2026 NCLEX-RN · SAFE & EFFECTIVE CARE ENVIRONMENT · MANAGEMENT OF CARE

Handoff, SBAR, *Admission, Transfer & Discharge*

06

DAILY ADVANCED REVIEW
NGN CLINICAL JUDGMENT MODEL

WHAT'S INSIDE TODAY

SECTION 01 · FOUNDATION

High-Yield Overview

Handoff, admission, transfer, and discharge are the four *handover points* where most NCLEX safety errors are tested. They share one principle: **the safest RN is the one who closes the loop**. Every time the client moves — from ambulance to ED, ED to floor, floor to ICU, hospital to home — information, accountability, and risk transfer with them. If the receiving nurse cannot say back what is critical, the handoff has not happened.

The 2026 NCLEX-RN test plan lists these activities directly under *Continuity of Care*: "Provide and receive handoff of care (report) on assigned clients," "Perform procedures necessary to safely admit, transfer and/or discharge a client," and "Follow up on unresolved issues regarding client care (e.g., laboratory results, client requests)." NGN questions in this area are almost always testing **whether you can recognize what is missing** — a pending culture, an unverified allergy, an unclarified DNR, a missing teach-back.

> THINK LIKE AN ENTRY-LEVEL RN
>
> The NGN tester is asking: *"Did the nurse hand off the things that change what the next nurse will DO in the next 8 hours?"* Pending results, code status, isolation, allergies, lines/tubes/drains, last pain medication, last assessment of a deteriorating system, and any unresolved concern — those are the items that win the question.

The four handover points

- **Admission** — establish baseline, identify risks, verify identity, allergies, code status, advance directive, medication reconciliation, fall risk, skin, isolation, and orient to the room.
- **Handoff (shift report)** — SBAR / I-PASS, bedside report when possible, structured, two-way, with read-back of critical items.
- **Transfer** — internal (ED→floor, floor→ICU, OR→PACU) or external (acute→rehab, hospital→LTC). Code status, isolation, IVs, infusions, pending labs, and the receiving location must be ready.
- **Discharge** — written instructions, medication reconciliation, prescriptions filled or in hand, follow-up appointments, equipment in place, transportation, teach-back, and a safe destination.

SBAR vs I-PASS — quick anchor

SBAR = Situation · Background · Assessment · Recommendation. The most common NCLEX framework for both nurse-to-nurse handoff AND nurse-to-provider communication of a deteriorating client. **I-PASS** = Illness severity · Patient summary · Action list · Situation awareness/contingency · Synthesis by receiver. The "Synthesis" is the read-back — the NGN tests love this concept under the name "closed-loop communication."

> ANCHOR PHRASE TO MEMORIZE
>
> **"Hand off what changes the next decision."** If a finding will change what the next nurse, the next shift, the receiving unit, or the family DOES next — it goes in the handoff.

SECTION 02 · FOUNDATIONS

10 Must-Know Rules for NCLEX

01 Handoff is a two-way verification, not a monologue

The receiving nurse must read back high-risk information: high-alert drips, pending critical labs, code status, and isolation. If only one nurse is talking, it is not a handoff.

02 Bedside report is the safest standard

Bedside shift report lets both nurses lay eyes on the client, the IV pump, the drains, the dressings, and the armbands. NCLEX rewards bedside report unless privacy or a specific clinical situation forbids it.

03 Never hand off and leave with unresolved critical issues

Pending stat labs, abnormal vitals not yet reported, a deteriorating client, or a held medication — these are NOT "next-shift problems." Resolve or escalate before report.

04 Admission priorities: ABC → ID → Allergies → Code Status → Falls → Baseline

Before ANY routine task on a new admit, the RN confirms airway/breathing/circulation, two identifiers, allergy band, code status, and fall risk. Documentation comes after stabilization, not before.

05 Medication reconciliation happens at every transition

Admission, transfer between units, AND discharge. NCLEX often tests the discharge step: the nurse compares the home list to the discharge prescription list and resolves duplicates or omissions BEFORE the client leaves.

06 Transfer requires a verbal AND a written report

Verbal SBAR + written transfer form + medication administration record (MAR) + active orders + pending studies. Internal transfers also require checking that the receiving room/equipment is ready.

07 Discharge is not complete until teach-back is documented

"Tell me in your own words how you will take this medication" is the NCLEX gold standard. The client demonstrates understanding — the nurse does not just hand them a paper and say "any questions?"

08 AMA discharge requires capacity, education, and signature — not detention

A client with decision-making capacity may leave AMA. The nurse educates about risks, offers prescriptions and follow-up, documents the conversation, and notifies the provider. Restraining the client is false imprisonment.

09 Code status, isolation, and allergies belong on every handoff — every time

These are the three "never-forget" items. If an NGN question lists a handoff that omits one of these, that omission IS the test.

10 Document the handoff, not just the care

Time of report, name of receiving nurse, items reported, and any unresolved issues. NCLEX legal questions hinge on whether the giving nurse can show that the receiving nurse was informed.

SECTION 03 · CLINICAL JUDGMENT

RN Safety Decision Table

SITUATION	BEST RN ACTION	WHY THIS IS SAFEST	COMMON NCLEX TRAP
Off-going nurse hands off a client whose troponin was drawn but	Document pending lab on the handoff, identify who will follow up,	Pending labs are the #1 missed handoff item nationally; a positive	Choosing "wait for the next shift to check" — pending critical labs are

SITUATION	BEST RN ACTION	WHY THIS IS SAFEST	COMMON NCLEX TRAP
not yet resulted.	and verify the receiving nurse acknowledges it.	troponin requires immediate provider notification.	an active responsibility, not a passive one.
New admission arrives from ED with a no-band wristband and verbal allergy report.	Verify identity with two identifiers, place a hospital ID band and an allergy band, and document the allergy and reaction in the EHR.	An allergy that is not banded and charted does not exist to the next provider; a verbal report is not protection.	Choosing "begin the admission assessment" before banding — banding precedes all care.
Client is being transferred to the ICU on a heparin infusion.	Give verbal SBAR with infusion rate, last aPTT, last titration time, MAR, and weight; physically accompany or hand off pump at bedside.	High-alert infusions are a sentinel-event risk; a two-nurse pump verification at transfer prevents misprogramming.	Choosing "fax the orders and send the client" — high-alert drugs require independent double-check at the transfer.
Discharge teaching: client cannot read the discharge instructions.	Use teach-back with verbal instructions in the client's preferred language, involve a qualified medical interpreter, and document the method.	Health literacy and language are safety issues; written-only instructions are inadequate when literacy is limited.	Choosing "have the family member translate" — family interpretation is unsafe and not a substitute for a qualified interpreter.
Client with a DNR is being transferred to a rehab facility.	Send a copy of the signed DNR / advance directive with the transfer paperwork and call report to confirm the receiving facility has it.	Code status does not "transfer" automatically; a DNR not received by the new facility may not be honored.	Choosing "the family will tell rehab" — code status is a clinical document, not a verbal family report.
Postoperative client transferred to floor with a JP drain, Foley, and PCA pump.	At bedside, count and document lines, drains, tubes; verify PCA settings with two nurses; check Foley output; trace each line to its source.	"Trace every line from origin to insertion" prevents tubing misconnections — a JCAHO sentinel-event topic.	Choosing "verify in the chart" — lines must be physically traced, not assumed from documentation.
Client requests to leave AMA before discharge education is complete.	Assess capacity, notify provider, complete focused teaching on red flags, offer prescriptions and follow-up, witness AMA form, document.	Capacity + informed refusal = a legally valid AMA discharge; the nurse's job is to make the refusal as safe as possible.	Choosing "refuse to let the client leave until the provider arrives" — that is false imprisonment.
Receiving nurse interrupts SBAR to take a phone call.	Pause report, do not abandon the room, resume report when the receiving nurse is fully attentive.	Distracted handoff is the most common root cause of missed information in RCA reports.	Choosing "continue and let her catch up later" — interrupted handoff is unsafe handoff.
Discharged client's home oxygen has not arrived from the DME company.	Hold discharge, notify case manager, contact the DME vendor, and notify the provider; do not discharge to an unsafe home environment.	Discharge to a home without ordered equipment is unsafe discharge — a recognized hospital-acquired-condition concern.	Choosing "discharge the client and tell them to call DME" — the RN owns safe discharge until the client leaves.
Off-going nurse realizes a postop blood transfusion order was never completed.	Notify provider, communicate to oncoming nurse with rationale and timing, document the omission and the notification.	Errors and near-misses are escalated and documented in real time, not held for the next shift to "discover."	Choosing "let the next shift start the transfusion without telling them it was missed" — that is concealment, not handoff.

SECTION 04 · DELEGATION & SCOPE

Delegation / Scope Table — Handoff & Transitions

Use this table to think about who can perform which transition task. The RN cannot delegate *assessment*, *teaching*, or *evaluation* — those are the three "untouchables" anchored by every NCLEX delegation question on this topic.

TASK	RN	LPN/VN	UAP	DELEGATE?	WHY / WHY NOT
Admission assessment of a newly arrived client	✓	✗	✗	No	Initial assessment is RN-only; it sets the baseline and the plan of care.

TASK	RN	LPN/VN	UAP	DELEGATE?	WHY / WHY NOT
Take admission vital signs on a stable client	✓	✓	✓	Yes	Stable client + routine task = UAP; RN still interprets and integrates.
Verify two-identifier ID band on admission	✓	✓	✓	Yes (with oversight)	All can verify; the RN remains responsible for accuracy of the band placement.
Discharge teaching — first dose insulin, new diagnosis	✓	✗	✗	No	Teaching that introduces new content is RN scope; LPN can reinforce existing teaching.
Reinforce previously taught discharge instructions	✓	✓	✗	Reinforcement only	LPN/VN may reinforce; new teaching and evaluation of understanding remain RN.
Bedside handoff report (give or receive)	✓	✓ (within scope)	✗	Within scope	An LPN may receive report for an LPN-appropriate client; complex/unstable clients require RN-to-RN handoff.
Accompany stable discharged client to lobby in wheelchair	✓	✓	✓	Yes	Stable client + routine transport = UAP; RN confirms client is stable for discharge first.
Transport unstable ICU transfer to CT scan	✓	✗	✗	No	Unstable client on infusions or monitor must be accompanied by RN; UAP may assist.
Medication reconciliation at discharge	✓	Assist	✗	No (RN finalizes)	RN and provider reconcile; LPN may gather the home list; final review and teaching is RN.
Collect a stable client's belongings for discharge	✓	✓	✓	Yes	Routine, predictable task with no clinical judgment — perfect UAP task.
Witness AMA discharge form signature	✓	✓	✗	RN preferred	Capacity assessment and risk teaching are RN; signature witness can be a licensed nurse.
Call SBAR transfer report to receiving ICU nurse	✓	✗	✗	No	Transfer of an unstable or complex client = RN-to-RN handoff only.

MEMORIZE

The three "untouchables" the RN never delegates: **Initial Assessment · Teaching · Evaluation**. If a delegation question mentions any of those three verbs — the answer is the RN.

SECTION 05 · RECOGNIZE CUES

Red-Flag Cues

IMMEDIATE ASSESSMENT

- Admit arrives diaphoretic, anxious, or short of breath
- Post-transfer client confused or less responsive than handoff described
- Discharged client returns "feeling worse" within 24 h
- New onset chest pain in a client awaiting discharge

PROVIDER NOTIFICATION

- Pending stat lab now resulted as critical value
- Allergy missed on admission — discovered after dose given
- Client refuses ordered post-discharge therapy
- Family disputes the documented code status
- DME / oxygen has not arrived prior to discharge

RAPID RESPONSE TEAM

- SpO_2 drop after PACU-to-floor handoff
- New altered mental status post-transfer
- Hypotension on a heparin or insulin drip received in handoff
- Suspected stroke symptoms in a client about to be discharged

CHAIN OF COMMAND

- Provider refuses to clarify an unclear transfer order
- Receiving facility refuses to accept transfer despite stable client
- Charge nurse assigns RN unsafe number of admits
- Staff member gives report while impaired

MANDATORY REPORTING

- Discharge environment shows suspected child or elder abuse/neglect
- Communicable disease (e.g., TB, measles) confirmed near discharge
- Gunshot, stab wound, or suspected assault on admission
- Impaired colleague at handoff (substance use, falsified documentation)

HOLD DELEGATION, REASSESS

- UAP reports VS on the admission that fall outside parameters
- LPN starts teaching a brand-new diagnosis
- UAP transporting a "stable" client who is suddenly diaphoretic
- Float / agency nurse unfamiliar with the unit's transfer protocol

SECTION 06 · APPLICATION

Advanced NGN Practice Questions

Twelve mixed-format NGN-style questions. Read each stem carefully — many turn on a single overlooked cue. After you choose, expand the rationale to see *why* the right answer is right, the trap, and which Clinical Judgment Model step is being tested.

Question 01

MULTIPLE CHOICE · TAKE ACTION

An RN is receiving handoff from the ED for a 68-year-old client with new-onset atrial fibrillation. The ED nurse states, "Heparin drip is running at 12 units/kg/hr; last aPTT was 60 seconds." Which action by the receiving RN is the priority?

A. Document the report and place the chart in the bin.

B. Perform an independent two-nurse pump verification at bedside with the ED nurse.

C. Ask the unit secretary to call the lab for the next aPTT.

D. Begin the admission assessment after the ED nurse leaves.

▸ REVEAL RATIONALE

Question 02

SELECT ALL THAT APPLY · ANALYZE CUES

During SBAR handoff, the off-going RN reports a client admitted for pneumonia. Which items **must** be included in the handoff to be considered complete? Select all that apply.

A. Code status

B. Isolation precautions

C. Pending blood culture results

D. Last bowel movement three days ago, no complaints

E. Allergies and reactions

F. The family's home address

G. Active IV lines and infusions

H. Last dose of PRN pain medication and effect

▸ REVEAL RATIONALE

Question 03

MATRIX / GRID · GENERATE SOLUTIONS

For each nursing action during transfer of a post-CABG client from PACU to step-down, indicate whether the action is *Indicated*, *Contraindicated*, or *Nonessential*.

ACTION	CLASSIFICATION
Trace each chest tube from the client to the drainage system at the bedside	Indicated
Verify and reset the PCA pump settings without the PACU nurse present	Contraindicated
Confirm the client's code status before the PACU nurse leaves	Indicated
Ask the UAP to complete a head-to-toe assessment	Contraindicated
Confirm the receiving room has a working cardiac monitor and oxygen	Indicated
Reorganize the client's belongings before assessing the client	Nonessential
Verify last analgesic time, dose, and pain score in handoff	Indicated
Sign the transfer form before completing the bedside report	Contraindicated

▸ REVEAL RATIONALE

Question 04

BOW-TIE · MULTI-STEP

A client is being discharged home after a left total hip arthroplasty. Complete the bow-tie diagram by selecting the priority condition to address, two actions to take, and two parameters to monitor.

Priority condition (choose 1): a) Postoperative DVT prevention | b) Hospital-acquired pneumonia | c) Urinary retention | d) Hyperglycemia

Actions to take (choose 2): a) Teach use of incentive spirometer at home | b) Reinforce enoxaparin self-injection technique with teach-back | c) Teach abduction precautions and avoiding hip flexion > 90° | d) Apply a Foley catheter for home use | e) Order blood glucose checks q6h at home

Parameters to monitor (choose 2): a) Calf swelling, redness, and pain | b) Dietary fiber intake | c) Unilateral leg pain disproportionate to expected post-op pain | d) Daily weight

▸ REVEAL RATIONALE

Question 05

ORDERED RESPONSE · PRIORITIZE

A 56-year-old client is being admitted from the ED at 0700 with new-onset shortness of breath and a temperature of 102.4 °F. Place the nurse's actions in the correct order.

1. Confirm identity with two identifiers and place ID and allergy bands.
2. Assess airway, breathing, and circulation; obtain SpO_2.
3. Place the client on the prescribed oxygen and droplet precautions while awaiting workup.
4. Complete the full admission history and medication reconciliation.
5. Orient the client to the room, call light, and bed alarm.

▸ REVEAL RATIONALE

Question 06

DROP-DOWN / CLOZE · EVALUATE

The RN is performing discharge teach-back for a client with newly diagnosed heart failure. Complete the sentence by selecting the most appropriate option.

"I will know my teaching is effective when the client **[A]** and when the client **[B]**."

Option A: 1) repeats the medication list back word-for-word | 2) explains in their own words how to weigh themselves daily and when to call the provider | 3) signs the discharge instruction sheet | 4) says "yes, I understand"

Option B: 1) demonstrates use of the pillbox correctly | 2) takes the medication sheet home | 3) has a family member sign the form | 4) tells the nurse they "got it"

▸ REVEAL RATIONALE

Question 07

CASE-STYLE · RECOGNIZE CUES

At 1900 handoff, the day nurse states: "The client refused her 1700 hydralazine. I didn't notify the provider because the BP was 138/82 at 1600. Otherwise stable." Which finding is most concerning to the receiving nurse?

A. The BP measurement was timely.

B. The hydralazine refusal was not communicated to the provider.

C. The client refused medication.

D. The BP is within an acceptable range.

▸ REVEAL RATIONALE

Question 08

DELEGATION SCENARIO · TAKE ACTION

The RN is responsible for four clients. Which task is most appropriate to delegate to the UAP?

A. Reinforce discharge instructions for a newly diagnosed diabetic client.

B. Take the routine 0800 vital signs on a stable client being transferred to a rehab facility this afternoon.

C. Perform the admission assessment for a newly arrived client with chest pain.

D. Educate the family on safe oxygen use at home.

▸ REVEAL RATIONALE

Question 09

SBAR SCENARIO · GENERATE SOLUTIONS

The RN is calling the provider about a client whose BP dropped from 132/78 to 92/54 after a transfer from PACU. Which SBAR element is the RN's recommendation?

A. "The client had a right hip replacement at 0900 with EBL of 200 mL."

B. "Mr. Smith's BP is 92/54 and he is more drowsy than at PACU report."

C. "I think we need a 500 mL bolus of normal saline and a STAT hemoglobin. Can you come evaluate?"

D. "Lungs are clear, abdomen soft, peripheral pulses 2+."

▸ REVEAL RATIONALE

Question 10

HANDOFF SCENARIO · MULTIPLE SELECT

A client is being transferred from a med-surg unit to the ICU for worsening sepsis. Which information must accompany the transfer? Select all that apply.

A. Most recent vital signs, mental status, urine output, and lactate

B. Active infusion of vasopressors with pump and tubing intact

C. Code status and any advance directive documentation

D. A copy of the inpatient menu preferences

E. Time and result of last antibiotic dose

F. Isolation precautions, if applicable

G. The name of the receiving ICU nurse

H. The client's preferred discharge destination

▸ REVEAL RATIONALE

Question 11

PRIORITIZATION · RECOGNIZE + PRIORITIZE

At the start of shift, the RN receives report on four clients. Which client should the RN see first?

A. 72-year-old admitted overnight with pneumonia, currently on 2 L NC, SpO_2 94%.

B. 45-year-old post-op day 1 cholecystectomy, requesting discharge teaching.

C. 60-year-old who was transferred in from ICU at 0600 on a heparin drip; last aPTT pending.

D. 30-year-old waiting on a wheelchair to be discharged to home with a family member.

▸ REVEAL RATIONALE

Question 12

CASE · EVALUATE OUTCOMES

Two hours after discharge teaching for a client with newly prescribed warfarin, the RN performs follow-up teach-back. Which client statement indicates the teaching was effective?

A. "I will take ibuprofen when my joints hurt."

B. "I should eat as much spinach as I want because it's healthy."

C. "I will call my provider if I see blood in my urine or my stool turns black."

D. "If I forget a dose, I will double the next one."

▸ REVEAL RATIONALE

SECTION 07 · INTEGRATED CLINICAL JUDGMENT

Unfolding NGN Case Study

CASE STUDY

Mrs. R., 78 years old — Hospital-to-Home Transition Crisis

NURSE'S NOTES · 1300

78-year-old female admitted 4 days ago for community-acquired pneumonia and new-onset atrial fibrillation. Started on oral apixaban hospital day 2. Lives alone in a second-floor apartment with no elevator. Daughter lives 90 minutes away. Client states, "I want to go home today. I feel fine." Client appears mildly fatigued, gait slightly unsteady on ambulation observed this morning. Discharge planned for 1500.

VITAL SIGNS · 1300

TEMP	HR	RR	BP	SpO_2 RA	PAIN
99.1 °F	96	22	132/76	91%	2/10

PROVIDER DISCHARGE ORDERS

- Discharge home with daughter today
- Apixaban 5 mg PO BID — new prescription
- Amoxicillin/clavulanate 875 mg PO BID × 7 days — new prescription
- Follow-up with cardiology in 1 week
- Home oxygen 2 L NC PRN — DME to deliver today
- Home health nurse referral for medication teaching

RECENT LABS / DIAGNOSTICS

- CBC: WBC 12.8, Hgb 11.0, Plt 220
- BMP: Cr 1.4 (baseline 0.9), K 3.4
- Chest X-ray (this morning): "Residual right lower lobe infiltrate, slight improvement"
- INR: 1.1 · PT/PTT pending from this morning

FAMILY / CLIENT STATEMENTS

Daughter (by phone): "I can drive her home today, but I have to be back at work tomorrow morning. I won't be able to stay. She's been really wobbly."

Client: "I don't need that oxygen thing. I've never used one before and it scares me."

HEALTH CARE TEAM NOTES

- Case Manager: DME delivery confirmed for between 1600–1800 today.
- Pharmacy: Apixaban prescription not yet filled; client says she will fill it tomorrow.
- PT: Recommends home safety evaluation and continued strengthening; gait unsteady.
- Home Health: Cannot begin until tomorrow afternoon at the earliest.

Case Q1 · Recognize Cues — SATA

Which findings should the nurse identify as cues that the planned 1500 discharge may not be safe? Select all that apply.

A. SpO_2 91% on room air

B. RR 22

C. Cr increased from 0.9 to 1.4

D. Apixaban prescription not yet filled

E. Daughter unable to stay overnight

F. Home oxygen DME not arriving until after 1600

G. Client refuses oxygen teaching

H. Home health cannot start until tomorrow afternoon

▸ REVEAL

Case Q2 · Analyze Cues

DROP-DOWN / CLOZE

Complete the analysis statement.

"The client is at greatest risk for **[A]** due to **[B]** and at additional risk for **[C]** due to **[D]**."

A. 1) hypoxic respiratory failure | 2) constipation | 3) infection | 4) hyperglycemia

B. 1) immobility | 2) SpO_2 91% RA, RR 22, and refused oxygen | 3) low potassium | 4) anticoagulant use

C. 1) thromboembolic event or bleeding | 2) urinary tract infection | 3) skin breakdown | 4) altered mental status

D. 1) age alone | 2) new apixaban not yet filled and no caregiver overnight | 3) low albumin | 4) hypothermia

▸ REVEAL

Case Q3 · Prioritize Hypotheses

ORDERED RESPONSE

Place the nurse's actions in priority order, beginning with the most urgent.

1. Reassess respiratory status and place client on 2 L NC; notify provider of SpO_2 91% RA.
2. Recommend delaying discharge until DME is delivered, oxygen teaching is complete, and prescription is filled.
3. Coordinate with the case manager and provider to arrange overnight caregiver support or alternative placement.
4. Complete teach-back for apixaban bleeding precautions and the antibiotic schedule.
5. Provide written discharge instructions in the client's preferred format and document teach-back.

▸ REVEAL

Case Q4 · Generate Solutions

MATRIX

For each potential intervention, indicate whether it is *Indicated*, *Contraindicated*, or *Nonessential* at this point.

INTERVENTION	CLASSIFICATION
Notify the provider that discharge should be delayed	Indicated
Send the client home and document that the daughter will follow up	Contraindicated
Verify pharmacy can fill the apixaban prescription before discharge	Indicated
Place client on 2 L NC and recheck SpO_2	Indicated

INTERVENTION	CLASSIFICATION
Use teach-back for bleeding precautions in client's own words	Indicated
Ask the UAP to explain how oxygen tubing works	Contraindicated
Insert a Foley catheter for ease of transport	Contraindicated
Reorganize the client's belongings into a bag	Nonessential

▸ REVEAL

Case Q5 · Take Action

MULTIPLE CHOICE

The provider agrees to delay discharge until tomorrow. Which action should the nurse take FIRST?

A. Cancel the DME oxygen order.

B. Place the client on 2 L NC, reassess respiratory status, and document the new plan.

C. Tell the daughter not to come.

D. Discharge the client to the lobby to wait.

▸ REVEAL

Case Q6 · Evaluate Outcomes

SATA

The next morning, the client is reassessed before discharge. Which findings indicate the revised plan was effective? Select all that apply.

A. SpO_2 95% on 2 L NC, RR 18

B. Apixaban filled and brought to bedside; client demonstrates correct dose and timing

C. Client states, "If my urine is red or my stool is black, I'll call the doctor."

D. Cr now 1.0; potassium 3.8

E. Daughter has arranged to stay overnight for 48 h

F. Client signs the discharge form without reading it

G. DME oxygen delivered with home setup confirmed by case manager

H. Home health visit confirmed for that afternoon

▸ REVEAL

SECTION 08 · PRIORITIZATION DRILLS

"What should the nurse do FIRST?"

1. *During shift report, the off-going RN mentions that a client's stat troponin was drawn 90 minutes ago but the result is not in yet.*

   `First action` › Check the EHR and/or call the lab for the result before continuing report. A pending stat troponin can change the entire plan; the rest of report can wait two minutes.

2. *A newly admitted client is wheeled to the room with no ID band, only an ED stretcher tag, while UAP is offering to start vital signs.*

   `First action` › Verify identity with two identifiers and apply the hospital ID and allergy bands. Banding precedes any care, including vitals.

3. *A transferred ICU client arrives on the med-surg floor on a fentanyl PCA pump.*

   `First action` › Independent two-nurse PCA verification at the bedside with the ICU nurse — settings, concentration, lockout, dose, and tubing trace. The high-alert verification precedes admission paperwork.

4. *A client scheduled for discharge develops new shortness of breath while dressing in their room.*

   `First action` › Assess airway, breathing, vitals, SpO_2 — and halt the discharge process. Notify the provider. No client is discharged through a change in condition.

5. *During SBAR at end of shift, the receiving nurse interrupts to take a phone call about another client.*

   `First action` › Pause the report. Do not continue speaking into a distracted listener. Resume only when the receiving nurse is fully present.

SECTION 09 · DELEGATION DRILLS

"Can this be delegated?"

1. *Reinforcing previously taught insulin self-injection technique with a stable client.*

   `Who` › **LPN/VN.** Reinforcement of established teaching is within LPN scope. New teaching and evaluation of understanding remain RN.

2. *Taking a stable transfer client to the lobby for discharge in a wheelchair.*

   `Who` › **UAP.** Stable client, routine task, no clinical judgment required.

3. *Performing the initial admission assessment on a new client with chest pain.*

   `Who` › **RN only.** Initial assessment is the RN's untouchable. The UAP and LPN cannot establish the baseline.

4. *Calling SBAR report to the receiving ICU for an unstable septic client.*

   `Who` › **RN only.** Transfer of a complex/unstable client is RN-to-RN handoff.

5. *Witnessing a competent client's signature on an AMA discharge form after the RN completes teaching.*

   `Who` › **RN or LPN/VN.** Capacity assessment and risk teaching are RN scope; a licensed nurse may witness the signature. UAPs do not witness AMA forms.

SECTION 10 · REFERRALS & COLLABORATION

"Who should the nurse contact?"

1. *A client being discharged today cannot afford the new apixaban prescription.*

   `Contact ›` **Case manager / social worker** and **pharmacy** for affordability options (manufacturer programs, formulary alternative). Notify the provider if an alternative is needed.

2. *A post-stroke client is being discharged but has new swallowing concerns at meal trial.*

   `Contact ›` **Speech-language pathologist (SLP)** for swallow evaluation before discharge; notify provider. Discharge should be delayed pending evaluation.

3. *Discharged client has a complex dressing change required twice weekly and lives alone.*

   `Contact ›` **Home health nurse referral** via case management; obtain provider order. Verify durable wound supplies are arranged before discharge.

4. *A transferred ICU client on a vasopressor drip develops a sudden drop in BP and altered mental status on the floor.*

   `Contact ›` **Rapid Response Team** immediately, then notify the primary provider. Do not wait for routine pages.

5. *A terminally ill client with a DNR is being discharged home but family is unprepared for end-of-life care.*

   `Contact ›` **Hospice / palliative care services** with provider order; involve **chaplain** and **social work** for family support and bereavement resources.

SECTION 11 · LEGAL & ETHICAL TRAPS

Legal / Ethical Trap Scenarios

1. *A competent client wishes to leave AMA after the provider has refused to write the discharge order.*

   `Correct response ›` Assess capacity, educate on risks, offer prescriptions and follow-up, witness the AMA form, document refusal and education. The nurse may NOT physically detain a competent client — that is false imprisonment.

2. *During handoff in a public hallway, the off-going nurse uses the client's full name and diagnosis at normal speaking volume.*

   `Correct response ›` Move report to a private location. This is a HIPAA breach — the nurse intervenes immediately, completes the report privately, and reports the breach per facility policy if a third party overheard PHI.

3. *An admission packet shows a signed advance directive naming the client's son as healthcare proxy. The client's spouse demands that the spouse make decisions instead.*

   `Correct response ›` The healthcare proxy / DPOA-HC named in a valid advance directive has legal authority when the client lacks capacity. The nurse honors the document, notifies the provider, and involves social work / chaplain / ethics if family conflict is significant.

4. *A nurse discovers that a colleague documented a discharge teach-back that did not occur.*

   `Correct response ›` This is falsification of records — a reportable practice issue. Notify the charge nurse and follow the chain of command; complete an incident report. Document objectively; do not confront the colleague in front of clients.

5. *A receiving nurse refuses to take handoff on a client whose advance directive includes a DNR, stating, "I don't believe in that."*

   `Correct response ›` Code status and advance directives must be honored regardless of personal beliefs. Escalate to the charge nurse/supervisor for reassignment; the client cannot be left without an accepting nurse. Document the assignment change. A conscientious objection does not allow abandonment.

SECTION 12 · END-OF-DAY SYNTHESIS

Quick Review

10 ONE-LINE MUST-REMEMBER POINTS

1. Bedside SBAR is the safest standard for shift handoff.
2. Code status, isolation, and allergies are reported every time.
3. Pending stat labs are an active handoff item, not a passive one.
4. Two-nurse verification is required for all high-alert infusions at transfer.
5. Admission priority sequence: ABC → ID/allergies → code status → falls → baseline.
6. Medication reconciliation occurs at admission, transfer, AND discharge.
7. Teach-back means the client explains in their own words OR demonstrates.
8. Discharge is not complete until equipment, transport, and follow-up are arranged.
9. AMA discharge requires capacity + education + witnessed form — not detention.
10. The RN documents who received report, what was reported, and any unresolved issues.

5 COMMON NCLEX TRAPS

1. Choosing a paperwork step before stabilizing ABC.
2. Confusing reinforcement (LPN) with new teaching (RN).
3. Picking the "discharge-ready" client as the priority over the recently transferred one.
4. Treating verbal report as sufficient when written documentation is required.
5. Delegating teaching, evaluation, or initial assessment to UAP.

5 "NEVER DO THIS" RULES

1. Never give report while the receiving nurse is on the phone.
2. Never discharge a client through a change in condition.
3. Never delegate the initial assessment.
4. Never restrain a competent client requesting AMA discharge.
5. Never assume code status transfers automatically — send the document.

5 SAFETY-FIRST PHRASES TO RECOGNIZE ON NCLEX

1. "Two-identifier verification" / "two-nurse independent check"
2. "Teach-back in the client's own words"
3. "Closed-loop communication / read-back"
4. "Trace each line from origin to insertion"
5. "Bedside shift report with the client"

DAY 06 · VISUAL SUMMARY · SCREENSHOT ME

Handoff, SBAR, Admission, Transfer & Discharge

SBAR Anatomy

S	B	A	R
Situation	Background	Assessment	Recommendation
Who, where, what's happening right now	Dx, admit reason, relevant Hx, code status, allergies	VS, exam, labs, your clinical judgment	What you need from the receiver — order, eval, transfer

Admission Priority Order

- ABC first ›
- Two-identifier ID + allergy band ›
- Code status & advance directive ›
- Fall + skin risk ›
- Baseline assessment + med rec ›
- Orient to room & call light

Every Handoff Includes

- Code status
- Isolation precautions
- Allergies + reactions
- Active IVs + high-alert infusions
- Pending labs / studies
- Lines · tubes · drains
- Last analgesic + effect
- Unresolved concerns

Safe Transfer Checklist

- Verbal SBAR + written transfer form
- Updated MAR + active orders
- Pending studies communicated
- Two-nurse pump verification at bedside
- Code status document accompanies client
- Receiving room/equipment ready
- Trace every line origin → insertion

Discharge: 7 Boxes to Tick

- Med reconciliation finalized
- Prescriptions filled or in hand
- DME / oxygen delivered & set up
- Transportation confirmed
- Follow-up appointments scheduled
- Teach-back documented
- Written instructions in preferred language

RN-Only (Never Delegate)

- Initial assessment
- New teaching
- Evaluation of teaching/outcome
- Unstable transfers
- SBAR for complex clients
- Med reconciliation review

Stop the Discharge If...

- New change in condition
- DME / oxygen not delivered
- Prescription unfilled / unaffordable
- Caregiver gap / unsafe home
- Teach-back fails
- Pending critical lab unresolved

Red Flags to Escalate

- Critical pending lab back as abnormal
- Allergy missed → dose already given
- Family disputes documented code status
- Impaired colleague at handoff
- Falsified documentation discovered
- Discharge to suspected unsafe environment

Legal Anchors

- HIPAA: minimum necessary info
- AMA: capacity + education + witness
- DNR: send copy with transfer
- Interpreter: qualified, not family
- Document who received report
- Incident report for near-miss

DAY 06 COMPLETE • NEXT UP: DAY 07 — CASE MANAGEMENT, REFERRALS & DISCHARGE PLANNING • SAVE · SCREENSHOT · REVIEW