2026 NCLEX-RN • MANAGEMENT OF CARE

Day 9 — Legal Responsibilities, Mandatory Reporting & Scope of Practice

SAFE & EFFECTIVE CARE ENVIRONMENT // NGN CLINICAL JUDGMENT MEASUREMENT MODEL

Application-level | NGN item types | 10+ practice questions | 1 unfolding case study | 20 mini-scenarios

01 / HIGH-YIELD OVERVIEW

§1 Why this day matters

The NCLEX wants to know whether you can **protect the client and yourself** by working **within the legal scope of practice**, **reporting what the law requires you to report**, and **recognizing unsafe or illegal practice** in yourself, your team, and the system.

Three legal pillars run through every question on this topic:

PILLAR 1

Scope of Practice

Defined by the **State Nurse Practice Act** (jurisdiction) + facility policy + your demonstrated competency. You may not perform — or delegate — anything outside that scope, even with a provider order.

PILLAR 2

Standard of Care

What a **reasonable, prudent nurse** with similar training would do in the same situation. Failure to meet it is the root of **negligence** and **malpractice**.

PILLAR 3

Mandatory Reporting

You are **legally required** — not optional — to report abuse, neglect, certain communicable diseases, gunshot/stab wounds, impaired colleagues, and unsafe practice. Reasonable suspicion is enough.

NGN translation

Expect items that combine cues (a client refusing care, a coworker smelling of alcohol, a child with patterned bruising, a verbal order phoned from home) with a question asking you to **recognize, prioritize, or act**. The correct answer is almost always the choice that protects the client first and follows the legal/ethical chain second.

02 / 10 MUST-KNOW RULES

§2 Ten rules that score points

01 **Scope is jurisdictional.** The Nurse Practice Act of the state where you practice — not the school you attended or where you're licensed — defines what you may do.

02 **An order does not expand scope.** A provider cannot order you to perform a task outside your legal scope (e.g., RN performing surgery, LPN/VN doing initial assessment in many states, UAP administering meds).

03 **"I didn't know" is not a defense.** The standard of care assumes you know your scope, your policies, and the medication you are giving.

04 **Negligence vs. malpractice.** Negligence = failure to act as a reasonable person; **malpractice = negligence by a professional acting in their professional role.** Malpractice requires the 4 Ds: *Duty, Dereliction (breach), Damages, Direct cause.*

05 **Mandatory reporting overrides confidentiality.** HIPAA does *not* protect abuse, neglect, gunshot wounds, communicable diseases on the reportable list, or impaired/unsafe practice.

06 **Reasonable suspicion is enough.** You do *not* need proof. You report to the correct agency (CPS, APS, public health, BON) and document objectively.

07 **Incident/variance reports are internal QI tools.** They are *never* placed in the chart, *never* referenced in the chart, and *never* used to assign blame.

08 **The chart is a legal document.** Chart objectively, in real time, using approved terminology. Late entries are labeled as such. *Never* alter, erase, or "white out" — single line through, initial, date.

09 **Abandonment is a license issue.** Once you accept an assignment, you cannot leave without proper handoff. Refusing an unsafe assignment is done *before* accepting it, in writing, up the chain of command.

10 **You are mandated to report your peers.** An impaired, diverting, or unsafe nurse must be reported to the charge nurse/supervisor and ultimately the Board of Nursing — protecting the public is your higher duty.

03 / RN SAFETY DECISION TABLE

§3 Situation → Best RN action

SITUATION	BEST RN ACTION	WHY IT'S SAFEST	COMMON NCLEX TRAP
Provider gives a verbal order over the phone for a high-alert medication.	Write it down, **read it back word-for-word**, get confirmation, then enter and have it co-signed within facility timeframe.	Read-back is the evidence-based barrier against transcription error; required by Joint Commission NPSG.	Trap: "Repeat the order back." Repeating is not the same as reading back what you wrote.
Colleague returns from break smelling of alcohol; speech is slurred.	Remove her from client care *immediately*, notify charge nurse/supervisor, document objectively. Report to BON per policy.	Public protection is the nurse's highest duty; impairment = imminent risk to clients.	Trap: "Confront her privately and offer to drive her home." Kind, but unsafe and not your role first.
Toddler in ED with spiral fracture of femur; mother's story keeps changing.	Treat injuries first, then **report suspected abuse to CPS**. Document objective findings only — quote the caregiver in quotation marks.	Mandatory reporters act on reasonable suspicion; investigation is CPS's job, not yours.	Trap: "Wait for the social worker to decide." You are an independent mandated reporter.
Provider orders a dose that you believe is 10× too high.	**Hold the medication**, contact the provider, state your concern using SBAR, document. Escalate via chain of command if not resolved.	"Following orders" is not a defense; the nurse is independently accountable for medication safety.	Trap: "Give the dose and notify the supervisor afterward." Never give what you believe is unsafe.
Client newly diagnosed with active pulmonary TB asks the nurse to keep it from his family.	Explain that TB is a **reportable communicable disease**; public health will be notified and will contact-trace. Offer support and education.	Public health law overrides individual confidentiality for reportable diseases.	Trap: "Honor the request because of HIPAA." HIPAA permits disclosure required by law.
UAP charts that the client ambulated 50 ft without difficulty — but client is in bed and IV is intact, not what UAP described.	Address with UAP, correct the documentation per policy (line through, initial, date, "error"), notify supervisor, complete variance report.	Falsifying records is fraud — a license and criminal issue. Documentation must reflect reality.	Trap: "Delete the entry from the EHR." Never delete; correct per policy and preserve audit trail.
You are floated to a unit where you have no competency (e.g., a med-surg RN floated to L&D).	Accept the assignment but state, *in writing*, that you will perform only tasks within your competency; request a buddy. Document up the chain.	Refusing outright = abandonment risk; performing outside competency = malpractice. Limited-scope acceptance protects both.	Trap: "Refuse the float assignment and go home." That is abandonment after report begins.

04 / DELEGATION & SCOPE

§4 Who can legally do what?

Scope varies by jurisdiction; NCLEX tests the **most restrictive, nationally accepted** version. When in doubt, default to: *RN does the first, the unstable, the teaching, the evaluation, and the IV push.*

TASK	RN	LPN/VN	UAP	CAN RN DELEGATE?	WHY / WHY NOT
Initial admission assessment of a new client	Yes	No	No	No — RN only	Initial assessment requires RN judgment and care-plan initiation.
Focused reassessment of a stable client	Yes	Yes	No	Yes, to LPN/VN	Reassessment of stable clients is within LPN/VN scope with RN oversight.
Vital signs on a stable post-op day 2 client	Yes	Yes	Yes	Yes	Routine, predictable, stable client = within UAP scope.
Vital signs immediately post-op or on unstable client	Yes	Sometimes	No	No to UAP	Unstable client requires nurse interpretation in real time.
Administer oral, SQ, IM medications	Yes	Yes	No	Yes, to LPN/VN	UAP cannot administer medications in most jurisdictions.
Administer IV push medications	Yes	No (most states)	No	No	IV push has narrow margin for error; RN-only on NCLEX.
Hang/initiate blood products	Yes	No	No	No	Initiation requires RN assessment; LPN/VN may monitor after RN initiates per facility policy.
Client and family *teaching*	Yes	Reinforce only	No	No (initial teaching)	Initial teaching is RN scope; LPN/VN may reinforce what RN already taught.
Evaluate client response / care plan effectiveness	Yes	No	No	No	Evaluation is the final nursing-process step and is RN-only.
Accept verbal/telephone orders	Yes	Per state	No	No (UAP)	UAP cannot receive orders; RN is preferred receiver for read-back.
Witness client signature on informed consent	Yes	Yes	No	Yes	Witness verifies signature only — not that the client understands. UAP cannot witness legal documents in nursing role.
Bathing, feeding, ambulating stable client	Yes	Yes	Yes	Yes	ADLs on stable clients are core UAP tasks.

TASK	RN	LPN/VN	UAP	CAN RN DELEGATE?	WHY / WHY NOT
Trach suctioning (established trach, stable)	**Yes**	**Yes**	**No**	**Yes, to LPN/VN**	Sterile/clinical judgment task; not within UAP scope.
Sterile dressing change on a stable wound	**Yes**	**Yes**	**No**	**Yes, to LPN/VN**	Requires sterile technique & assessment of wound — beyond UAP.
Reporting suspected abuse to CPS/APS	**Yes**	**Yes**	**Tell RN**	**Not delegable**	Each licensed nurse is an independent mandated reporter; UAP reports concerns to the RN.

5 Rights of Delegation — apply in this order

1. Right **task** (within scope & not RN-only)
2. Right **circumstance** (stable, predictable client)
3. Right **person** (competency verified)
4. Right **direction/communication** (clear, specific, with what to report back)
5. Right **supervision/evaluation** (RN follows up and evaluates outcome)

05 / RED-FLAG CUES

§5 What requires what — fast

IMMEDIATE ASSESSMENT

- Patterned bruising, cigarette-burn marks, retinal hemorrhages, frenulum tear in an infant
- Pressure injuries in a long-term-care resident with poor hygiene and weight loss
- Client states “he hits me when I forget my pills”
- Coworker stumbling, smelling of alcohol, pupils constricted
- Sudden discrepancy between narcotic count and EHR record

PROVIDER NOTIFICATION

- Client signs AMA discharge after risk education
- Order that appears unsafe (dose, route, allergy)
- New refusal of a critical treatment
- Significant change in client condition during your shift
- Family insists on care contradicting advance directive

RAPID RESPONSE

- Acute change in mental status, SpO_2, BP, HR, RR meeting RRT criteria
- Worried gut feeling about a deteriorating client
- New chest pain with diaphoresis
- Seizure activity outside known seizure pattern
- Suspected stroke (last known well documented)

CHAIN OF COMMAND

- Provider will not return your call and client is at risk
- Provider refuses to change unsafe order after you’ve voiced concern
- Staffing assignment is unsafe
- Manager dismisses a serious safety concern
- Ethical conflict that you cannot resolve at the bedside

MANDATORY REPORTING

- Suspected child abuse/neglect → CPS
- Suspected elder/vulnerable-adult abuse → APS
- Gunshot/stab wounds, certain animal bites → law enforcement
- Reportable communicable diseases (TB, measles, pertussis, HIV per state, meningococcal) → Public Health
- Impaired, diverting, or unsafe nurse → Supervisor & Board of Nursing

HOLD & REASSESS DELEGATION

- Client status changes from stable to unstable
- UAP reports an unexpected finding
- LPN/VN unsure about a task
- Float staff lacks competency for the task
- You did not give clear, specific direction

06 / NGN PRACTICE QUESTIONS

§6 Twelve advanced NGN items

Click *Reveal rationale* after attempting each item. Each rationale identifies the NCLEX trap and the clinical-judgment step being measured.

Q1 MULTIPLE CHOICE

A nurse on a medical–surgical unit is assigned four clients. Which client requires the nurse to perform an action that cannot be delegated to the LPN/VN or UAP?

A. A 72-year-old being admitted directly from the emergency department with newly diagnosed pneumonia.

B. A 56-year-old POD #2 from cholecystectomy who needs ambulation in the hallway.

C. A 64-year-old with stable heart failure who needs a fingerstick blood glucose.

D. A 48-year-old with a healing surgical wound who needs a routine sterile dressing change.

▸ REVEAL RATIONALE

Q2 SELECT ALL THAT APPLY

A nurse is legally mandated to report which of the following? *Select all that apply.*

A. An 80-year-old client at home who arrives with multiple stages of bruising and dehydration; daughter is sole caregiver.

B. A coworker who told the nurse she is sober but in recovery for opioid use disorder.

C. A 6-year-old with a spiral fracture and a story that does not match the injury.

D. A client newly diagnosed with active tuberculosis.

E. A 20-year-old who comes to the ED with a gunshot wound.

F. A client who states he plans to harm his sister tomorrow.

▸ REVEAL RATIONALE

Q3 MATRIX / GRID

For each finding, indicate whether the nurse is legally required to report, should document only, or should escalate to charge nurse first.

FINDING	MANDATORY REPORT	DOCUMENT ONLY	ESCALATE FIRST
Adult client states partner forced her to have sex last night	**✓ (per pt consent in some states / law enforcement in others)**		✓ — clarify pt wishes & legal jurisdiction
Coworker observed pocketing a hydromorphone vial	**✓ to supervisor & BON**		✓ — charge nurse immediately
Client with confirmed measles	**✓ Public Health**		
Client refuses ordered SCDs after risk education and demonstrates understanding		**✓ refusal + teaching**	
Toddler with cigarette-shaped burns and no caregiver explanation	**✓ CPS**		
UAP reports forgetting to do an I&O		**✓ correct & coach**	

▶ REVEAL RATIONALE

Q4 BOW-TIE

The nurse suspects a peer is diverting opioids: doses are signed out for clients who are alert and denying pain, the peer frequently volunteers to administer PRN narcotics, and post-administration pain scores remain unchanged.

Fill in the bow-tie:

Action 1 to take _____	**Condition most likely** _____	**Action 2 to take** _____
Parameter to monitor 1 _____	**Parameter to monitor 2** _____	

Choices: Confront the coworker privately • Notify the nurse manager immediately • Document objective observations • Continue to assist with PRN administration • **Substance use disorder / diversion** • Discharge planning • Witness all narcotic waste from this nurse for the remainder of shift • Client pain scores after administration • Narcotic dispensing-system reports • Coworker's break schedule

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▶ REVEAL RATIONALE

Q5 ORDERED RESPONSE

A provider gives a phone order for IV potassium chloride at a rate the nurse believes is unsafe. Place the nurse's actions in the correct order.

1. Document the order, the concern raised, and the resolution.
2. Hold the medication.
3. Read the order back to the provider and clearly state the safety concern using SBAR.
4. Notify the charge nurse / nursing supervisor.
5. If unresolved, escalate up the chain of command (medical director / risk management).
6. Administer per the corrected order.

▶ REVEAL RATIONALE

Q6 DROP-DOWN / CLOZE

Complete the sentence: A nurse who fails to raise the side rails on a sedated client, who then falls and fractures a hip, may be liable for [Blank 1] because the nurse breached the [Blank 2] owed to the client, which directly caused [Blank 3].

Blank 1 options: assault • battery • *malpractice* • false imprisonment

Blank 2 options: consent • *standard of care / duty* • advance directive • contract

Blank 3 options: emotional distress only • a HIPAA violation • *damages* • abandonment

▶ REVEAL RATIONALE

Q7 PRIORITIZATION

The nurse begins shift report and learns the following about four clients. Which client should the nurse see first?

A. An 18-month-old with a femur fracture; parents' explanation is inconsistent and the toddler is now resting comfortably with caregiver at bedside.

B. A 79-year-old with new-onset confusion and a temperature of 38.6 °C (101.5 °F) since the previous shift.

C. A client recently extubated who is hoarse but maintaining SpO_2 96 % on 2 L NC.

D. A client scheduled for surgery in 2 hours who has not yet signed the consent form.

▶ REVEAL RATIONALE

Q8 CASE-STUDY STYLE

A nurse on a busy unit is asked by a physician to "quickly co-sign" for a controlled-substance waste the physician already discarded down the sink 10 minutes ago. The nurse did not witness the waste. What is the nurse's best response?

A. "Sure, where do I sign?"

B. "I can't co-sign a waste I didn't witness. Let's follow the policy and report this through the Pyxis discrepancy report."

C. "I'll sign this time, but please call me before you waste next time."

D. "I'll ask another nurse to sign for you."

▶ REVEAL RATIONALE

Q9 DELEGATION SCENARIO

Which tasks may the RN appropriately delegate to a UAP? *Select all that apply.*

A. Obtaining vital signs on a stable client awaiting discharge.
B. Reinforcing a sterile dressing that has come loose.
C. Assisting a stable client with a bath and oral care.
D. Performing the initial fall-risk assessment on a new admission.
E. Recording oral intake and output during a meal.
F. Verifying a unit of blood at the bedside before transfusion.
G. Ambulating a POD #2 client who has been walking without difficulty.

▶ REVEAL RATIONALE

Q10 HANDOFF / SBAR

During end-of-shift report, the off-going nurse says, "I think the surgical resident may be using something — he was acting odd and the narcotic counts have been off the last three nights I've worked with him." What is the on-coming nurse's best response?

A. "We should both ignore it — we don't have proof."
B. "Let's file an anonymous complaint to the Board."
C. "We need to report this to the nurse manager today and document the objective findings."
D. "Talk to him directly first — he deserves a chance to explain."

▶ REVEAL RATIONALE

Q11 CLOZE

A nurse witnesses a UAP slap a confused resident in a long-term-care facility. The nurse should [Blank 1], then [Blank 2], and finally [Blank 3].

Blank 1: finish the medication pass • *immediately stop the UAP and ensure the resident is safe* • call the family

Blank 2: wait for the supervisor to arrive in the morning • *notify the charge nurse / administrator and complete a variance report* • document only in the resident's chart

Blank 3: *report to APS and the state survey agency as required by law* • forget about it if the resident is unhurt • discuss with the UAP at lunch

▶ REVEAL RATIONALE

Q12 EVALUATE OUTCOMES

A nurse completed a mandatory report to CPS yesterday regarding a toddler with suspected non-accidental trauma. Today the nurse reviews the plan of care. Which findings indicate that the nurse's legal and clinical responsibilities have been appropriately fulfilled? *Select all that apply.*

A. Objective documentation in the chart of bruising patterns, measurements, and direct quotes from caregivers.

B. A photograph of the caregiver included in the chart.

C. Notation that CPS report was made, including date, time, and report number, in the facility's designated location (not in the public chart in most facilities).

D. A handwritten note explaining the nurse's personal opinion of the caregiver's guilt.

E. Care plan updated with safety, comfort, and trauma-informed communication interventions.

F. Coordination with social work and child-protective team prior to discharge planning.

▶ REVEAL RATIONALE

07 / UNFOLDING NGN CASE STUDY

§7 Case: "The verbal order, the bruise, and the impaired nurse"

CHART — CONFIDENTIAL

SETTING	Med-surg unit, 1900 shift change.
CLIENT	M.B., 4-year-old female, admitted at 1730 with suspected pneumonia.
VITAL SIGNS (1900)	T 39.1 °C (102.4 °F) • HR 142 • RR 38 • SpO_2 91 % on RA • BP 92/56
ALLERGIES	No known drug allergies.
NURSE'S NOTES	Child quiet, withdrawn, flinches when nurse approaches. Linear bruise pattern across upper back, 4×6 cm, yellow-green. Old, healed circular burn on right forearm. Mother present, irritable; states, "She's clumsy, she always bumps into things." Father not present; per mother, "he's at work."
PROVIDER ORDERS (VERBAL, PHONED FROM HOME BY DR. K AT 1850)	"Ceftriaxone 2 g IV now. Acetaminophen 320 mg PO PRN fever. Discharge home in the morning if afebrile."
LAB/IMAGING	CXR: right lower lobe consolidation. WBC 18.4. CRP elevated. Lactate 2.4.
FAMILY STATEMENT	Mother (to nurse, in hallway): "Please don't ask any more questions. She's fine. Just give her the antibiotic and we'll be on our way."
TEAM NOTES	Off-going RN (J.L.) reports she has been working extra shifts and admits she "took a hydromorphone home last week by accident and brought it back today." She appears tearful and asks the on-coming RN, "Please don't say anything."

CASE Q1 | RECOGNIZE CUES — SATA

Which findings are cues of concern that the nurse must act on? ***Select all that apply.***

A. SpO_2 91 % on room air with RR 38

B. Ceftriaxone 2 g IV now

C. Linear bruise pattern across upper back + old healed burn

D. Mother asking the nurse to stop asking questions

E. Verbal order to discharge home in the morning

F. Off-going RN admitting to taking a controlled substance home

G. Mother's statement that child is "clumsy"

▶ REVEAL RATIONALE

CASE Q2 | ANALYZE CUES — MATRIX

For each issue, identify the *primary* nursing concern.

ISSUE	PRIMARY CONCERN
RR 38, SpO_2 91 %, lactate 2.4, WBC 18.4	Worsening pneumonia / early sepsis — physiological instability
Pattern bruising + healed burn + behavioral changes	Suspected child abuse — mandatory report
Verbal order to discharge in AM	Premature discharge given physiology & safety concerns
Mother's deflective statements	Caregiver dynamic that may not be safe for child
Off-going RN's admission of diverting	Impaired/diverting nurse — mandatory report to manager & BON

▶ REVEAL RATIONALE

CASE Q3 | PRIORITIZE HYPOTHESES — ORDERED RESPONSE

Place the nurse's actions in the correct priority order.

1. Report suspected child abuse to CPS.
2. Report the off-going RN's admission of diversion to the nurse manager.
3. Notify the provider of the child's vital signs and lactate, and clarify the discharge plan.
4. Apply supplemental oxygen and initiate sepsis bundle as ordered.
5. Document objective findings in the chart and complete the CPS-report documentation per facility protocol.

▶ REVEAL RATIONALE

CASE Q4 | GENERATE SOLUTIONS — SATA

Which interventions are appropriate? *Select all that apply.*

A. Place child on continuous SpO_2 monitoring, apply O_2 to maintain > 94 %, draw repeat labs.
B. Speak with mother privately and threaten her with arrest if she does not tell the truth.
C. Notify provider via SBAR; recommend admission continuation and sepsis workup; request social work and pediatric trauma consult.
D. Call CPS from a private area as soon as the child is stabilized; document the report time/number per policy.
E. Allow off-going RN to “sleep it off” in the break room until shift end.
F. Remove off-going RN from the floor, notify the nurse manager / supervisor immediately, and ensure she does not drive impaired.
G. Document objective findings using approved terminology; quote caregiver statements in quotation marks.

▶ REVEAL RATIONALE

CASE Q5 | TAKE ACTION — DROP-DOWN

The nurse calls Dr. K back. Complete the SBAR script:

“Dr. K, this is M.S., RN, on the pediatric floor. **Situation:** M.B., 4 y/o, admitted with right-lower-lobe pneumonia. **Background:** Currently **[Blank 1: HR 142, RR 38, SpO_2 91 % RA, T 39.1, lactate 2.4]**. **Assessment:** I am concerned for **[Blank 2: early sepsis]** and I have also identified **[Blank 3: pattern bruising and a healed burn]** which I am required to report. **Recommendation:** I recommend **[Blank 4: continued admission, sepsis bundle, social work + child protection consult, and reversal of the AM-discharge plan]**.*”*

▶ REVEAL RATIONALE

CASE Q6 EVALUATE OUTCOMES — MATRIX

Two hours later. Indicate whether each outcome shows improvement, no change, or worsening.

FINDING AT 2100	IMPROVEMENT	NO CHANGE	WORSENING
HR 118, RR 28, SpO_2 95 % on 2 L NC, T 38.4	✓		
Lactate 2.5		✓	
Social work and CPS report initiated; safety plan documented	✓		
Off-going RN escorted off unit; employee health and manager notified; BON report initiated per policy	✓		
Mother demands AMA discharge against medical advice			✓

▶ REVEAL RATIONALE

08 / "DO THIS FIRST"

§8 Five prioritization mini-scenarios

1. While preparing a high-alert medication, the nurse is interrupted by a UAP who says, "Mr. Jones in Room 4 says his chest hurts."

First action: Stop preparing the medication, leave it in a secured area, and immediately go assess Mr. Jones. *Why:* A new chest-pain complaint is a possible MI / unstable cue (ABCs) and outranks medication preparation. Never administer a medication you stopped mid-prep.

2. The nurse discovers a verbal order entered into the EHR that the nurse did not receive and that contains a dose discrepancy.

First action: Hold the medication, contact the prescribing provider, and clarify the order using read-back. *Why:* Receiving and verifying provider orders is RN scope; the nurse must independently ensure safety before administration.

3. A nurse sees a colleague photograph a child client during a procedure "for personal memories."

First action: Direct the colleague to stop and delete the photo; ensure no images are stored or posted. *Why:* HIPAA + facility privacy + state law all prohibit unauthorized photography. Stopping the breach now is the first protective step; reporting follows.

4. The nurse arrives to a new assignment to find a continuous heparin infusion running at a rate that does not match the provider order.

First action: Stop / adjust the infusion to a safe rate per order, then assess the client for bleeding/clotting effects, then notify provider and complete a variance report. *Why:* High-alert medication mismanagement requires immediate correction of the active harm.

5. During admission, a competent adult client states, "Whatever happens, do not put me on a breathing machine." There is no documentation on file.

First action: Document the client's verbal statement and immediately initiate the advance-directive conversation; notify provider; involve social work / case management to formalize the directive in writing. *Why:* Self-determination must be respected; documentation begins the legal record.

09 / CAN THIS BE DELEGATED?

§9 Five delegation mini-scenarios

1. A UAP asks if she may obtain a urine culture from a Foley bag drainage port on a stable client.

Answer: No — this requires sterile technique, sampling-port aspiration, and clinical judgment about specimen integrity. *RN or LPN/VN* should perform.

2. A stable client one day after a planned vaginal delivery needs help walking to the bathroom for the first time.

Answer: Yes — UAP may assist with first ambulation of a *stable* client once the RN has verified ambulation safety and instructed UAP what to report (dizziness, bleeding).

3. The RN wants to delegate the AM bath of a client on droplet precautions for influenza.

Answer: Yes — UAP may perform if competent in droplet precautions and PPE is available. The RN confirms competency and PPE access first.

4. An LPN/VN asks if she may complete the initial admission assessment for a new chemotherapy admission.

Answer: No — initial admission assessment is RN-only; the LPN/VN may collect data and contribute, but the RN must complete and sign.

5. The RN delegates blood glucose checks to a UAP on a newly admitted client with brittle type 1 diabetes whose recent readings have ranged from 38 to 412 mg/dL.

Answer: No — the client is *unstable/unpredictable*. While fingersticks are usually delegable, the 5th right (right circumstance) fails. RN performs.

10 / WHO SHOULD THE NURSE CONTACT?

§10 Five referral mini-scenarios

1. A client newly diagnosed with end-stage pancreatic cancer asks the nurse what "comfort care" means.

Contact: Palliative care + chaplain + social work; provider for orders to consult. *Why:* Goals-of-care conversations and symptom management are palliative scope; spiritual and psychosocial support align with comprehensive care.

2. A client who is non–English speaking is consenting to surgery, and the nurse suspects he does not understand.

Contact: Qualified medical interpreter (in-person or telephonic per facility policy) *and* the surgeon to re-explain. *Never* use family or untrained staff as interpreters for informed consent.

3. A 16-year-old client confides she has been physically assaulted by a parent at home.

Contact: CPS (mandatory report), social work, charge nurse, provider; consider law enforcement per facility/state policy. *Why:* 16-year-old is a minor — CPS mandatory.

4. A client with a tracheostomy is being discharged home but lacks a working suction machine.

Contact: Case management / discharge planner + DME (durable medical equipment) vendor + home health. *Why:* Discharge without essential equipment is unsafe and breaches the standard of care.

5. The RN is concerned that staffing assignments tonight are unsafe and the charge nurse has dismissed the concern.

Contact: Nursing supervisor → nursing director → administrator-on-call (chain of command). Document in writing. *Why:* Documented escalation protects the nurse's license and prompts system response.

11 / LEGAL / ETHICAL TRAP

§11 Five tested traps

1. A competent adult Jehovah's Witness with active GI bleeding refuses blood. Family begs the nurse to "just give it."

Trap & correct action: Autonomy / refusal of care. The competent adult's refusal stands — the nurse advocates, documents informed refusal, explores alternatives (cell salvage, EPO), and supports family without coercing client. Giving blood against the client's informed wishes = *battery*.

2. A spouse asks the nurse to give a status update by phone.

Trap & correct action: HIPAA — verify identity and confirm the client has authorized disclosure of information to that spouse. Without authorization, do not disclose. Marriage alone does not equal automatic authorization.

3. The RN discovers a coworker has posted a photo of a unit hallway with a partially visible patient name board to social media.

Trap & correct action: Even partial PHI on social media = HIPAA breach. Direct coworker to remove the post, notify privacy officer/manager, document. Posting workplace images with identifying details is a sanctionable, sometimes terminating offense.

4. A confused older adult with no DNR repeatedly removes his oxygen mask. The family demands that the nurse restrain him.

Trap & correct action: Restraints require a provider order, are *last-resort*, and require continuous monitoring, documentation, and time-limited renewals. Try least-restrictive interventions first (reorientation, family presence, sitter, alternative O_2 delivery). Restraining without proper order/policy = *false imprisonment*.

5. A nurse working a 16-hour shift charts vital signs that she did not actually obtain because "the values were probably the same."

Trap & correct action: *Falsification of records* — fraud, license revocation, and possible criminal liability. The chart is a legal document. Chart only what was performed; if missed, document the omission and address it (late entry only with policy compliance).

12 / END-OF-DAY QUICK REVIEW

§12 What you must remember

10 one-line must-remember points

1. The Nurse Practice Act of the state of practice defines your scope.
2. A provider order does not legalize an action outside your scope.
3. Malpractice = Duty + Breach + Damages + Direct cause.
4. Mandatory reporting overrides HIPAA.
5. Reasonable suspicion — not proof — triggers a report.
6. Incident/variance reports stay *out of* the chart.
7. Late entries are labeled "late entry," never disguised.
8. Hold first, then clarify, then escalate.
9. Refusing an unsafe assignment must happen *before* accepting.
10. Reporting an impaired peer protects clients and the peer.

5 common NCLEX traps

1. "Confront the impaired coworker privately first." → wrong; go to chain of command.
2. "Honor confidentiality and don't report TB." → wrong; communicable disease reporting is law.
3. "Co-sign a waste you didn't witness — just this once." → wrong; federal record falsification.
4. "Sign for a verbal order without read-back." → wrong; read-back is the standard.
5. "Delete or white-out a charting error." → wrong; line-through, initial, date, "error."

5 "Never do this" rules

1. Never administer a medication you believe is unsafe — hold first.
2. Never witness a consent you have not seen the client sign or whose competency you doubt.
3. Never restrain a client without an order, plan, and continuous reassessment.
4. Never share PHI on social media, even "de-identified."
5. Never leave an accepted assignment without proper handoff — that is abandonment.

5 safety-first phrases on NCLEX

1. "Hold the medication and contact the provider."
2. "Notify the charge nurse and complete a variance report."
3. "Report to CPS / APS / Public Health."
4. "Use SBAR with read-back."
5. "Document objective findings using approved terminology."

13 / SCREENSHOT & SAVE

§13 Day 9 Infographic Summary

CUE → CLARIFY SCOPE → CLIENT SAFE NOW? → REPORT (if required) → ESCALATE → DOCUMENT

Scope of Practice — Quick Filter

- **RN only:** initial assessment, teaching, evaluation, IV push, blood initiation, unstable clients
- **LPN/VN:** reinforced teaching, stable reassessment, PO/IM/SQ meds, sterile dressings, trach care
- **UAP:** ADLs, VS on stable clients, I&O, ambulation, fingersticks (stable)
- **Rule:** if the client is unstable, the RN takes it back

Mandatory Reporting Map

- Child abuse / neglect → CPS
- Elder / vulnerable adult abuse → APS
- Gunshot / stab wounds → Law enforcement
- Reportable communicable disease → Public health
- Impaired / diverting nurse → Manager + BON
- Threat to identifiable third party → Law enforcement / intended victim

4 Ds of Malpractice

- **D**uty owed to the client
- **D**ereliction (breach) of that duty
- **D**amages — actual harm occurred
- **D**irect cause linking breach to harm

5 Rights of Delegation

- Right task
- Right circumstance
- Right person
- Right direction / communication
- Right supervision / evaluation

Documentation Rules

- Objective + approved terminology
- Real-time entries, signed & timed
- Late entries labeled “late entry”
- Errors: single line, initial, date, “error”
- No subjective opinions / no blame
- Incident reports = QI tool, not in chart

Unsafe Order Algorithm

- **1.** Hold the medication / intervention
- **2.** SBAR + read-back to provider
- **3.** Charge nurse if unresolved
- **4.** Supervisor → medical director → risk mgmt
- **5.** Document everything

Chain of Command (typical)

- Primary RN → Charge nurse
- Charge nurse → Nursing supervisor
- Supervisor → Nursing director
- Director → Administrator-on-call

HIPAA in 5 lines

- Minimum-necessary information
- No PHI on social media — ever
- Verify identity before disclosing by phone
- Family ≠ automatic authorization

- Parallel: provider → medical director → risk mgmt / ethics committee

- Reporting required by law is permitted disclosure

Intentional Torts to Recognize

- **Assault** — threatening to act on the client
- **Battery** — unconsented touching (e.g., giving refused blood)
- **False imprisonment** — improper restraint use
- **Invasion of privacy** — disclosing PHI without consent
- **Defamation** — false statements (libel/slander)

NGN Judgment Cycle Today

- **Recognize:** patterned injuries, slurred speech in peer, dose discrepancies
- **Analyze:** separate physiologic vs legal vs ethical layers
- **Prioritize:** ABCs > immediate harm > required report
- **Generate:** hold, SBAR, escalate, report, refer
- **Take action:** within scope + within law
- **Evaluate:** client safer? duty fulfilled? documentation complete?

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