2026 NCLEX-RN · MANAGEMENT OF CARE · DAILY BUILD

Case Management, *Referrals* & Discharge Planning

THE BRIDGE BETWEEN HOSPITAL & HOME · COORDINATING SAFE CONTINUITY OF CARE

07

15 DAY SERIES
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SECTION 01 · FOUNDATION

High-Yield Overview

If **Day 6 taught you how to hand a client off safely**, Day 7 teaches you how to *send the client home safely*. Case management and discharge planning are the moment where the entire hospitalization either succeeds or unravels — and NCLEX knows this. The 2026 RN Test Plan explicitly lists *"Explore resources available to assist client with achieving or maintaining independence," "Assess the need for referrals and obtain necessary orders,"* and *"Practice and advocate for quality and cost-effective care"* as Management of Care activities you must demonstrate.

The single biggest cause of hospital readmission is **not** the disease — it's a discharge that ignored the social determinants of health. The client who cannot afford the prescription does not take it. The client whose home has no working bathroom on the first floor falls. The client whose caregiver does not speak the language of the discharge papers cannot follow them. NGN questions in this domain are testing whether you can **recognize the gap before the client leaves the building**.

> THINK LIKE AN ENTRY-LEVEL RN
>
> Case management is not a department — it is a way of thinking. Every shift, ask: *"What does this client need that this hospital alone cannot provide? Who in the community can provide it? Who arranges that? Who pays for it? Who follows up?"* If you cannot answer those five questions before discharge, the discharge is unsafe.

Case management vs. discharge planning — clearing the confusion

Case management is the broader, ongoing coordination of the client's care across the continuum — across diagnoses, providers, settings, and sometimes years. **Discharge planning** is one episode of case management focused on the transition out of one care setting. Both involve assessing resources, coordinating referrals, advocating for cost-effective care, and educating the client and family.

On NCLEX, when you see *"the case manager"* in the answer choices, the test is usually pointing at issues of **complex coordination, insurance, transitions between levels of care, durable medical equipment (DME), or community resources**. When you see *"the social worker,"* the test is usually pointing at issues of **finances, housing, food insecurity, transportation, suspected abuse/neglect, mental health linkage, or community advocacy**. The two often overlap; either may be acceptable, but the more specific match wins.

The four pillars of a safe discharge

1. **The client has what they need at home** — medications filled, equipment delivered, oxygen set up, wound supplies available, dressings demonstrated.
2. **The client and caregiver know what to do** — teach-back confirmed in the client's preferred language; written instructions at appropriate literacy level; warning signs and red flags reviewed.
3. **The client has somewhere safe to go** — physical home is appropriate (steps, bathroom, oxygen, electricity, refrigeration for insulin); caregiver is willing and able; no suspected abuse or neglect.
4. **The client has follow-up** — appointment scheduled, transportation arranged, home health initiated when needed, contact number for questions.

Where NCLEX traps live

- **The "fine on paper" trap** — the chart says everything is ready, but the question hints at a missing piece (no transportation, prescription not yet filled, oxygen not yet delivered).
- **The "wrong referral" trap** — the right need with the wrong professional (e.g., picking the dietitian for a food-insecurity problem, when food insecurity is a *social worker* referral).
- **The "early teaching" trap** — saving discharge teaching for the day of discharge. NCLEX expects teaching to begin **on admission**, with reinforcement throughout the stay.
- **The "delegate the teaching" trap** — discharge teaching is RN-only on NCLEX; reinforcement of *previously taught* material can be delegated to LPN/VN within scope, but the initial teach-back and evaluation belong to the RN.

SECTION 02 · ANCHOR RULES

The 10 Must-Know *Rules*

01 **Discharge planning begins on admission** — not the day of discharge. NCLEX expects you to identify discharge needs in the admission assessment and continuously update the plan.

02 **Initial teaching and final evaluation of teach-back belong to the RN.** Reinforcement of previously taught material may be delegated to an LPN/VN within scope. UAP can never teach.

03 **A referral requires a provider's order** in most cases. The RN recognizes the need, recommends the referral, obtains the order, and coordinates with the team — but does not independently initiate consults that require orders (PT, OT, home health, hospice, dietitian).

04 **Cost-effective care is a Management of Care activity** the test plan explicitly names. Avoiding readmission is the single most cost-effective intervention an RN provides.

05 **Food insecurity, housing instability, transportation, and medication affordability are SOCIAL WORK referrals.** The social worker is the bridge to community resources, SNAP, Meals on Wheels, paratransit, prescription assistance programs.

06 **Complex equipment, insurance coordination, and transitions between levels of care are CASE MANAGER referrals.** DME, home health linkage, rehab placement, hospice intake.

07 **Home oxygen requires verification of: a working smoke detector, no smoking in the home, no open flames, and electricity for the concentrator**, plus a backup tank. The RN verifies before discharge.

08 **Hospice = life expectancy ≤6 months, comfort focus, client/family chose to forgo curative care.** Palliative care can run alongside curative care at any stage. Do not confuse these on NCLEX.

09 **Home health is intermittent skilled care** (RN visits, PT, OT, wound, IV therapy) — the client must be considered *homebound* for Medicare coverage. It is *not* 24/7 care.

10 **A safe discharge requires teach-back in the client's preferred language using a qualified medical interpreter** — never family, never minor children, never bilingual staff who are not certified.

SECTION 03 · CLINICAL JUDGMENT

RN Safety *Decision Table*

SITUATION	BEST RN ACTION	WHY THIS IS SAFEST	COMMON NCLEX TRAP
Client being discharged on home oxygen lives alone; smokes 1 ppd.	Hold discharge, notify provider, refer to case management and smoking-cessation; verify written/verbal safety teaching and smoke-detector status.	Oxygen + open flame = fire risk. Unsafe environment is a discharge-stopper.	"Provide oxygen safety teaching and discharge" — teaching alone does not eliminate the live ignition source.
Client cannot afford prescribed eliquis after discharge.	Notify provider; refer to social worker for prescription assistance/manufacturer program; request alternative if needed.	Affordability is the #1 reason a client does not take a prescribed medication. Refer before discharge.	"Tell client to ask the pharmacist for a discount" — this transfers the burden without resolving the gap.
Older adult lives alone post-hip arthroplasty; no caregiver, no first-floor bathroom.	Notify case manager; consider rehab placement or home health PT + home safety eval before discharge home.	The home is not safe for the current functional status; placement or skilled service is required.	"Discharge home with crutches teaching" — the client physically cannot navigate the home.
Client with new ileostomy asks how to change the appliance; discharge tomorrow.	RN provides initial teaching and teach-back today; refer to wound/ostomy nurse (WOCN); arrange home health for first home visit.	Skilled care plus teaching reinforcement at home reduces readmission for skin breakdown and dehydration.	"Delegate ostomy teaching to UAP for tomorrow" — never delegate teaching to UAP.
Client with stage IV pancreatic CA and 4-month prognosis wants "no more chemo, just comfort at home."	Notify provider, request hospice referral, support client's autonomy, coordinate with case management and chaplain as desired.	Hospice fits prognosis ≤6 months with comfort focus. Client autonomy drives the decision.	"Encourage the client to talk to family before deciding" — undermines client autonomy.
Caregiver tearfully says "I can't do this anymore" at discharge teaching.	Stop teaching; assess caregiver; notify case management/social work; consider respite, home health, or alternate placement.	Caregiver collapse is a safety risk for the client. Address before discharge.	"Continue teaching; reassure the family it gets easier" — dismisses a real safety cue.
Non–English-speaking client; spouse offers to translate the discharge instructions.	Decline; obtain qualified medical interpreter (in-person or telephone/video) for teaching and consent.	Family members are not certified, may filter information, and may have conflicts of interest. Legal/safety risk.	"Use the spouse because the client trusts them" — trust does not equal qualification.
Client refuses home health visits after MI.	Respect autonomy, ensure client has capacity, document refusal, provide written warning-sign list and follow-up plan, notify provider.	A client with capacity may refuse; the RN ensures informed refusal and safety net.	"Cancel all follow-up because the client refused home health" — follow-up appointments are separate.
Client tells nurse "I have no food at home" on day of discharge.	Refer to social work for SNAP/food bank/Meals on Wheels; involve dietitian for nutrition plan tailored to budget.	Food insecurity directly affects medication adherence and disease control.	"Refer only to the dietitian" — dietitian addresses diet, not access.
Client with new G-tube; family willing but anxious.	RN teaches and validates technique with return demonstration; refer to home health for skilled follow-up; provide written instructions and 24-hour contact number.	Skilled care + reinforcement + safety net reduces readmission for displacement, infection, aspiration.	"Schedule a clinic visit in two weeks" — the family needs support sooner than two weeks.

SECTION 04 · SCOPE & DELEGATION

RN / LPN / UAP *Delegation Grid* — Case Management & Discharge Tasks

TASK	RN	LPN/VN	UAP	CAN DELEGATE?	WHY OR WHY NOT?
Initial discharge teaching	Yes	No	No	No	Initial teaching requires assessment and judgment — RN only.
Reinforcement of teaching previously delivered by the RN	Yes	Yes	No	Yes (LPN)	Reinforcement is within LPN scope; UAP cannot teach.
Identifying the need for a referral	Yes	No	No	No	Assessment/judgment activity — RN.
Obtaining the order for a referral	Yes	Per facility	No	Sometimes	RN typically obtains the order; LPN may take verbal/written orders per state and policy.
Coordinating home health intake	Yes	No	No	No	Care coordination requires nursing judgment — RN/case manager.
Verifying DME delivery to the home	Yes	Yes	Yes	Yes	This is a confirmation/clerical task UAP can make calls for; the RN evaluates the result.
Teaching ostomy/wound care	Yes	No	No	No	New, complex teaching — RN only (WOCN may co-teach).
Reviewing a teach-back response	Yes	No	No	No	Evaluation of learning is an RN activity.
Transporting client to discharge curb	Yes	Yes	Yes	Yes	Stable client, routine task — appropriate for UAP.
Final discharge assessment	Yes	No	No	No	The "is this client safe to leave?" decision is an RN judgment.
Reviewing prescription list/medication reconciliation	Yes	Reinforce	No	Sometimes	RN performs and verifies; LPN may help reinforce previously reconciled list.
Suctioning a tracheostomy at home (skilled visit)	Yes	Yes	No	Yes	Stable client with established care plan; LPN within scope. UAP cannot.
Setting up the home oxygen concentrator	DME vendor	DME vendor	DME vendor	No	DME company sets up; RN verifies safety and teaches use.
Calling pharmacy to verify Rx was filled	Yes	Yes	Yes	Yes	Clerical verification — UAP appropriate; RN interprets the result.

THE 5 RIGHTS OF DELEGATION, APPLIED HERE

Right task, right circumstance, right person, right direction/communication, right supervision/evaluation. **If any one fails, do not delegate.** The RN remains accountable for the outcome of every delegated task.

SECTION 05 · RED-FLAG CUES

Findings That Should Stop, Delay, or *Escalate* Discharge

IMMEDIATE RN ASSESSMENT

- Client reports new SOB, chest pain, or dizziness during discharge prep
- Caregiver appears overwhelmed, tearful, dissociated
- Client cannot demonstrate insulin draw-up or pen use
- Wound shows new drainage, odor, or color change
- Client refuses to discuss the discharge plan

PROVIDER NOTIFICATION

- Prescription unaffordable / unavailable in client's area
- Caregiver gap that prevents safe discharge home
- Pending critical lab returns abnormal
- Client/family request a change in code status
- New DVT symptoms in a soon-to-be-discharged client

RAPID RESPONSE TEAM

- Acute change in mental status during discharge education
- New hypotension, hypoxia, or arrhythmia
- Stroke-like symptoms (FAST positive)
- Acute respiratory distress on discharge ambulation
- Suspected pulmonary embolism (sudden SOB, chest pain, tachycardia)

CHAIN OF COMMAND

- Provider insists on discharging client with unfilled critical prescription
- Provider refuses to order needed home health for an unsafe situation
- Insurance denies covered service and client cannot self-pay safely
- Charge nurse instructs to discharge without teach-back
- Discharge plan does not match the client's stated wishes

MANDATORY REPORTING

- Suspected elder neglect at discharge destination
- Suspected child abuse in caregiver/household
- Suspected intimate partner violence
- Communicable disease per local public health requirements
- Client makes credible threat of self-harm at discharge

HOLD DELEGATION & REASSESS

- UAP asked to "remind" client of insulin technique
- LPN/VN delegated the initial discharge teaching
- UAP delegated to verify teach-back understanding
- Inexperienced UAP delegated to ambulate a new-amputee client
- Float staff unfamiliar with home oxygen safety teaching delegated to discharge

SECTION 06 · ADVANCED NGN PRACTICE

12 NGN Items — *Mixed Formats*

Answer each item **before** reading the rationale. Each rationale identifies the correct answer, why each incorrect option is wrong, the NCLEX trap being tested, and the clinical judgment step.

Q01

MULTIPLE CHOICE · RECOGNIZE CUES

A nurse is preparing a 78-year-old client for discharge after a hip fracture repair. Which finding requires the nurse to act *first*?

a. The client lives alone in a second-floor apartment without an elevator.

b. The client's daughter says she cannot visit until next week.

c. The client has not yet been given the prescription for oxycodone.

d. The client's home does not have grab bars in the bathroom.

CORRECT **A.** An older adult post–hip repair who cannot physically access the home is at immediate risk of fall and re-injury. This is a discharge-stopper; the RN must notify case management for rehab placement, home modification, or alternative housing before discharge.

B Reduced visiting is a concern but is not a structural barrier to a safe discharge today.

C The Rx is important but is solved by ordering and filling — not a discharge-stopper.

D Grab bars are recommended but are a modification target, not an absolute access barrier.

TRAP Mistaking "annoyance" cues (no grab bars, family delay) for "danger" cues (cannot enter home).

CJMM Step 1 — Recognize Cues.

Q02

SELECT ALL THAT APPLY · ANALYZE CUES

A client with newly diagnosed type 1 diabetes is being discharged. Which findings should prompt the nurse to coordinate *additional referrals* before the client leaves? Select all that apply.

a. Client says, "I lost my job last week and I don't have insurance."

b. Client says, "Sometimes I skip meals because food is tight."

c. Client demonstrates correct insulin draw-up on the first attempt.

d. Client lives in a rural area 60 miles from the nearest clinic.

e. Client states, "I'm not really sure how to count carbs yet."

f. Client's spouse says, "I just don't think I can give him the shots."

CORRECT **A, B, D, E, F.**

A → social worker for insurance navigation and manufacturer assistance programs. **B** → social worker for SNAP/food resources *and* dietitian for budget-friendly diabetic meal planning. **D** → case manager for telehealth, transportation, or local resources. **E** → dietitian for carb counting (and RN reinforcement). **F** → reinforce teaching, evaluate caregiver readiness, consider home health.

C is a positive finding — not a referral trigger.

TRAP Picking only "obvious" referrals and missing the social determinants of health that NCLEX is increasingly testing.

CJMM Step 2 — Analyze Cues.

Q03

MATRIX / GRID · GENERATE SOLUTIONS

For each client need, indicate the ***most appropriate*** referral.

CLIENT NEED	SOCIAL WORKER	CASE MANAGER	DIETITIAN	HOME HEALTH
Client cannot afford insulin	•			
Client needs DME oxygen at home		•		
Client with renal disease needs low-K meal plan			•	
Post-op wound needs skilled dressing change 3×/week				•
Client reports unsafe housing	•			
Transitioning from hospital to skilled rehab		•		

CORRECT Social worker handles finances, housing, and community-resource linkage. Case manager handles complex coordination, DME, and inter-facility transitions. Dietitian handles diet education for medical nutrition therapy. Home health handles intermittent skilled services in the home.

TRAP Confusing social worker and case manager — they overlap but social worker leans *social/financial* while case manager leans *care-coordination/insurance*.

CJMM Step 4 — Generate Solutions.

Q04

BOW-TIE · TAKE ACTION / GENERATE SOLUTIONS

A 68-year-old client with COPD is being discharged on continuous home oxygen 2 L/min via nasal cannula. The client lives alone and smokes 1 ppd. Complete the bow-tie.

ACTIONS TO TAKE

- **Hold the discharge pending safety plan**
- **Notify the provider & case manager**
- Continue prescription reconciliation
- Schedule cardiology follow-up

PRIORITY PROBLEM

PARAMETERS TO MONITOR

- **Client/family commitment to no-smoke policy at home**
- **Working smoke detector & CO detector verified**
- Pulse oximetry on discharge oxygen rate
- RR, work of breathing

CORRECT The two bolded actions and two bolded monitors are correct. Oxygen + ignition source is a discharge-stopper. The RN escalates and engages case management. Smoking-cessation referral, fire-safety teaching, and verification of smoke/CO detectors are core to the safety plan.

WRONG "Continue prescription reconciliation" and "schedule cardiology follow-up" are routine tasks unrelated to the priority problem. "Pulse ox" and "RR" are appropriate monitors but secondary to fire-safety verification.

TRAP Choosing clinically reasonable actions that are not *priority* actions — bow-tie items test prioritization, not "is this nursing care?"

CJMM Steps 4 & 5 — Generate Solutions and Take Action.

Q05

ORDERED RESPONSE · TAKE ACTION

Place these RN actions in the correct order when preparing a client with a new ileostomy for discharge.

1. Validate teach-back of ostomy care with return demonstration.
2. Obtain a provider order for a WOCN consult.
3. Assess the client's and caregiver's baseline knowledge and readiness.
4. Reinforce teaching with written materials in the client's preferred language.
5. Coordinate home health for first home visit within 24–48 hours.
6. Deliver initial teaching of pouch change, skin care, and S/Sx of complications.

CORRECT **3 → 2 → 6 → 4 → 1 → 5**

Always **assess** first (ADPIE). Then **refer** to the specialist (WOCN). Then **teach**, then **reinforce**, then **evaluate** with teach-back/return demo. Finally **coordinate** the home-health bridge for continuity.

TRAP Skipping the assessment step (#3) and going straight to teaching. NCLEX always wants *assess → plan → intervene → evaluate* first.

CJMM Step 5 — Take Action (with explicit Step 1 anchoring).

Q06

DROP-DOWN / CLOZE · ANALYZE CUES

Complete the statement by selecting the correct option for each blank.

A 72-year-old client with end-stage heart failure (EF 12%) and a prognosis of approximately 4 months is being discharged home. The client states, "No more hospitals. I want to be home." The nurse should anticipate a referral to **[hospice / palliative care / home health]** and recognize that this service is appropriate because the client has a prognosis of **[≤ 6 months / ≤ 12 months / ≤ 30 days]**, has chosen **[comfort-focused care / curative care / both]**, and may continue to receive care **[at home / only inpatient / only in a SNF]**.

CORRECT **hospice · ≤ 6 months · comfort-focused care · at home**. Hospice is appropriate for life expectancy of 6 months or less when the client/family chooses comfort over curative care and can be delivered in the home, inpatient hospice unit, SNF, or assisted living.

WRONG "Palliative care" can occur alongside curative care at any stage of illness — not the precise match. "Home health" is intermittent skilled care, not end-of-life focused.

TRAP Defaulting to "palliative care" because it sounds gentle. Pay attention to the prognosis and the client's expressed wishes.

CJMM Step 2 — Analyze Cues.

Q07

PRIORITIZATION · RECOGNIZE/PRIORITIZE HYPOTHESES

The RN is preparing four clients for discharge. Which client should the RN see *first*?

a. A 45-year-old post–lap chole client requesting pain medication before leaving.

b. A 30-year-old asthma client whose albuterol prescription has not yet been filled by the pharmacy.

c. A 72-year-old client with new home oxygen who reports "a little dizzy" when standing.

d. A 60-year-old client with diabetes who cannot remember how to give the morning insulin.

CORRECT **C.** "Dizzy when standing" in a client about to be discharged is a potential safety event — possible orthostasis, hypoglycemia, hypoxia, arrhythmia. The RN must assess *now* before any other discharge task. ABCs and acute change trump teaching gaps and Rx delays.

A Pain is real but stable.

B Important — but pharmacy delay can be solved by a phone call.

D Teaching gap is high-priority but predictable; client C may be unstable *now*.

TRAP Choosing the most "interesting" teaching problem over the unstable-cue client.

CJMM Step 3 — Prioritize Hypotheses.

Q08

DELEGATION SCENARIO · TAKE ACTION

The RN is discharging a client with a new tracheostomy to home. Which task is most appropriate to delegate to the LPN/VN?

a. Provide the initial teaching of trach suctioning to the caregiver.

b. Reinforce previously taught trach care, using the RN's teaching plan.

c. Evaluate the caregiver's teach-back demonstration of trach suctioning.

d. Determine whether the client meets criteria for home health referral.

CORRECT **B.** Reinforcement of *previously taught* material is within the LPN/VN scope.

A Initial teaching = RN. C Evaluation of learning = RN. D Referral decision = RN judgment.

TRAP Confusing "the LPN/VN is competent at trach care" with "the LPN/VN can teach trach care." Competence at performing a skill does not extend to initial teaching or evaluation.

CJMM Step 5 — Take Action.

Q09

SATA · EVALUATE OUTCOMES

The RN reviews discharge teaching outcomes for a client going home with intravenous antibiotics through a PICC line. Which client statements indicate that ***further teaching is needed***? Select all that apply.

a. "If the dressing gets wet, I'll just let it air-dry."

b. "I'll flush the line with normal saline before and after the antibiotic."

c. "I'll call the home health nurse if my arm becomes red or swollen."

d. "If the tubing disconnects, I'll just reconnect it with clean hands."

e. "I'll keep the cap clean by scrubbing it before each use."

f. "If I get a fever, I'll wait until my next doctor appointment to mention it."

CORRECT **A, D, F.**

A Wet dressings must be changed, not air-dried — infection risk. **D** Disconnections require sterile technique and assessment for air embolism risk — not "clean reconnect." **F** Fever may indicate line infection or sepsis — call immediately, not wait.

B, C, E Reflect correct knowledge and do not need re-teaching.

TRAP Misreading "indicates further teaching is needed" as "is correct." Always read the stem twice.

CJMM Step 6 — Evaluate Outcomes.

Q10

CASE-STYLE · MULTIPLE CHOICE · GENERATE SOLUTIONS

A 55-year-old client is being discharged after community-acquired pneumonia. The client uses a wheelchair, has Medicaid, lives in a basement apartment with no AC, and reports that the prescribed levofloxacin will cost $45 out of pocket. Which referral is the priority?

a. Dietitian for high-protein meal planning.

b. Social worker for prescription assistance and housing-resource review.

c. Physical therapy for wheelchair conditioning.

d. Spiritual care for emotional support.

CORRECT **B.** Affordability of the antibiotic is the immediate risk to outcomes; basement apartment without AC raises housing-quality concerns. Both are *social-worker territory.*

A Dietitian is reasonable but not priority. C PT is not the time-critical need. D Spiritual care is optional and client-driven.

TRAP Picking the "warm" answer (spiritual care) instead of the answer that prevents readmission (medication and housing access).

CJMM Step 4 — Generate Solutions.

Q11

HANDOFF/SBAR SCENARIO · TAKE ACTION

During SBAR handoff to the home health RN, which information is ***most*** critical for the discharging RN to communicate?

a. The client prefers a vegetarian diet.

b. The client's last bowel movement was yesterday morning.

c. The client received the last IV antibiotic dose at 0800 and has a 1300 oral dose due today.

d. The client's daughter usually visits on Thursdays.

CORRECT **C.** Pending or due medications — especially time-sensitive antibiotics — are critical handoff items that change what the receiving clinician will *do next*. Time-critical, safety-critical = always communicate.

A, B, D All are useful background but not safety-critical handoff content.

TRAP Padding handoff with social details while burying a time-sensitive medication. SBAR is about decision-relevant information.

CJMM Step 5 — Take Action.

Q12

MULTIPLE CHOICE · TAKE ACTION

A client recovering from a stroke is being discharged to a daughter's home. The daughter pulls the nurse aside and whispers, "I really don't know if I can handle this. Please don't tell my dad I said anything." The best action by the nurse is to:

a. Reassure the daughter and continue with discharge as planned.

b. Document the daughter's statement and proceed with discharge.

c. Stop the discharge process, notify the case manager and provider, and explore caregiver support options.

d. Tell the father what the daughter said so the family can plan together.

CORRECT **C.** Caregiver collapse is a safety risk. The RN halts the unsafe discharge, engages case management/social work for respite, home health, or alternative placement, and protects the client and the caregiver.

A Dismisses the cue. B Document but do not act — unsafe. D Breaks the daughter's confidence; not the RN's role to disclose without consent unless safety requires it.

TRAP Choosing "documentation" as if it equals safety. Documentation alone is not an intervention.

CJMM Step 5 — Take Action.

SECTION 07 · UNFOLDING NGN CASE

Mrs. Aliyah Boateng — 72, Post-Ischemic Stroke, Day 6

NURSE'S NOTES — 0800 · STROKE STEP-DOWN UNIT

0800. Pt is a 72-year-old female admitted 6 days ago for left MCA ischemic stroke. She received IV tPA within window and has improved steadily. Current deficits: mild right-sided weakness (4/5 UE, 4/5 LE), expressive aphasia (improving), mild dysphagia per SLP. She walks with a rolling walker and supervision for short distances. Continent. Skin intact.

Pt lives at home with husband (74, recently diagnosed with mild dementia) in a one-story rented house. One adult daughter lives in the same state but works full time. The daughter states, "I can come on weekends. I can't do daily." Husband attends visits but at this morning's visit was unable to recall the morning's plan after 10 minutes.

Pt's BP has been labile this admission. She is on aspirin, atorvastatin, lisinopril, and a new prescription for apixaban. Last pharmacy benefit check: apixaban copay $312/month.

Pt states (with effort): "I want... home. Not nursing home."

VITAL SIGNS — 0800

TEMP	HR	BP	RR	SpO_2
37.0°C	82	168/94	16	97% RA

PROVIDER ORDERS — 0815

- Discharge to home tomorrow if stable.
- Continue ASA 81 mg PO daily, atorvastatin 40 mg PO daily, lisinopril 20 mg PO daily, apixaban 5 mg PO BID.
- PT/OT evaluation prior to discharge.
- SLP swallowing reassessment prior to discharge.
- Home health referral.
- Follow-up with neurology in 1 week.
- Diet: soft, thin liquids as tolerated per SLP.

HEALTH CARE TEAM NOTES — 0900

SLP (0910): Mild residual dysphagia. Recommend soft, moist textures. Family teaching done. Recommend home swallow strategies sheet.

PT (1005): Pt ambulates 30 ft with rolling walker and supervision. Recommend home PT 3×/week ×4 weeks. Home safety eval recommended.

Case manager (1100): Home health intake initiated; pending insurance auth. Apixaban manufacturer assistance program pending. Husband's cognitive status flagged — caregiver burden concern.

Daughter (1130): "I love my parents but I can't be there every day. Is there anyone who can help?"

Q01

CJMM STEP 1 · RECOGNIZE CUES · SATA

Which findings in Mrs. Boateng's chart are ***concerning*** and require the nurse to act? Select all that apply.

a. BP 168/94

b. SpO_2 97% on room air

c. Husband unable to recall the morning's plan after 10 minutes

d. Pt walks 30 ft with walker and supervision

e. Apixaban copay $312/month

f. Daughter cannot be present daily

g. Pt states "I want home, not nursing home"

CORRECT **A, C, E, F.**

A labile/elevated BP after recent stroke increases re-stroke risk and may need adjustment before discharge. **C** the husband's memory deficit means he cannot reliably supervise medications, swallowing, or watch for stroke recurrence. **E** $312/month copay is a major adherence barrier — apixaban prevents a second stroke. **F** the only daily caregiver option is uncertain — a caregiver gap.

B, D, G are expected findings or client wishes that *guide*, not stop, the plan.

TRAP Treating the client's wish (G) as a "cue to fix" rather than a value to honor.

Q02

CJMM STEP 2 · ANALYZE CUES · DROP-DOWN

The nurse synthesizes the cues. The most likely safety concerns are that Mrs. Boateng is at risk for **[re-stroke / pneumonia / falls]** due to **[uncontrolled BP and possible apixaban nonadherence / poor pulmonary hygiene / new dysphagia]**, and that her home environment **[has an inadequate primary caregiver / is unsafe due to oxygen / lacks running water]**.

CORRECT **re-stroke · uncontrolled BP and possible apixaban nonadherence · has an inadequate primary caregiver.**

The cues cluster into two patterns: *physiologic risk for recurrent stroke* (BP, anticoagulant access) and *caregiver inadequacy* (husband's dementia, daughter unable daily).

TRAP Latching onto dysphagia or fall risk because they are visible deficits, while missing the deeper recurrent-stroke risk and the caregiver gap.

Q03

CJMM STEP 3 · PRIORITIZE HYPOTHESES · MULTIPLE CHOICE

Which is the ***priority*** hypothesis the nurse should address first?

a. Mrs. Boateng will aspirate at home due to dysphagia.

b. Mrs. Boateng will not be able to afford apixaban and will have a recurrent stroke.

c. Mrs. Boateng's husband will become overwhelmed.

d. Mrs. Boateng will not be able to ambulate safely at home.

CORRECT **B.** A recurrent stroke is the most lethal and time-sensitive outcome. Without apixaban, the risk skyrockets. Resolving the affordability problem is a discharge-stopper-level priority.

A Managed by SLP plan and diet. C Real but addressed via referrals. D Addressed via home PT/OT.

TRAP Choosing the "human" priority (caregiver burden) over the lethal physiologic priority (recurrent stroke).

Q04

CJMM STEP 4 · GENERATE SOLUTIONS · MATRIX

For each problem, identify the ***most appropriate*** referral.

PROBLEM	PHARMACIST	SOCIAL WORKER	CASE MANAGER	HOME HEALTH RN	SLP
Apixaban affordability	•	•			
Home BP monitoring & weekly visits				•	
Coordinating insurance auth & DME			•		
Caregiver respite resources		•	•		
Swallowing reassessment in home					•

CORRECT Pharmacist and social worker collaborate on affordability (manufacturer programs, generic substitutions, prescription assistance). Home health RN delivers intermittent skilled care. Case manager coordinates insurance, DME, and complex transitions. SLP handles dysphagia care. Caregiver burden falls to both social work and case management.

TRAP Picking only one professional when two are correct. NGN matrix items often have multiple correct combinations per row.

Q05

CJMM STEP 5 · TAKE ACTION · ORDERED RESPONSE

Place the nurse's actions in the correct order before discharging Mrs. Boateng tomorrow.

1. Verify pharmacy filled apixaban or assistance program is confirmed.
2. Notify provider of BP 168/94 and the husband's cognitive status.
3. Confirm home health intake is approved and first visit is scheduled within 24–48 hours.
4. Provide written discharge instructions in the client's preferred language with teach-back.
5. Coordinate with case manager regarding caregiver respite and home safety eval.
6. Reassess BP and ambulation prior to physical discharge.

CORRECT **2 → 1 → 5 → 3 → 4 → 6.**

Notify the provider first (the BP and caregiver findings affect the entire plan). Confirm the lethal-risk solution next (apixaban access). Coordinate the systemic supports (caregiver respite). Confirm the bridge (home health). Then teach. Then reassess just before physical discharge.

TRAP Putting teaching first. Teaching does not fix unaffordable medication or an unsafe caregiver plan.

Q06

CJMM STEP 6 · EVALUATE OUTCOMES · MATRIX

At a 72-hour post-discharge home health visit, which findings indicate the discharge plan was *effective*?

FINDING	EFFECTIVE	INEFFECTIVE	UNRELATED
BP 132/78 at home visit	•		
Apixaban bottle on the counter, dated today	•		
Husband saying "I forgot what the pills are for"		•	
Daughter on speakerphone reviewing the medication list	•		
Client lost 1 lb since discharge			•
No follow-up appointment scheduled		•	

CORRECT Controlled BP and active anticoagulant use indicate stroke-prevention goals are being met. Husband's confusion is a sign that the caregiver plan needs reinforcement (ineffective). Daughter participating remotely is an effective caregiver workaround. No follow-up scheduled is an ineffective coordination outcome. A 1-lb weight change is clinically unrelated at this visit.

TRAP Marking every "concerning" finding as "ineffective" — the weight change is not a discharge-plan outcome.

SECTION 08 · PRIORITIZATION DRILLS

"What Should the Nurse *Do First*?"

1. A client being discharged on warfarin says, "I can't read the instructions. Can my granddaughter just read them to me later?" The granddaughter is 10 years old.

   First: Obtain a qualified interpreter or a literacy-appropriate teaching method *before* discharge; do not delegate teaching to a minor. Family members — especially minors — are never the teaching pathway.

2. A home-bound client on home oxygen reports "the concentrator alarmed and I think it's broken" 30 minutes after discharge.

   First: Switch to portable/backup oxygen tank (RN should have taught this), then call DME vendor for replacement. Patient safety (oxygenation) precedes problem solving.

3. A new admission says her wound dressing supplies "never got delivered" before today's discharge.

   First: Stop the discharge process, notify case management/DME vendor, and verify supplies are en route or hand-delivered before client leaves the unit.

4. A client with home hospice care says, "I changed my mind. I want full treatment again."

   First: Honor client autonomy. Notify the provider and case manager to coordinate withdrawal from hospice and resumption of curative care. The client may revoke hospice at any time.

5. An LPN/VN reports that a discharged client's family called and "wants to know what dose of insulin to give if Grandma is sleepy after dinner."

   First: RN must take the call. This is an assessment + judgment question that requires the RN's scope; refer family to home health or the provider as appropriate.

SECTION 09 · DELEGATION DRILLS

"Can This Be *Delegated*?"

1. Teaching a stable, ambulating client how to use a new walker before discharge.

   Answer: Yes — to **PT (initial teaching)** or the RN can reinforce. UAP can ambulate the client *after* teaching is established. NCLEX flag: do not delegate *initial* walker teaching to UAP.

2. Calling the durable medical equipment company to confirm the home oxygen concentrator delivery time.

   Answer: Yes — to UAP or unit clerk. Clerical/verification task. The RN evaluates the result.

3. Reviewing the client's medication reconciliation list with the client at discharge.

   Answer: No — RN only. Medication reconciliation requires assessment of understanding and intervention if discrepancies exist.

4. Performing the first home suctioning of a tracheostomy on a stable client by an experienced LPN/VN.

   Answer: Yes — within LPN/VN scope for a stable client with an established care plan. NCLEX flag: never to UAP.

5. Determining whether a client needs a hospice referral.

   Answer: No — this is an RN/provider judgment. Initiation of the referral requires assessment of prognosis, client wishes, and order.

SECTION 10 · REFERRAL DRILLS

"Who Should the Nurse *Contact*?"

1. A discharged client cannot afford the prescribed inhaler.

   Contact: Social worker (prescription assistance, manufacturer programs); **pharmacist** may identify generic/lower-cost alternatives; notify **provider** if a switch is needed.

2. A client recovering from a CVA has new-onset dysphagia identified pre-discharge.

   Contact: Speech-language pathologist (SLP) for swallow eval and diet recommendations; **dietitian** for tailored texture-modified meal plan; **home health** for follow-up.

3. The client and family are choosing comfort over curative treatment with a 5-month prognosis.

   Contact: Hospice referral via the provider; engage **chaplaincy/spiritual care** as the client requests; **case manager** coordinates intake.

4. A discharged client with new heart failure asks about home BP/weight monitoring.

   Contact: Home health RN for intermittent skilled visits; **case manager** for DME (scale, BP cuff); **dietitian** for low-sodium diet teaching.

5. A client about to be discharged tells the nurse, "My husband took my last paycheck and now I'm afraid to go home."

   Contact: Social worker immediately (intimate partner violence resources, safe housing); ensure privacy; follow mandatory reporting laws by state; notify **provider** and document objectively.

SECTION 11 · LEGAL & ETHICAL TRAPS

Legal / Ethical *Trap Scenarios*

1 A 16-year-old client wishes to refuse a recommended home-health follow-up after a suicide attempt; the parents disagree.

Trap: Minors do not have the same autonomy as adults; depending on state mandatory hold laws and emancipation, the parent and the team may be required to ensure follow-up. Engage **social work, mental health team, and ethics committee**; never discharge a high-risk client without a safety plan.

2 A client with capacity refuses all proposed home services, saying "Let me die in peace." The daughter insists you "make her accept the help."

Trap: Autonomy wins. Capacity + informed refusal = right to refuse. Document carefully, provide warning signs, offer a re-entry point, notify provider. Engage the daughter compassionately but do not coerce the client.

3 A nurse posts a non-identifying photo of "my favorite patient leaving today!" on a private Instagram.

Trap: Even non-identifying posts can violate HIPAA when combined with time, location, or relationship cues. The photo and post must be removed; the nurse should be educated; severe cases warrant reporting per facility policy.

4 A case manager calls and says, "Just discharge the patient. The insurance won't pay another day." The client is hypotensive and weak.

Trap: Discharge decisions are clinical, not financial. The RN escalates via the **chain of command** and the provider; document objectively. Refusal to discharge an unstable client is part of the RN's legal duty.

5 The nurse notices bruising in various stages on an older adult client's arms during discharge prep. The client says, "My son grabs me sometimes when he's tired." Son is the planned caregiver.

Trap: Mandatory reporting applies. Do not discharge to the suspected abuser. Notify **social work, provider, case management,** and the appropriate **Adult Protective Services** agency per state law. Document the client's exact statements in quotes; the RN's duty is to the client's safety, not family preservation.

SECTION 12 · END-OF-DAY QUICK REVIEW

Quick-Review *Tablets*

10 One-Line Must-Remember Points

1. Discharge planning begins on the day of admission.
2. Initial teaching = RN; reinforcement = LPN/VN; UAP never teaches.
3. Social worker handles social, financial, housing, food, IPV, abuse, transportation.
4. Case manager handles complex coordination, insurance, DME, transitions of care.
5. Home health is intermittent skilled care; client must be homebound for Medicare coverage.
6. Hospice = ≤6-month prognosis + comfort-focus; palliative care can run with curative care any time.
7. Affordability and access — not effort — drive medication adherence.
8. Oxygen + ignition source = hold the discharge.
9. Family members (especially minors) are not interpreters.
10. The RN's final job is to evaluate teach-back; "knows it" without teach-back is a failed discharge.

5 Common NCLEX Traps

1. Picking the dietitian when the issue is food *access* (social worker).
2. Picking the case manager when the issue is finances/housing (social worker).
3. Choosing "document and discharge" for a true safety cue.
4. Letting the spouse interpret the teaching.
5. Delegating the *first* teaching session to LPN/VN or UAP.

5 "Never Do This" Rules

1. Never discharge a client to an unsafe environment.
2. Never delegate the initial teach-back evaluation.
3. Never use a minor as an interpreter.
4. Never discharge against the client's stated wishes if they have capacity.
5. Never accept "insurance won't pay" as a reason to discharge an unstable client.

5 Safety-First Phrases to Recognize on NCLEX

1. "Notify the case manager / social worker / provider before discharge."
2. "Validate understanding with teach-back."
3. "Obtain a qualified medical interpreter."
4. "Coordinate home health follow-up within 24–48 hours."
5. "Initiate referral and obtain provider order."

★ DAY 07 INFOGRAPHIC ★

Day 7 — Case Management, Referrals & Discharge Planning at a Glance

ADMIT · BEGIN DISCHARGE PLAN → ASSESS · RISKS & RESOURCES → REFER · GET ORDERS → TEACH · TEACH-BACK → COORDINATE · BRIDGE TO HOME → EVALUATE · FOLLOW-UP

Social Worker

- Financial & insurance navigation
- Medication assistance programs
- Housing instability
- Food insecurity, SNAP, Meals on Wheels
- Transportation barriers
- IPV, abuse, neglect
- Community resources, mental-health linkage

Case Manager

- DME (oxygen, wheelchair, walker)
- Home health coordination
- Rehab placement, SNF, LTAC
- Insurance authorization
- Hospice intake (often with provider)
- Inter-facility transitions
- Complex care plans

Home Health

- Skilled RN, PT, OT, ST, MSW visits
- Wound care, IV therapy, trach
- Disease-management teaching
- Client must be homebound
- Intermittent — NOT 24/7
- Requires provider order

Hospice

- Prognosis ≤6 months
- Comfort focus, no curative care
- Home, inpatient unit, SNF, AL
- Interdisciplinary (RN, MSW, chaplain, MD, HHA)
- Bereavement for 13 months post-death
- Client may revoke at any time

Palliative Care

- Any stage of serious illness
- Symptom & quality-of-life focus
- Can run with curative care
- No prognosis cutoff
- Consult-based, all settings

The Discharge "Stop" List

- Med unaffordable / unfilled
- DME / oxygen not delivered
- Unsafe home environment
- Caregiver collapse
- Teach-back fails
- Suspected abuse/neglect
- Pending critical lab abnormal
- New change in client condition

RN-Only Tasks

- Initial teaching
- Teach-back evaluation
- Identifying referral need
- Medication reconciliation
- Final discharge assessment
- Care coordination & judgment

LPN / UAP — Yes

- Reinforce previously taught content (LPN)
- Stable skilled tasks per scope (LPN)
- Verify DME delivery, call pharmacy (UAP)
- Transport to discharge curb (UAP)
- Stable ADL care (UAP)

Legal Anchors

- Capacity + informed refusal = right to refuse
- Mandatory report: abuse, neglect, IPV
- HIPAA — no social media re: patients
- Interpreter must be qualified — never minors
- Document objectively in client's words
- Discharge is clinical, not financial

DAY 07 COMPLETE · NEXT UP: DAY 08 — COLLABORATION WITH THE INTERPROFESSIONAL TEAM · SAVE · SCREENSHOT · REVIEW