Never override a valid DNR because family is upset.
5. Never use chain of command alone in place of a legally required external report.

5 SAFETY-FIRST PHRASES TO RECOGNIZE ON NCLEX

"Hold the order and contact the prescriber" | "Activate the Rapid Response Team" | "Stay at the bedside and delegate the call"

"Notify the charge nurse first" | "Document objectively and notify the supervisor"

13 STANDALONE INFOGRAPHIC SUMMARY

CHAIN OF COMMAND — IN ORDER

- Bedside RN
- Charge Nurse
- Provider (clinical concerns)
- Nursing Supervisor (after-hours / unresolved)
- Nurse Manager → Director → CNO
- Risk Mgmt / Ethics / Board of Nursing

SKIP-THE-LADDER TRIGGERS

- Code Blue → Code team
- Pre-arrest decline → Rapid Response
- Active threat / abuse → Security + legal report
- Imminent harm → Stop the action first

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SBAR FRAMEWORK

- **S**ituation — who/where/why now
- **B**ackground — relevant history
- **A**ssessment — objective findings + concern
- **R**ecommendation — what you need

UNSAFE ORDER ALGORITHM

- 1️⃣ Hold the order
- 2️⃣ Contact the prescriber → clarify
- 3️⃣ If unresolved → nursing supervisor
- 4️⃣ If still unresolved → medical director
- 5️⃣ Document every step objectively

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RRT VS. CODE BLUE

- **RRT** — pre-arrest: ↓SpO_2, ↑RR, ↓BP, ↓LOC, "something's wrong"
- **Code** — pulseless, apneic, or both
- Both: RN-activated, no provider order needed

MANDATORY EXTERNAL REPORTS

- Suspected abuse/neglect (CPS, APS)
- Reportable communicable disease (public health)
- Gunshot / stab wound (law enforcement)
- Impaired licensed practitioner (Board of Nursing)

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RN CANNOT DELEGATE

- Initial assessment
- Clinical judgment
- Teaching
- Evaluation of outcomes
- Unstable client tasks
- Obtaining/reinforcing consent

RN CAN DELEGATE (TO RIGHT PERSON)

- Stable VS, I&Os, ADLs → UAP
- Compressions during code → trained UAP
- Sterile dressing, PO/IM meds (most states) → LPN
- Reinforced teaching → LPN
- Activation of RRT → anyone

The Day-11 Mantra

"Clarify the order, climb the ladder, document the climb, never abandon the client, and report what the law requires."

End of Day 11 — Chain of Command, Unsafe Orders & Escalation

TOMORROW → DAY 12: QUALITY IMPROVEMENT, INCIDENT REPORTS & SAFETY SYSTEMS