◆ CAPSTONE · DAY 15 OF 15 ◆ FINAL MIXED REVIEW · MANAGEMENT OF CARE

The Final *Mixed NGN Review* with Case Studies

Every prior day folded into one sitting: prioritization, delegation, advocacy, consent, advance directives, confidentiality, handoff, case management, collaboration, legal/ethical, escalation, quality improvement, resource management, and conflict — tested at the NGN application level the way real items appear on the 2026 NCLEX-RN.

FRAMEWORK	CATEGORY	SUBCATEGORY	MODEL
2026 NCLEX-RN Test Plan	Safe & Effective Care Environment	Management of Care (15–21%)	NGN Clinical Judgment (CJMM)

What's inside today

§ 1 · High-yield synthesis

Management of Care is **18%** of the NCLEX-RN — the largest single subcategory — and almost every NGN case study weaves it into Physiological Integrity and Psychosocial Integrity questions. The exam is not testing whether you can recite "the five rights of delegation." It is testing whether you can make *the safest decision a brand-new RN should make* in a chaotic, multi-client, time-pressured environment.

Across Days 1–14 you built five decision frames. On Day 15, you stack them:

The five capstone frames

1. **Prioritization frame** — ABC → safety → comfort → psychosocial. Unstable beats stable. Acute beats chronic. Actual beats potential. Unexpected beats expected.
2. **Scope & delegation frame** — The RN owns the nursing process. LPN/VN reinforces and performs on *stable* clients with predictable outcomes. UAP performs *tasks*, not judgment.
3. **Rights & advocacy frame** — The client decides. Provider gets consent; nurse witnesses understanding. Documented advance directives outrank family wishes.
4. **Legal/ethical frame** — Document objectively. Report suspected abuse and reportable diseases. Incident reports never appear in the chart. Stay inside scope.
5. **Escalation frame** — Stay with the client → notify charge nurse → notify provider → rapid response/code → nursing supervisor → risk management/ethics. Skip steps only when life-or-limb demands it.

On NGN, you will see **three case-study item sets (18 items)** plus standalone items. Many will appear physiological (chest pain, sepsis, post-op bleeding) but the answer hinges on a Management of Care decision: *which client first, whom to call, what to delegate, what to chart, what to refuse.* That is what we drill today.

Where this lives on the 2026 Test Plan

This day integrates every activity statement in **Management of Care**: Establishing Priorities · Assignment, Delegation & Supervision · Advocacy · Client Rights · Advance Directives/Self-Determination · Informed Consent · Confidentiality/Information Security · Continuity of Care (handoff/admission/transfer/discharge) · Case Management · Collaboration with Multidisciplinary Team · Referrals · Legal Rights & Responsibilities · Ethical Practice · Concepts of Management (conflict, resource use) · Performance Improvement (QI).

§ 2 · The ten capstone rules

If you can recite these and apply them under pressure, you have an answer to most Management of Care NGN items.

01 **ABCs win, then safety, then comfort/psychosocial.** A silent client with a compromised airway beats a screaming one. Maslow is the tiebreaker when two clients are physiologically equal.

02 **Unstable > stable. Acute > chronic. Actual > potential. Unexpected > expected.** A new change in condition outranks a known chronic problem every time.

03 **The RN owns the nursing process.** Never delegate *assessment, planning, teaching, evaluation*, the first dose of a new med, blood, IV push, or any unstable client. The phrase "the LPN can do everything except…" is a trap — the RN does the *thinking*.

04 **UAP do tasks, not judgment.** ADLs, vitals on stable clients, I&O, ambulation of stable clients, weights, transfers, simple specimen collection — never assessment, never teaching, never an unstable client.

05 **Provider obtains informed consent; nurse witnesses the signature and verifies understanding.** Client says "I don't understand"? Stop. Hold the procedure. Call the provider. Never re-explain a procedure as the substitute for the provider.

06 **A valid advance directive outranks family wishes.** When the client has lost capacity, the documented health-care agent/proxy speaks. Family preferences are not legal authority. Engage palliative care and ethics when conflict persists.

07 **HIPAA protects the client, not the institution.** Minimum necessary information. No social media. No public-hallway report. No discussing one client where another can hear. Family gets information only with client permission.

08 **Document objectively, in approved terminology, in real time.** Facts, observations, direct quotes, time, actions, notifications. Never opinions, labels, or blame. Never reference the incident report in the chart.

09 **Mandatory reports are not optional and do not require proof.** Suspected abuse/neglect of children, elders, vulnerable adults; reportable communicable diseases; gunshot/stab wounds. Suspect → report. Investigation is not the nurse's job.

10 **Escalate the way the facility taught you.** Stay with the client → charge nurse → provider → rapid response/code → supervisor → risk management/ethics. Skip levels only when life is in immediate danger, and document who you called and when.

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§ 3 · RN safety decision table

Twelve mixed-topic situations testing the way real NGN items are written.

SITUATION	BEST RN ACTION	WHY THIS IS SAFEST	COMMON NCLEX TRAP
Post-op day 1 client with O_2 sat 86% on 2 L NC, RR 28, restless. Another client is asking for pain medication.	Go to the post-op client first; raise HOB, increase O_2 per protocol, assess, then notify provider.	Airway/breathing compromise is unstable and acute. Pain medication is expected.	"Give the pain med first because pain is the 5th vital sign." Comfort never outranks airway.
Provider gives a verbal order for a high-alert med during a code.	Repeat back the order, write it down, give it, and obtain the written/electronic signature within the facility-defined window.	Verbal orders are permitted in emergencies with read-back. Documentation closes the loop.	"Refuse the verbal order in a code." Refusal in an emergency is unsafe.
UAP reports a client's BP is 78/40 and asks if it's okay to ambulate.	Tell the UAP to hold ambulation, stay with the client; RN goes to assess.	Hypotension is an abnormal cue that requires nursing assessment before any further task.	"Have the UAP re-take the BP and call back." Delays assessment of an unstable cue.
Family member asks the nurse for the client's lab results "since I'm her son."	Confirm the client has authorized disclosure to this person; if not, defer the conversation to the client.	HIPAA permits disclosure only with client authorization or for treatment, payment, or operations.	"Tell him because he's family." Family relationship does not equal HIPAA authorization.
Client with documented DNR/DNI deteriorates; daughter (not the agent) says "do everything."	Honor the DNR/DNI. Provide comfort care. Notify the provider and contact palliative/ethics if the family conflict escalates.	A valid advance directive is the legal expression of client autonomy. Family preferences cannot override it.	"Call a code because the family is upset." Performs care against client wishes.
Pre-op client signing consent says, "I'm still not sure what they're cutting out."	Stop the procedure preparation. Notify the surgeon. Do not witness the signature.	Informed consent requires the client to understand. The nurse witnesses the signature; the provider explains.	"Re-explain the surgery to the client and have them sign." That is practicing outside scope.
Nurse smells alcohol on a coworker handing off report.	Remove the coworker from client care immediately; notify the charge nurse/supervisor; document objectively.	Impaired practice is a client-safety issue requiring immediate escalation under most state nurse practice acts.	"Talk to the coworker first to give them a chance." Delays protection of clients.
UAP wants to take a photo of an unusual rash "for educational purposes."	Stop them. Photographs of clients are facility property and require consent and clinical purpose; never on personal devices.	Protects privacy and prevents HIPAA/social-media breach.	"Allow it if no face is in the photo." Identifiable health information includes more than faces.
Charge nurse assigns the new graduate RN to a fresh post-cardiac-cath client with active bleeding from the femoral site.	Speak privately with the charge nurse; request a different assignment using "I'm concerned" language;	Self-recognition of limits is a 2026 Test Plan activity statement; it protects clients.	"Take the assignment and call for help if needed." Accepting an unsafe assignment shifts liability to the new RN.

SITUATION	BEST RN ACTION	WHY THIS IS SAFEST	COMMON NCLEX TRAP
	document the conversation if not changed.		
Discharge teaching: client speaks limited English; spouse offers to interpret.	Use a qualified medical interpreter (phone, video, or in-person), not the family member.	Family interpreters create bias, omission, and consent-validity problems. Federal law requires meaningful access.	"Use the spouse because the client trusts them." Trust does not equal qualification.
The nurse discovers a medication error after the client has received the wrong dose; the client is asymptomatic.	Assess the client, notify the provider, monitor per facility protocol, document the assessment in the chart, complete an incident report separately.	Quality improvement requires near-miss/error reporting outside the medical record.	"Document 'incident report filed' in the chart." That references the incident report in legal record.
Client with newly diagnosed TB is refusing isolation: "I don't want to be locked in."	Maintain airborne isolation. Engage public health (mandatory reporting). Use therapeutic communication and explore the refusal; involve social work and the provider.	Communicable disease reporting is a legal duty; community protection overrides individual preference.	"Honor the refusal because the client has autonomy." Autonomy is limited when public health is at risk.

§ 4 · Mixed delegation & scope table

One mixed table covering thirteen tasks across the most-tested clinical situations. The "Can delegate?" column asks: *to the lowest competent provider.*

TASK	RN	LPN/VN	UAP	CAN DELEGATE?	WHY OR WHY NOT
Initial admission assessment on a new admit	✓	✗	✗	**No**	Initial assessment is RN scope under the nursing process; the LPN/VN may contribute to ongoing data collection on stable clients but cannot perform the admission assessment.
Reinforce previously taught discharge teaching on insulin storage to a stable client	✓	✓	✗	**Yes — LPN/VN**	LPN/VN may *reinforce* teaching the RN has already provided; the RN must perform initial teaching and evaluate understanding.
First dose of IV piggyback antibiotic in a client with no documented allergy	✓	✗	✗	**No**	First-dose IV medications require RN assessment for reaction; most boards restrict IV push and first IVPB to RN.
Administering a tube feeding via established PEG to a stable client	✓	✓	✗	**Yes — LPN/VN**	Established enteral feeding on a stable client is within LPN/VN scope; UAP cannot administer medications or feedings.
Vital signs on a stable client on telemetry with no recent rhythm changes	✓	✓	✓	**Yes — UAP**	UAP may obtain vitals on stable clients; the RN must interpret the values and act on any abnormal findings.
Vital signs on a client one hour after a blood transfusion was started	✓	✗	✗	**No**	Blood-transfusion monitoring is RN scope for the duration of the infusion because the client is potentially unstable.
Foley insertion in a stable adult with no anatomical anomaly	✓	✓	✗	**Yes — LPN/VN**	Sterile catheter insertion is within LPN/VN scope on stable clients per most state boards.
Bed bath and oral hygiene for a stable client on bed rest	✓	✓	✓	**Yes — UAP**	ADLs are core UAP scope; this is the lowest competent provider.
Witnessing a client's signature on the surgical consent form	✓	✗	✗	**No**	The RN witnesses the *signature* and verifies the client appears to understand and is acting voluntarily. The provider obtains the consent.
Suctioning a stable, established tracheostomy via oral/oropharyngeal route	✓	✓	✗	**Yes — LPN/VN**	Suctioning is within LPN/VN scope; UAP generally do not suction. Many policies allow UAP to suction oral cavity only on stable trained clients — verify facility policy.
Evaluating effectiveness of pain medication 30 min after administration	✓	✗	✗	**No**	Evaluation is part of the nursing process and stays with the RN.

TASK	RN	LPN/VN	UAP	CAN DELEGATE?	WHY OR WHY NOT
Ambulating a stable post-op day 2 client who has ambulated successfully twice already	✓	✓	✓	**Yes — UAP**	Ambulation of stable clients with predictable outcomes is UAP scope; report any change immediately.
Discharge teaching for new anticoagulant therapy	✓	✗	✗	**No**	Discharge teaching of new content is RN scope. The LPN/VN may later reinforce.

The hidden trap of "stable"

The single biggest delegation trap on NCLEX: the test changes a task from *safe to delegate* to *unsafe to delegate* by making the client **unstable**. A "vital sign" on a stable post-op client → UAP. A "vital sign" 15 minutes after starting blood, in a new-onset SOB client, or 1 hour after a code → RN. Read the client status as carefully as the task.

§ 5 · Integrated red-flag cues

Mixed cues from across the 15-day plan. These are the findings that change the answer.

IMMEDIATE RN ASSESSMENT

- New change in mental status
- SpO_2 drop ≥4% from baseline
- New chest pain, dyspnea, or syncope
- Sudden BP <90/60 or MAP <65
- Active uncontrolled bleeding
- New focal neurological deficit
- Sudden severe pain (esp. post-op, post-procedure)
- Temp >38.5 °C in a neutropenic client

NOTIFY PROVIDER

- Abnormal lab outside critical-value protocol
- Persistent change in condition after intervention
- Client refusal of treatment
- "I don't understand" during consent
- Suspected adverse drug reaction
- New incontinence, retention, or oliguria (<30 mL/hr × 2 hr)
- Failure to wean/respond to therapy
- Unsafe or ambiguous order

RAPID RESPONSE TEAM

- Two or more SIRS/sepsis criteria with concern
- Persistent SBP <90 despite fluids
- RR >28 or <8
- SpO_2 <90% despite supplemental O_2
- Sustained HR >130 or <40
- Acute altered mental status
- New seizure
- "Nurse's worry" — provider not available

CHAIN OF COMMAND

- Unsafe or unclear provider order
- Provider refuses to respond/change order
- Unsafe staffing or assignment
- Impaired colleague
- Family conflict over advance directives
- Ethical dilemma without resolution
- Repeated near misses on the unit
- Recurring boundary violation

MANDATORY REPORTING

- Suspected child abuse/neglect
- Suspected elder/vulnerable adult abuse
- Reportable communicable disease (TB, measles, pertussis, etc.)
- Gunshot, stab, or other reportable injury
- Suspected nurse impairment/diversion (state board)
- Sentinel event (per facility/TJC)
- Workplace injury (per OSHA/policy)

HOLD DELEGATION & REASSESS

- Client status changed since assignment
- New abnormal vital sign reported
- UAP/LPN reports something "off"
- Care plan revised but staff not updated
- New isolation or fall-risk status
- Float or new staff unfamiliar with task
- Equipment failure or unavailability
- Family or visitor escalating

§ 6 · Twelve advanced NGN practice questions

Mixed item types covering every topic from Days 1–14. Read each rationale fully — the trap and the CJMM step matter more than the right letter.

Question 01

MULTI-CLIENT PRIORITIZATION · SINGLE-BEST

The day-shift RN receives report on four clients. Which client should the nurse assess first?

A. A 64-year-old post-op day 1 (lap chole) with pain 7/10, last analgesic 4 hours ago.

B. A 78-year-old with pneumonia, SpO_2 90% on 2 L NC (baseline 92%), RR 22, mildly confused, family at bedside.

C. A 45-year-old admitted overnight with new-onset atrial fibrillation, HR 88 on rate-control infusion, asymptomatic, awaiting echo.

D. A 32-year-old with cellulitis on day 3 of IV antibiotics, afebrile, requesting discharge teaching.

RATIONALE

Correct: B. Drop in SpO_2 from baseline plus new confusion in an older adult with pneumonia is a change-in-condition red flag suggesting hypoxia and possible decompensation. Airway/breathing + new mental-status change beats expected post-op pain.

A — wrong. Pain at 7/10 is expected post-op and is comfort-level concern. Important, but not the priority over compromised oxygenation.

C — wrong. A-fib with rate-controlled and asymptomatic is acute but currently stable; expected response to therapy.

D — wrong. Stable, afebrile, requesting teaching is a stable predictable client — last in line.

Trap: Choosing A because pain is "the fifth vital sign." Comfort never outranks airway and a new neuro change.

CJMM step: *Recognize cues → Prioritize hypotheses.*

Question 02

DELEGATION · SATA

The RN is making assignments on a busy medical-surgical floor. Which tasks may be appropriately delegated to the UAP? Select all that apply.

A. Obtaining vital signs on a stable client awaiting discharge.

B. Reinforcing instructions to a client on use of an incentive spirometer.

C. Assisting a stable client to ambulate to the bathroom.

D. Measuring intake and output for a client with a Foley catheter.

E. Performing the initial pain assessment on a client returning from surgery.

F. Recording oral intake at meals for a client on a regular diet.

G. Suctioning a new tracheostomy.

RATIONALE

Correct: A, C, D, F. Vitals on a stable client, ambulation of a stable client, I&O documentation, and meal-intake recording are tasks (not judgment) on stable clients with predictable outcomes — core UAP scope.

B — wrong. "Reinforcing teaching" is LPN/VN scope (after RN has performed initial teaching). UAP do not teach or reinforce teaching.

E — wrong. The initial pain assessment is part of the nursing assessment process — RN only.

G — wrong. Suctioning a *new* tracheostomy involves an unstable airway and possible complications — RN scope.

Trap: "Reinforcing teaching" sounds passive and easy — but UAP never teach or reinforce teaching on NCLEX.

CJMM step: *Take action (safe delegation).*

Question 03

DELEGATION MATRIX

Indicate the most appropriate provider for each task on a medical-surgical unit. Select **only one** provider per row.

TASK	RN	LPN/VN	UAP
Initial assessment of a client admitted with chest pain	●	○	○
Insertion of an indwelling Foley catheter in a stable male client	○	●	○
Bed bath and linen change for a stable client	○	○	●
Administering the first dose of IV vancomycin	●	○	○
Reinforcing previously taught crutch-walking technique to a stable client	○	●	○
Recording I&O for a stable client	○	○	●
Witnessing the signature on a surgical consent form	●	○	○
Discharge teaching for a new anticoagulant	●	○	○

RATIONALE

Why these answers: Initial assessment, first-dose IV med, witnessing consent, and any teaching (new content) require the RN. Sterile Foley insertion and reinforcing previously taught content are within LPN/VN scope. Bed bath and I&O are UAP tasks on stable clients.

Trap: Many test-takers assign "reinforce teaching" to RN — but if the RN already taught it, the LPN/VN may reinforce. Initial teaching = RN; reinforcement = LPN/VN.

CJMM step: *Generate solutions → Take action.*

Question 04

ORDERED RESPONSE · CODE/RRT

A client on a med-surg unit suddenly becomes unresponsive. Place the nurse's actions in the correct order.

1. Begin chest compressions if no pulse.
2. Check responsiveness and call for help/activate the code team.
3. Assess breathing and pulse for no more than 10 seconds.
4. Attach AED/defibrillator as soon as available; analyze rhythm.
5. Open airway and deliver rescue breaths once airway adjunct is available.

RATIONALE

Correct order: 2 → 3 → 1 → 5 → 4. BLS sequence: check responsiveness, call for help/activate code, assess breathing/pulse ≤10 sec, start compressions if pulseless, ventilate, attach AED/defib when available.

Trap: Starting compressions before activating the code. Always call for help first — you need the team and the defibrillator.

CJMM step: *Take action (sequencing emergency care).*

Question 05

DROP-DOWN / CLOZE · SBAR HANDOFF

The RN is giving an SBAR handoff to the ICU. Complete each blank with the most appropriate option.

Situation: "Mr. K is a 67-year-old male admitted for [__*1*__] with worsening hypoxia." Options: ① pneumonia ② fall ③ chronic back pain

Background: "He has [__*2*__] and a documented DNR/DNI on file." Options: ① a healthy baseline ② COPD and CHF ③ no significant history

Assessment: "Current vitals BP 92/56, HR 118, RR 28, SpO_2 87% on 4 L NC. He's [__*3*__]." Options: ① alert and joking ② confused and using accessory muscles ③ asleep but easily roused

Recommendation: "I recommend [__*4*__] and review of code status with the family on arrival." Options: ① initiating BiPAP per protocol ② intubation ③ no change in plan

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RATIONALE

Correct: 1 = pneumonia · 2 = COPD and CHF · 3 = confused and using accessory muscles · 4 = initiating BiPAP per protocol. The SBAR must include the admitting reason, relevant comorbidities affecting management, current physiologic state, and an action-oriented recommendation. With a DNR/DNI, intubation is not appropriate; BiPAP supports ventilation noninvasively and is consistent with the directive.

Trap: Choosing "intubation" because it sounds aggressive and appropriate for hypoxia — but the documented DNR/DNI prohibits it. Always read advance directives before recommending escalation.

CJMM step: *Generate solutions → Take action (communication).*

Question 06

INFORMED CONSENT · SINGLE-BEST

The nurse enters the pre-op holding area to verify the surgical consent. The client states, "I signed the paper but honestly I still don't know exactly what they're going to remove." Which action should the nurse take first?

A. Explain the procedure again to the client in simpler language.

B. Reassure the client that the surgeon will explain everything in the OR.

C. Hold the procedure preparation and notify the surgeon to return and re-explain the procedure.

D. Have the client sign a witness statement that consent was obtained.

RATIONALE

Correct: C. Informed consent is invalid without client understanding. The provider — not the nurse — must re-explain. The nurse holds the procedure and notifies the surgeon.

A — wrong. Explaining the procedure is the surgeon's responsibility. The nurse practicing outside this scope invalidates consent.

B — wrong. Reassurance without clarification ignores autonomy and may proceed under invalid consent.

D — wrong. A signed witness statement cannot retroactively create informed consent.

Trap: Re-explaining "in simpler language" feels nurse-y and helpful — but it is scope-of-practice abuse.

CJMM step: *Take action (advocacy, scope).*

Question 07

ADVANCE DIRECTIVE · SATA

A client with end-stage cancer has a valid living will and a POLST/MOLST specifying "Do Not Resuscitate, comfort measures only." The client has lost decisional capacity. The adult daughter, who is not the named health-care agent, insists the team "do everything." Which actions should the nurse take? Select all that apply.

A. Continue to honor the documented DNR and comfort-measure orders.

B. Initiate full resuscitation if the client's heart stops, since the daughter requests it.

C. Notify the provider of the family conflict and request a palliative-care/ethics consult.

D. Communicate with the named health-care agent on file.

E. Document the daughter's statements verbatim, the actions taken, and the team members notified.

F. Defer all care decisions to the daughter as the surrogate decision maker.

RATIONALE

Correct: A, C, D, E. A valid advance directive remains binding. The named agent, not "the family," speaks for the client. Ethics/palliative care helps resolve conflict, and objective documentation is essential.

B — wrong. Performing resuscitation against a valid DNR is battery and overrides client autonomy.

F — wrong. The daughter is not the named agent. Family relationship does not equal legal authority.

Trap: Choosing F because the daughter is "next of kin" — but the named agent supersedes default surrogacy when the client has executed an advance directive.

CJMM step: *Analyze cues → Take action (advocacy/ethics).*

Question 08

BOW-TIE · CONFIDENTIALITY

A new graduate nurse posts a vague status on social media: "Crazy shift today — lost my favorite patient on 4 East. Heartbroken." Drag the items into the diagram.

Condition identified: _____
Two immediate actions: _____ / _____
Two parameters to monitor (follow-up): _____ / _____

Drag options:
① HIPAA / privacy breach
② Notify nurse manager & risk management
③ Have the nurse delete the post immediately
④ Praise the nurse for honoring the client
⑤ Repeated postings / future social-media activity
⑥ Outcomes of mandatory re-education and disciplinary process
⑦ Discuss the death openly at the next staff meeting

RATIONALE

Correct: Condition = ① HIPAA/privacy breach. Actions = ② notify manager & risk management and ③ have the nurse delete the post. Monitor = ⑤ repeat postings and ⑥ re-education/discipline outcomes. Even without a name, identifying the unit/date narrows the population and can constitute a breach. Removal stops further harm; notification triggers required institutional process.

④ — wrong. Empathy is appropriate, but the action is a privacy breach.

⑦ — wrong. Discussing a specific client death openly compounds the breach.

Trap: Believing that "no name = no breach." Combining time, unit, and outcome can identify the client.

CJMM step: *Recognize cues → Take action → Evaluate outcomes.*

Question 09

PRIORITIZATION · 5 CLIENTS

The RN is starting a shift on the post-surgical unit. Place the clients in the order the RN should assess them, from first to last.

1. Client A — Post-op day 1 colectomy with new-onset SpO_2 88% on room air and crackles bilaterally.
2. Client B — Post-op day 2 hip replacement with calf pain and unilateral swelling.
3. Client C — Post-op day 3 cholecystectomy awaiting discharge, asking for printed instructions.
4. Client D — Post-op day 1 lumpectomy with pain 6/10 unrelieved by last dose 1 hour ago.
5. Client E — Stable post-op day 4 hernia repair ready to transfer to a rehab unit.

RATIONALE

Correct order: A → B → D → C → E. A = airway/breathing compromise, unstable. B = potential pulmonary embolus from DVT, acute risk. D = comfort issue, evaluation of pain medication needed but not immediately life-threatening. C = stable, predictable, teaching task. E = stable, transferable.

Trap: Putting D (unrelieved pain) before B (calf pain/swelling). Pain is comfort; new unilateral calf swelling is potentially an actual life-threatening DVT/PE risk.

CJMM step: *Recognize cues → Prioritize hypotheses.*

Question 10

MANDATORY REPORTING · SINGLE-BEST

A 6-year-old is brought to the ED for "falling down the stairs." On assessment, the nurse notes multiple bruises in varying stages of healing on the back and buttocks and a healing burn shaped like a circle on the forearm. The parent refuses to leave the bedside and answers every question on the child's behalf. Which action by the nurse is most appropriate?

A. Discuss concerns directly with the parent before any further action.

B. Document objective findings, separate the child from the parent for assessment, and report suspected abuse to Child Protective Services per facility protocol.

C. Refer the family to outpatient counseling and home services.

D. Wait until additional injuries are documented to confirm a pattern before reporting.

RATIONALE

Correct: B. Nurses are mandated reporters. Reasonable suspicion of abuse — not proof — triggers the duty to report. Document objectively, allow private assessment, and follow facility protocol.

A — wrong. Tipping off the alleged perpetrator may place the child at greater risk.

C — wrong. Referrals are appropriate but do not satisfy the legal duty to report suspected abuse.

D — wrong. Mandatory reporting does not require proof — only reasonable suspicion.

Trap: "Investigating first." Investigation is not the nurse's role. Report, then document.

CJMM step: *Take action (legal/ethical duty).*

Question 11

INCIDENT REPORT · SATA

An RN administered the wrong dose of insulin to a client. The client is asymptomatic. Which actions should the nurse take? Select all that apply.

A. Assess the client (blood glucose, vital signs, mental status) and notify the provider.

B. Document the client's current status, the medication actually given, and the provider notification in the chart.

C. Complete an incident/occurrence report per facility policy.

D. Document "incident report filed" in the client's chart for legal protection.

E. Monitor the client per protocol for hypoglycemia (s/sx, blood-glucose recheck).

F. Hide the error to protect the unit's quality scores.

RATIONALE

Correct: A, B, C, E. Client safety first (assess and notify), objective documentation of clinical facts in the chart, complete the incident report *separately*, and continue monitoring per protocol.

D — wrong. Never reference the incident report in the chart. It is a quality-improvement document, not part of the legal medical record.

F — wrong. Concealing an error endangers the client and violates ethical and legal standards.

Trap: Choosing D feels "thorough" but it compromises the legal protection of the incident report.

CJMM step: *Take action → Evaluate outcomes (QI).*

Question 12

CASE-STYLE · RECOGNIZE / ANALYZE CUES

A 72-year-old client is admitted from a long-term care facility with confusion, fever, and urinary frequency. Initial findings include: T 38.7 °C, HR 108, BP 96/58, RR 22, SpO_2 94% on room air, WBC 16.4 × 10^9/L, lactate 2.4 mmol/L, urinalysis with positive nitrites and leukocyte esterase, and a tender suprapubic area. Which findings indicate the nurse should immediately escalate to the rapid response team or provider? Select all that apply.

A. Temperature 38.7 °C

B. Blood pressure 96/58 with heart rate 108

C. Lactate 2.4 mmol/L

D. SpO_2 94% on room air

E. Positive nitrites and leukocyte esterase

F. New-onset confusion

RATIONALE

Correct: B, C, F. The pattern — fever, tachycardia, hypotension, elevated lactate, new confusion — meets sepsis screening criteria. Hemodynamic instability, elevated lactate (≥2), and new altered mental status are immediate-escalation triggers.

A — wrong. Fever alone is consistent with infection but is not by itself an escalation trigger separate from the constellation.

D — wrong. SpO_2 94% on room air is within an acceptable range; trend matters more than a single value.

E — wrong. Positive UA is consistent with UTI source but not the escalation trigger; the systemic response is.

Trap: Marking every abnormal value. The escalation question is about *which findings signal deterioration*, not which are abnormal.

CJMM step: *Recognize cues → Analyze cues → Prioritize hypotheses.*

§ 7 · Unfolding NGN Case Study 1

CASE 01 · PRIORITIZATION × DELEGATION × HANDOFF

"Start-of-Shift Storm"

Setting: 0700, 30-bed medical-surgical unit. You are the day-shift RN receiving handoff for four assigned clients. One LPN/VN and one UAP are also on the team.

HANDOFF REPORT

Client 1 · Room 412 · 68 M, post-op day 1 right total knee. Pain 5/10 last assessed at 0500. PCA morphine ongoing. SCDs in place. VS stable.

Client 2 · Room 414 · 74 F, COPD exacerbation day 3 on IV antibiotics. SpO_2 overnight has trended 91 → 89 → 88% on 2 L NC. RR 22 → 26. Restless. Family at bedside.

Client 3 · Room 416 · 55 M, admitted overnight with new-onset chest pain. Cardiac enzymes pending. Telemetry, IV nitroglycerin drip titrated for pain (currently asymptomatic, last episode 4 h ago). On home aspirin and metoprolol.

Client 4 · Room 418 · 81 F admitted yesterday with UTI; awaiting transfer to rehab today. Pending: physical-therapy clearance and the morning culture.

0700 VITAL SIGNS (MOST RECENT WITHIN LAST HOUR)

Client 1: T 37.0 · BP 132/78 · HR 86 · RR 18 · SpO_2 97% RA	**Client 2:** T 38.3 · BP 108/68 · HR 112 · RR 26 · SpO_2 88% on 2 L	**Client 3:** T 36.9 · BP 142/88 · HR 70 · RR 16 · SpO_2 98% RA	**Client 4:** T 37.1 · BP 124/72 · HR 84 · RR 18 · SpO_2 96% RA

PROVIDER ORDERS (TODAY)

- Client 1: Advance diet as tolerated; physical therapy BID; D/C PCA when tolerating PO analgesia.
- Client 2: Continue ceftriaxone IV. Titrate O_2 to maintain SpO_2 ≥92%. Notify provider if RR >28 or SpO_2 <90% despite escalation. ABG if not improving.
- Client 3: Cardiology consult; NPO until cleared; titrate nitroglycerin for chest pain only; troponin q6h.
- Client 4: Transfer to rehab today pending PT clearance.

FAMILY/CLIENT STATEMENT

"My mother's breathing has been getting worse since night shift. She can hardly finish a sentence now. The nurse said she'd come back, but no one's been in for a while." — Client 2's daughter, at the door, at 0705.

CJMM 1 RECOGNIZE CUES

Which findings in Client 2 are immediate red flags? Select all that apply.

A. SpO_2 88% on 2 L NC (down from baseline 92%)

B. RR 26 with restlessness

C. Temperature 38.3 °C

D. Family report of worsened breathing and inability to complete a sentence

E. HR 112

Correct: A, B, D, E. Drop in SpO_2 below the provider-defined threshold, rising RR with restlessness, family report of worsening, and tachycardia all indicate decompensating respiratory status. Fever is consistent with the admitting diagnosis but is not by itself the change-in-condition cue.

Tested: *Recognize cues.*

CJMM 2 ANALYZE CUES / PRIORITIZE HYPOTHESES

Which client should the RN see first?

A. Client 1 — to assess pain and review PCA use.

B. Client 2 — to assess airway/breathing and intervene.

C. Client 3 — to verify chest-pain status and IV drip.

D. Client 4 — to coordinate the transfer to rehab.

Correct: B. Client 2 has airway/breathing compromise with a documented worsening trend that crosses the provider's notification threshold (SpO_2 <90% on current O_2). ABCs win every prioritization.

C is the second-place trap: Acute chest pain is high-risk, but Client 3 is currently *asymptomatic* and on a stable drip. Expected/known stable beats actual unstable here.

Tested: *Analyze cues → Prioritize hypotheses.*

CJMM 3 GENERATE SOLUTIONS

For Client 2, which actions are appropriate? Select all that apply.

A. Raise the head of the bed to high-Fowler's.

B. Titrate O_2 up per the provider's order to keep SpO_2 ≥92%.

C. Have the UAP perform repeat vital signs every 15 minutes while you assess.

D. Page the provider with an SBAR report.

E. Delegate listening to lung sounds to the LPN/VN.

F. Stay with the client until the response is verified.

Correct: A, B, D, F. Position, oxygenate per order, notify the provider via SBAR, and stay with the unstable client. The UAP cannot interpret vitals on an unstable client (assignment/delegation rule), and lung-sound assessment in an unstable client is the RN's responsibility — not the LPN's.

Tested: *Generate solutions → Take action.*

CJMM 4 TAKE ACTION — DELEGATION

While the RN manages Client 2, what is the safest delegation of the remaining workload?

A. UAP: take vitals on Clients 1 and 4; ambulate Client 1 to chair. LPN/VN: administer scheduled non-IV-push medications to Clients 1 and 4; reinforce previously-taught crutch teaching with Client 1; ensure Client 3 remains NPO and monitored.

B. UAP: monitor Client 3's nitroglycerin drip while RN is busy. LPN/VN: complete Client 4's transfer report to rehab.

C. UAP: complete the discharge teaching for Client 4. LPN/VN: assess Client 3 if chest pain returns.

D. UAP: titrate Client 3's IV drip per pain. LPN/VN: complete Client 1's initial PCA teaching.

Correct: A. Stable tasks on stable clients flow to UAP; reinforcing previously taught content and routine non-IV-push meds flow to LPN/VN. Client 3 remains on the RN because of the IV drip and pending evaluation.

B — wrong. Monitoring an IV drip (titrated cardiovascular med) is RN scope. Transfer report is RN.

C — wrong. UAP do not perform discharge teaching; LPN/VN do not perform assessment of new chest pain.

D — wrong. Drip titration and initial teaching are RN-only.

Tested: *Take action (safe delegation under workload pressure).*

CJMM 5 TAKE ACTION — SBAR TO PROVIDER

Complete the nurse's SBAR call to the provider about Client 2 by selecting the best phrase for each element:

S: "This is RN ____ calling about Mrs. R in 414, [__*1*__]."
Options: ① and I'm worried about her breathing ② whenever you have a chance ③ for a routine update

B: "She's a 74-year-old admitted with [__*2*__]."
Options: ① a knee replacement ② a COPD exacerbation, day 3 on IV ceftriaxone ③ chest pain

A: "Right now her SpO_2 is 88% on 2 L NC, RR 26, HR 112, BP 108/68. She is [__*3*__] and meeting your notification threshold."
Options: ① alert and joking ② restless and unable to complete a sentence ③ asleep

R: "I have raised the head of the bed and increased O_2 per your titration order. [__*4*__]"
Options: ① No further action needed ② I recommend you assess at bedside and consider escalation including ABG and respiratory therapy ③ I'd like to discharge her

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Correct: 1 = ① · 2 = ② · 3 = ② · 4 = ②. SBAR must include an urgency cue ("I'm worried"), the pertinent background, the specific assessment values that meet the threshold, and an actionable recommendation.

Trap: Calling "for an update" or "no further action needed" — both fail to make the urgency clear.

Tested: *Take action (communication).*

CJMM 6 EVALUATE OUTCOMES

One hour later, which findings indicate that Client 2's interventions were effective? Select all that apply.

A. SpO_2 now 93% on 4 L NC, RR 20.

B. Client now able to complete sentences and oriented x3.

C. HR 92, BP 116/72.

D. Client appears asleep but rouses only to deep stimulation.

E. Family reports breathing "much easier."

Correct: A, B, C, E. Improvement in oxygenation, work of breathing, mental status, and hemodynamic parameters all indicate response. Family-reported improvement supports the trend.

D — wrong. Reduced responsiveness suggests hypercapnia or further deterioration — escalate, not reassure.

Tested: *Evaluate outcomes.*

Case 1 takeaway

The four-client problem is the most common Management of Care pattern on NCLEX. Walk the same loop every time: **scan all clients → identify red flags → match to ABC/safety → see the unstable client → delegate the stable tasks → SBAR with a recommendation → evaluate.** If you do this on every multi-client item, you will almost never miss a prioritization question.

§ 8 · Unfolding NGN Case Study 2

CASE 02 · CONSENT × ADVANCE DIRECTIVE × ETHICAL CONFLICT

"The Refusal"

Setting: 1430, step-down unit. The RN is caring for a 78-year-old client with end-stage heart failure and chronic kidney disease, admitted three days ago for fluid overload. The client has a documented Living Will, a POLST/MOLST signed by client and provider specifying *DNR, DNI, no dialysis, comfort-focused care*, and a Durable Power of Attorney for Healthcare naming his son as agent. Today, an estranged daughter has flown in from out of state.

NURSE'S NOTES — 1430

Client drowsy but arousable, oriented to person only. Breathing labored at rest, on 4 L NC with SpO_2 92%. Bilateral crackles ⅔ up. Pitting edema +3 lower extremities. Mottling beginning at knees. Verbalizes: "I'm tired. I just want to rest. No more tubes." Daughter arrived at 1400, currently raising her voice at the bedside. Son (agent) reached by phone and is en route.

VITAL SIGNS · 1430

T 36.7 · BP 92/54 · HR 108 · RR 26 · SpO_2 92% on 4 L NC

ACTIVE PROVIDER ORDERS

- Comfort measures only per MOLST.
- IV morphine 2 mg q2h PRN dyspnea/pain.
- Oxygen titrate for comfort, target SpO_2 ≥90%.
- Discontinue routine vital signs (q4h for comfort only).
- Chaplain and palliative care consult — placed.
- Social work consult for family support — placed.

FAMILY/CLIENT STATEMENTS

Client (1430): "I'm tired. No more tubes."
Daughter (1432, at the bedside): "I want him intubated. I want dialysis. I want a code team if his heart stops. He doesn't know what he's saying."
Son (1435, by phone, named agent): "Dad signed those papers with me. He wanted this. Please honor what he asked for."

MULTIDISCIPLINARY TEAM NOTES

- Palliative-care MD note 1330: "Goals of care reviewed with client this morning while alert. Client reaffirmed DNR/DNI and no dialysis. Comfort care plan in place."
- Social work 1410: "Family conflict identified; will meet with daughter on arrival."
- Chaplain 1415: "Daughter expressing guilt about estrangement; pastoral support offered."

CJMM 1 RECOGNIZE CUES

Which cues indicate this is an ethical/legal conflict and not a clinical-decompensation event? Select all that apply.

A. Client signed POLST/MOLST with DNR/DNI/no dialysis.

B. Documented DPOA naming the son as agent.

C. Palliative-care note from earlier today confirming client reaffirmed wishes while alert.

D. Daughter demanding interventions inconsistent with the directive.

E. SpO_2 92% on 4 L NC.

Correct: A, B, C, D. A valid AD, a named agent, recent confirmation of wishes, and a family-member request to override the directive together define an ethical/legal conflict, not a clinical emergency. SpO_2 is at the comfort threshold.

Tested: *Recognize cues.*

CJMM 2 ANALYZE CUES

Which statement most accurately reflects the legal hierarchy of decision making in this case?

A. The daughter is "next of kin" and therefore can override the directive.

B. The client's documented wishes, reaffirmed today while alert, are the controlling authority; the named agent (son) speaks if the client loses capacity.

C. The medical team can override the directive if family disagrees.

D. The provider can rescind the DNR if the daughter signs a waiver.

Correct: B. A valid advance directive expresses the client's autonomy and remains binding. The named health-care agent speaks for the client when capacity is lost. Default surrogacy (next of kin) only applies when there is no advance directive and no named agent.

Trap: "Next of kin always decides." Default surrogacy is the lowest tier; AD and named agent supersede it.

Tested: *Analyze cues.*

CJMM 3 PRIORITIZE HYPOTHESES

What is the nurse's most urgent priority?

A. Honor the existing comfort-care plan and protect the client from interventions inconsistent with the directive.

B. Initiate full resuscitation in case the daughter's request is legally binding.

C. Wait until the son arrives to clarify the directive.

D. Ask the client to sign a new directive in front of the daughter.

Correct: A. The directive is valid and binding now. The nurse continues comfort care, manages the conflict separately, and uses team resources.

B — wrong. Resuscitation against a valid DNR is battery.

C — wrong. Care continues per the directive — no waiting required.

D — wrong. Coerced/witnessed-by-conflicting-party signature invalidates consent.

Tested: *Prioritize hypotheses.*

CJMM 4 GENERATE SOLUTIONS

Which actions/resources are appropriate for the family-conflict component? Select all that apply.

A. Move the daughter to a private space with the chaplain and social worker.

B. Page palliative care for a family meeting.

C. Consult the ethics committee if the conflict cannot be resolved.

D. Document the daughter's statements, the team members notified, and the actions taken.

E. Tell the daughter that "she has no say" and ask security to remove her.

F. Engage the named health-care agent (son) by phone and document.

Correct: A, B, C, D, F. Private space, palliative-care family meeting, ethics consult, objective documentation, and engagement of the named agent are appropriate, scope-aligned, and de-escalating.

E — wrong. Therapeutic communication first; security only if a safety threat develops.

Tested: *Generate solutions.*

CJMM 5 TAKE ACTION

Which response by the nurse to the daughter is most therapeutic and within scope?

A. "Your father will die without intubation. I can't believe you weren't here sooner."

B. "I can see how hard this is. Your father has documented his wishes and reaffirmed them this morning. I'd like to step into a private space with the chaplain and our palliative-care team so we can talk through what's happening."

C. "There's nothing we can do. He doesn't want it."

D. "You'll need to take this up with the provider after he dies."

Correct: B. Validates emotion, restates the client's documented wishes factually, moves the conversation to a private space, and engages the right resources. This is the script the test rewards.

A — wrong. Blaming and abandoning.

C — wrong. Closed and dismissive; fails to use resources.

D — wrong. Cold, deflecting, and abandons the family.

Tested: *Take action (therapeutic communication + advocacy).*

CJMM 6 EVALUATE OUTCOMES

By 1630, which findings would indicate the plan is working? Select all that apply.

A. Daughter has met with palliative care and chaplain in a private space; emotional intensity has decreased.

B. Son (agent) has arrived; the family has had a goals-of-care conversation with palliative care.

C. The client is resting comfortably; morphine titrated for dyspnea; SpO_2 91% on 4 L NC.

D. The team intubated the client pending further family discussion.

E. Daughter expresses understanding of the directive even if she disagrees emotionally.

Correct: A, B, C, E. De-escalation, engagement of the legal agent, ongoing comfort, and family understanding (even without agreement) are signs the plan is working.

D — wrong. Intubation against the directive is a sentinel event.

Tested: *Evaluate outcomes.*

Case 2 takeaway

An end-of-life family conflict is a Management of Care case, not a code. The nurse's job is to **protect the directive, advocate for the client, document objectively, and route the family to the right resources.** Anyone who tries to "fix" the family by overriding the AD is the wrong NCLEX answer.

§ 9 · Unfolding NGN Case Study 3

CASE 03 · DELEGATION × SCOPE × INCIDENT REPORTING × CHAIN OF COMMAND

"The Near Miss"

Setting: 2000, oncology unit. You are the charge RN on evening shift. The shift includes an experienced LPN/VN, a UAP, and a float RN from an unrelated unit who arrived 30 minutes ago.

EVENTS OF THE SHIFT

- 1830 — The UAP performs accuchecks on three clients and documents results. One reading (Client A) is 48 mg/dL.
- 1845 — You discover the UAP did not report the 48 mg/dL reading; she only documented it. The client is currently asymptomatic.
- 1850 — The float RN is preparing to hang an IV piggyback antibiotic on Client B (new chemotherapy patient, first dose) without checking the medication-administration history or the allergy band. You intervene and stop the administration. The client has a documented penicillin allergy that the float RN did not see.
- 1905 — The LPN/VN reports she has just performed initial discharge teaching with Client C on a new oral chemotherapy regimen because "the RN was busy."
- 1920 — An oncologist arrives, smelling of alcohol, and attempts to write new orders.

VITAL SIGNS · MOST RECENT

Client A (BG 48): alert, SpO_2 98%, no symptoms reported.

Client B (allergy near-miss): stable, no med given.

Client C (taught by LPN): stable, discharge pending tomorrow.

CJMM 1 RECOGNIZE CUES — WHICH EVENTS REQUIRE IMMEDIATE ACTION?

A. The UAP's failure to report a critical glucose.

B. The float RN's near-miss with a contraindicated antibiotic.

C. The LPN/VN performing initial teaching.

D. The oncologist's apparent impairment.

E. The asymptomatic glucose of 48 mg/dL itself.

Correct: A, B, D, E. All four are client-safety issues requiring immediate intervention or escalation. The LPN/VN scope violation is significant but not an immediate life-or-limb event; it requires correction and follow-up education.

Tested: *Recognize cues.*

CJMM 2 TAKE ACTION — GLUCOSE

For Client A's glucose of 48 mg/dL, place the RN actions in correct order.

1. Notify the provider.
2. Assess the client (mental status, symptoms, repeat blood-glucose).
3. Treat hypoglycemia per protocol (fast-acting carbohydrate or IV dextrose per facility protocol).
4. Recheck blood glucose in 15 minutes.
5. Document assessment, intervention, response, and provider notification.

Correct order: 2 → 3 → 4 → 1 → 5. Assess first to confirm the value and client status. Treat hypoglycemia immediately per protocol. Recheck in 15 minutes. Notify the provider. Document all of it in real time.

Trap: Calling the provider before treating. Hypoglycemia protocols are standing orders that allow immediate treatment; notification follows.

Tested: *Take action (emergency sequencing).*

CJMM 3 TAKE ACTION — THE FLOAT RN NEAR-MISS

For Client B's near-miss antibiotic, which actions are appropriate? Select all that apply.

A. Complete an incident/occurrence report (near miss).

B. Document the event in the medical record stating "incident report filed."

C. Document the actual events: medication ordered, allergy noted, medication not administered, provider notified, alternative obtained.

D. Notify the float RN's home unit and the nursing supervisor.

E. Review the medication-rights process with the float RN; ensure orientation gaps are addressed.

F. Tell the float RN not to mention it because no harm occurred.

Correct: A, C, D, E. Near misses are still reportable. The chart documents what happened clinically (no medication administered) without referencing the incident report. The float RN's home unit needs to know about orientation gaps; the supervisor needs to know about staffing and competency. Coaching/review is performance improvement.

B — wrong. Never reference the incident report in the chart.

F — wrong. Concealing a near miss undermines the entire quality system; no harm now does not equal no harm next time.

Tested: *Take action (QI + documentation).*

CJMM 4 TAKE ACTION — SCOPE VIOLATION

For the LPN/VN who performed initial teaching, what is the charge nurse's most appropriate action?

A. Allow it because the RN was busy and the client needed teaching.

B. Privately review scope of practice with the LPN/VN, perform RN-led teaching with the client, evaluate the client's understanding, and document the RN-performed teaching.

C. Write the LPN/VN up in the chart.

D. Notify the state board.

E. Tell the client to disregard everything the LPN/VN said.

Correct: B. Initial teaching is RN scope. The charge nurse coaches the LPN/VN privately, performs/verifies RN teaching, evaluates understanding, and documents the RN-performed teaching.

A — wrong. Workload does not change scope.

C — wrong. Personnel issues never go in the client chart.

D — wrong. A single instance of scope confusion is managed locally first; state-board reporting is for impairment, diversion, or pattern of unsafe practice.

E — wrong. Undermines the client's trust and the LPN/VN.

Tested: *Take action (scope + supervision).*

CJMM 5 TAKE ACTION — SUSPECTED IMPAIRMENT

For the oncologist who appears impaired, what is the charge nurse's correct first action?

A. Accept the orders to avoid embarrassing the provider, then call later if needed.

B. Refuse to take the orders, remove the provider from active client care immediately, and notify the nursing supervisor, attending/medical director, and follow facility impairment policy.

C. Tell the provider to "go take a break and come back."

D. Post about the encounter on a private nurse forum to seek advice.

Correct: B. Suspected impairment is an immediate client-safety issue. Do not accept orders. Escalate via the chain of command per facility impairment policy. Document objective findings only.

A — wrong. Accepting orders from an impaired prescriber jeopardizes clients.

C — wrong. Informal "advice" delays protection.

D — wrong. Identifying details on a forum is a privacy breach.

Tested: *Take action (chain of command, mandatory reporting).*

CJMM 6 EVALUATE OUTCOMES

Which outcomes by end of shift indicate effective resolution? Select all that apply.

A. Client A's glucose returned to a safe range; provider notified; documentation complete.

B. Client B received an appropriate alternative antibiotic with no harm; incident report filed; float RN home-unit notified.

C. Client C's teaching repeated by an RN; client demonstrates understanding (teach-back).

D. Nursing supervisor and medical leadership engaged regarding the impaired provider; provider removed from active care; coverage arranged.

E. UAP coached on critical-value reporting; competency reviewed.

F. No charting at all done because the shift was overwhelming.

Correct: A, B, C, D, E. Each safety issue has a closed loop: assess → act → document → educate/escalate.

F — wrong. Documentation is a legal duty regardless of workload.

Tested: *Evaluate outcomes.*

Case 3 takeaway

Real shifts have *multiple* Management of Care issues at once. The charge RN's job: **secure each client → close each safety loop → escalate impairment immediately → document the clinical facts → file QI/incident reports outside the chart → coach scope violations privately.** "One thing at a time" does not mean "ignore the others" — it means handling each at the right level of urgency.

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

1. The chemo drip and the chest pain.

You are caring for two clients. Client A is receiving chemotherapy by infusion and just developed flushing and shortness of breath. Client B is on the telemetry monitor showing new chest pain.

First: Go to Client A and *stop the chemotherapy infusion immediately* (keep IV line open with normal saline if facility protocol allows), then assess and call rapid response. Client A has an active anaphylaxis-suspect reaction caused by an ongoing intervention you can stop in two seconds. Client B is acute but already on monitor — call the team for B en route or assign the LPN/charge to stand with B while you manage A.

2. The post-op bleed and the new admit.

Your post-op day 1 hip-replacement client's dressing is saturated and the bedding has fresh blood. A new admit just arrived and needs an initial assessment.

First: Go to the post-op client. Active bleeding is an actual life-threat. Apply pressure, monitor vitals, notify provider. The new admit can wait briefly; ask the charge or another RN to greet and start the orientation if available.

3. The "I don't understand" client.

You enter the pre-op holding area for the surgical time-out. The client says, "I'm not really sure what they're taking out."

First: Stop the time-out. Hold the procedure. Notify the surgeon. Do not witness the consent. Document.

4. The medication error you just discovered.

You realize you administered the wrong dose of insulin 30 minutes ago. The client is alert and asymptomatic.

First: Assess the client (blood glucose, mental status, vital signs). Treat per protocol if hypoglycemic. Then notify provider, document the clinical events in the chart, and complete the incident report separately.

5. The family asking for confidential information.

The adult son of a client calls the unit asking for "today's labs."

First: Verify the client has authorized disclosure to this person. If unauthorized, do not disclose. Defer to the client and offer to facilitate a conversation with permission.

§ 11 · Can this be delegated? (×5)

1. Daily weights on the heart-failure unit.

The RN needs daily weights on six stable HF clients.

Delegate to UAP. Weights on stable clients are a task with predictable parameters. The RN interprets the trend and acts on changes.

2. First Heparin drip titration on a new DVT client.

A new client just started a heparin infusion with q6h PTT and titration.

Do not delegate. RN only. Titrated IV anticoagulant with q6h monitoring is RN scope; the client is unstable until therapeutic and the meds are high-alert.

3. Reinforcing crutch teaching with a stable post-op day 2 client.

The RN performed crutch teaching yesterday. Today the client is reviewing it before discharge.

Delegate to LPN/VN. Reinforcement of previously taught content on a stable client is within LPN/VN scope.

4. Initial admission assessment on a new ED admit.

A new client arrives from the ED with abdominal pain.

Do not delegate. RN only. Initial admission assessment is part of the nursing process and stays with the RN.

5. Bringing a stable client a meal tray and assisting with feeding.

An older client who is alert, oriented, and on a regular diet needs help opening packaging.

Delegate to UAP. Routine feeding assistance for a stable client without swallowing problems is UAP scope. Anyone with new dysphagia or a swallowing-evaluation pending requires RN/SLP involvement.

§ 12 · Who should the nurse contact? (×5)

1. The client who fails the swallow screen.

A post-stroke client coughs after a sip of water during the initial swallow screen.

Contact: Speech-Language Pathologist (SLP). SLP performs the formal swallow evaluation and dietary-texture recommendations. Hold oral intake and notify the provider, but the SLP is the team member who advances the evaluation.

2. The client without housing or food at discharge.

A client with newly diagnosed diabetes and limited transportation reports they will be staying in a shelter after discharge.

Contact: Social Work and/or Case Management. They coordinate transportation, food resources, medication assistance, shelter referrals, and follow-up access.

3. The high-alert medication question.

You receive an order for an IV vasopressor at a concentration you've never used and want to verify compatibility with the client's existing infusions.

Contact: Pharmacist. Pharmacy verifies dose, concentration, compatibility, and stability. Also re-check the order with the provider if anything seems inconsistent.

4. The post-op client unable to wean from oxygen.

A post-op client cannot maintain SpO_2 ≥92% on room air, requires repeat suctioning, and has a productive cough.

Contact: Respiratory Therapy (in addition to the provider). RT assists with oxygen-delivery optimization, nebulizers, suctioning, and ABGs.

5. The family struggling with end-of-life decisions.

The family of a dying client is conflicted about whether to continue aggressive measures.

Contact: Palliative Care (and Chaplaincy, Social Work, Ethics as needed). Palliative-care teams lead goals-of-care conversations and align care with the client's values and directives.

§ 13 · Legal / ethical traps (×5)

1. The "I just need to vent" social-media post.

A coworker posts on a private group: "Worst shift ever. Lost my 70-year-old male MI patient on the cath lab unit at 0300."

Trap: Believing privacy settings or absence of a name removes the breach. **Action:** Identify the breach, advise removal, notify the manager and risk management; document objectively. Combinations of unit, time, age, sex, and diagnosis can identify a client.

2. The client refusing dialysis.

A capacitated adult with ESRD refuses dialysis after extensive teaching, fully understanding the consequences.

Trap: Treating the refusal as a clinical problem to "fix." **Action:** Verify capacity and understanding. Honor the refusal. Notify the provider. Document the refusal, the teaching, the client's understanding, and the verbatim statement. Offer palliative-care/social-work resources. Autonomy applies to refusing even life-sustaining treatment.

3. The suspected elder abuse caller.

An older client whispers, "My son hits me when I forget things." Then asks the nurse not to tell anyone "because he's all I have."

Trap: Keeping the confidence to honor the client's wishes. **Action:** Nurses are mandated reporters of suspected elder/vulnerable-adult abuse. Reasonable suspicion triggers the duty regardless of client wishes. Maintain therapeutic communication, ensure safety, document objectively, and report per state law.

4. The mandatory reporting of a communicable disease.

A client tests positive for active tuberculosis and asks the nurse not to "tell anyone."

Trap: Promising confidentiality. **Action:** Maintain isolation, explain that public-health reporting is required by law (does not require client permission), engage the local health department, and use therapeutic communication to support the client.

5. The client who wants their chart "fixed."

A client asks the nurse to "delete the part about my drinking" from the chart.

Trap: Altering the record to please the client. **Action:** Decline. The chart is a legal document. The client has a right to request an amendment per HIPAA. The nurse provides information about the formal amendment process and contacts health-information management. Never alter or backdate.

§ 14 · End-of-day quick review

10 ONE-LINE MUST-REMEMBERS

1. ABC > safety > comfort > psychosocial.
2. Unstable beats stable. Acute beats chronic. Actual beats potential. Unexpected beats expected.
3. RN owns assessment, planning, teaching, evaluation, first dose, blood, IV push, and any unstable client.
4. UAP do tasks on stable clients with predictable outcomes — never judgment.
5. Nurse witnesses consent; provider obtains it. "I don't understand" = stop.
6. A valid advance directive outranks family preferences.
7. HIPAA = minimum necessary, no social media, no public-place report.
8. Incident reports never appear in the chart.
9. Suspected abuse, reportable diseases, and certain injuries are mandatory reports.
10. Escalate via chain of command: charge → provider → RRT/code → supervisor → risk/ethics.

5 COMMON NCLEX TRAPS

1. Answers that pick a comfort/psychosocial action over an ABC problem.
2. Answers that delegate assessment or teaching to UAP or LPN/VN.
3. Answers that have the nurse re-explain a procedure the client doesn't understand (scope violation).
4. Answers that override a documented advance directive because "the family is upset."
5. Answers that say "document 'incident report filed'" in the medical record.

5 "NEVER DO THIS" RULES

1. Never give a verbal report in a public hallway, elevator, or cafeteria.
2. Never witness consent when the client says they don't understand.
3. Never override a valid DNR or advance directive because of family insistence.
4. Never reference an incident or occurrence report in the legal chart.
5. Never accept an unsafe assignment without speaking up via chain of command.

5 SAFETY-FIRST PHRASES TO RECOGNIZE

1. "I'll stay with the client while..."
2. "Let me notify the provider before..."
3. "The client's documented wishes state..."
4. "I need to clarify this order before administering."
5. "Let's step into a private space."

The capstone mantra

Airway. Safety. Comfort. Mind. | Unstable beats stable. Acute beats chronic. Actual beats potential. | The RN thinks; the team does. Provider obtains; the nurse witnesses. | The client decides; the directive controls. | Suspect → report. Document facts. Escalate up the chain.

§ 15 · Capstone infographic summary

Screenshot-ready. Every Management of Care decision frame at a glance.

The Day-15 decision flow

01 Recognize
Scan all clients. Mark the red flags.

→

02 Analyze
Unstable beats stable. Acute beats chronic.

→

03 Prioritize
ABC → safety → comfort → psych.

→

04 Generate
Match resource to problem.

→

05 Act
SBAR. Delegate down. Escalate up.

→

06 Evaluate
Did the cue improve? Did harm occur?

PRIORITIZATION FRAME

- ABC first, always.
- Maslow as the tiebreaker.
- Unstable > stable.
- Acute > chronic.
- Actual > potential.
- Unexpected > expected.

DELEGATION FRAME

- RN: assessment, teaching, evaluation, unstable, first dose, blood, IV push.
- LPN/VN: stable, reinforced teaching, sterile tasks, routine non-push meds.
- UAP: ADLs, vitals/I&O on stable, ambulation of stable, weights.
- 5 rights: task · circumstance · person · direction · supervision.

CONSENT & DIRECTIVE FRAME

- Provider obtains consent.
- Nurse witnesses signature + understanding.
- "I don't understand" → stop, call provider.
- Capacity > AD > agent > default surrogate.
- Family wishes never override a valid AD.

CONFIDENTIALITY FRAME

- Minimum necessary.
- No social media identifiers.
- No public-place report.
- Disclose to family only with client permission.
- Photos require consent and clinical purpose.

LEGAL/ETHICAL FRAME

- Suspected abuse → report.
- Reportable diseases → report.
- Impairment → remove + escalate + document.
- Incident report ≠ chart.
- Document facts, time, quotes, actions, notifications.

ESCALATION FRAME

- Stay with the client.
- Charge nurse → provider.
- RRT for clinical deterioration.
- Code for arrest.
- Supervisor → risk → ethics.
- Skip steps only when life is in immediate danger.

WHO TO CALL

- Pharmacist → med safety, compatibility.
- RT → oxygen, suction, ABG.
- SLP → swallow safety.

DOCUMENTATION RULES

- Approved terminology only.
- Objective + factual.
- Time-stamped + signed.
- Direct quotes when relevant.

QI & SAFETY

- Near misses → still reportable.
- Sentinel events → mandatory review.
- Root-cause analysis = system, not blame.

- PT/OT → mobility, ADL.
- Dietitian → nutrition, tube feeds.
- Social work → resources, family.
- Case management → discharge, DME.
- Palliative → goals of care.
- Chaplain → spiritual support.
- Ethics → unresolved ethical conflict.

- Never opinions, blame, labels.
- Never "incident report filed."
- Refusal → document teach, refuse, notify.

- Evidence-based practice = standard.
- Cost-effective ≠ withhold safety.

The Day-15 capstone mantra

Recognize the cue. Analyze the trend. Prioritize the unstable. Generate the right solution. Take the safest action. Evaluate the outcome. Document the facts.

◆ ◆ ◆

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