DAY 14 · MANAGEMENT OF CARE

Conflict Management, Team Communication & Professional Boundaries

How a safe entry-level RN holds difficult conversations, de-escalates conflict, refuses to cross professional lines, and uses therapeutic communication as a clinical tool — not a personality trait.

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

Conflict, communication, and boundaries are **clinical safety skills**, not soft skills. On NCLEX, every "tension on the unit" item is really a question about: *Did the nurse protect the client, follow the chain of command, use therapeutic communication, and stay inside their role?*

The 2026 Test Plan explicitly lists *"Manage conflict among clients and staff"* under Concepts of Management. That means NGN items will give you scenarios with friction — between staff, between family members, between a client and the team — and ask you which response is **therapeutic, professional, and inside scope**.

THREE JOBS THE RN OWNS IN EVERY CONFLICT

1. Make sure the client is safe right now. **2.** Use therapeutic communication to lower the temperature, not raise it. **3.** Move the conflict to the right resource (charge nurse, manager, ethics committee, security, social work, employee assistance) — without abandoning the client or violating confidentiality.

Professional boundaries are the invisible line between a **therapeutic relationship** (focused on the client's goals) and a **personal or social relationship** (focused on the nurse's needs, friendship, or attraction). Boundary violations show up as: accepting gifts, self-disclosure that shifts focus to the nurse, sharing personal contact info, social-media friend requests with current clients, swapping roles with the family ("I'll take her home with me"), or providing care to a family member without delegation/policy support.

The NGN-style question almost always rewards the option that is: **therapeutic, specific, client-centered, evidence-based, and inside scope**. It punishes options that are: false reassurance ("everything will be fine"), closed-ended ("are you okay?"), blaming ("you should have..."), boundary-crossing ("here's my number"), or that skip the chain of command.

Where this lives on the 2026 Test Plan

- **Management of Care > Concepts of Management** — "Manage conflict among clients and staff."
- **Management of Care > Advocacy** — speaking up when care is unsafe.
- **Management of Care > Ethical Practice** — recognize and report ethical dilemmas; practice consistent with the nurse's code of ethics.
- **Psychosocial Integrity > Therapeutic Communication** — use therapeutic communication techniques.
- **Psychosocial Integrity > Therapeutic Environment** — promote a therapeutic environment.

2 · Ten must-know rules

01 **Safety before resolution.** If a conflict puts a client, staff member, or visitor in danger, secure safety first (separate parties, call security, hit the panic button). Talking comes after.

02 **Therapeutic communication is the technique, not the personality.** Pick open-ended, reflective, exploratory responses. Avoid false reassurance, "why" questions, advice-giving, and minimizing.

03 **Never confront on the floor in front of the client.** Move private conversations to a private space — break room, manager's office, conference room. Client units are public spaces.

04 **Boundaries are the nurse's job, not the client's.** The client can ask for anything; the nurse decides what is therapeutic and inside scope.

05 **"No" can be therapeutic.** Politely declining a gift, friend request, ride home, or personal favor protects the relationship and is the correct NCLEX answer.

06 **Document objectively.** Chart facts, observations, and direct quotes — never opinions, blame, or "she was rude." Conflict documentation belongs in incident reports, not the chart.

07 **Chain of command beats hallway argument.** Disagreement with a peer/provider goes up the chain (charge → manager → supervisor → medical director → ethics) — not louder, not on social media.

08 **Self-disclosure is a tool, not a habit.** A small, purposeful disclosure to build rapport can be therapeutic; ongoing disclosure that shifts focus to the nurse is a boundary violation.

09 **Impaired or unsafe colleagues require reporting.** Suspicion of substance use, diversion, or impairment goes to the supervisor immediately; it is not a "talk to them first" situation when client safety is at risk.

10 **Social media is patient care.** Photos, room numbers, identifiable details, dates of admission, "vague" venting posts, and friend requests with current clients are HIPAA and boundary violations even when names are removed.

3 · RN safety decision table

SITUATION	BEST RN ACTION	WHY THIS IS THE SAFEST ACTION	COMMON NCLEX TRAP
A family member begins yelling at a UAP in the hallway about "slow care."	Step in, ask the UAP to step away, invite the family to a private space, and use therapeutic communication ("I can see this is frustrating — tell me what's happening.").	Protects the UAP, removes a public conflict that frightens other clients, opens dialogue, and keeps the conversation inside scope.	Defending the UAP in the hallway or telling the family "you cannot speak to staff that way" — both escalate.
Two RNs are openly arguing at the nurses' station about a delegation decision.	Pull both nurses aside, into a private room; if needed, involve the charge nurse to mediate.	Public conflict undermines the team, frightens clients, and violates professionalism. Private mediation preserves both function and dignity.	Letting them "work it out" or taking one side immediately.
A long-term client offers the nurse a $50 gift card "for everything you've done."	Decline warmly, explain the policy, suggest a thank-you note or a donation to the unit, document the offer per policy.	Accepting personal gifts crosses professional boundaries, may violate facility policy, and can create real or perceived favoritism.	"Accepting it would hurt their feelings" — feelings do not override boundaries.
A discharged client sends a Facebook friend request to the RN.	Do not accept. Maintain professional boundaries even after discharge; document if required by policy.	The therapeutic relationship does not "end" cleanly; readmission, recommendation, and confidentiality concerns persist. Most facility policies prohibit it.	"They're discharged now, so it's fine" — boundary obligations continue.
A coworker smells of alcohol at the start of the shift and is slurring words.	Notify the charge nurse and nursing supervisor immediately; do not confront the coworker alone on the unit; do not allow them to assume client care.	Client safety is the priority. Impairment is a reportable concern under most state nurse practice acts.	"Cover for them this once" — collusion is itself a violation; also "wait until after the shift" — clients are at risk now.
A client states, "Promise me you won't tell anyone what I'm about to say."	"I can't promise that. Some things I would need to share with the team to keep you safe. Tell me what's on your mind."	Confidentiality is not absolute when safety is at stake. Honesty protects both the relationship and the client.	"Yes, I promise" — false reassurance and a promise the nurse cannot legally keep.
A grieving spouse says, "I just want to die too. I can't live without him."	Sit down, stay with the spouse, use reflective listening ("You're saying you don't want to go on without him."), assess for suicidal ideation, refer to social work / chaplain / mental health.	Reflective listening validates grief and opens an assessment for self-harm risk — a safety priority.	"He's in a better place now" — false reassurance/cliché shuts down communication.

SITUATION	BEST RN ACTION	WHY THIS IS THE SAFEST ACTION	COMMON NCLEX TRAP
A provider speaks sharply to the RN in front of a client.	Maintain composure, finish the client interaction, then privately address the issue with the provider or escalate to the charge nurse / manager.	Conflict in front of clients erodes trust in the team and is unprofessional regardless of who started it.	Responding in kind or walking off the unit — both unprofessional.
A nurse colleague posts a photo of a "cute confused patient" on Instagram with the room number cropped out.	Speak with the colleague privately, request immediate removal, and notify the manager / privacy officer per policy.	HIPAA violations do not require a name — any identifiable detail counts. Mandatory reporting per facility policy.	"No name was used, so it's fine" — false; identifiers include face, room, tattoos, voice, story.
A client repeatedly asks personal questions about the nurse's dating life.	Politely redirect: "I'd rather keep our time focused on you. What's been on your mind today?"	Maintains the therapeutic frame without shaming the client. Redirection is a recognized boundary technique.	Sharing personal details "to be friendly" — shifts focus away from the client and risks a dual relationship.

4 • Delegation / scope table

Even in conflict and communication contexts, scope rules still govern. The RN owns assessment, judgment, and any first-time/teaching/clinical instability conversation.

TASK	RN	LPN/VN	UAP	CAN DELEGATE?	WHY OR WHY NOT?
Conduct a family meeting about a new terminal diagnosis	✓	✗	✗	**No**	Requires RN-level assessment, therapeutic communication, and care planning. RN typically co-leads with provider/social work/chaplain.
De-escalate an actively agitated, threatening visitor	✓	~	✗	**No (RN leads)**	Safety event — RN coordinates with security, charge nurse, and provider. LPN may assist within training.
Sit with a grieving client to provide presence	✓	✓	✓	**Yes**	Therapeutic presence and silence are within scope of all team members; the RN remains accountable for ongoing assessment.
Reinforce previously taught therapeutic-communication coping cues	✓	✓	✗	**Yes — to LPN**	RN initiates teaching; LPN/VN may reinforce stable teaching. UAP does not teach.
Notify family of a change in client condition	✓	✗	✗	**No**	RN-level communication; involves assessment and judgment. UAP must never relay condition updates.
Take a phone call from a family member asking, "How is Mom?"	✓	✓	✗	**No (UAP)**	Confidentiality and clinical judgment apply; verify identity, check authorized contacts, and share minimum necessary information.
Sit 1:1 with a client on suicide precautions (constant observation)	✓	✓	✓	**Yes — to trained UAP**	Direct observation can be delegated to trained sitter; RN sets parameters, reassesses, and remains accountable.
Document an incident report after a staff-staff conflict	✓	~	~	**By involved party**	Each person involved or witnessing files their own factual report; report is for QI, not the chart.
Escort an angry family member off the unit	✗	✗	✗	**No**	Call security. Physical removal is outside nursing scope and a safety risk.
Hold a closed-door conversation with a peer about a disagreement	✓	✓	✓	**Self**	Professional, peer-to-peer communication; escalate if it remains unresolved or impacts care.
Initiate a Code Grey / behavioral emergency call	✓	✓	✓	**Anyone**	Any team member can activate emergency response; RN coordinates ongoing care.
Counsel a coworker suspected of impairment	✗	✗	✗	**No**	Not the RN's role to "counsel" — notify supervisor immediately; EAP and HR processes follow facility policy.

5 · Red-flag cues

IMMEDIATE ASSESSMENT / INTERVENTION

- Threats of harm to self, staff, or others ("If you don't...")
- Verbal abuse escalating toward physical aggression
- Client/family in physical distress during a conflict
- Visible weapon, intoxication, or active psychosis
- Client recants a safety plan during emotional conversation

PROVIDER NOTIFICATION

- Client refusing care due to conflict with team member
- Family demands to withdraw care contrary to advance directive
- Provider-nurse disagreement about an order's safety
- Sentinel event identified during a conflict
- Need for ethics consult / palliative consult

RAPID RESPONSE / BEHAVIORAL EMERGENCY

- Acute agitation with imminent risk of harm
- Suicidal statements with a plan and means
- Delirious client attempting to harm self or staff
- Visitor threatening violence on the unit
- Code Grey / Code Silver / behavioral team triggers per facility

CHAIN OF COMMAND

- Unsafe order the provider will not change
- Repeated short-staffing or unsafe assignment
- Coworker conflict that impacts client care
- Unresolved family-staff friction across shifts
- Hostile workplace or harassment by a peer

MANDATORY REPORTING

- Suspected impairment, diversion, or substance use by staff
- Abuse or neglect (client by staff, family by client, etc.)
- HIPAA / social-media breach by self or peer
- Sexual contact or romantic relationship with a current client
- Practice outside scope by a peer

HOLD DELEGATION / REASSESS

- Recipient of delegation is in conflict with client or family
- UAP refuses task without clear reason
- LPN is too distressed to safely perform a complex task
- Float staff unfamiliar with behavioral protocols
- Recent boundary violation by the staff member

6 · Advanced NGN practice questions

Twelve questions across NGN item types — single-best, SATA, matrix/grid, ordered response, drop-down/cloze, bow-tie, prioritization, delegation, handoff. Each item is tagged with the clinical-judgment step it tests.

Q1 SINGLE BEST · THERAPEUTIC COMMUNICATION TAKE ACTION

A 58-year-old client newly diagnosed with metastatic pancreatic cancer says, *"There's no point in any of this. Just let me go."* Which response by the RN is most therapeutic?

- **A** "You shouldn't talk like that. Your family loves you."
- **B** "Why are you saying that? The new treatment has good odds."
- **C** "It sounds like you're feeling hopeless right now. Tell me what's on your mind." ✓
- **D** "Many people in your situation feel the same. It will pass."

WHY C IS CORRECT

Reflective listening + open invitation. It names the feeling ("hopeless"), validates without endorsing, and opens an exploratory conversation — which also lets the RN screen for suicidal ideation. This is the exact pattern NCLEX rewards.

WHY THE OTHERS ARE WRONG

A — moralizing/blocking; tells the client they are wrong to feel what they feel. **B** — "Why" question + false reassurance about prognosis; double trap. **D** — minimization + false reassurance ("it will pass") — invalidates the experience.

TRAP TESTED

False reassurance and "why" questions look kind but shut down communication.

CJMM

Take Action — selecting a therapeutic communication technique.

Q2 SATA · PROFESSIONAL BOUNDARIES ANALYZE CUES

Which of the following actions by an RN represent a professional-boundary violation? Select all that apply.

- **A** Giving a long-term client the nurse's personal cell-phone number "in case she needs to talk after discharge." ✓
- **B** Accepting a homemade quilt from a family as a personal gift. ✓
- **C** Sitting in silence with a crying client and gently placing a hand on the client's shoulder.
- **D** Accepting a Facebook friend request from a client one week after discharge. ✓
- **E** Telling a client extensive details about the nurse's own divorce to "show I understand." ✓
- **F** Briefly disclosing that the nurse is also a parent to build rapport during pediatric admission.
- **G** Agreeing to give a discharged client a ride home because their family is late. ✓

WHY THESE ANSWERS

A, B, D, E, G all shift the relationship away from therapeutic and into personal/social — the defining marker of a boundary violation. C is a recognized therapeutic-presence technique. F is a brief, purposeful self-disclosure that returns focus to the client; it is acceptable when limited and goal-directed.

TRAP TESTED

"It was kind" / "they really needed me" / "discharge means it's over" — kindness and good intent never license boundary crossings.

CJMM

Analyze Cues — separating therapeutic actions from boundary violations.

Q3 MATRIX · CONFLICT RESPONSE SELECTION GENERATE SOLUTIONS

For each scenario, indicate the RN's **first** action.

SCENARIO	DE-ESCALATE VERBALLY	CALL SECURITY	NOTIFY CHARGE NURSE	INITIATE BEHAVIORAL EMERGENCY / CODE GREY	NOTIFY NURSING SUPERVISOR & PROVIDER	MOVE TO PRIVATE SPACE + USE THERAPEUTIC COMMUNICATION
A family member is loudly criticizing care in the hallway but is not threatening.						✓
A visitor begins throwing items and threatens to "hurt someone."		✓				
A confused, ambulatory client is becoming physically aggressive with staff during morning care.				✓		
Two RNs are having a heated disagreement at the nurses' station.			✓			
A provider refuses to change an order the RN believes is unsafe, despite clarification.					✓	
An anxious post-op client is loudly demanding pain medication 30 minutes early.	✓					

WHY THESE ANSWERS

Public, non-threatening complaint → private space + therapeutic communication. Active threats/items being thrown → security first; staff safety enables client care. Aggressive confused client → behavioral emergency for organized team response. Staff-staff conflict on the floor → charge nurse mediates privately. Unsafe order that won't change after clarification → escalate up the chain. Anxious early-pain request → verbal de-escalation and assessment first.

TRAP TESTED

Jumping to "call security" for every conflict or "talk it out" for every threat. The level of response must match the level of risk.

CJMM

Generate Solutions — match intervention intensity to risk.

Q4 ORDERED RESPONSE · BOUNDARY BREACH ESCALATION TAKE ACTION

A charge nurse learns that a staff RN has been romantically texting with a current inpatient. Place the charge nurse's actions in the correct order from **first** to **last**.

1. Ensure the client is safe and reassign the involved RN off that client immediately. ✓
2. Notify the nursing supervisor and document the facts objectively. ✓
3. Report per facility policy to the manager / HR / compliance officer and complete an incident report. ✓
4. Refer the matter to the state board of nursing per state law / policy. ✓
5. Coordinate ongoing client care with social work and provider follow-up; ensure client has access to support. ✓

WHY THIS ORDER

Safety first — remove access. Then internal escalation — supervisor, documentation, incident report. Then external mandatory reporting per state law. Finally, ongoing care planning so the client isn't abandoned during the investigation.

TRAP TESTED

"Talk to the RN first" or "wait to see if it continues." Boundary violations involving a current client require immediate removal from care and reporting — not a counseling conversation.

CJMM

Take Action — protect client first, then escalate per policy and law.

Q5 DROP-DOWN / CLOZE · THERAPEUTIC PHRASING TAKE ACTION

Complete the RN's response by selecting the most therapeutic option for each blank.

Client: "I'm so tired of being in this hospital. Nobody listens to me. Even my doctor doesn't care."

Nurse: " BLANK 1 being in the hospital this long has felt frustrating, and you don't feel heard. BLANK 2 tell me more about what's been happening, and we can BLANK 3 from there."

BLANK 1 OPTIONS

- **A** It sounds like ✓
- **B** You shouldn't feel that way about
- **C** Why do you think that
- **D** Everyone feels that way about

BLANK 2 OPTIONS

- **A** Don't worry,
- **B** Can you ✓
- **C** You need to
- **D** I'm sure your doctor cares, but

BLANK 3 OPTIONS

- **A** decide what's wrong
- **B** make sure that doesn't happen again
- **C** figure out what to do next together ✓
- **D** talk about something more positive

WHY THESE ANSWERS

"It sounds like..." is a reflective opener that names the feeling. "Can you..." invites elaboration. "Figure out what to do next together" preserves the client's agency and signals partnership. Each rejected option contains a classic NCLEX block (false reassurance, "why," minimization, dismissing).

TRAP TESTED

Therapeutic options always: validate → invite → collaborate. Non-therapeutic options redirect, minimize, defend, or moralize.

CJMM

Take Action — choosing therapeutic phrasing in real time.

Q6 BOW-TIE · CONFLICT DE-ESCALATION PRIORITIZE HYPOTHESES + GENERATE SOLUTIONS

An adult son arrives at his mother's bedside, voice rising, accusing the team of "letting her die." The client is awake, anxious, and on continuous telemetry. Build the RN's bow-tie response.

Select 1 priority condition the RN must address, 2 actions to take, and 2 parameters to monitor.

PRIORITY CONDITION (CHOOSE 1)

- **A** Visitor non-compliance with hospital policy
- **B** Acute risk of harm and escalating distress for both client and visitor ✓
- **C** Family conflict requiring social work referral
- **D** Anticipatory grief in the family

ACTIONS TO TAKE (CHOOSE 2)

- **A** Invite the son into a private space and use therapeutic communication ("I can see how worried you are; tell me what's most concerning."). ✓
- **B** Demand the visitor lower his voice or leave the unit immediately.
- **C** Stay between the client and the rising stimulus; check on the client and offer reassurance and reorientation. ✓
- **D** Document in the client's chart that "the son was aggressive and disruptive."

PARAMETERS TO MONITOR (CHOOSE 2)

- **A** Client telemetry, BP, respiratory rate, and reported anxiety ✓
- **B** Family member's BP and HR
- **C** Continued safety of all parties (escalation cues, verbal threats, body language) ✓
- **D** Number of times the son visits per shift

WHY THESE ANSWERS

Priority is the acute risk created by the dynamic — both the client (physiologic response, fear) and the visitor (escalating distress). Actions are private engagement + client buffering. Monitoring focuses on the two safety streams: the client's physiologic data and ongoing escalation cues.

TRAP TESTED

"Tell him to leave" is satisfying but escalates and often violates the family's right to be present. Charting subjective labels ("aggressive," "rude") is also a trap — chart facts and quotes.

CJMM

Prioritize Hypotheses + Generate Solutions.

Q7 SATA · DOCUMENTING A CONFLICT EVALUATE OUTCOMES

Which of the following are appropriate to include in the client's medical record after a conflict between a family member and the nursing staff? Select all that apply.

- **A** Date, time, and location of the interaction ✓
- **B** Direct quotes from the client and family member when relevant to care ✓
- **C** "Family was rude and disrespectful to staff."
- **D** Interventions taken (e.g., conversation moved to a private space, security present, charge nurse notified) ✓
- **E** A copy of the incident report filed with risk management
- **F** Provider notified and any new orders received ✓
- **G** Speculation about why the family was upset
- **H** Client's response to the event (vital signs, verbal report, behavior) ✓

WHY THESE ANSWERS

The medical record gets *facts*: time, location, quotes, observations, interventions, notifications, and client response. The incident report (C, E, G) is a separate, confidential QI document — never referenced in or attached to the chart. Subjective labels ("rude") and speculation ("she was upset because...") never belong in any clinical documentation.

TRAP TESTED

Adding the incident report to the chart is a classic NCLEX legal trap. Incident reports are protected QI documents.

CJMM

Evaluate Outcomes — documenting accurately to communicate care and protect the client.

Q8 SINGLE BEST · IMPAIRED COLLEAGUE TAKE ACTION

During shift report, an RN notices that a colleague's speech is slurred and that the colleague smells of alcohol. The colleague has just received a full assignment of six clients. What should the RN do first?

A Pull the colleague aside and ask whether they have been drinking.

B Notify the charge nurse and the nursing supervisor immediately and prevent the colleague from assuming client care. ✓

C Quietly take over a few of the colleague's clients to help.

D Wait until after the shift and file a written report.

WHY B IS CORRECT

Client safety is the immediate priority. Mandatory reporting kicks in the moment impairment is suspected and clients are at risk. The supervisor coordinates removal from care, drug/alcohol testing per policy, and EAP referral.

WHY THE OTHERS ARE WRONG

A — confrontation on the floor is not the RN's role and may give the colleague time to leave or alter behavior. **C** — "covering" is enabling and exposes the RN to legal/ethical liability. **D** — delay is unsafe; clients are at risk now.

TRAP TESTED

The "compassionate" answer — covering for or counseling a colleague — is the wrong answer when client safety is on the line.

CJMM

Take Action — escalate per chain of command for a safety-critical event.

Q9 HANDOFF / SBAR · CONFLICT CONTEXT TAKE ACTION

An RN is giving handoff to the oncoming shift for a client whose family had a verbal altercation with day-shift staff. Which statement best represents an appropriate SBAR **Background** entry?

A "The family is impossible. Good luck."

B "Family member became loud and verbally critical of staff at 1430; security was present, no threats made. Charge nurse notified, manager aware, social work consulted. Client's vitals stable throughout; client states he is 'okay' but tearful. Plan: continue family-meeting attempt with social work tomorrow AM." ✓

C "There was some drama with the daughter today. Watch out."

D "The daughter doesn't trust us. She's been aggressive."

WHY B IS CORRECT

Objective, time-stamped, includes the action taken, the client's response, the team consulted, and the plan. SBAR is for safety continuity — not for venting or labeling.

WHY THE OTHERS ARE WRONG

A and **C** — subjective, unprofessional, and provide no actionable information. **D** — label ("aggressive") without facts; biases the next nurse and damages the therapeutic relationship.

TRAP TESTED

"Vent in report" — opinion-loaded handoff biases the next shift and is documentation malpractice.

CJMM

Take Action — using SBAR to communicate facts that protect the client.

Q10 PRIORITIZATION · MULTIPLE CONFLICTS PRIORITIZE HYPOTHESES

An RN on a 24-bed med-surg unit receives the following four notifications within five minutes. Which should be addressed **first**?

A A UAP reports a family member is "complaining loudly" about cold food at the bedside.

B A nurse reports that an agitated visitor in Room 14 has thrown a chair and is yelling at the post-op client. ✓

C A discharged client's spouse calls the unit asking for the nurse manager about a billing complaint.

D A coworker asks the RN to speak privately about an interpersonal conflict that happened yesterday.

WHY B IS CORRECT

An object has been thrown and there is active escalation at the bedside of a vulnerable client. This is immediate physical safety — security, behavioral emergency, and client buffering must happen now.

WHY THE OTHERS ARE WRONG

A — service complaint, important but not life-safety. **C** — administrative concern, route to manager. **D** — interpersonal conflict, important but not time-critical.

TRAP TESTED

Volume of complaint ≠ acuity. Threat to bodily safety always wins.

CJMM

Prioritize Hypotheses — ABCs / safety / acuity hierarchy.

Q11 DROP-DOWN · CHAIN OF COMMAND TAKE ACTION

An RN believes a provider's order is unsafe. The provider, when contacted by phone, will not change the order. Complete the next steps in the correct chain of command.

The RN should next notify the BLANK 1, then escalate to the BLANK 2, and finally — if unresolved and the client is at imminent risk — escalate to the BLANK 3.

BLANK 1 (CHOOSE ONE)

- **A** Charge nurse ✓
- **B** Hospital administrator on call
- **C** State board of nursing
- **D** Local newspaper

BLANK 2 (CHOOSE ONE)

- **A** CEO of the hospital
- **B** Nursing supervisor / manager ✓
- **C** Ethics committee
- **D** Risk-management department only

BLANK 3 (CHOOSE ONE)

- **A** State board only
- **B** Police
- **C** Chief medical officer / medical director and rapid-response if clinically indicated ✓
- **D** Quality department only

WHY THESE ANSWERS

Standard chain: charge nurse → nursing supervisor/manager → medical director / chief medical officer (and rapid response if the client is deteriorating now). Ethics, risk management, and the state board come in as parallel or later steps depending on the issue.

TRAP TESTED

"Skipping levels" is a common wrong answer. The RN never jumps to media, the board, or the CEO before climbing the internal ladder, unless there is imminent client harm or required mandatory reporting.

CJMM

Take Action — escalation logic.

Q12 DELEGATION SCENARIO · CONFLICT ON THE TEAM GENERATE SOLUTIONS

A charge RN is making the next shift's assignment. Two RNs on the team have been in repeated, escalating conflict that has impacted teamwork over the past week. Which assignment / action plan by the charge RN is most appropriate?

A Assign them to the same pod so they can "work it out."

B Assign each nurse the most acute client to keep them occupied.

C Assign each nurse to separate pods, share the situation with the nurse manager, and arrange a private mediation meeting after the shift. ✓

D Refuse to allow either RN to work this shift until the conflict is resolved.

WHY C IS CORRECT

Protects client care now (separation), preserves staffing, escalates appropriately (manager), and provides a structured forum for resolution (mediation). It addresses both the operational and interpersonal issues without abandoning the unit.

WHY THE OTHERS ARE WRONG

A — places conflict directly at the bedside; clients are harmed. **B** — distraction is not a resolution and risks compounded errors. **D** — short-staffing the unit creates a new safety problem and exceeds the charge nurse's authority.

TRAP TESTED

"Conflict can teach them" — not at the bedside. Resolve interpersonally, not with client risk.

CJMM

Generate Solutions — structural separation + escalation.

7 · Unfolding NGN case study

NGN CASE · MULTI-STEP

The Family Meeting That Wasn't

Setting: 36-bed medical unit, 1900 evening shift. The RN is caring for 5 clients. One client, Mr. R, age 74, was admitted three days ago with end-stage heart failure and worsening renal function. He has a documented MOLST/POLST indicating "DNR / comfort-focused care, no intubation, no dialysis."

NURSE'S NOTES (1845)

- Client awake, oriented x3, slightly dyspneic on 4 L NC, SpO_2 91%.
- Adult daughter arrived from out of state at 1830. Loudly insisting "everything be done" and asking why "Dad is just lying here."
- Adult son (local, has been at bedside daily, listed as health-care agent) states, "We talked about this. He doesn't want a tube."
- Daughter raising voice in hallway; other clients' doors opening.
- Provider was at bedside earlier; no new orders.

VITAL SIGNS (1850)

- BP 96/58 · HR 112 (sinus) · RR 26 · SpO_2 91% on 4 L NC · Temp 36.8 °C
- Client report: "I'm tired. I just want them to stop fighting."
- Pain 4/10 (chest pressure, mild)

PROVIDER ORDERS (ACTIVE)

- Code status: DNR / comfort-focused per MOLST
- Morphine 2–4 mg IV q2h PRN dyspnea/pain
- O_2 titrate to comfort, not target SpO_2
- Palliative care consult — placed today, pending
- Social work consult — placed today, pending

FAMILY / CLIENT QUOTES

> *Daughter (in hallway): "If we don't put him on a ventilator he will DIE. How can you people just stand there?"*

> *Son (quietly, to RN): "Please don't change what we decided. It took him months to make this plan."*

> *Mr. R: "I'm tired. I just want them to stop fighting."*

TEAM NOTES

- Charge nurse aware; suggests private family conversation in the conference room.
- Palliative care team available by phone after-hours.
- Chaplain on call, paged 1845, awaiting response.

Case Q1 RECOGNIZE CUES · SATA RECOGNIZE CUES

Which findings indicate the situation requires **immediate intervention**? Select all that apply.

- **A** Daughter raising her voice in the hallway with other clients' doors opening ✓
- **B** Conflict between family members about following the client's documented MOLST ✓
- **C** Client's statement: "I'm tired. I just want them to stop fighting." ✓
- **D** Client RR 26, SpO_2 91%, HR 112 with subjective dyspnea ✓
- **E** Pending palliative care and social work consults
- **F** Son's calm support of the existing care plan

WHY THESE ANSWERS

A, B, C, D are *current* cues that affect client safety and rights — a noisy escalation in the hallway, conflict over a legally binding advance directive, and physiologic distress in a dying client. E and F are stable / supportive findings.

CJMM

Recognize Cues — sort current safety-relevant findings from background context.

Case Q2

ANALYZE CUES · DROP-DOWN | ANALYZE CUES

The RN analyzes the situation. Complete the statement.

The client's current care plan is governed by his **BLANK 1**, which directs **BLANK 2**. The daughter's request for ventilation conflicts with the client's documented wishes; the son is the designated **BLANK 3**. The RN's role is to **BLANK 4**.

BLANK 1

- **A** MOLST/POLST and documented advance directive ✓
- **B** family consensus
- **C** daughter's preference as next of kin

BLANK 2

- **A** DNR and comfort-focused care, no intubation, no dialysis ✓
- **B** full code until family agrees
- **C** ICU-level escalation

BLANK 3

- **A** health-care agent / proxy ✓
- **B** primary caregiver
- **C** witness

BLANK 4

- **A** defer to the daughter to avoid conflict
- **B** advocate for the client's documented wishes, support the family, and coordinate the right team ✓
- **C** document the daughter's request as new consent

WHY THESE ANSWERS

The client's *own* wishes — recorded in a MOLST and supported by the designated health-care agent (the son) — control the plan. The RN's job is to protect those wishes while also caring for the family in distress.

CJMM

Analyze Cues — connect the legal-ethical framework to the immediate situation.

Case Q3 PRIORITIZE HYPOTHESES PRIORITIZE HYPOTHESES

Which client problem is the **top priority** right now?

- **A** Family conflict requiring social work referral
- **B** Client distress (physiologic and emotional) in the setting of escalating family conflict that risks overriding his documented advance directive ✓
- **C** Daughter's grief and anticipatory loss
- **D** Pending palliative consult

WHY B IS CORRECT

Two safety streams collide: the client's physiologic distress (HR 112, RR 26, SpO_2 91%) and the threat that his documented wishes will be overridden. Both belong to the client and both must be protected immediately. The family work matters but is downstream.

CJMM

Prioritize Hypotheses — choose the threat that places the client at greatest risk.

Case Q4

GENERATE SOLUTIONS · SATA

GENERATE SOLUTIONS

Which actions should the RN take? Select all that apply.

A	Move the family conversation out of the hallway into the conference room.	✓
B	Stay with the client briefly, reassure him, and reposition for comfort while titrating O_2 to comfort.	✓
C	Notify the charge nurse and request the on-call palliative care team and chaplain.	✓
D	Quickly initiate intubation per the daughter's request "just to keep the peace."	
E	Acknowledge the daughter's distress with reflective listening ("This is overwhelming — you just got here.").	✓
F	Reaffirm to the family, factually, the existence of the MOLST and the son's role as health-care agent.	✓
G	Document in the chart that "the daughter was hysterical and uncooperative."	
H	Administer morphine 2 mg IV per PRN order for dyspnea.	✓

WHY THESE ANSWERS

Move conflict off the unit; protect the client physically and emotionally; bring the right specialists (palliative, chaplain, social work); use therapeutic communication with the distressed daughter; restate facts about the directive without arguing; treat dyspnea per the orders that exist.

D would be assault — performing a non-consented procedure against the client's written wishes. G is subjective labeling — never in the chart.

CJMM

Generate Solutions — assemble a multi-pronged plan that protects rights and physiology.

Case Q5

TAKE ACTION · ORDERED RESPONSE

TAKE ACTION

Place the following nursing actions in the correct order, from first to last:

1. Briefly intervene at the bedside: comfort the client, titrate O_2, prepare morphine per PRN order, ensure dignity. ✓
2. Invite the daughter (and son if able) into the conference room with the charge nurse present. ✓
3. Use therapeutic communication to acknowledge the daughter's distress; restate the documented advance directive factually; clarify the son's role as health-care agent. ✓
4. Page the on-call palliative care team and the chaplain; consult social work for ongoing family support. ✓
5. Document objectively: facts, time, interventions, who was notified, client and family responses. ✓

WHY THIS ORDER

The client is at the center — stabilize and comfort first. Then move the conflict off the unit. Therapeutic communication while delivering accurate information. Bring in the right team to support both client and family. Document objectively to preserve continuity and the client's rights.

CJMM

Take Action — coordinated multi-step plan.

Case Q6 EVALUATE OUTCOMES · MATRIX EVALUATE OUTCOMES

Two hours later, indicate whether each outcome is **effective** or **ineffective**.

OUTCOME	EFFECTIVE	INEFFECTIVE
Client RR 18, SpO_2 94% on 4 L NC, states he feels "calmer."	✓	
Daughter is tearful but now sitting at bedside holding her father's hand.	✓	
Son thanks the RN for "making sure no one rolled over Dad's wishes."	✓	
RN's chart entry reads: "Daughter was hysterical and uncooperative."		✕
Palliative care and chaplain at bedside; family meeting scheduled for AM.	✓	
RN gave 2 L of fluid bolus and called rapid response based on daughter's request.		✕

WHY THESE ANSWERS

Physiologic improvement, emotional repair, family alignment around the directive, and proper team engagement = effective. Subjective charting and any intervention contrary to the client's documented wishes = ineffective and unsafe.

CJMM

Evaluate Outcomes — measure both clinical and ethical outcomes.

8 · What should the nurse do first? (×5)

SCENARIO 1

An angry husband is yelling at his postpartum wife at the bedside; the newborn is crying. The wife has bruising on her forearm she didn't have at the morning assessment.

> **First action:** Ensure immediate safety — separate the husband from the room (call security if needed), move mother and infant to a safe location, then assess privately and follow mandatory reporting for suspected abuse. Safety first, then assessment, then mandatory report.

SCENARIO 2

Two UAPs are loudly arguing about a delegation issue at the nurses' station while families and clients can hear them.

> **First action:** Stop the public conflict immediately and move the UAPs into a private space. The audience matters as much as the dispute. Mediate or involve charge nurse.

SCENARIO 3

A client tells the RN, "Don't tell anyone, but I've been stockpiling my pain pills at home. I just feel safer knowing they're there."

> **First action:** Stay with the client and assess for suicidal ideation with intent, plan, and means. Do not promise confidentiality. Notify the provider, mental health team, and family per facility policy.

SCENARIO 4

A coworker says to the RN, "I'm so burned out I almost gave the wrong med yesterday — please don't say anything."

> **First action:** Encourage the coworker to self-report and use EAP, but the RN must also escalate to the charge nurse/manager. Patient safety and near-miss reporting are non-negotiable; the conversation cannot stop with the RN.

SCENARIO 5

The RN finds another nurse posting a "vague but recognizable" photo of a patient room on Instagram during break.

> **First action:** Ask the colleague to remove the post immediately, then notify the manager and privacy officer per facility policy. Even without names, identifiable details = HIPAA breach + reportable boundary issue.

9 • Can this be delegated? (×5)

SCENARIO 1 — FAMILY UPDATE

A daughter calls and asks how her mother (post-op day 1) is doing.

> **Who:** RN (or LPN/VN for stable, factual updates per policy). **Not UAP.** Verify identity, check authorized contacts, and disclose only the minimum necessary information per HIPAA.

SCENARIO 2 — THERAPEUTIC PRESENCE

A grieving client wants someone to sit with them for 30 minutes.

> **Who:** Any team member — RN, LPN, UAP, chaplain, volunteer. Therapeutic presence is within scope of all. RN remains accountable for ongoing assessment and care planning.

SCENARIO 3 — BEHAVIORAL 1:1 SITTER

A client on suicide precautions needs constant observation.

> **Who:** A trained UAP / sitter under RN supervision. RN sets parameters (line of sight, no sharps, environmental sweep), receives reports, and reassesses suicide risk per protocol.

SCENARIO 4 — FAMILY MEETING ABOUT A NEW TERMINAL DIAGNOSIS

The family is requesting a meeting to discuss prognosis.

> **Who:** RN co-leads with provider, palliative care, and social work / chaplain. **Not delegable.** Requires assessment, planning, therapeutic communication, and integration of advance directives.

SCENARIO 5 — ESCORTING AN ANGRY VISITOR OFF THE UNIT

A visitor has become threatening and refuses to leave the unit.

> **Who:** Security — not nursing. Physical removal is outside the nursing scope of practice; the RN coordinates and continues client care.

10 · Who should the nurse contact? (×5)

SCENARIO 1 — DIAGNOSIS-RELATED FAMILY CONFLICT

Family members at the bedside disagree about whether a client should be told a new cancer diagnosis. The client is alert and oriented.

> **Contact:** Provider (to clarify disclosure plan), **social work** (family dynamics), and **ethics committee** if the conflict persists. The client's right to be informed is paramount; this is an autonomy issue.

SCENARIO 2 — SPIRITUAL DISTRESS DURING CONFLICT

A dying client asks for spiritual support after a heated family meeting.

> **Contact: Chaplain / spiritual care**, with the client's preferred tradition documented. Coordinate with palliative care.

SCENARIO 3 — SUSPECTED DIVERSION

An RN suspects a coworker is diverting controlled substances after multiple "wasted" doses with the same RN.

> **Contact: Nursing supervisor**, then unit manager, then pharmacy and security per policy. Mandatory reporting to the state board of nursing follows facility investigation per state law.

SCENARIO 4 — LANGUAGE BARRIER TURNING INTO FAMILY CONFLICT

A client and family speak a language the staff don't, and the family is misinterpreting medical decisions — leading to tension.

> **Contact:** A **qualified medical interpreter** (in-person or video). Never use family members as primary medical interpreters. Then social work for ongoing communication support.

SCENARIO 5 — REPEATED UNSAFE ASSIGNMENTS

The RN has voiced concerns about unsafe staffing multiple shifts; charge nurse has not been able to resolve.

> **Contact: Nursing supervisor / manager**, file an Assignment Despite Objection (ADO) form, and continue caring for assigned clients. Do not abandon. Escalate further if not resolved.

11 · Legal / ethical traps (×5)

TRAP 1 — "I PROMISE I WON'T TELL ANYONE."

A client asks the RN to promise confidentiality before disclosing something.

> **Right answer:** "I can't promise that. Anything that affects your safety I would need to share with the team. Tell me what's going on." Confidentiality is not absolute — safety overrides.

TRAP 2 — "JUST ACCEPT THE GIFT TO BE POLITE."

A long-term client gives the RN an expensive scarf at discharge.

> **Right answer:** Warmly decline per facility policy. Suggest a thank-you note or a donation to the unit. Document the offer if policy requires. The therapeutic relationship is not transactional.

TRAP 3 — "FAMILY KNOWS BEST."

An adult son demands the team intubate his father despite a documented DNR / MOLST.

> **Right answer:** Advocate for the client's documented wishes. Engage palliative care, social work, and the health-care agent. Performing intubation against a valid advance directive is battery and a violation of the client's right to self-determination.

TRAP 4 — "IT'S ONLY FACEBOOK."

A coworker posts a "funny" photo from work, no patient identifiers visible to her.

> **Right answer:** Ask the coworker to remove it immediately, notify the manager and privacy officer. Even unintentional identifiers (tattoos, room layout, face) are HIPAA violations. Social media is patient care.

TRAP 5 — SEXUAL CONTACT / ROMANTIC RELATIONSHIP WITH A CLIENT

An RN admits to a peer that they exchanged personal text messages with a current inpatient.

> **Right answer:** This is a mandatory-reporting boundary violation. Notify supervisor immediately, document objectively, file an incident report, and follow state board reporting. The RN should be removed from that client's care immediately. There is no "context" that makes this acceptable while the therapeutic relationship is active.

12 · End-of-day quick review

10 ONE-LINE MUST-REMEMBER POINTS

1. Safety first, talk second.
2. Therapeutic communication is a technique, not a personality.
3. Move conflict off the unit, into a private space.
4. Open-ended > closed-ended. Reflective > reactive.
5. The medical record gets facts; the incident report gets the rest.
6. Boundaries are the nurse's job, not the client's.
7. Chain of command beats hallway argument.
8. Impairment and diversion = report now, not after the shift.
9. Social media is patient care — identifiers count.
10. The client's documented advance directive outranks family preferences.

5 COMMON NCLEX TRAPS

1. "Why" questions and false reassurance disguised as kindness.
2. Defending or counseling a colleague suspected of impairment.
3. Charting subjective labels ("rude," "aggressive," "hysterical").
4. Skipping levels of the chain of command (going straight to the board / media / CEO).
5. Putting the incident report into the medical record.

5 "NEVER DO THIS" RULES

- Never accept personal gifts, friend requests, or rides from clients.
- Never give your personal phone number to a client.
- Never argue with a peer or provider in front of a client.
- Never override a documented advance directive based on family pressure.
- Never promise unconditional confidentiality.

5 SAFETY-FIRST PHRASES TO RECOGNIZE ON NCLEX

- "Move to a private space and use therapeutic communication."
- "Notify the charge nurse / supervisor."
- "Ensure the safety of the client and staff first."
- "Activate the rapid response / behavioral emergency team."
- "Document objectively; file an incident report per policy."

13 · Infographic summary

Day 14 · Conflict, Communication & Boundaries — Master Map

SAFETY → THERAPEUTIC COMMUNICATION → PRIVATE SPACE → RIGHT RESOURCE → DOCUMENT FACTS

THERAPEUTIC VS. NON-THERAPEUTIC

- ✓ Reflective listening
- ✓ Open-ended questions
- ✓ Validate feelings
- × "Why" questions
- × False reassurance
- × Advice-giving
- × Minimization

BOUNDARY RED LINES

- No personal contact info to clients
- No personal gifts
- No social-media connections
- No rides / favors / shared meals
- No romantic / sexual contact
- Self-disclosure: brief + purposeful only

CONFLICT ESCALATION LADDER

- 1. Direct, private conversation
- 2. Charge nurse
- 3. Nurse manager / supervisor
- 4. Risk management / ethics / CMO
- 5. State board / mandatory reporting (parallel)

DOCUMENTATION RULES

- Chart facts, time, quotes, actions, notifications
- Never label ("rude," "uncooperative")
- Never reference the incident report in the chart
- Quote the client / family directly when relevant
- Include client physiologic response during events

MANDATORY REPORT TRIGGERS

- Suspected impairment / diversion
- Suspected abuse or neglect
- Boundary violations with current clients
- HIPAA / social-media breaches
- Practice outside scope

WHO TO CALL

- Security → threats / weapons / physical removal
- Charge nurse → unit conflict, assignment issues
- Supervisor → impairment, repeated unsafe practice
- Palliative care → end-of-life conflict
- Ethics → unresolved values conflict
- Social work → family dynamics, resources
- EAP → coworker support, burnout
- Risk management → near miss, sentinel event

THE RIGHT PHRASE LIBRARY

- "It sounds like..."
- "Tell me more about that."
- "I can see this is hard."
- "I can't promise that, but I want to help."
- "Let's step into a private space."

ADVANCE DIRECTIVE VS. FAMILY PRESSURE

- Client's documented wishes ALWAYS win
- Health-care agent / proxy speaks for client
- Family preferences ≠ legal authority

- "I'd rather keep the focus on you."

- Engage palliative + ethics if needed
- Never perform a procedure against a valid AD

THE DAY 14 MANTRA

Safety first. Speak therapeutically. Step into a private space. Stay inside your scope. Send the conflict to the right resource. Sign the chart with facts only.