DAY 13 · MANAGEMENT OF CARE

Resource Management, Time Management & Safe Staffing

How a safe entry-level RN organizes a chaotic shift, refuses to be rushed into unsafe practice, and uses every available resource — people, policy, technology, time — to keep clients alive.

FRAMEWORK
2026 NCLEX-RN Test Plan

CATEGORY
Safe & Effective Care Environment

SUBCATEGORY
Management of Care

MODEL
NGN Clinical Judgment Measurement Model

WHAT'S INSIDE TODAY

1 · High-yield overview

Resource management is about **matching the right people, time, supplies, and information to the right client at the right moment.** Time management is the engine that makes that possible. Safe staffing is the floor underneath both — you cannot organize your way out of an unsafe assignment.

The NCLEX tests three skills here:

- **Prioritize** — sort the shift by acuity and time-criticality, not by "what's loudest."
- **Coordinate** — cluster care, delegate within scope, use the chain of command and the resources you already have.
- **Protect** — speak up about unsafe staffing in writing through the chain of command, without abandoning clients.

THE ONE-SENTENCE FRAME

Unstable + acute + time-critical + high-risk > Stable + chronic + routine + low-risk — and your job as the RN is to keep that ordering true all shift, no matter who interrupts you.

From the 2026 NCLEX-RN Test Plan, the activity statements driving this day include:

- *Organize workload to manage time effectively.*
- *Recognize limitations of self and others and utilize resources.*
- *Utilize resources to promote quality client care (e.g., evidence-based research, information technology, policies and procedures).*
- *Practice and advocate for quality and cost-effective care.*
- *Evaluate effectiveness of staff members' time management skills.*

2 · Ten must-know rules

1	**ABC + acute change wins.** Always reassess the unstable, deteriorating, or unexpectedly-quiet client first — not the loud one or the one closest to the nurses' station.
2	**Do a safety sweep first.** After report, lay eyes on every assigned client within 30–60 minutes. Confirm airway, IV site, monitors, fall risk, and pending time-critical interventions.
3	**Cluster care.** Combine assessment, meds, hygiene, and teaching into one purposeful encounter when safe. Fewer entries = fewer infections, fewer interruptions, fewer missed cues.
4	**Never delegate the nursing process.** Assessment, analysis, planning, teaching, evaluation, and unstable-client care stay with the RN. *Always.*
5	**Time-critical > routine.** Sepsis antibiotics, stroke thrombolytics, insulin coverage, blood products, and chemo windows trump scheduled meds, baths, and ambulation.
6	**Use a no-interruption zone.** During medication preparation, blood administration, and central-line procedures, do not stop for non-emergent requests.
7	**Speak up about unsafe staffing — in writing.** Notify the charge nurse and supervisor, document the concern on the facility form (e.g., Assignment Despite Objection / ADO), and continue caring for clients. Do **not** walk out.
8	**Float ≠ float into anything.** A floated nurse is assigned within competency. A med-surg RN does not run a code-level ICU drip on day one — the RN requests orientation and a safe assignment.
9	**Resources exist for a reason.** Policy and procedure manuals, charge RN, pharmacist, rapid response, EHR alerts, and evidence-based guidelines are *NCLEX-correct* answers when offered.
10	**Cost-effective ≠ cheap.** Use the least invasive, lowest-cost intervention that still meets the safety standard (e.g., avoid duplicate labs, reuse equipment per policy, choose oral over IV when appropriate).

3 · RN safety decision table

SITUATION	BEST RN ACTION	WHY THIS IS SAFEST	COMMON NCLEX TRAP
You receive report on 5 clients at the start of shift.	Triage by acuity, then do a brief safety sweep on each client within 30–60 min, beginning with the most unstable.	Catches early deterioration; matches ABC + acuity logic.	Going room-to-room in numerical order, or seeing the "complaining" client first.
You are floated to a unit you have not worked before.	Notify the charge, request orientation, and ask for an assignment within your demonstrated competency.	Practicing within scope is a legal obligation; protects clients and license.	Refusing the float entirely and going home → abandonment.
Mid-medication pass, a family member stops you in the hall to ask non-urgent questions.	Acknowledge the request, tell them you will return after the medication is given safely, and complete the pass without interruption.	Medication errors spike during interruptions; honors a "no-interruption zone."	Stopping mid-pass to "be polite," then giving the wrong med to the wrong client.
Charge assigns you 6 clients including 1 actively septic and 1 receiving blood — clearly unsafe.	Notify the charge, then nursing supervisor; document the concern on the facility ADO form; accept assignment under protest; continue caring for the clients.	Uses chain of command, creates a paper trail, avoids abandonment.	"Refuse the assignment and clock out" → abandonment + license risk.
UAP reports vitals: BP 84/52, HR 118 on the post-op client they just took.	RN goes immediately to reassess the client.	Acute change → RN reassessment, not delayed recheck.	"Have UAP recheck in 15 min and call back."
Pharmacy has not delivered the 0900 piperacillin-tazobactam for a septic client.	Call pharmacy, escalate; if delay continues, notify the provider; document.	Antibiotic timing is part of the sepsis bundle and outcome-driven.	Charting "med unavailable" and moving on without follow-up.
You have 9 tasks queued at 0800: blood, antibiotic, insulin, dressing, IV restart, ambulation, vitals, teaching, documentation.	Sequence by ABC + time-critical + high-risk: insulin/blood/antibiotic first; delegate vitals and ambulation to UAP; teaching and documentation cluster later.	Time-critical and high-risk before routine, delegated, or low-risk.	Doing tasks in the order they appear on the brain sheet.
Charge nurse will not respond to your staffing concern.	Move up the chain: nursing supervisor → manager → administrator on call. Document each step.	Chain of command exists precisely for when the first contact does not respond.	Posting on social media, calling local news, or texting other staff to complain.

SITUATION	BEST RN ACTION	WHY THIS IS SAFEST	COMMON NCLEX TRAP
A new orientee on your team looks overwhelmed and is behind on charting.	Help them prioritize, take one of their unstable clients if needed, and notify the charge.	Supervising RN responsibility; protects clients and supports the new nurse.	Reporting the orientee to administration instead of intervening at the bedside.
You realize halfway through shift a routine task is going to be missed (e.g., scheduled bath).	Re-prioritize: pass the task to UAP, defer to next shift in handoff, or document why it could not be completed safely.	Safety-critical care first; routine care is reschedulable.	Rushing and skipping client identification or assessment to "stay on time."

4 • Delegation & scope-of-practice table

Scope varies slightly by state and facility — these are the safest *NCLEX-RN* defaults.

TASK	RN	LPN/VN	UAP	DELEGABLE?	WHY OR WHY NOT
Initial admission assessment	✓	✗	✗	NO	RN-only — the first assessment drives the plan of care.
Re-take stable client's routine vitals	✓	✓	✓	YES → UAP	UAP scope when client is stable; RN sets the report parameters.
Triaging acuity for a new admission	✓	✗	✗	NO	Requires nursing judgment.
Reinforce previously taught discharge instructions	✓	✓	✗	YES → LPN	LPN may reinforce; initial teaching is RN.
Hang first dose of new IV antibiotic	✓	✗	✗	NO	First-dose reaction monitoring is RN.
Administer routine subsequent IV antibiotic on stable client	✓	✓*	✗	VARIES	*State- and facility-dependent for LPN.
Insert indwelling urinary catheter (stable adult)	✓	✓	✗	YES → LPN	Sterile but routine; not UAP scope.
Administer blood products	✓	✗	✗	NO	RN initiates and monitors; reaction risk is high.
Bathing a stable client	✓	✓	✓	YES → UAP	Basic hygiene = UAP scope.
Suction an established stable tracheostomy	✓	✓	✗	YES → LPN	Airway = never UAP.
Feed a stable client without dysphagia	✓	✓	✓	YES → UAP	Dysphagia or new stroke client = RN/SLP, not UAP.
Evaluate response to PRN pain medication	✓	✗	✗	NO	Evaluation is part of nursing process — RN only.
Ambulate stable post-op day 2 client	✓	✓	✓	YES → UAP	First ambulation, dizziness, or orthostatic risk → RN/PT.
I&O measurement, emptying drains	✓	✓	✓	YES → UAP	Recording is UAP scope; trend interpretation is RN.
Change a sterile central-line dressing	✓	✓*	✗	OFTEN RN	*Facility-specific; CLABSI risk drives RN-only policy in many places.
Discharge teaching for a brand-new diagnosis	✓	✗	✗	NO	Initial teaching = RN.
Reposition unconscious / immobile client q2h	✓	✓	✓	YES → UAP	Routine repositioning per care plan.

TASK	RN	LPN/VN	UAP	DELEGABLE?	WHY OR WHY NOT
Triaging incoming phone calls from family	✓	✗	✗	NO	Requires HIPAA judgment and clinical assessment.

FIVE RIGHTS OF DELEGATION — KEEP THEM ON A LOOP

Right task · Right circumstances · Right person · Right direction & communication · Right supervision & evaluation.
Miss any one and the delegation is unsafe — and the RN is accountable.

5 · Red-flag cues

IMMEDIATE RN ASSESSMENT

- New confusion or LOC change
- New chest pain or dyspnea
- BP < 90/60 or > 180/110 (sustained)
- SpO_2 < 90% on prescribed O_2
- Sudden output drop < 30 mL/hr × 2
- Asymmetry, slurred speech, facial droop
- Hypoglycemia < 70 mg/dL

PROVIDER NOTIFICATION

- Critical lab values
- No response to ordered intervention
- Persistent abnormal vitals after first action
- Suspected adverse drug reaction
- New rhythm change or arrhythmia
- Pending labs that prevent safe discharge

RAPID RESPONSE TEAM

- Acute mental-status change
- SBP < 90 or > 180 (sustained)
- HR < 50 or > 130 (sustained)
- RR < 8 or > 28
- SpO_2 < 90% on O_2
- New chest pain
- Sepsis screening positive
- "Something is not right" — staff worry

CHAIN OF COMMAND

- Unsafe staffing ratio
- Unsafe or questionable order
- Provider not responding
- Refused safety policy by staff
- Floated to unfamiliar high-acuity area
- Ethical conflict not resolvable on the unit

MANDATORY REPORTING

- Suspected child / elder / vulnerable-adult abuse
- Communicable disease (TB, measles, certain STIs)
- Gunshot or stab wound
- Impaired or unsafe colleague
- Sentinel events

HOLD DELEGATION & REASSESS

- Delegate reports out-of-range values
- Client status changing
- Task drifts outside delegate's scope
- Delegate unsure how to perform task
- New orientee paired with high-risk task

6 · Twelve advanced NGN practice questions

Mixed item types. Walk through the rationales the way you would on test day — what's the trap, what clinical-judgment step is being tested.

Q1 · PRIORITIZATION (SINGLE-BEST) *CJMM: Prioritize Hypotheses*

A med-surg RN receives report on 4 clients. Which client should the RN assess **first?**

(A) A 68-year-old, post-op day 1 hip replacement, reports pain 6/10, last analgesic 2 hours ago.

(B) A 54-year-old admitted last night with pneumonia; current SpO_2 91% on 2 L nasal cannula, RR 26, anxious.

(C) A 72-year-old with stable atrial fibrillation, due for the next dose of oral diltiazem in 30 minutes.

(D) A 45-year-old being discharged today, awaiting prescriptions from the pharmacy.

CORRECT **B.** SpO_2 91% with RR 26 and anxiety on a pneumonia client signals impending respiratory decompensation — ABC plus an acute change in trend. Earliest sign of hypoxia is restlessness/anxiety.

A WRONG Pain is real and important, but a stable post-op pain is predictable and not life-threatening.

C WRONG A scheduled med 30 minutes away in a stable client can wait.

D WRONG A pharmacy delay is a logistics problem, not an acuity problem.

TRAP Choosing the "loud" or "scheduled" client over the quietly hypoxic one. **CJMM step:** Prioritize hypotheses.

Q2 · SELECT-ALL-THAT-APPLY (SATA) *CJMM: Take Action*

The RN believes the current shift assignment is unsafe due to high acuity and inadequate staffing. Which actions are appropriate? *Select all that apply.*

(A) Notify the charge nurse of the specific safety concern.

(B) Refuse the assignment and leave the unit.

(C) Document the concern in writing on the facility's Assignment Despite Objection (ADO) form.

(D) Escalate to the nursing supervisor if the charge does not act.

(E) Continue to provide care to the assigned clients while pursuing resolution.

(F) Post about the unsafe staffing on a public social-media page to draw attention.

CORRECT A, C, D, E.

B WRONG Leaving accepted clients is *abandonment* — a discipline and license risk.

F WRONG Public social-media posting violates HIPAA and the chain of command.

TRAP "Refuse and walk out" feels protective but it is the opposite — the RN protects clients by documenting and escalating *while* staying with them. **CJMM step:** Take action through proper channels.

Q3 · DELEGATION MATRIX / GRID

CJMM: Generate Solutions

Indicate which team member can **most appropriately** perform each task on a busy med-surg unit.

TASK	RN ONLY	RN OR LPN	RN, LPN, OR UAP
Performing the initial admission assessment on a new client	✓		
Reinforcing previously taught insulin self-injection technique		✓	
Measuring intake and output for a stable client			✓
Hanging the first dose of a newly ordered IV antibiotic	✓		
Assisting a stable post-op day 3 client to ambulate			✓
Triaging incoming family phone calls about a client's status	✓		

WHY Anything requiring nursing judgment, first-dose reaction monitoring, or HIPAA discretion stays with the RN. Reinforcement of teaching is LPN-eligible. Stable routine ADL-level care is UAP scope.

TRAP Confusing "reinforce" (LPN-okay) with "initial teach" (RN only). **CJMM step:** Generate solutions safely matched to scope.

Q4 · ORDERED RESPONSE (DRAG-AND-DROP)

CJMM: Prioritize Hypotheses → Take Action

Place the following 0800 tasks in the order the RN should complete or initiate them.

1. Administer scheduled 0800 IV piperacillin-tazobactam to the septic client.
2. Provide a.m. care to a stable post-op day 3 client (delegable).
3. Reassess the post-op client whose UAP reported BP 84/52 and HR 118.
4. Document last shift's discharge teaching note in the EHR.
5. Begin discharge teaching for a stable client going home at 1100.

CORRECT ORDER 3 → 1 → 5 → 2 → 4.

WHY Acute change (3) outranks everything. Time-critical sepsis antibiotic (1) is next. Teaching for an 1100 discharge (5) is time-bound but not unstable. AM care (2) is delegable to UAP and routine. Documentation (4) is important but never the *first* action over a deteriorating client.

TRAP Treating documentation as urgent because it is "left over." **CJMM step:** Sequence actions by acuity + time-criticality.

Q5 · DROP-DOWN / CLOZE

CJMM: Analyze Cues

Complete the sentence. "When a UAP reports a client's blood pressure of 82/48, the RN should **[A]** and then **[B]**."

Options for A: reassess the client at the bedside · ask the UAP to recheck in 15 minutes · chart the value as reported · administer the next antihypertensive.
Options for B: notify the provider with full assessment data · delegate the recheck again · increase IV maintenance fluids without an order · reassign the client.

CORRECT A = reassess the client at the bedside; B = notify the provider with full assessment data.

WHY Acute change → RN re-assessment first, then full SBAR to the provider. Charting before reassessing or "rechecking later" delays care.

TRAP Delegating the recheck again instead of personally assessing. **CJMM step:** Analyze cues before action.

Q6 · BOW-TIE

Full CJMM

A 78-year-old client returns from the OR after a hip replacement. The UAP reports the client is "more sleepy than before" and SpO_2 is 88% on room air. The RN finds the client arousable to voice, RR 9, with a recent PCA hydromorphone bolus.

Drag two priority **actions**, the most likely **condition**, and two priority **parameters to monitor** into the bow-tie.

Actions options: stop the PCA infusion · administer naloxone per protocol · administer the next scheduled opioid · place the client supine flat · apply oxygen via non-rebreather · obtain blood cultures.
Condition options: opioid-induced respiratory depression · post-op hemorrhage · pulmonary embolism · alcohol withdrawal.
Monitor options: respiratory rate & SpO_2 · level of consciousness · serum potassium q4h · 24-hour I&O · pupil size after naloxone.

CORRECT Actions → *stop the PCA infusion* and *administer naloxone per protocol*. Condition → *opioid-induced respiratory depression*. Monitor → *respiratory rate & SpO_2* and *level of consciousness*.

WHY Sleepiness + RR 9 + recent opioid bolus = classic opioid-induced respiratory depression. Stop the source first, reverse, then monitor reversal and re-sedation (naloxone is short-acting).

TRAP Choosing "next scheduled opioid" or "supine flat" — both worsen the situation. **CJMM step:** Recognize → analyze → prioritize → take action → evaluate.

Q7 · CASE-STYLE (SINGLE-BEST)

CJMM: Take Action

A float RN from med-surg is assigned to a step-down telemetry unit and is told to manage a client on a titrating cardizem drip. The RN has never titrated cardiac drips. What is the **best** initial action?

(A) Refuse the entire assignment and clock out.

(B) Notify the charge nurse, request reassignment within scope, and ask for a competent buddy if no other RN is available.

(C) Accept the assignment and titrate the drip using the protocol on the wall.

(D) Wait for the original step-down nurse to return from break before doing anything.

CORRECT B. The RN recognizes a limitation, requests assignment within competency, and uses available resources — all required by the test plan.

A WRONG Abandonment.

C WRONG Practicing outside scope risks the client.

D WRONG Ignoring a client to wait is unsafe.

TRAP Confusing "refuse unsafe" with "refuse the shift." **CJMM step:** Take action — chain of command without abandonment.

Q8 · SATA — TIME MANAGEMENT

CJMM: Generate Solutions

Which actions demonstrate effective time management on a busy med-surg shift? *Select all that apply.*

(A) Cluster assessment, medication administration, and teaching during one client encounter when safe.

(B) Delegate vital-sign rechecks on stable clients to UAP.

(C) Defer all documentation until the very end of the shift.

(D) Use a "no-interruption zone" during medication preparation.

(E) Re-prioritize the task list whenever a client's status changes.

(F) Accept every non-urgent request from family or staff in the order received.

CORRECT A, B, D, E.

C WRONG Delayed documentation = inaccurate, missed assessments, legal risk.

F WRONG Accepting in order received is not prioritization.

TRAP "Politeness" as a substitute for clinical judgment. **CJMM step:** Generate solutions that protect time and safety.

Q9 · DELEGATION SCENARIO

CJMM: Take Action

A charge RN is making assignments for a 12-hour shift on a 24-bed med-surg unit. Which assignment is **most** appropriate?

(A) UAP assigned to take initial admission vital signs and complete admission assessment on a newly admitted client.

(B) LPN/VN assigned to administer the first dose of a newly prescribed IV antibiotic for a client with a history of multiple drug allergies.

(C) RN assigned to perform discharge teaching on a newly diagnosed type 1 diabetic and administer the first dose of long-acting insulin.

(D) UAP assigned to reinforce previously taught wound-care instructions to a family member at discharge.

CORRECT C. Initial teaching for a new diagnosis and first-dose insulin administration are both RN-only.

A WRONG Admission assessment is RN.

B WRONG First-dose IV antibiotic with allergy history → RN.

D WRONG UAP cannot teach, even "reinforcing."

TRAP Mixing "reinforce" with "first teach." **CJMM step:** Take action — assign within scope.

Q10 · HANDOFF / SBAR SCENARIO

CJMM: Take Action

The off-going RN is providing end-of-shift handoff. Which component is **most essential** to communicate in SBAR before the oncoming RN takes over?

(A) A summary of the client's hobbies and family visitors during the shift.

(B) Pending lab results, unresolved abnormal vitals, and time-critical medications that are due.

(C) The off-going RN's personal opinion about the client's prognosis.

(D) A recap of the off-going RN's documentation style.

CORRECT B. SBAR handoff prioritizes *pending* and *time-critical* information — labs, abnormal vitals, due meds, code status, allergies, lines/tubes/drains, unresolved concerns.

A, C, D WRONG Not part of safe handoff; opinion and hobbies don't transfer responsibility.

TRAP Confusing chatty handoff with safe handoff. **CJMM step:** Take action with structured communication.

Q11 · DROP-DOWN / CLOZE — COST-EFFECTIVE CARE

CJMM: Generate Solutions

Complete: "For a client able to tolerate oral medications with a stable IV access not needed for other therapy, the most appropriate action is to **[A]** because **[B]**."

Options for A: request a change from IV to oral antibiotic · maintain the IV antibiotic until discharge · start a second IV "just in case" · add a daily peripheral IV change.
Options for B: oral is equally effective when tolerated, lower cost, and lower infection risk · IV is always better than oral · keeping multiple IVs reduces nursing workload · daily IV changes prevent thrombosis.

CORRECT A = request a change from IV to oral antibiotic; B = oral is equally effective when tolerated, lower cost, and lower infection risk.

WHY Cost-effective, quality care = least invasive, lowest risk, equally effective. CLABSI prevention is a hospital-acquired-condition target.

TRAP Treating IV as always-superior. **CJMM step:** Generate cost-effective solutions.

Q12 · SINGLE-BEST — RESOURCE UTILIZATION

CJMM: Generate Solutions

An RN is unsure how to set up a new wound-vac device for a client. Which action is **best**?

(A) Apply the device based on what was done in nursing school.

(B) Ask the UAP what they have seen done before.

(C) Consult the facility policy and procedure manual and the wound-care nurse or vendor representative.

(D) Postpone the dressing change until the next shift.

CORRECT C. Recognize limitations, use evidence-based resources (policy, specialty nurse, vendor), and act safely. This is an exact match to the test plan activity statement.

A WRONG School demonstrations don't substitute for current facility protocol.

B WRONG UAP is not the appropriate resource.

D WRONG Delaying necessary care risks infection.

TRAP Pride or shame as a barrier to asking for help. **CJMM step:** Generate solutions by using available resources.

7 • Unfolding NGN case study

"It's 0700 and the unit is short two nurses."

SCENARIO

You are a med-surg RN, 18 months out of orientation, working a 12-hour day shift on a 28-bed unit. Two nurses called out. The charge nurse hands you a 6-client assignment — the unit usually staffs 4–5 per nurse, and two of your clients are higher acuity.

YOUR ASSIGNMENT

- **Client 1 (Rm 412):** 72-year-old, post-op day 1 from open cholecystectomy, PCA hydromorphone, last assessed by night RN at 0500 — stable.
- **Client 2 (Rm 414):** 56-year-old, septic on IV antibiotics, due for next piperacillin-tazobactam at 0800, last temp 38.4 °C at 0500.
- **Client 3 (Rm 416):** 81-year-old, admitted overnight with new-onset confusion and a UTI workup, fall risk, family at bedside.
- **Client 4 (Rm 418):** 45-year-old, awaiting discharge at 1100 after appendectomy — needs teaching and prescriptions.
- **Client 5 (Rm 420):** 63-year-old, COPD exacerbation, on 2 L NC, SpO_2 92% per overnight report.
- **Client 6 (Rm 422):** 38-year-old, fresh blood transfusion ordered to start at 0900 for symptomatic anemia.

NURSE'S NOTES — 0710

Brief safety sweep complete on all six clients. Client 1 (post-op chole): drowsy, RR 10, "just dozing." Client 3 (UTI/confusion): attempting to climb out of bed despite family at bedside. Client 5 (COPD): sitting up, leaning forward, RR 28, SpO_2 88% on 2 L NC, "I can't catch my breath." Other clients stable on initial sweep.

VITAL SIGNS — 0710

CLIENT 1 RR	CLIENT 1 SPO_2	CLIENT 3 HR	CLIENT 5 RR	CLIENT 5 SPO_2	CLIENT 5 HR
10	93%	102	28	88%	116

PROVIDER ORDERS (ACTIVE)

- Client 1: PCA hydromorphone 0.2 mg q10 min lockout; naloxone 0.4 mg IV PRN respiratory depression.
- Client 5: O_2 titrate to $SpO_2 \geq 90\%$; albuterol nebulizer q4h scheduled and q2h PRN; methylprednisolone IV q6h.
- Client 6: Type & crossmatch complete; blood ready in blood bank at 0900.

FAMILY / CLIENT STATEMENT

Client 3's daughter (in Room 416): "She's been like this all night, she keeps trying to get up — I'm exhausted, can someone watch her so I can take a break?"

HEALTH-CARE TEAM NOTE

Charge nurse: "I know your assignment is heavy. The nursing supervisor is working on pulling one more nurse, but she may not arrive until 0900. You have one UAP shared with two other RNs and one LPN."

Q1 · RECOGNIZE CUES — SATA

Which findings are **cues of concern** that the RN must act on now? Select all that apply.

- (A) Client 1's RR of 10 on PCA hydromorphone.
- (B) Client 3 attempting to climb out of bed despite family at bedside.
- (C) Client 5's SpO_2 of 88% on 2 L NC with tripod positioning and RR 28.
- (D) Client 4 awaiting 1100 discharge.
- (E) Client 2's next antibiotic dose due at 0800.
- (F) Client 6's blood transfusion scheduled to begin at 0900.

CORRECT A, B, C, E. A = opioid-induced respiratory depression risk. B = imminent fall risk. C = acute respiratory failure presentation. E = time-critical sepsis antibiotic. D and F are scheduled but not yet acutely problematic.

Q2 · ANALYZE CUES — DROP-DOWN

"Client 5 is most likely experiencing **[A]**, which is supported by **[B]**."

A options: opioid overdose · acute COPD decompensation · pulmonary embolism · panic attack.
B options: tripod position, RR 28, SpO_2 88% on 2 L · pinpoint pupils · acute chest pain radiating to the jaw · history of recent travel.

CORRECT A = acute COPD decompensation. B = tripod position, RR 28, SpO_2 88% on 2 L.

Q3 · PRIORITIZE HYPOTHESES — ORDERED RESPONSE

Place the clients in the order the RN should address them **first → last**.

- (1) Client 5 (COPD, SpO_2 88%, RR 28)
- (2) Client 1 (post-op, RR 10 on PCA)
- (3) Client 3 (confused, attempting to get up)
- (4) Client 2 (sepsis, antibiotic due at 0800)
- (5) Client 6 (blood transfusion at 0900)
- (6) Client 4 (1100 discharge teaching)

CORRECT ORDER 5 → 1 → 3 → 2 → 6 → 4.

WHY Client 5 has an acute airway/breathing emergency. Client 1 has impending opioid-induced respiratory depression — the next number on the list because RR 10 needs intervention before the next bolus is pushed. Client 3 has imminent fall risk. Client 2 has a time-critical sepsis antibiotic. Client 6's blood is not yet scheduled to hang. Client 4's discharge has a window.

Q4 · GENERATE SOLUTIONS — SATA

Which solutions should the RN **generate** to manage this assignment safely? Select all that apply.

A Delegate to UAP: stay with Client 3 (1:1 sitter) until the RN can return.

B Stop the PCA on Client 1 and assess for opioid-induced respiratory depression before any further dose is delivered.

C Titrate Client 5's O_2 up per the active order and prepare for albuterol nebulizer.

D Delegate the 0800 antibiotic administration to the UAP.

E Notify the charge nurse that the assignment is unsafe and document on the ADO form.

F Defer all documentation until 1900.

CORRECT A, B, C, E. UAPs can sit with a confused client as a safety intervention (no clinical decision-making required). PCA must be stopped before any further dose. O_2 titration and nebulizer fall under active orders. Document the unsafe assignment in writing while continuing care. D is wrong — UAP cannot administer IV antibiotics. F is wrong — deferring all documentation is unsafe.

Q5 · TAKE ACTION — SINGLE-BEST

After stabilizing Client 5 on 4 L NC with SpO_2 92% post-nebulizer, what is the RN's **next** best action?

A Document Client 5's response and proceed to Client 1 to reassess RR and consider naloxone per protocol.

B Begin discharge teaching for Client 4.

C Start Client 6's blood transfusion.

D Take a 30-minute lunch break.

CORRECT A. Client 1's RR of 10 on a PCA is the next-most acute concern. Naloxone is available per active order if criteria are met.

Q6 · EVALUATE OUTCOMES — MATRIX

For each finding, indicate whether the intervention was **effective**, **not effective**, or **unrelated**.

FINDING (POST-INTERVENTION)	EFFECTIVE	NOT EFFECTIVE	UNRELATED
Client 5 SpO_2 94% on 4 L NC, RR 18, no tripod.	✓		
Client 1 RR remains 9 after PCA stopped and naloxone 0.4 mg IV given; client now arousable, RR 14.	✓		
Client 3 attempted to climb the side rail again despite the UAP at bedside.		✓	
Client 2 received 0800 antibiotic on time, temperature down to 37.8 °C at 1000.	✓		
Client 4's blood pressure trended from 124/78 to 122/76 throughout the shift.			✓

WHY Client 3's continued attempts to climb out indicate that 1:1 sitter alone is no longer sufficient — escalate to the provider for further evaluation (delirium workup, possible chemical or environmental adjustment). Client 4's stable BP is unrelated to today's interventions for the acute clients.

8 • "What should the nurse do first?" — 5 scenarios

SCENARIO 1

At 0800 you have four tasks: hang a unit of PRBCs on Client A, give scheduled insulin to Client B before breakfast, ambulate Client C, and document last shift's PRN notes.

FIRST Give the scheduled insulin to Client B before the breakfast tray arrives. Insulin timing relative to food is non-negotiable safety. Then verify blood-product two-RN check and hang PRBCs. Ambulation is delegable; documentation is not first.

SCENARIO 2

You walk onto the unit and four clients need attention simultaneously: one is requesting pain medication, one has a beeping IV pump, one is vomiting, and one has the call light on for toileting.

FIRST Go to the vomiting client — aspiration and airway risk trump pain, IV beeping (often air-in-line), and toileting. Then quickly silence the IV pump (likely not life-threatening), delegate the toileting to UAP, address pain.

SCENARIO 3

A client just back from PACU shows BP 88/52, HR 122, and dressing saturated with bright red blood.

FIRST Reinforce the dressing (do not remove it) and stay with the client while calling for help and notifying the surgeon. Hemorrhagic shock requires immediate provider notification and stabilization; everything else waits.

SCENARIO 4

At 1900 you receive report on five clients. One is a stable rule-out chest pain client whose troponin from 1500 has not yet returned.

FIRST After the rapid safety sweep, follow up on the pending troponin — unresolved lab results that drive clinical decisions are a continuity-of-care priority per the test plan. Do not let pending results "fall through the cracks" at handoff.

SCENARIO 5

The UAP reports that the client in Room 410 "doesn't seem like himself" and is "answering my questions weirdly." Vital signs were stable 2 hours ago.

FIRST Go assess the client. Subtle mental-status change is one of the earliest signs of sepsis, hypoxia, hypoglycemia, stroke, or sedation overdose. The UAP's pattern recognition is a legitimate cue — never wave it off.

9 · "Can this be delegated?" — 5 scenarios

SCENARIO 1

A stable client recovering from pneumonia needs vital signs taken every 4 hours, oral intake recorded, and assistance with the shower.

YES — TO UAP All three tasks fall within UAP scope for a stable client. The RN should give clear report parameters: "Tell me if RR > 24, SpO_2 < 92%, or HR > 110."

SCENARIO 2

A stable client with an established tracheostomy needs routine inner-cannula cleaning and oral care.

SPLIT Oral care → UAP. Tracheostomy cleaning → LPN/VN (airway-related; not UAP scope). Suctioning of an established trach → LPN or RN, depending on state/facility — never UAP.

SCENARIO 3

A newly admitted client requires the initial admission assessment, discharge teaching about a new heart-failure diagnosis, and assistance with toileting.

RN KEEPS the admission assessment and discharge teaching. **UAP gets** toileting. Assessment + teaching are nursing-process activities — never delegated.

SCENARIO 4

An LPN/VN on your team asks if she can administer a first dose of a newly prescribed IV antibiotic to a client with documented multiple drug allergies.

NO First-dose IV medication on a high-risk client stays with the RN. The risk of immediate hypersensitivity reaction requires RN-level assessment.

SCENARIO 5

A confused client at high fall risk needs continuous observation, but the unit has no sitter available.

YES — UAP CAN SIT Continuous observation does not require nursing judgment; it requires presence and alerting. The RN delegates with clear parameters ("Call me if she tries to get out of bed, becomes more drowsy, or her color changes"). The RN remains responsible for the plan.

10 • "Who should the nurse contact?" — 5 scenarios

SCENARIO 1

A client is being discharged home but cannot afford their new prescriptions and has no transportation home.

CONTACT Social worker / case manager. They coordinate financial assistance, transportation vouchers, prescription-assistance programs, and follow-up resources. The RN initiates the referral and documents.

SCENARIO 2

A client with new-onset dysphagia after a stroke needs swallowing assessment before any oral intake.

CONTACT Speech-language pathologist (SLP). The RN keeps the client NPO until SLP clears the swallow. Diet advancement without SLP risks aspiration — a major hospital-acquired condition.

SCENARIO 3

A client with a complex non-healing pressure injury on the sacrum has had three different dressing changes ordered in the last week.

CONTACT Wound, ostomy, and continence (WOC) nurse. Specialty consult for evidence-based, standardized wound care; reduces variation and improves healing.

SCENARIO 4

Your client's family is in conflict about whether to honor the client's prior expressed wish for "no aggressive treatment." The client is currently sedated and cannot speak.

CONTACT Palliative care and/or ethics committee. Identify the legally designated health-care agent or proxy; ensure the advance directive is on the chart; involve the provider. Chaplaincy can support family.

SCENARIO 5

A client on the med-surg unit suddenly develops acute mental-status change, SpO_2 84% on room air, and BP 88/50.

CONTACT Rapid Response Team (RRT). Do not wait for the primary provider to call back — RRT exists for exactly this scenario. Notify the provider in parallel.

11 · Legal / ethical traps — 5 scenarios

SCENARIO 1 · ABANDONMENT VS. UNSAFE ASSIGNMENT

You are floated to ICU after working 11 hours on med-surg. The charge tells you to take two ventilated clients on titrating drips, areas you have never worked.

RIGHT MOVE Notify charge, request reassignment within competency, request a buddy if one is available, escalate to the nursing supervisor. Do not refuse the entire shift or walk off — that is abandonment. Document the unsafe assignment on the ADO/facility form.

SCENARIO 2 · IMPAIRED COLLEAGUE

You notice your RN coworker slurring her speech, smelling of alcohol, and incorrectly drawing up insulin.

RIGHT MOVE Immediately remove her from client care, notify the charge nurse or supervisor, and follow facility policy. Impaired practice is mandatory reporting to leadership and, in many states, to the Board of Nursing. Confronting alone or "covering" for her endangers clients.

SCENARIO 3 · UNSAFE ORDER

A provider orders potassium chloride 40 mEq IV push for a hypokalemic client.

RIGHT MOVE Do not give it. IV-push KCl can be fatal. Contact the provider for clarification; refuse to administer if the order is not changed; document; escalate to the charge nurse and supervisor if not resolved. The RN's legal duty is to question and refuse unsafe orders.

SCENARIO 4 · SOCIAL MEDIA

Frustrated with staffing, a coworker posts on social media: "Just had 9 patients tonight, one of them coded — this is insane."

RIGHT MOVE This is a HIPAA and professional-conduct violation even without names. Educate the coworker, encourage removal of the post, and report to the nurse manager per policy. Use ADO forms, chain of command, professional advocacy — not public posts.

SCENARIO 5 · COST-EFFECTIVE VS. UNSAFE

Your manager tells the team to reuse single-use suction catheters "to save costs."

RIGHT MOVE Refuse. Reusing single-use devices violates infection-prevention standards and HAC prevention. Escalate to infection prevention and the chief nursing officer if necessary. Cost-effective care never means abandoning safety standards.

12 · End-of-day quick review

10 MUST-REMEMBER POINTS

1. ABC + acute change beats everything.
2. Safety sweep every assigned client within 60 min of report.
3. Cluster care to protect time.
4. Never delegate assessment, planning, evaluation, teaching, IV-push meds, or unstable clients.
5. Unsafe staffing → document on ADO + escalate; never abandon.
6. Float = assign within competency + offer buddy.
7. No-interruption zone during med prep and blood admin.
8. Time-critical > routine > delegable.
9. Use policy, charge, pharmacist, RRT — they are NCLEX-correct answers.
10. Cost-effective means lowest invasive option that still meets the safety standard.

5 COMMON NCLEX TRAPS

1. "Refuse the assignment and clock out" → abandonment.
2. "Delegate reinforcement" ≠ "delegate initial teaching."
3. Treating the loudest client as the highest priority.
4. Stopping a med pass to be polite.
5. Choosing IV when oral is equally effective and safer.

5 "NEVER DO THIS" RULES

1. Never delegate the nursing process.
2. Never delegate a first-dose IV medication.
3. Never push KCl IV.
4. Never post identifiable client details (or unit details) on social media.
5. Never leave the unit without handing off accepted clients.

5 SAFETY-FIRST PHRASES TO RECOGNIZE

1. "Assess the client first."
2. "Notify the charge nurse / supervisor."
3. "Document the concern in writing."
4. "Consult policy / pharmacist / RRT."
5. "Within scope of practice."

SCREENSHOT-READY SUMMARY

Day 13 — at a glance

Receive report → Safety sweep ≤ 60 min → Triage: ABC + acute + time-critical → Cluster & delegate → Reassess & document

PRIORITIZATION ORDER

- Unstable / acute change
- Time-critical meds (sepsis abx, insulin, blood)
- High-risk / unfamiliar tasks
- Scheduled / routine care
- Delegable ADLs
- Documentation (ongoing, not last)

UAP SCOPE — GREEN-LIT

- Routine VS on stable clients
- Bathing & hygiene
- Feeding stable / no-dysphagia clients
- I&O, ambulation (stable), positioning
- 1:1 sitter / continuous observation

RN-ONLY — NEVER DELEGATE

- Initial assessment & triage
- Plan of care + evaluation
- Initial teaching
- First-dose IV meds, blood, IV push
- Unstable client care
- HIPAA-sensitive communication

UNSAFE STAFFING — 4 STEPS

- 1. Notify charge nurse — specific concern
- 2. Escalate to supervisor → manager → admin on call
- 3. Complete ADO / written form
- 4. Continue caring for assigned clients

5 RIGHTS OF DELEGATION

- Right task
- Right circumstances
- Right person
- Right direction & communication
- Right supervision & evaluation

WHEN TO CALL WHOM

- RRT → acute deterioration on the floor
- Social work → resources, transport, finances
- WOC nurse → complex / non-healing wounds
- SLP → dysphagia / stroke swallow
- Palliative / ethics → end-of-life conflict
- Pharmacist → med interactions, dosing

THE DAY 13 MANTRA

Prioritize by acuity. Delegate by scope. Cluster by efficiency. Escalate by chain of command. Never abandon, never silence yourself, never trade safety for speed.