CLINICALJUDGE™ · MASTER STUDY GUIDE

MANAGEMENT OF CARE

The largest scored category on the 2026 NGN NCLEX-RN. This guide gives you everything inside "Management of Care" under the Safe & Effective Care Environment domain — prioritization, delegation, legal & ethical practice, client rights, consent, confidentiality, collaboration, case management, quality & risk, leadership, and documentation — at the depth needed to master it.

2026 NGN BLUEPRINT | SAFE & EFFECTIVE CARE ENVIRONMENT | ~15–20% OF THE EXAM | LEGAL · ETHICAL · LEADERSHIP | DELEGATION · CONSENT · QI

RED	BLUE	GREEN	ORANGE	YELLOW	PURPLE	TEAL
PRIORITY / LEGAL RISK	CONCEPT / DEFINITION	CORRECT NURSING ACTION	ROLES / TIERS	MUST-KNOW FACT	FRAMEWORK	STRATEGY / TEACHING

WHAT "MANAGEMENT OF CARE" ACTUALLY TESTS

It rewards the nurse who can **prioritize correctly, delegate within scope, protect client rights and safety, follow legal/ethical standards, and coordinate care across the team.** Master the principles below and the question's "best answer" becomes predictable.

01 ESTABLISHING PRIORITIES

WHO TO SEE FIRST · WHAT TO DO FIRST

PRIORITY-SETTING FRAMEWORKS

Run options through these, top to bottom

1. **ABC** — Airway → Breathing → Circulation (C-A-B in cardiac arrest)
2. **Maslow** — physiological needs before psychosocial
3. **Safety** — protect from imminent harm (falls, errors, self-harm, infection)
4. **Nursing process** — assess before acting (unless an emergency threatens ABCs → act)
5. **Acute / unstable / unexpected / actual** over chronic / stable / expected / potential

FIRST-ACTION LOGIC

When the question asks "what first?"

- Address the airway/breathing threat before anything else
- Choose the **least invasive** effective action before escalating
- **Treat the client, not the monitor** — assess the person before an alarm/number
- Do independent nursing actions before calling the provider (unless an order is required)
- Don't leave an unstable client to "call" or "fetch"; don't pick "document" first in a crisis

Reframe: "Priority" = the client most physiologically unstable and most likely to be harmed without immediate nursing action.

SORTING CLIENTS FAST

DIMENSION	OFTEN WAITS	OFTEN FIRST
Stability	Stable, predictable	**Unstable, changing**
Acuity	Chronic, unchanged baseline	**Acute, new onset**
Expectedness	Expected for the situation	**Unexpected / abnormal**
Problem type	Potential / "risk for"	**Actual / happening now**
System threatened	Comfort, mobility, psychosocial	**Airway, breathing, circulation, neuro**

02 DELEGATION & ASSIGNMENT

RIGHT TASK · RIGHT PERSON · RIGHT SCOPE

THE 5 RIGHTS OF DELEGATION

NCSBN framework

1. **Right Task** — delegable, routine, predictable
2. **Right Circumstance** — stable client, expected outcome
3. **Right Person** — within that worker's scope & competence
4. **Right Direction/Communication** — clear, specific, measurable
5. **Right Supervision/Evaluation** — RN follows up & evaluates result

THE RN NEVER DELEGATES

Mnemonic: you can't delegate what you "EAT"

- **E**valuation of care & client outcomes
- **A**ssessment (initial and ongoing nursing assessment)
- **T**eaching & any task requiring nursing judgment

Also RN-only: care of **unstable/unpredictable** clients, the first dose & IV titration of high-alert meds, blood transfusion initiation, and developing the plan of care.

SCOPE OF PRACTICE — WHO CAN DO WHAT

ROLE	CAN DO	CANNOT DO
RN	Assessment, nursing diagnosis, care planning, teaching, evaluation; unstable clients; IV-push meds; blood; triage; any task requiring judgment	—
LPN / LVN	Stable clients with predictable outcomes; most routine meds (PO/IM/SubQ); wound care; tube feeds; foley/ostomy care; reinforce teaching; focused data collection & monitoring	Initial assessment; create care plan; IV-push (most states); start blood; teach new content; evaluate outcomes; unstable clients
UAP / AP / CNA	ADLs, bathing, feeding (no dysphagia), ambulation, hygiene, repositioning, vital signs & I&O on STABLE clients, weights, specimen collection, stocking	Assessment, teaching, meds, sterile/invasive procedures, evaluation, interpreting data, anything on unstable clients

ASSIGNMENT PRINCIPLES

PRINCIPLE	APPLY IT LIKE THIS
Match acuity to scope	Most complex/unstable → RN; stable/predictable → LPN; basic ADLs & stable monitoring → UAP.
Match competency & experience	New grads/floats get stable, common conditions — not the highest-acuity or specialized clients.
Infection control / cohorting	Don't pair an immunocompromised client with an infectious client on the same nurse; honor isolation needs.
Pregnant staff cautions	Pregnant nurses avoid clients with rubella, CMV, radioactive implants, and shingles/varicella exposure.
Float nurse rule	Float to the area most like their own competency; don't assign unfamiliar specialty high-acuity clients.

03 SUPERVISION & CONCEPTS OF MANAGEMENT

OVERSIGHT · ACCOUNTABILITY · FUNCTIONS

SUPERVISION & ACCOUNTABILITY

Delegation ≠ abdication

- **Supervision** = providing guidance, direction, oversight, and evaluation of a delegated task.
- The RN who delegates **remains accountable** for the overall outcome and for appropriate delegation.
- The delegatee is accountable for **their own actions** within their scope.
- Verify competency, give clear direction, monitor, and intervene if care is unsafe.

Key: You can delegate a **task**, but you cannot delegate the **accountability** for the nursing process.

FUNCTIONS OF MANAGEMENT

What a manager/charge nurse does

- **Planning** — set goals, allocate resources, anticipate needs
- **Organizing** — structure work, staffing, assignments
- **Directing/Leading** — guide, motivate, communicate, delegate
- **Controlling/Evaluating** — monitor quality, outcomes, performance, budgets

Time management: do high-priority/urgent items first, cluster care, delegate appropriately, avoid interruptions, and reassess priorities as conditions change.

04 LEGAL RIGHTS & RESPONSIBILITIES

STANDARDS · TORTS · LIABILITY

THE LEGAL FOUNDATION

What governs nursing practice

- **Nurse Practice Act** — state law defining scope of practice (varies by state); board of nursing enforces & issues licensure
- **Standards of care** — what a reasonably prudent nurse would do in similar circumstances
- **Mandatory reporting** — abuse/neglect (child, elder, vulnerable), certain communicable diseases, gunshot/stab wounds
- **Good Samaritan laws** — protect nurses giving reasonable emergency aid in good faith

NEGLIGENCE VS MALPRACTICE

Unintentional torts

Negligence: failure to act as a reasonably prudent person would. **Malpractice:** professional negligence by a licensed person.

4 elements (all must be present):

1. **Duty** — a duty of care was owed
2. **Breach** — the standard of care was breached
3. **Causation** — the breach caused the harm
4. **Damages** — actual injury/harm resulted

INTENTIONAL TORTS & LEGAL TERMS

TERM	DEFINITION	NURSING EXAMPLE
Assault	Threat that creates fear of harmful contact	Threatening to inject a client who refuses
Battery	Harmful or unconsented physical contact	Giving an injection after refusal; treating without consent
False imprisonment	Unjustified restriction of movement	Improper restraint use; refusing to let a competent client leave
Invasion of privacy	Unauthorized disclosure/exposure	Sharing PHI; exposing a client unnecessarily
Defamation	False statement harming reputation	**Slander** = spoken; **Libel** = written
Negligence	Failure to meet the standard of care	Forgetting to raise side rails → client falls

TERM	DEFINITION	NURSING EXAMPLE
Malpractice	Professional negligence	Med error causing harm; failure to monitor

RESTRAINTS — LEGAL & SAFETY REQUIREMENTS

RULE	WHAT IT MEANS
Last resort	Use only after less-restrictive alternatives fail; least restrictive type for the shortest time.
Provider order required	Need an order specifying type, reason, and time limit; emergency application may precede the order but the order must follow promptly.
Time-limited	Behavioral restraints renewed q4h (adult), q2h (ages 9–17), q1h (<9); reassess frequently.
Never PRN	Restraints can never be ordered "as needed."
Monitor & document	Check circulation, skin, ROM, food/fluids/toileting on a schedule; quick-release knot to a movable bed part, never a side rail.

05 ETHICAL PRACTICE

PRINCIPLES · DILEMMAS · DECISION-MAKING

CORE ETHICAL PRINCIPLES

PRINCIPLE	MEANING	EXAMPLE IN PRACTICE
Autonomy	Respect the client's right to self-determine	Honoring a competent client's refusal of treatment
Beneficence	Do good / act in the client's best interest	Providing comfort, advocating for effective pain control
Nonmaleficence	Do no harm	Preventing falls; double-checking high-alert meds
Justice	Fairness; equal/equitable treatment	Allocating care without bias; fair resource distribution
Fidelity	Keeping promises & commitments	Following through on what you tell a client you'll do
Veracity	Truthfulness	Honest disclosure; not deceiving the client
Confidentiality	Protecting private information	Sharing PHI only with the care team / as authorized

WORKING THROUGH AN ETHICAL DILEMMA

When values conflict

1. Identify the problem & the competing values/principles
2. Gather relevant facts (clinical, client wishes, legal)
3. Consider options & consequences
4. Involve the client, family, team, and the **ethics committee** as needed
5. Act, then evaluate the outcome

Nurse's stance: support the client's informed, autonomous choice — even when it differs from your own values; provide nonjudgmental care.

ETHICS VS LAW

Two overlapping systems

- **Ethics** = standards of right/good conduct (ANA Code of Ethics guides nurses).
- **Law** = enforceable rules; violating it carries legal penalties.
- Something can be legal but ethically debated (and vice versa).
- When conflicts arise, use facility policy, the ethics committee, and the chain of command.

Confidentiality limit: the **duty to warn / protect** (e.g., a serious threat to an identifiable person, or mandatory reporting) can override confidentiality.

06 CLIENT RIGHTS & ADVOCACY

RIGHTS · SELF-DETERMINATION · THE NURSE AS ADVOCATE

CLIENT RIGHTS (PATIENT BILL OF RIGHTS)

Core protections

- Respectful, considerate care free from discrimination
- Information about diagnosis, treatment, and prognosis in understandable terms
- Right to participate in care decisions and to **refuse treatment**
- Privacy & confidentiality of information
- Informed consent; access to one's own medical records
- To formulate advance directives; to know about facility policies/charges
- To voice complaints/grievances without fear of reprisal

THE NURSE AS ADVOCATE

Protecting the client's interests

- Ensure the client has the information to make decisions; clarify misunderstandings
- Support the client's choices even when they differ from your own or the family's wishes
- Speak up about unsafe conditions; use the **chain of command**
- Mediate between the client and the system; protect vulnerable clients

Advocacy first move: when a client is confused about or disagrees with care, the nurse **clarifies/informs and notifies the provider** — not pressures the client to comply.

07 INFORMED CONSENT

WHO EXPLAINS · WHO WITNESSES · WHEN IT'S VALID

THREE ELEMENTS OF VALID CONSENT
All must be met

1. **Voluntary** — given freely, without coercion
2. **Informed** — client understands the procedure, risks, benefits, alternatives, and the right to refuse
3. **Competent** — client is capable (adult, alert, not impaired by drugs/sedation/incapacity)

Provider's job vs nurse's job: the **provider** performing the procedure explains it and obtains consent. The **nurse** witnesses the signature and confirms the client understands — if the client is unclear, the nurse stops and notifies the provider.

SPECIAL SITUATIONS
Who can consent & exceptions

- **Emergency:** implied consent when life/limb is threatened and the client can't consent
- **Minors:** parent/guardian consents; exceptions for **emancipated minors** and some care (often STI, contraception, mental health, substance — varies by state)
- **Incompetent adult:** legal guardian or healthcare proxy/POA consents
- A client may **withdraw consent at any time**, even after signing
- Consent obtained after sedation is **not valid** — obtain before pre-op meds

08 ADVANCE DIRECTIVES & SELF-DETERMINATION
LIVING WILL · POA · DNR

DOCUMENT	WHAT IT DOES	KEY NURSING POINT
Living Will	Written instructions for care if the client can't communicate (e.g., life-sustaining measures)	Activated only when the client is incapacitated/terminal per criteria
Durable Power of Attorney for Health Care (Healthcare Proxy)	Names a person to make medical decisions if the client can't	Proxy decides based on the client's known wishes/best interest
DNR / DNAR / AND	Order to withhold CPR/resuscitation	Must be a **current provider order**; the client may still receive all other care/comfort measures
POLST / MOLST	Portable medical orders for the seriously ill across settings	Travels with the client; signed by provider

§ PATIENT SELF-DETERMINATION ACT
Facilities must **inform clients on admission** of their right to make healthcare decisions and to formulate advance directives, and document whether they have one. The nurse does not pressure a client to create one — only informs and facilitates.

09 CONFIDENTIALITY, HIPAA & INFORMATION SECURITY
PROTECTED HEALTH INFORMATION

HIPAA ESSENTIALS
Protecting PHI

- Share **protected health information (PHI)** only with those directly involved in the client's care, or as the client authorizes.
- **"Minimum necessary"** — disclose only what's needed for the task.
- No discussing clients in public areas, elevators, or with unauthorized people (including family) without consent.
- Verify identity before releasing information; clients control who is told.

Permitted without specific authorization: treatment, payment, healthcare operations, and required reporting (e.g., abuse, certain diseases).

INFORMATION SECURITY & SOCIAL MEDIA
Digital responsibilities

- Never share passwords; log off the EHR; access only clients you're caring for.
- Looking at records out of curiosity (including your own family/celebrities) is a **violation**.
- **No client information or photos on social media** — even without a name, identifiable details breach privacy.
- Secure printed reports; dispose of PHI properly (shred).

Breach response: report suspected breaches/unauthorized access promptly per facility policy.

10 INTERDISCIPLINARY COLLABORATION & REFERRALS
TEAM ROLES · COMMUNICATION

KNOW THE TEAM — WHO TO REFER TO

TEAM MEMBER	REFER WHEN THE CLIENT NEEDS…
Physical Therapist (PT)	Gait, strength, mobility, transfers, ambulation training
Occupational Therapist (OT)	ADLs, fine motor, adaptive equipment for daily function
Speech-Language Pathologist (SLP)	Swallowing (dysphagia) evaluation, speech/communication
Registered Dietitian (RD)	Nutrition assessment, therapeutic diets, enteral/parenteral planning
Social Worker (MSW)	Financial/insurance, placement, community resources, psychosocial support
Case Manager	Care coordination, utilization, discharge planning across the continuum
Respiratory Therapist (RT)	Airway/ventilation support, breathing treatments, ABGs
Chaplain / Spiritual Care	Spiritual, religious, end-of-life support

TEAM MEMBER	REFER WHEN THE CLIENT NEEDS…
Pharmacist	Med reconciliation, interactions, dosing, education

SBAR — STRUCTURED HANDOFF
Standardized communication

- **S**ituation — what is happening right now
- **B**ackground — relevant history/context
- **A**ssessment — what you think the problem is
- **R**ecommendation — what you need/are requesting

Use for: calling the provider, shift handoff, transfers, and any critical-information exchange to reduce errors.

CHAIN OF COMMAND & COLLABORATION
Resolving issues & coordinating care

- Address concerns through the proper chain (charge nurse → supervisor → administration) when issues aren't resolved.
- Question/clarify orders that seem unsafe or incorrect — never carry out an unsafe order.
- Collaborative care planning improves outcomes; the RN coordinates the interdisciplinary plan.

Unsafe order: seek clarification first; if still unsafe, do not implement and escalate up the chain of command.

11 CASE MANAGEMENT & CONTINUITY OF CARE
COORDINATION · TRANSITIONS · DISCHARGE

CASE MANAGEMENT & CARE COORDINATION
Right care, right place, right cost

- Coordinates services across the continuum to optimize outcomes and resource use.
- Uses clinical pathways/care maps to standardize care & track **variances**.
- Bridges hospital, home health, rehab, long-term care, and community resources.

CONTINUITY & TRANSITIONS OF CARE
Safe handoffs

- **Discharge planning starts on admission**, not at discharge.
- Accurate, complete handoffs (SBAR) at every transition prevent errors.
- Medication reconciliation at admission, transfer, and discharge.
- Confirm the client/caregiver understands meds, follow-up, warning signs, and resources before discharge.

Discharge readiness: stable vitals, met outcomes/milestones, understanding of self-care, and a safe destination/support.

12 QUALITY & RISK MANAGEMENT
PERFORMANCE IMPROVEMENT · SAFETY EVENTS

PERFORMANCE / QUALITY IMPROVEMENT
Continuous improvement

PDSA cycle:

1. **Plan** — identify the problem & a change to test
2. **Do** — implement on a small scale
3. **Study** — analyze results/data
4. **Act** — adopt, adapt, or abandon

QI focus: improving systems and processes (not blaming individuals); uses data & benchmarks to raise the standard of care.

SAFETY EVENTS & ANALYSIS
Definitions to know

- **Sentinel event** — unexpected occurrence causing death or serious harm; triggers immediate investigation.
- **Near miss** — an error caught before reaching the client.
- **Root cause analysis (RCA)** — retrospective process to find **why** an event happened & prevent recurrence (system focus).
- **Failure mode & effects analysis (FMEA)** — proactive process to prevent errors before they occur.

INCIDENT / OCCURRENCE REPORTS — THE RULES

DO	DON'T
Complete factually & objectively (what you saw/did)	Don't include opinions, blame, or assumptions
File for any error, injury, or unusual occurrence (and near misses)	Don't reference the report in the medical record
Document the client's condition & care given in the chart separately	Don't treat it as an admission of liability
Use it as a risk-management/QI tool to prevent recurrence	Don't photocopy or share outside the proper channel

⚠ AFTER AN ERROR REACHES THE CLIENT
First priority is the **client's safety** — assess and stabilize, then notify the provider, implement corrective orders, document the facts in the chart, and complete an incident report. Honesty/disclosure follows facility policy.

13 LEADERSHIP, CONFLICT & CHANGE
STYLES · RESOLUTION · CHANGE THEORY

LEADERSHIP STYLES

STYLE	CHARACTERISTICS	BEST WHEN…
Autocratic	Leader makes decisions alone; high control	Emergencies — fast, directive decisions needed
Democratic	Participative; involves the team in decisions	Most situations; promotes buy-in & growth
Laissez-faire	Hands-off; minimal direction	Highly skilled, self-directed teams; little structure
Transformational	Inspires & motivates toward a shared vision	Driving change, engagement, innovation
Transactional	Rewards/consequences for performance	Task completion, structured environments

CONFLICT RESOLUTION
Choosing an approach

- **Collaborating** — win/win; address all concerns (often ideal)
- **Compromising** — each side gives up something
- **Accommodating** — yield to the other party
- **Competing/forcing** — one side wins (useful in emergencies)
- **Avoiding** — sidestep; only for trivial/cool-down situations

Approach: address conflict directly, privately, and professionally; focus on the issue/behavior, not the person.

LEWIN'S CHANGE THEORY
Managing planned change

1. **Unfreezing** — recognize the need for change, reduce resistance, motivate
2. **Change/Moving** — implement the new process; support & educate
3. **Refreezing** — integrate & stabilize the change as the new norm

Resistance to change is expected — involve stakeholders early, communicate clearly, and provide support to ease the transition.

14 DOCUMENTATION & INFORMATION TECHNOLOGY
THE LEGAL RECORD

DOCUMENTATION STANDARDS
"If it wasn't documented, it wasn't done"

- **Factual, accurate, complete, timely, and objective** — chart what you observe & do.
- Document **as soon as possible** after care; never pre-chart.
- Use approved terminology; avoid error-prone/unapproved abbreviations.
- The medical record is a **legal document** and may be used in court.

CORRECTIONS, LATE ENTRIES & EHR
Doing it right

- **Error (paper):** single line through it, write "error," initial & date — never erase, scribble, or use correction fluid.
- **Late entry:** label clearly as a late entry with the correct date/time.
- EHR: log in under your own credentials, never share passwords, log off when done.
- Don't document for someone else or chart care not yet performed.

Verbal/telephone orders: write it down, **read it back** to verify, and have the provider co-sign within the required timeframe.

15 RAPID-FIRE MUST-KNOWS
THE FACTS THAT WIN POINTS

TOPIC	LOCK THIS IN
First action, no emergency	Assess / gather more data before intervening
First action, ABC threat	Intervene to protect airway/breathing/circulation immediately
RN never delegates	Evaluation, Assessment, Teaching (+ unstable clients)
UAP can do	ADLs, vitals/I&O on stable clients, ambulation, hygiene
Who explains for consent	The provider; the nurse witnesses & confirms understanding
Consent after sedation	Invalid — must be obtained before pre-op/sedating meds
Battery	Treating/touching without consent (e.g., injecting after refusal)
4 elements of malpractice	Duty, Breach, Causation, Damages — all required
Restraints	Provider order, time-limited, never PRN, least restrictive, monitor
DNR	Must be a current provider order; other care continues
PHI on social media	Never — even without a name, identifiable details are a breach
Incident report	Factual; not referenced in the chart; not an admission of liability
Sentinel event	Death/serious harm → root cause analysis to prevent recurrence

TOPIC	LOCK THIS IN
Calling the provider (SBAR)	Situation, Background, Assessment, Recommendation
Telephone order	Write down, read back, verify, provider co-signs
Dysphagia/swallow referral	Speech-language pathologist (SLP)
Unsafe/incorrect order	Clarify first; if still unsafe, don't implement & use chain of command
Discharge planning	Begins on admission
Emergency leadership style	Autocratic (fast, directive)
Client refuses treatment	Honor autonomy; ensure informed, document, notify provider

16 MASTERY CHECKLIST

SELF-CHECK BEFORE TEST DAY

I CAN CONFIDENTLY... ✓

- ☑ Rank clients using ABC → Maslow → Safety → nursing process → acuity
- ☑ Apply the 5 rights of delegation and the RN's non-delegables (E-A-T)
- ☑ Make safe assignments matching acuity, competency, and infection control
- ☑ Distinguish assault, battery, false imprisonment, invasion of privacy, defamation
- ☑ Apply autonomy, beneficence, nonmaleficence, justice, fidelity, veracity
- ☑ Differentiate living will, healthcare POA, DNR, and POLST/MOLST
- ☑ Match clients to the correct interdisciplinary team member/referral
- ☑ Handle incident reports, sentinel events, and root cause analysis correctly
- ☑ Document accurately, correct errors properly, and verify telephone orders
- ☑ Decide "assess first" vs "act first" based on stability
- ☑ Sort tasks correctly among RN, LPN/LVN, and UAP
- ☑ Define negligence vs malpractice and the 4 required elements
- ☑ State restraint rules: order required, time-limited, never PRN, monitor
- ☑ Explain the nurse's role in informed consent and special-population exceptions
- ☑ Apply HIPAA/PHI rules including social media and EHR security
- ☑ Use SBAR and the chain of command appropriately
- ☑ Select leadership/conflict styles and apply Lewin's change theory
- ☑ Act as a client advocate and protect the right to refuse care

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