2026 NCLEX-RN • Management of Care

Day 2 — Delegation, Assignment & Supervision

Application-level review built around the NGN Clinical Judgment Measurement Model.

Today's Lesson Map

1. High-Yield Overview

Delegation = transferring *the responsibility for performing a task* to another qualified person while the RN **retains accountability** for the outcome. You can hand off the task, but you can never hand off the responsibility for thinking about the patient.

Assignment = giving a task that is already within someone's licensed scope of practice (e.g., assigning a stable post-op client to an LPN — wound care and meds are *already* within LPN scope).

Supervision = providing direction, evaluating performance, and following up to ensure the task was done safely and correctly.

> 🧠 **The Big NCLEX Picture**
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> On the NGN, delegation questions are really *prioritization-of-safety* questions. The test writers want to know: **Will you protect the most unstable client by keeping the RN-required tasks with you?** If a task involves *assessment, teaching, evaluation, an unstable client, or clinical judgment* — the RN does it. Period.

The 5 Rights of Delegation (memorize the exact order)

1. **Right Task** — Is this task delegable at all? (Routine, repetitive, with predictable outcomes = usually yes.)
2. **Right Circumstance** — Is the client *stable*? Is the setting appropriate? Has the client's status changed in the last hour?
3. **Right Person** — Does *this specific staff member* have the license, training, and competency? (Just because a UAP "usually" does vital signs doesn't mean this UAP knows how to take an apical pulse.)
4. **Right Direction / Communication** — Clear, concise, specific. ("Take vital signs every 2 hours on Mr. Lee and report a temperature above 38.5 °C to me immediately.") Never vague.
5. **Right Supervision / Evaluation** — Follow up. Did the task get done? Was it done correctly? Did the patient respond as expected?

The RN's Non-Delegable Core (the "A-PIE-T" rule)

The RN keeps anything that requires **nursing judgment**:

- **A**ssessment — *initial* assessment, admission assessment, any focused assessment of a change in condition
- **P**lanning — care plan, nursing diagnoses, goal setting
- **I**nterpretation / Implementation of complex care — IV push meds, blood products, titrating drips, first dose of a new med, triage
- **E**valuation — outcomes, response to therapy, effectiveness of teaching
- **T**eaching — initial education, discharge teaching, anything involving new content

2. Ten Must-Know Rules for NCLEX

1. **The RN keeps accountability.** Delegating a task does not delegate the responsibility for the patient's outcome.
2. **Unstable client = RN only.** If the client is unstable, newly admitted, post-op < 4 hr, returning from a procedure, or has had a recent status change — do not delegate.
3. **The nursing process is non-delegable.** Assessment, planning, evaluation, and teaching stay with the RN.
4. **UAPs do routine, predictable, stable-client tasks only.** ADLs, ambulation of stable clients, vital signs on stable clients, intake & output, weights, simple specimen collection, positioning, oral care.
5. **LPN/VN tasks involve *standard, predictable* care.** Reinforce (not initiate) teaching, sterile dressing changes, urinary catheter insertion, NG tube insertion/feeding, oral / IM / SQ meds, monitoring of stable clients. LPN scope *varies by state* — on NCLEX, follow the most conservative interpretation.
6. **Never delegate the first time.** First dose, first ambulation post-op, first feed, first time using a new device — the RN performs and assesses.
7. **Clarify, don't assume.** If a UAP says "I've never done that" — STOP. Right person fails.
8. **Five Rights, in order.** Right Task → Right Circumstance → Right Person → Right Direction → Right Supervision / Evaluation.
9. **Supervision is not optional.** "I delegated and assumed it was done" is a failure of the 5th right and is a documentation/legal risk.
10. **When in doubt, do it yourself or call the charge nurse.** NCLEX will never penalize the answer that keeps the patient safer — but it *will* penalize you for delegating outside scope.

3. RN Safety Decision Table

Situation	Best RN Action	Why It's Safest	Common NCLEX Trap
UAP reports a new finding (e.g., "Mr. Lee's BP is 88/52").	The **RN** goes to assess the client personally. Do not delegate the re-check.	A change in condition requires *nursing judgment*; assessment is non-delegable.	Choosing "tell the UAP to recheck in 15 minutes" — delegates assessment to UAP.
New admission arrives at the same time as another client needs pre-op teaching.	RN performs the **admission assessment** first; reinforce-only teaching can be assigned to LPN.	Initial assessment is RN-only and time-sensitive; teaching can be reinforced once started.	"Ask LPN to do the admission assessment" — outside LPN scope.
UAP states "I don't feel comfortable doing this."	Stop, do not insist. The RN performs the task or finds qualified staff.	Right Person includes *self-reported competency*. Forcing it is unsafe and legally indefensible.	"Reassure the UAP and tell them to try" — ignores Right Person.
LPN asks if they can give the first dose of IV vancomycin.	RN gives all IV push meds and first doses; LPN scope for IV meds varies by state — default to *no* on NCLEX for first dose & IV push.	First dose = potential first reaction = needs RN judgment.	"Yes, because vancomycin is a routine antibiotic" — ignores first-dose rule.
UAP is given vitals on a post-op client 1 hour after surgery.	RN takes the post-op vitals (immediate post-op = unstable).	"Stable" is the keyword for UAP vital signs; post-op < 4 hr is unstable by default.	"Have UAP take vitals q15min" — ignores instability of fresh post-op.
Charge nurse offers to delegate restraint application	RN must assess the need, get the order, and evaluate alternatives. UAP	The *decision* to restrain is a nursing judgment; *application* can	"UAP can apply restraints because they know how" —

Situation	Best RN Action	Why It's Safest	Common NCLEX Trap
to UAP.	may *help* apply once decision is made.	be assisted by UAP.	confuses physical task with the decision.
LPN reports they "forgot to chart" the dressing change from 4 hours ago.	Have LPN chart now using a **late entry** with current date/time and the actual time of the event.	Documentation must be accurate; late entries are legal & required, retroactive timestamps are fraud.	"Tell LPN to chart it as if it were done at the actual time" — falsification.
UAP is asked to "watch" a client with new chest pain while the RN gets the EKG machine.	RN stays with the unstable client; delegate the *errand* (get the machine, call provider) to UAP.	Unstable clients are not "watched" by UAPs — they are assessed by RNs.	"UAP watches while RN gets supplies" — flips the priority.
You are floated to a unit you've never worked on; charge nurse assigns you the sickest client.	Notify charge nurse / nursing supervisor; request a safe assignment matching your competency.	Accepting an unsafe assignment exposes the client and your license.	"Refuse and walk off the unit" — patient abandonment.
UAP asks the RN to "verify a med" before giving it.	RN does *not* verify — UAPs do not give meds. Redirect: only licensed staff give medications.	UAPs are outside med-administration scope.	"RN double-checks and lets UAP give it" — outside UAP scope, even with verification.

4. Delegation / Scope Table

Task	RN	LPN/VN	UAP	Can RN delegate?	Why / Why not
Admission assessment of new client	✅	❌	❌	❌ No	Initial assessment requires RN judgment.
Vital signs on a *stable* client	✅	✅	✅	✅ Yes — to UAP or LPN	Routine, predictable, stable client.
Vital signs on post-op (< 4 hr) client	✅	⚠️ With caution	❌	❌ Not to UAP	Unstable / fresh post-op needs licensed assessment.
Reinforce teaching about a low-sodium diet	✅	✅	❌	✅ Yes — to LPN	RN initiates; LPN reinforces.
Initial discharge teaching	✅	❌	❌	❌ No	Teaching is RN-only when initial / new content.
Sterile dressing change (stable client)	✅	✅	❌	✅ Yes — to LPN	Standardized procedure within LPN scope.
Wound care for complex/new wound	✅	⚠️	❌	❌ No (initial)	Complex wound = assessment + judgment.
Urinary catheter insertion	✅	✅	❌	✅ Yes — to LPN	Within LPN sterile procedure scope.
Catheter care / perineal care / emptying bag	✅	✅	✅	✅ Yes — to UAP or LPN	Routine hygiene + I&O.
NG tube insertion	✅	✅	❌	✅ Yes — to LPN	Within LPN scope after RN verifies placement plan.
NG/PEG tube feeding (already established)	✅	✅	❌	✅ Yes — to LPN	Established, ongoing, predictable.

Task	RN	LPN/VN	UAP	Can RN delegate?	Why / Why not
Oral, IM, SQ medications (stable client)	✅	✅	❌	✅ Yes — to LPN	Within LPN med-admin scope (state-dependent).
IV push medications	✅	❌ (default on NCLEX)	❌	❌ No	High risk; RN scope.
Blood product administration	✅	❌	❌	❌ No	Verification + reaction monitoring = RN only.
Titrating IV drips (insulin, heparin, vasopressors)	✅	❌	❌	❌ No	Requires ongoing assessment & judgment.
Suctioning (oropharyngeal, established trach)	✅	✅	❌	✅ Yes — to LPN	Within LPN scope for established airway.
Suctioning a *new* trach	✅	❌	❌	❌ No	New / unstable airway needs RN.
Bathing, feeding, ambulating *stable* client	✅	✅	✅	✅ Yes — to UAP	Routine ADLs.
Feeding a client with new dysphagia/stroke	✅	⚠️	❌	❌ Not to UAP (initial)	Aspiration risk needs swallow assessment.
Intake & output measurement and recording	✅	✅	✅	✅ Yes — to UAP	Routine measurement.
Daily weights	✅	✅	✅	✅ Yes — to UAP	Routine; RN interprets the trend.
Bedside glucose monitoring	✅	✅	✅ (if trained & per policy)	⚠️ Sometimes — to UAP per facility policy	Many facilities allow UAP; RN interprets & acts.
Simple specimen collection (urine, stool)	✅	✅	✅	✅ Yes — to UAP	Routine collection.
Receiving verbal / telephone orders	✅	⚠️ Limited	❌	❌ No (RN)	Requires read-back & clinical judgment.
Triage (ED, telephone, disaster)	✅	❌	❌	❌ No	Acuity decisions = RN judgment.
Care planning / nursing diagnoses	✅	❌ (contributes)	❌	❌ No	Planning = nursing process = RN.
Evaluation of client response / outcomes	✅	❌	❌	❌ No	Evaluation = nursing process = RN.

🧭 **Quick mental filter**

Ask three questions in order:
① *Is the client stable?* If no → RN.
② *Is the task routine and predictable?* If no → RN.
③ *Does it require nursing judgment, teaching, or evaluation?* If yes → RN.

5. Red-Flag Cues

🚨 Immediate Assessment by RN (don't delegate)

- UAP reports new chest pain, SOB, change in LOC, syncope, or sudden weakness.
- LPN reports a BP drop > 20 mmHg or new tachycardia > 120 bpm.
- UAP reports "the patient looks different" — vague is a red flag.
- Sudden change in mental status, agitation, or confusion in any client.
- Drop in O_2 sat > 4% from baseline or below 90%.
- New onset of bleeding, large emesis, or melena.

📞 Provider Notification

- Critical lab value (e.g., K+ < 3.0 or > 5.5, glucose < 70 or > 400, INR > 4 on warfarin).
- Sustained vital sign change (T > 38.3 °C, HR > 120 or < 50, RR < 10 or > 28, SBP < 90).
- Suspected medication error or adverse drug reaction.
- Unsafe or unclear order discovered during med reconciliation.
- Client refusal of a critical treatment after informed discussion.

⚡ Rapid Response Team

- Acute change in respiratory status (RR > 30 or < 8, new SpO_2 < 90% on O_2).
- Acute change in cardiovascular status (SBP < 90, HR < 40 or > 130, new chest pain).
- Acute change in neuro status (sudden confusion, GCS drop ≥ 2, new seizure, focal weakness).
- Staff member "just worried" — gestalt counts; activate.

🪜 Chain of Command

- Provider has not returned a page after the second attempt for a deteriorating client → charge nurse → nursing supervisor → medical director.
- Order appears unsafe and provider refuses to clarify or change it.
- Staffing assignment is unsafe (e.g., 1:8 on a step-down unit, floated without orientation).
- Suspected impaired colleague.
- Ethical concern (e.g., family pushing CPR on a DNR client).

🗒️ Mandatory Reporting (state-dependent but expect on NCLEX)

- Suspected child, elder, or dependent adult abuse / neglect.
- Communicable diseases per state list (TB, measles, pertussis, HIV/AIDS, hepatitis, STIs, COVID-19, meningococcal).
- Gunshot, stab, or suspicious injury.
- Impaired or unsafe practice by a licensed colleague (state board of nursing).

⏸️ Hold Delegation & Reassess

- UAP reports a sudden change in the client's condition — do not delegate further until you've assessed.
- Staff member says "I haven't been trained on this."
- You realize the client became unstable since the original assignment.
- The task now involves a first-dose med, blood, or new device.
- You're called away — reassign or take the task back; never assume.

6. Ten Advanced NGN Practice Questions

Q1 Multiple Choice Prioritize Hypotheses

The RN is making assignments for a 12-hour shift on a medical-surgical unit. Which client is **most appropriate** to assign to the LPN/VN?

A. A 68-year-old admitted 30 minutes ago with new-onset atrial fibrillation, awaiting cardiology consult.
B. A 54-year-old day-2 post-op cholecystectomy with a stable abdominal dressing and oral pain medications scheduled.
C. A 72-year-old receiving the first unit of packed red blood cells.
D. A 45-year-old with new diabetes mellitus type 2 requiring initial insulin teaching before discharge.

Correct: B. Stable, predictable, day-2 post-op with routine wound care and oral meds = within LPN scope.

A is wrong: New admission with new-onset arrhythmia = unstable + initial assessment = RN.

C is wrong: Blood administration is RN-only (verification + reaction monitoring).

D is wrong: *Initial* teaching is RN-only; LPN reinforces.

Trap tested: Equating "stable" with "any post-op." Always check stability + complexity.

CJ step: Prioritize Hypotheses — matching client acuity to staff scope.

Q2 SATA Generate Solutions

The RN is delegating to a UAP. Which tasks are **appropriate to delegate**? Select all that apply.

A. Measure and record intake and output for a stable client with heart failure.
B. Assist a 24-hour post-op client with a shower.
C. Reinforce teaching about the use of an incentive spirometer.
D. Take vital signs on a client one hour after returning from the OR.
E. Empty a Foley catheter drainage bag and record the output.
F. Feed a client recovering from a stroke who had a swallow study yesterday showing aspiration risk.
G. Apply antiembolism stockings on a stable post-op client.

Correct: A, B, E, G. All routine, predictable, on stable clients.

C is wrong: Reinforcing teaching is LPN scope, not UAP.

D is wrong: Fresh post-op (< 4 hr) = unstable; vitals stay with licensed staff.

F is wrong: Aspiration-risk client needs licensed feeder until cleared.

Trap tested: "Routine" tasks become non-delegable when the client is unstable or high-risk.

CJ step: Generate Solutions — selecting appropriate interventions/staff matches.

Q3 Drop-Down / Cloze Take Action

Complete the sentence by selecting the most appropriate options:

"The nurse should delegate **[A]** to the UAP and **[B]** to the LPN, while the RN personally performs **[C]**."

Blank	Options	Correct
A (UAP)	① Assessing a new admission ② Bathing a stable client ③ Reinforcing diet teaching ④ Giving an oral med	② Bathing a stable client
B (LPN)	① IV push furosemide ② Sterile dressing change on stable client ③ First-dose IV antibiotic ④ Blood transfusion	② Sterile dressing change on stable client
C (RN)	① Daily weights ② Empty Foley bag ③ Initial discharge teaching ④ Assist with shower	③ Initial discharge teaching

Logic: Routine ADL → UAP; standardized sterile procedure on stable client → LPN; initial teaching → RN.

Trap tested: Mixing "initial" vs. "reinforce" — only RN does *initial*.

CJ step: Take Action — matching the right intervention to the right provider.

Q4 Ordered Response Take Action

The RN is preparing to delegate a task. Place the following actions in the correct order using the 5 Rights of Delegation:

A. Confirm the staff member has the competency and license for the task.
B. Decide whether the task is appropriate to delegate at all.
C. Follow up to ensure the task was completed correctly.
D. Determine that the client is stable and the circumstances allow delegation.
E. Provide clear, specific instructions including what to report back.

Correct order: B → D → A → E → C.

Right Task (B) → Right Circumstance (D) → Right Person (A) → Right Direction/Communication (E) → Right Supervision/Evaluation (C).

Trap tested: Jumping to "Right Person" without confirming the task and circumstance first.

CJ step: Take Action in the structured order of delegation.

Q5 Matrix / Grid Analyze Cues

For each task, mark whether it is **appropriate** or **inappropriate** to delegate to the UAP.

Task	Appropriate	Inappropriate
1. Ambulate a stable client recovering from pneumonia.	✅	
2. Take blood glucose before breakfast on a stable diabetic.	✅ (per policy)	
3. Reposition a client with a Stage 2 pressure injury.	✅	
4. Discontinue a peripheral IV line that has infiltrated.		❌
5. Assess pain level using a numeric scale and report to RN.		❌
6. Provide perineal care to an incontinent client.	✅	
7. Feed a client with a recent NG tube placement.		❌
8. Take vital signs on a client 1 hour post-blood transfusion start.		❌

4. Removing an IV is a clinical decision and requires licensed staff.
5. Pain *assessment* is nursing judgment — UAPs can report what a client says, but they don't "assess." NCLEX often uses the word "assess" to disqualify the UAP.
7. New NG tube → not yet predictable; placement verification + risk = RN.
8. Blood transfusion monitoring is RN-only throughout.

Trap tested: The verb "assess" in any answer choice should make you pause when UAP is involved.

CJ step: Analyze Cues — interpreting which tasks require licensed judgment.

Q6 Prioritization Prioritize Hypotheses

The RN receives report on four clients. Which client should the RN see **first**?

A. A 60-year-old with COPD whose SpO_2 has dropped from 94% to 88% on 2 L nasal cannula in the last 30 minutes.
B. A 45-year-old post-op day 1 who is requesting pain medication.
C. A 72-year-old with stable heart failure who needs morning daily weight recorded.
D. A 30-year-old being discharged who needs the discharge paperwork reviewed.

Correct: A. ABCs — airway/breathing first. A 6-point drop in SpO_2 with COPD is an unstable change in respiratory status.

B: Important, but pain is not immediately life-threatening; LPN can administer if scheduled.

C: Routine; can be delegated to UAP.

D: Time-sensitive but not acute; complete after A is stabilized.

Trap tested: Choosing "discharge" because it feels urgent — discharge is never the answer when oxygenation is failing.

CJ step: Prioritize Hypotheses using ABCs + unstable vs. stable.

Q7 Delegation Scenario Evaluate Outcomes

The RN delegated 1700 vital signs to a UAP. At 1745, the UAP has not yet documented vitals on three of the assigned clients. The RN's **best action** is to:

A. Document an incident report and continue with rounds.

B. Speak privately with the UAP about time management and ensure the vitals are obtained now.

C. Report the UAP to the nursing supervisor immediately.

D. Take the vital signs personally and confront the UAP in the hallway.

Correct: B. The 5th Right (Supervision/Evaluation) requires follow-up. Private, professional communication addresses both the immediate patient-safety issue (get the vitals now) and the systemic issue (time management coaching).

A: Incident reports are for client harm, not first-time staff performance issues.

C: Escalation should be progressive; first attempt direct coaching.

D: Public confrontation violates professional communication standards.

Trap tested: "Just do it yourself" — robs the UAP of growth and abandons the supervision rule.

CJ step: Evaluate Outcomes of delegation and intervene appropriately.

Q8 Handoff / SBAR Take Action

The off-going RN is giving handoff to the oncoming RN. Which element is **most critical** to include in the "Background" portion of SBAR for a client receiving a heparin drip?

A. The client's favorite breakfast preference.

B. The current heparin infusion rate, last aPTT result, and time of last titration.

C. The phone number of the client's daughter.

D. The hospital's policy on heparin protocols.

Correct: B. Background should include relevant history and treatments tied to current safety — for a high-alert med drip, the rate, last lab, and titration time are essential.

A & C: Useful but not safety-critical handoff content.

D: Policies belong to the unit, not the patient handoff.

Trap tested: Confusing "nice to know" with "must know" in SBAR.

CJ step: Take Action — structured, safety-focused communication.

Q9 Bow-Tie Generate Solutions + Take Action

A 75-year-old client with new confusion and an SpO_2 of 89% is becoming agitated and trying to pull out the IV. The RN must decide what to do *and* what to delegate.

Actions to Take (RN performs)	Priority Condition	Actions to Delegate / Assign
① Assess airway, breathing, mental status ② Reposition for airway and apply O_2 per protocol ③ Notify provider / call rapid response	**Hypoxia with acute change in mental status**	① UAP: stay with client, ensure safety, do not leave bedside ② LPN: gather supplies, bring vitals machine, place call to provider

Logic: RN owns assessment + immediate intervention + escalation. UAP provides physical presence (safety/sitter role). LPN supports with predictable tasks.

Trap tested: Delegating the bedside "watching" of an unstable client to UAP alone without RN assessment first.

CJ step: Generate Solutions + Take Action simultaneously while preserving RN judgment.

Q10 Case-Study Style / SATA Recognize + Analyze Cues

A UAP tells the RN, "I just took Mrs. Chen's vital signs and her BP is 88/54 — she said she felt a little dizzy when she sat up." Which actions are **appropriate** for the RN? Select all that apply.

A. Tell the UAP to recheck the BP in 30 minutes.
B. Personally assess Mrs. Chen, including a focused cardiovascular and neuro exam.
C. Review recent medications (e.g., antihypertensives, opioids, diuretics).
D. Have the UAP help the client to the bathroom now to "see if she can walk."
E. Notify the provider with the changed vital signs and findings.
F. Place the client in semi-Fowler's or supine and ensure call light is in reach.
G. Document the UAP's findings and the RN's assessment and notification.

Correct: B, C, E, F, G.

A: Delegates assessment back to UAP; ignores the change in condition.

D: Adds fall risk during hypotension — dangerous.

Trap tested: "Recheck in X minutes" is almost always wrong when a UAP reports a new abnormal finding — the RN goes *now*.

CJ step: Recognize Cues (low BP + dizziness) and Analyze Cues (orthostatic vs. true hypotension vs. drug effect).

7. Unfolding NGN Case Study

Nurse's Notes — 0700

Mr. James Carter, 68 years old, admitted yesterday for community-acquired pneumonia. Reports increased SOB this morning. Alert and oriented ×3. Productive cough with thick yellow sputum. Receiving IV ceftriaxone q24h, scheduled for the second dose at 0900. Foley catheter in place since admission. Ambulated 25 ft yesterday with PT. Lives alone, daughter is health care proxy.

Vital Signs — 0700

Parameter	Value
Temperature	38.6 °C (101.5 °F)
Heart Rate	112 bpm, regular
Respiratory Rate	26/min, labored
Blood Pressure	102/64 mmHg
SpO_2	89% on 2 L NC (was 94% at midnight)
Pain	4/10 chest, with cough

Provider Orders

- Ceftriaxone 1 g IV q24h
- Acetaminophen 650 mg PO q6h PRN T > 38 °C
- O_2 to maintain $SpO_2 \geq 92\%$
- Incentive spirometer q1h while awake
- Vital signs q4h
- Daily weight
- Out of bed with assistance TID
- Sputum culture & sensitivity (pending result)

Lab Data — 0600

Test	Result	Reference
WBC	16.4 $\times 10^9$/L	4.5–11.0
Lactate	2.4 mmol/L	< 2.0
BUN	28 mg/dL	7–20
Creatinine	1.3 mg/dL	0.6–1.2
Procalcitonin	0.8 ng/mL	< 0.5

Daughter's Statement (0715, by phone)

"He sounded weak this morning. He doesn't usually breathe that hard. Can you check him? And please don't transfer him without telling me — I'm his health care proxy."

Team Notes

Charge nurse: Two RNs out sick; today's RN/client ratio is 1:6. UAP and one LPN available.
Respiratory therapist: "I'll be free in 20 minutes if you need me."
PT: "Plan to ambulate at 1000 if stable."

Case-Based Questions

Case Q1 Recognize Cues — SATA

Which findings should the RN recognize as **cues of clinical deterioration**? Select all that apply.

A. SpO_2 dropped from 94% to 89%
B. RR 26 with labored breathing
C. HR 112 with fever 38.6 °C
D. Foley catheter in place
E. BUN 28, Creatinine 1.3, Lactate 2.4
F. Daughter is health care proxy
G. Ambulated 25 ft yesterday

Correct: A, B, C, E. These are the cues consistent with sepsis (q-SOFA: RR ≥ 22, altered LOC, SBP ≤ 100) and worsening pneumonia. Lactate > 2 + signs of organ stress = early sepsis red flag.

D, F, G: Background facts, not cues of deterioration.

CJ step: Recognize Cues.

Case Q2 Analyze Cues — Multiple Choice

Based on the data, the RN suspects the client is most likely experiencing:

A. Pulmonary embolism
B. Early sepsis from pneumonia
C. Acute kidney injury alone
D. Anxiety with hyperventilation

Correct: B. Source (pneumonia) + 2 SIRS criteria (T > 38, HR > 90, RR > 22, WBC > 12) + rising lactate + worsening O_2 = early sepsis.

A: Possible but no calf swelling, no sudden onset described; PE less likely as primary.

C: Renal labs mildly elevated, but kidneys are likely a *consequence*, not the source.

D: SpO_2 would not drop with pure anxiety.

CJ step: Analyze Cues — connecting data into a pattern.

Case Q3 Prioritize Hypotheses — Ordered Response

Place the RN's actions in the correct priority order:

A. Notify the provider with SBAR.
B. Increase oxygen to maintain $SpO_2 \geq 92\%$ per order.
C. Reassess full set of vitals, lung sounds, and mental status.
D. Call respiratory therapy.
E. Update the daughter (health care proxy).

Correct order: C → B → A → D → E.

Reassess (Recognize/Analyze) → titrate O_2 (immediate Airway/Breathing intervention within standing order) → notify provider (escalate) → involve RT (collaborate) → update proxy (advocacy/communication).

Trap tested: Calling the provider before doing your own assessment — you'll have no SBAR data to give.

CJ step: Prioritize Hypotheses.

Case Q4 Generate Solutions — SATA (Delegation)

While managing this client, what can the RN appropriately delegate? Select all that apply.

A. Assign the UAP to obtain a repeat blood glucose, set up the pulse oximeter, and stay with the client.
B. Assign the LPN to administer the scheduled IV ceftriaxone at 0900.
C. Have the UAP perform incentive spirometer coaching for the first time.
D. Ask the LPN to call the provider with the SBAR.
E. Ask the UAP to bring a portable vitals machine and notify the RN of any new readings.
F. Have the LPN reinforce previously taught coughing/deep-breathing techniques.
G. Delegate the initial sepsis assessment to the LPN.

Correct: A, B, E, F.

C: *First-time* IS coaching = teaching = RN.

D: Provider notification with SBAR for an unstable client = RN (you own the data and judgment).

G: *Initial* assessment of a deteriorating client = RN.

Trap tested: Confusing IV antibiotic *scheduled* dose (LPN may give per state/policy) with *first dose* (RN).

CJ step: Generate Solutions while preserving scope.

Case Q5 Take Action — Drop-Down SBAR

Complete the SBAR the RN will give to the provider:

Section	Best content
Situation	"Dr. Patel, this is RN Lee on 5-East. I'm calling about Mr. Carter in Room 512 — he's deteriorating: HR 112, RR 26, SpO_2 89% on 2 L."
Background	"68-year-old, admitted yesterday with community-acquired pneumonia, on ceftriaxone. SpO_2 was 94% at midnight."
Assessment	"I suspect early sepsis. WBC 16.4, lactate 2.4, procalcitonin 0.8, fever 38.6, labored breathing, BP trending down at 102/64."
Recommendation	"Requesting evaluation now. Can we get a blood culture × 2, lactate recheck in 2 hours, IV fluid bolus, possible ICU consult, and confirm sepsis bundle orders?"

Logic: SBAR for deterioration always ends with a concrete *recommendation* — don't leave the provider to figure out what you want.

Trap tested: Ending with "What do you want me to do?" — passive escalation.

CJ step: Take Action through structured communication.

Case Q6 Evaluate Outcomes — Matrix

Two hours after interventions (O_2 to 4 L, 30 mL/kg IV bolus, blood cultures × 2, lactate recheck ordered), which findings indicate **improvement**, **no change**, or **worsening**?

Finding	Improvement	No change	Worsening
SpO_2 now 95% on 4 L	✅		
HR now 96	✅		
BP now 90/56			❌
Lactate now 3.1 mmol/L			❌
RR 22, less labored	✅		
Mental status: now drowsy, slow to respond			❌

Mixed picture with three worsening markers (BP, lactate, LOC) = septic shock evolution. Escalate again: rapid response / ICU. The respiratory numbers improved because of supplemental O_2, but the perfusion picture is worsening.

Trap tested: Stopping at "SpO_2 improved" and missing the BP and LOC trends.

CJ step: Evaluate Outcomes — look at *all* systems, not just the one you fixed.

8. "What Should the Nurse Do First?" — Five Mini-Scenarios

Scenario 1

The RN has four clients. The UAP reports that the client in Room 4 "looks really pale and is breathing fast." The client in Room 1 needs their PRN pain med. The client in Room 2 needs to be ambulated. The client in Room 3 needs discharge teaching.

> **First:** Go to Room 4 personally. A change in respiratory status + pallor reported by a UAP is a red flag — assess airway/breathing first. Then delegate or defer the others.

Scenario 2

You receive shift report. Client A is post-op day 2 with mild pain, Client B is a new admission with chest pain, Client C has scheduled morning insulin and a blood glucose of 280, Client D is awaiting discharge.

> **First:** Go to Client B. New admission + chest pain = unstable + initial assessment = ABCs + RN-only. Insulin can be handled within the hour; pain and discharge can wait minutes.

Scenario 3

The LPN tells the RN: "I just hung the next bag of normal saline on Mrs. Lopez and she immediately started complaining of itching and chills." The IV antibiotic was infusing piggyback.

> **First:** Go to the client and *stop the infusion*. New itching + chills during an antibiotic = possible transfusion-like / hypersensitivity reaction. RN performs the assessment and intervention; LPN cannot independently manage a reaction.

Scenario 4

The UAP says, "I tried to take Mr. Park's BP three times and the machine kept saying 70/40, but he says he feels fine."

> **First:** Go to the bedside and manually re-check the BP. Confirm with a different cuff/arm, palpate pulses, assess LOC. Believe the data until proven artifact; treat as hypotension until ruled out.

Scenario 5

You walk into the med room and find a coworker pocketing a tablet of oxycodone after wasting "half" of it. They smile and say, "Don't worry about it."

> **First:** Do not confront publicly. Secure the medication if possible, document objectively, and report immediately to the charge nurse / nursing supervisor per facility policy. This is a mandatory report to the BON. Patient safety + license protection require escalation through chain of command.

9. "Can This Be Delegated?" — Five Mini-Scenarios

Scenario 1

A stable client with chronic heart failure needs daily weights, intake & output, and morning vital signs.

> ✅ **Delegate to UAP.** Routine, predictable, stable client. RN interprets the trend.

Scenario 2

A client admitted 6 hours ago with diabetic ketoacidosis is on an insulin drip with hourly glucose checks.

❌ **RN keeps.** Insulin drip = titration = ongoing assessment + clinical judgment. Glucose checks may be assisted, but interpretation and titration are RN.

Scenario 3

An alert, oriented client returning to the unit from PACU 5 hours ago, vital signs stable for 3 consecutive readings, needs a sterile dressing change.

✅ **Delegate to LPN.** Stable client past the immediate post-op window + standardized sterile procedure = LPN scope.

Scenario 4

A newly diagnosed Type 1 diabetic is going home tomorrow and needs to learn how to draw up insulin and self-inject.

❌ **RN keeps.** Initial teaching = RN. LPN can *reinforce* later; UAP cannot teach.

Scenario 5

A client on droplet precautions for influenza needs assistance ambulating to the bathroom.

✅ **Delegate to UAP** with clear direction on PPE (mask, eye protection per policy) and reporting any change in respiratory status. RN remains responsible for ensuring the UAP is competent in isolation procedures.

10. "Who Should the Nurse Contact?" — Five Mini-Scenarios

Scenario 1

A client newly diagnosed with stroke is having difficulty swallowing and is at risk for aspiration.

Contact: Speech-Language Pathologist (SLP) for a swallow evaluation. Also notify the provider for orders; hold PO intake meanwhile.

Scenario 2

A client being discharged on home oxygen lives in a third-floor walk-up apartment with no elevator and limited finances for equipment.

Contact: Case Manager / Social Worker to coordinate durable medical equipment (DME), home oxygen vendor, financial resources, and possibly home health.

Scenario 3

A client receiving warfarin has an INR of 5.2 and the provider's last order was "monitor INR."

Contact: the provider first (critical lab value requiring a new order — e.g., hold warfarin, consider vitamin K). Also collaborate with the **pharmacist** for dose adjustment.

Scenario 4

A client with a sacral pressure injury is not healing despite standard wound care and good nutrition.

> **Contact: Wound Care Nurse (WOCN)** for a specialty assessment and updated wound care plan. Also collaborate with **dietitian** for protein/calorie optimization.

Scenario 5

A client expresses persistent suicidal ideation after a recent loss and is medically cleared for discharge.

> **Contact: Mental Health / Psychiatric Team** immediately. The client should not be discharged until evaluated. Also involve the **social worker** for safety planning and outpatient resources.

11. Legal / Ethical Trap — Five Scenarios

Scenario 1 — Consent

The surgeon asks the RN to "go get the consent signed" for a procedure the RN has not discussed with the client. The client says, "I'm not sure what they're doing."

> **Trap:** The RN *witnesses* consent and verifies understanding; the **provider obtains** informed consent. If the client doesn't understand, stop and notify the surgeon — the provider must return to explain. Do not have the client sign.

Scenario 2 — Refusal

An alert, oriented adult refuses a blood transfusion that the team feels is life-saving.

> **Trap:** Competent adults have the right to refuse, even when refusal may lead to death. The RN advocates, ensures the client understands consequences, documents, and notifies the provider. *Do not* transfuse over a competent refusal.

Scenario 3 — Confidentiality

The client's adult son calls the unit and asks, "What are my mom's lab results?"

> **Trap:** Do not share without verifying authorization. Even adult children are not automatically authorized. Verify identity, check for documented release of information / proxy, and ask the client (if able) what they want shared. HIPAA violation otherwise.

Scenario 4 — Mandatory Reporting

A 7-year-old comes in with patterned bruising on the back and an explanation that "doesn't match" the injury. The parent insists no one report.

> **Trap:** Suspected child abuse is a *mandatory report* to child protective services regardless of parental consent. The RN does not have to prove abuse — only have reasonable suspicion. Document objectively (size, color, location, parent's exact words).

Scenario 5 — End-of-Life

A client has a documented DNR. The family at the bedside is insisting, "Do everything — start CPR!" when the client becomes pulseless.

> **Trap:** Follow the client's documented wishes. DNR stands. Provide comfort, support the family emotionally, and notify the provider. The family does not override an existing valid DNR. Document the family interaction and the care provided.

12. End-of-Day Quick Review

🔟 One-Line Must-Remember Points

1. RN keeps accountability — always — even after delegating.
2. The nursing process (assessment, planning, evaluation, teaching) is non-delegable.
3. UAP = routine, predictable, stable client tasks (ADLs, vitals on stable, I&O, weights).
4. LPN/VN = reinforces teaching, gives PO/IM/SQ meds, sterile dressings, urinary catheters, NG insertion/feeding on stable clients.
5. Unstable, new admission, fresh post-op, first dose, blood products, IV push, titrations = RN.
6. 5 Rights of Delegation: Task → Circumstance → Person → Direction → Supervision/Evaluation.
7. Right Person includes self-reported competency — "I don't know how" means stop.
8. Supervision means follow-up. Without evaluation, you didn't delegate — you abandoned.
9. If a UAP reports a change in condition, the RN goes to assess *now*.
10. When in doubt, do it yourself or call charge — never delegate outside scope to save time.

⚠️ Five Common NCLEX Traps

1. "Recheck in X minutes" by the UAP — sounds reasonable, almost always wrong when there's a new finding.
2. Treating "stable" as a permanent label — fresh post-op, new admission, or new symptom = unstable.
3. Delegating *initial* teaching, especially discharge teaching — RN only.
4. Assigning the sickest client to the LPN because they "did fine" yesterday — yesterday's status doesn't equal today's.
5. Letting the family override a competent client's expressed wishes or a valid advance directive.

🚫 Five "Never Do This" Rules

1. Never delegate *assessment*, *evaluation*, *planning*, or *initial teaching*.
2. Never delegate IV push meds, blood products, titrating drips, or first doses.
3. Never falsify documentation or backdate entries — use late entries with correct timestamps.
4. Never accept an unsafe assignment silently — escalate through chain of command.
5. Never share PHI without verified authorization, even with close family.

🟢 Five "Safety-First" Phrases to Recognize on NCLEX

1. "*Assess the client first*" — usually correct when there's a change or new finding.
2. "*Notify the provider*" — correct after assessment, before invasive intervention.
3. "*Stop the infusion / hold the medication*" — correct first action for transfusion reaction, infiltration, or sudden allergic symptoms.
4. "*Stay with the client / do not leave*" — correct for unstable, suicidal, seizing, or actively bleeding clients.
5. "*Use chain of command*" — correct for unsafe order, unsafe assignment, or unresolved safety concern.

13. Standalone Infographic Summary

📌 Day 2 — Delegation, Assignment & Supervision at a Glance

The 5 Rights of Delegation

Right Task → Right Circumstance → Right Person → Right Direction/Communication → Right Supervision/Evaluation

🩺 RN Only

- Initial assessment
- Care planning
- Initial teaching & discharge teaching
- Evaluation of outcomes
- Triage
- IV push meds, first doses
- Blood products
- Titrating drips
- Unstable client care
- Verbal/telephone orders

👩‍⚕️ LPN / VN

- Reinforce teaching
- Sterile dressing change (stable)
- Urinary catheter insertion
- NG tube insertion & feeding
- Suction established airway
- PO / IM / SQ meds (stable)
- Monitor stable, chronic clients
- Standard wound care

👷 UAP

- ADLs: bathe, feed, dress, ambulate (stable)
- Vital signs on stable clients
- Intake & output
- Daily weights
- Positioning & turning
- Oral care
- Empty drainage bags
- Simple specimen collection
- BG checks (if trained / per policy)

🚫 Never Delegate

- Initial assessment
- Planning
- Evaluation
- Initial / discharge teaching
- Triage
- First-dose meds
- Blood, IV push, titrations
- Unstable client care

🧠 Mental Filter Before You Delegate

Ask Yourself	If No / If Yes
Is the client stable?	No → RN keeps the task.
Is the task routine & predictable?	No → RN keeps the task.
Does it require nursing judgment, teaching, or evaluation?	Yes → RN keeps the task.
Has the assigned staff demonstrated competency?	No → Re-match or RN performs.
Did you give clear directions and a report-back plan?	No → Don't delegate yet.
Will you follow up & evaluate?	No → You haven't truly delegated.

⬇

🚒 When in Doubt — Escalation Ladder

Assess client → Charge nurse → Nursing supervisor → Provider → Rapid Response → Chain of Command / Medical Director / Ethics

🎯 NCLEX Verb Decoder

If the answer choice says...	Think...
"Assess," "Evaluate," "Plan," "Teach"	RN only — not UAP, usually not LPN for *initial*.
"Reinforce," "Administer routine PO med," "Sterile dressing change"	LPN OK on stable client.

"Bathe," "Ambulate," "Vital signs," "Weigh"	UAP OK if client is stable.
"New," "Initial," "First," "Unstable"	RN keeps.
"Change in condition"	RN goes to bedside now.

End of Day 2. Tomorrow → Day 3: Client Rights, Advocacy, and Refusal of Care.

Built for the 2026 NCLEX-RN Test Plan • Management of Care • NGN Clinical Judgment Measurement Model