DAY 04 / 15

NCLEX-RN · 2026 TEST PLAN · MANAGEMENT OF CARE

Informed Consent & Advance Directives

The legal voice of client autonomy. Today you'll learn to think like an entry-level RN who protects the right of a competent adult to decide what happens to their body — and who advocates fiercely when someone tries to override that right.

FRAMEWORK · 2026 NCSBN RN TEST PLAN **CLINICAL JUDGMENT** · NGN 6-STEP MODEL

DIFFICULTY · APPLICATION / ANALYSIS

SECTION 01 · HIGH-YIELD OVERVIEW

One principle behind every question: autonomy.

Informed consent and advance directives are the legal expressions of one ethical idea — a competent adult controls what happens to their body, including the right to refuse care that would save their life.

Informed consent is the process by which a client receives full information about a procedure — purpose, risks, benefits, alternatives, and what happens if they refuse — and then voluntarily agrees. NCLEX always tests the strict division of labor:

- The **provider** (physician, NP, surgeon, dentist) is **legally responsible** for explaining the procedure and obtaining consent.
- The **RN** witnesses the signature, verifies identity, confirms voluntariness, ensures the client appears to have capacity, and verifies understanding. The nurse does *not* explain the procedure.
- If the client expresses doubt, confusion, or new questions, the nurse **stops and contacts the provider**. The nurse does not "re-explain."

Advance directives are legal documents a competent adult creates to direct future care if they later lose decision-making capacity:

- **Living will** — *what* the client wants or refuses (intubation, CPR, tube feedings, dialysis).
- **Durable Power of Attorney for Health Care (DPOA-HC) / Health Care Proxy** — *who* speaks for the client when the client cannot.
- **DNR / DNAR / Allow Natural Death (AND)** — a *provider-written order* based on the client's wishes. The order must be in the chart before staff withhold resuscitation.
- **POLST / MOLST** — portable provider orders for seriously ill clients; travel with the client across settings.

> **PATIENT SELF-DETERMINATION ACT · 1990**
>
> Every adult admitted to a facility receiving Medicare/Medicaid funds must be asked about advance directives, informed of their right to create one, and have any existing directive **integrated into the plan of care**. On NCLEX, this means: ask on admission, place the document on the chart, notify the provider, and reflect the directive in care.

The NCLEX tests these as decision points, not definitions. A client says "I don't understand" → stop. The family says "Don't tell Dad" → the client decides. The wife wants everything done but the client has a DNR → honor the client's wishes. A confused client is being asked to sign → contact the provider; do not proceed.

SECTION 02 · THE 10 MUST-KNOW RULES

If you remember nothing else from today, remember these.

These ten rules answer roughly 80% of consent and advance-directive NCLEX items. Read them slowly. Each one is a tested distinction.

01
The provider obtains consent. The RN witnesses, verifies, and advocates. The nurse never explains the procedure itself.

02
Valid consent = Voluntary + Informed + Capacity (V-I-C). Lose one element, stop the process.

03
"I don't understand" → call the provider. Never re-explain risks/benefits or clinical detail yourself.

04
Capacity ≠ competence. Competence is a legal/court determination. Capacity is your clinical assessment *right now*: understand, retain, weigh, communicate.

05
Sedation cancels capacity. Sign first, medicate after. Opioids, benzos, intoxication = stop.

06
Emergency = implied consent only when delay = death/disability *and* no decision-maker is available. Routine procedures still require consent.

07
Minors cannot consent — except: emancipated minors, mature-minor doctrine (some states), and care for STIs, contraception, pregnancy, mental health, and substance use (in many states).

08
Living will = the *wishes*. DPOA-HC = the *person*. The proxy speaks *only* when the client cannot.

09
A DNR is only valid as a written provider order. Verbal report, tattoo, family statement → full code until the order is written.

10
Family wishes never override a competent client's wishes. The nurse advocates and, if conflict persists, escalates (chain of command → ethics).

SECTION 03 · RN SAFETY DECISION TABLE

Ten scenarios. The safe action. The trap they want you to fall into.

For each row, read the situation first, then cover the right side and predict the safest action and the most likely NCLEX distractor.

SITUATION	BEST RN ACTION	WHY IT'S SAFEST	COMMON NCLEX TRAP
Client about to sign consent says, "I'm not really sure what they're going to remove."	Stop and notify the provider *before* the client signs.	Lack of understanding voids consent. The nurse cannot supply what the provider must explain.	"Reinforce the teaching the surgeon gave."
Client received IV morphine 20 min ago; consent form on bedside table.	Hold consent. Document. Notify provider; reschedule signing when alert.	Consent signed under sedation is not informed.	"Have the spouse sign instead."
Family of a competent adult: "Don't tell my mom she has cancer."	Honor the client's right to information. Tell the family the client is the decision-maker.	Truth-telling and autonomy belong to the client.	"Document the family's request and withhold the diagnosis."
Client with a living will refusing intubation is now unresponsive; family screaming "Do everything!"	Notify provider, ensure directive is on chart, follow documented wishes.	The legal directive controls; the nurse advocates for the client.	"Begin BVM ventilation while waiting for the provider."

SITUATION	BEST RN ACTION	WHY IT'S SAFEST	COMMON NCLEX TRAP
Unconscious client in ED with head bleed; no family, no directive, no proxy.	Treat under emergency implied consent.	Life- or limb-threat + no decision-maker = implied consent.	"Wait until family arrives to act."
Client signed yesterday, today says, "I changed my mind."	Stop. Notify provider. Document refusal. Support decision.	Consent may be withdrawn at any time, for any reason.	"Encourage the client to talk to family first."
New admit with dementia asked to sign consent for a PEG tube.	Assess capacity. Hold consent. Contact DPOA-HC and provider.	A client without capacity cannot consent.	"Have the client sign with an X if they nod yes."
Spanish-speaking client; consent in English; nurse "speaks some Spanish."	Use a qualified medical interpreter (in person or facility video/phone service).	Legally required; prevents error; ensures voluntariness.	"Use the client's bilingual adult child to interpret."
Provider writes a DNR; family insists they were not consulted.	Verify order reflects the client's stated wishes. Notify provider; offer family meeting, social work, chaplain.	The client, not the family, drives the order. Communication gaps are addressed by escalation, not by ignoring the order.	"Hold the DNR order until family agrees."
UAP overhears the consent conversation and offers to witness.	The RN witnesses. UAP cannot witness consent.	Witnessing requires verifying identity, voluntariness, and capacity — RN scope.	"Anyone over 18 can sign as a witness."

SECTION 04 · DELEGATION & SCOPE TABLE

Who can witness, who can teach, who can file.

Consent and directive tasks are heavily RN-only. Memorize the few exceptions: physical filing, vital signs, and reinforcing previously taught stable information.

TASK	RN	LPN/VN	UAP	DELEGATE?	WHY / WHY NOT
Explain a surgical procedure, risks, alternatives	No	No	No	No	Provider only. Outside all nursing scope.
Witness the client's signature on consent	Yes	Varies*	No	No	Requires verifying capacity & voluntariness — RN role. *Some facilities allow LPN; default to RN on NCLEX.
Reinforce previously taught NPO time/post-op care	Yes	Yes	No	Yes (to LPN)	Reinforcement of stable teaching = LPN scope. UAP cannot teach.
Ask client about existing advance directives on admission	Yes	No	No	No	Initial admission assessment & integration = RN.
Place a copy of the living will into the chart binder	Yes	Yes	Yes	Yes	Clerical filing is delegable. RN still verifies it's the correct document.
Provide written advance-directive education at admission	Yes	No	No	No	Required client teaching under PSDA — RN performs/oversees.
Notify provider: "Client says I don't understand"	Yes	No	No	No	Critical communication & clinical judgment = RN.
Take vital signs before consent is signed	Yes	Yes	Yes	Yes	Stable, routine task. UAP appropriate.
Witness the client's verbal refusal of treatment	Yes	No	No	No	Refusal documentation + education on consequences = RN.

TASK	RN	LPN/VN	UAP	DELEGATE?	WHY / WHY NOT
Update the EHR/wristband to reflect a new DNR status	Yes	No	No	No	Requires verification of written provider order + clinical judgment.

SECTION 05 · RED-FLAG CUES

When you see these, stop. Then escalate.

NCLEX places these cues into the stem and watches whether you recognize them. Group them mentally by what they require: assessment, provider call, rapid response, chain of command, or mandatory report.

IMMEDIATE ASSESSMENT

- Client says "I don't understand" or asks new questions about the procedure
- Client appears sedated, confused, or intoxicated before signing
- Client withdraws consent at any point
- Mismatch between consent form and the scheduled procedure (side, site, name)

PROVIDER NOTIFICATION

- Client expresses doubt or wants more information
- Client refuses a previously consented procedure
- Discovery the client lacks decisional capacity
- Discovery of an existing advance directive not yet on the chart
- Family conflict with the client's documented wishes

RAPID RESPONSE

- Client with *no* DNR begins to deteriorate (full code until written)
- Acute change in mental status before a planned procedure

CHAIN OF COMMAND

- Provider not responding to "client doesn't understand" call
- Provider proceeding despite withdrawal of consent
- Pressure to obtain consent from a non-capacitated client
- Provider refusing to write a DNR the client has clearly requested

MANDATORY REPORTING

- Suspicion that consent was coerced (controlling family member)
- Abuse, neglect, or exploitation discovered during the conversation
- Impaired colleague obtaining or witnessing consent

HOLD DELEGATION, REASSESS

- Delegatee reports the client is confused after signing
- LPN/UAP reports the client changed their mind
- Any new clinical question returns from a delegated task

SECTION 06 · ADVANCED NGN PRACTICE QUESTIONS

Eleven application-level questions. Mixed item types.

Click each rationale to expand. Answer first, then read why — and notice which NGN clinical-judgment step is being tested.

Q1 MULTIPLE CHOICE

A surgeon has explained a laparoscopic cholecystectomy to a 62-year-old client now alone in the pre-op holding area. As the nurse enters with the consent form, the client says, "I'm still not clear on what 'converting to open' means." Which action should the nurse take first?

A. Explain that "converting to open" means switching from laparoscopic to a larger incision.

B. Ask the client to sign and document the question for the surgeon.

C. Notify the surgeon that the client needs more information before signing.

D. Reassure the client that this rarely happens and is a standard precaution.

Q2

SELECT ALL THAT APPLY

The nurse is preparing to witness a client's signature on a consent form for a scheduled colonoscopy. Which findings would cause the nurse to STOP the consent process? **Select all that apply.**

A. The client received midazolam 1 mg IV 15 minutes ago.
B. The client states, "My daughter said I have to do this."
C. The client correctly repeats back the purpose of the procedure.
D. The client is a 78-year-old with new mild dementia and no DPOA-HC.
E. The client asks, "What did the doctor mean by 'perforation'?"
F. The client speaks Mandarin and the form is in English; a qualified medical interpreter is on the phone.

Q3

MATRIX / GRID

For each nursing action regarding a client's living will, indicate whether it is **Indicated**, **Not Indicated**, or **Contraindicated**.

ACTION	INDICATED	NOT INDICATED	CONTRAINDICATED
Place the living will in the active chart at admission	✓		
Honor the family's request to "do everything" despite the directive			✓
Notify the provider that the client's living will refuses intubation	✓		
Initiate CPR on an unresponsive client with no written DNR order	✓		
Ask the spouse to sign a new directive on behalf of the alert client			✓
Document the client's verbal restatement of their living-will wishes	✓		

Q4

BOW-TIE

A 70-year-old is admitted with acute respiratory failure. The living will states *"No intubation, no mechanical ventilation."* Now lethargic. SpO_2 86% on 6 L/min NC, RR 32. The spouse asks the nurse to "do whatever it takes."

CENTER · Priority concern to address: _____

LEFT · Choose 2 actions to take:

A. Initiate bag-valve-mask ventilation
B. Notify the provider of clinical decline and review the directive
C. Position upright; titrate to high-flow nasal cannula per existing order
D. Begin BVM with PEEP and prepare for intubation
E. Take the spouse out of the room and obtain new consent

RIGHT · Choose 2 parameters to monitor:

A. Respiratory effort and SpO_2
B. Pulmonary artery pressure
C. Level of consciousness
D. Bilateral leg circumference
E. Hourly urine output via Foley

Q5

ORDERED RESPONSE

The pre-op nurse identifies five tasks for a client scheduled for laparoscopic appendectomy in 30 minutes. Place the tasks in correct order.

A. Administer the prescribed IV antibiotic.

B. Verify the surgeon has explained the procedure and obtained consent.

C. Administer the prescribed pre-op midazolam.

D. Verify the client's identity, allergies, and surgical site.

E. Transport the client to the OR.

Q6

CLOZE / DROP-DOWN

Complete the statement. Informed consent for a non-emergent procedure requires three elements: the client must have **(1)**, must receive complete **(2)** from the provider, and must give consent **(3)**. If any one element is missing, the nurse should **(4)**.

- **(1)** a) decision-making capacity · b) a power of attorney · c) a signed living will · d) fluent English
- **(2)** a) advance directive paperwork · b) risk and benefit information · c) a second opinion · d) pre-op antibiotics
- **(3)** a) after sedation · b) voluntarily · c) after the procedure is scheduled · d) in front of the family
- **(4)** a) sign on the client's behalf · b) stop the process and notify the provider · c) obtain consent from family · d) proceed under implied consent

Q7

DELEGATION SCENARIO

The charge nurse is making assignments. Which task is appropriate to delegate to the LPN/VN?

A. Obtain informed consent from a client for thoracentesis.

B. Conduct the admission advance-directive assessment on a newly admitted client.

C. Reinforce previously taught NPO instructions to a client awaiting endoscopy.

D. Witness the signature of a client signing a surgical consent.

Q8

MULTIPLE CHOICE · MINORS

A 16-year-old comes to the clinic asking for STI testing. She lives with her parents and is not emancipated. Which response by the nurse is correct?

A. "I'll need to call your parents to consent before I can test you."

B. "Most states allow minors to consent to STI testing without parental notification."

C. "Only emancipated minors can consent to any medical care."

D. "I'll need a court order to test you."

Q9

HANDOFF / SBAR

The night nurse is handing off a 78-year-old client with a documented DPOA-HC (the son) admitted for pneumonia and now meeting sepsis criteria. Which piece of information is MOST important to include in the SBAR?

A. The client prefers chicken broth over beef broth.

B. The client's daughter visited at 1900 and left at 2100.

C. The DPOA-HC contact information, current code status, and that the client is now confused.

D. The client received acetaminophen 650 mg PO at 0400.

Q10

PRIORITIZATION

The nurse is caring for four clients. Which client should the nurse see FIRST?

A. A 60-year-old post-op day 1 with pain rated 5/10 awaiting scheduled hydrocodone.

B. A 75-year-old with a new DNR order whose family is upset and wants to talk.

C. A 45-year-old who just signed pre-op consent and now says, "Wait, what is this surgery for?"

D. A 30-year-old with a stable IV antibiotic that is 15 minutes overdue.

Q11

SELECT ALL THAT APPLY · DIRECTIVES

A nurse is reviewing admission paperwork for a 68-year-old client. The client's daughter, the documented DPOA-HC, accompanies them. Which actions by the nurse demonstrate appropriate practice? **Select all that apply.**

A. Ask the alert, oriented client about their advance-directive wishes directly.

B. Allow the daughter to sign all consent forms because she is the DPOA-HC.

C. Place a copy of the advance directive on the chart.

D. Document the existence of the directive in the EHR.

E. Defer all medical decisions to the daughter while the client is alert.

F. Provide the client with the facility's written information about advance directives.

SECTION 07 · UNFOLDING NGN CASE STUDY

Mr. Thomas Bellamy. 74 years old. Heart failure & new pancreatic cancer.

Six questions across the NGN clinical-judgment model. Read each panel of data, then work through the questions in order.

Mr. Thomas Bellamy · Day 2 · 0700

MEDICAL FLOOR · BED 412 · ADMITTED 24H AGO

NURSE'S NOTE · 0700

Alert, oriented ×4. States, "I've had a good life. If my heart stops, I do not want to be brought back. I want to focus on comfort." Living will and DPOA-HC (designating wife) on chart, signed 3 years ago. Wife at bedside, tearful: "He's just scared. We need to fight this."

VITAL SIGNS · 0700

BP	HR	RR
102/58	96	22
SpO_2	TEMP	PAIN
92%	37.1	3/10

On 2 L/min NC · Epigastric pain

PROVIDER ORDERS

- Furosemide 40 mg IV BID
- Morphine 2 mg IV q4h PRN pain
- Continuous SpO_2
- Palliative care consult (yesterday — not yet seen)

LAB SNAPSHOT

- BNP 1,850 · Troponin neg ×2
- Na 132 · K 3.8 · Cr 1.6
- Hgb 10.8 · Bilirubin 4.2

CLIENT · 0730

"Please don't let my wife talk them out of this. I want a DNR."

WIFE (HALLWAY) · 0735

"I'm his medical power of attorney. I'm not signing any DNR."

HOSPITALIST NOTE · 0730

"Discussed prognosis with client. Client requests DNR. Will write order pending family meeting."

CARE TEAM STATUS

- Palliative care · pending
- Social work · not yet consulted
- Chaplain · not yet consulted

C1

RECOGNIZE CUES · SATA

Which of the following are cues the nurse should recognize as *relevant*? Select all that apply.

A. Client's stated wish for DNR despite spouse's objection
B. Wife identifying herself as DPOA-HC
C. BNP 1,850 with HR 96 and SpO_2 92% on 2 L
D. Palliative care consult ordered but not yet seen
E. Client's pain rating of 3/10
F. Hospitalist's note that the DNR order will be written pending a family meeting
G. Sodium 132

C2

ANALYZE CUES · DROP-DOWN

The client is alert and oriented ×4, so the DPOA-HC **(1)** decision-making authority. The DNR **(2)** be honored by staff until the provider writes the order. The wife's distress **(3)** override the client's documented wishes.

- **(1)** a) currently has · b) does *not* currently have
- **(2)** a) can · b) cannot
- **(3)** a) should · b) should not

C3

PRIORITIZE HYPOTHESES

Which client need is the priority right now?

A. Pain management with morphine 2 mg IV
B. Honoring autonomy and ensuring the DNR is correctly documented before any acute decompensation
C. Fluid balance and heart-failure symptom control
D. Family grief support

C4

GENERATE SOLUTIONS · SATA

Which actions appropriately advocate for the client? Select all that apply.

A. Document the client's verbal restatement of DNR wishes verbatim
B. Coordinate with the hospitalist to write the DNR order today
C. Sign a DNR consent form on the wife's behalf
D. Request the palliative care team be seen today
E. Offer the wife support resources: chaplain, social work
F. Ask the client in private if his wishes remain unchanged
G. Wait until the wife agrees before pursuing the order

C5

TAKE ACTION · ORDERED RESPONSE

Place the nurse's actions in correct order.

A. Document the conversation verbatim in the chart
B. Verify in private that the client's wishes are unchanged
C. Coordinate the palliative care consult and offer the wife chaplain / social work support
D. Place the written DNR order prominently on the chart and update wristband/EHR per policy
E. Notify the hospitalist that the client confirms the request and ask for the order to be written today

C6

EVALUATE OUTCOMES · MATRIX

For each outcome, indicate whether it has been **Met** or **Not Met** by end of shift.

OUTCOME	MET	NOT MET
DNR order written and visible on chart	✓	
Client states he feels heard and respected	✓	
Wife's grief has fully resolved		✓
No CPR initiated when client's status briefly worsened at 1400	✓	
Pain remains ≤ 3/10	✓	
Palliative care has seen the client	✓	

SECTION 08 · "WHAT SHOULD THE NURSE DO FIRST?"

Five priority drills.

1. Client about to be wheeled to OR says, "I think I changed my mind."

FIRST → Stop transport. Notify the surgeon. Do not move the client. Consent withdrawal halts everything.

2. Client signed consent yesterday for colonoscopy; this morning the nurse smells alcohol on their breath.

FIRST → Assess for intoxication; hold the procedure; notify the provider. Intoxication invalidates capacity.

3. New admit with a living will refusing tube feedings is unconscious; NG-tube order written.

FIRST → Notify provider and DPOA-HC; do not insert tube until the directive is reconciled with the order.

4. Client just signed consent for chemo. As the nurse leaves, the daughter says, "We didn't tell him it might affect his fertility — he doesn't know."

FIRST → Stop. Notify the provider. Consent was not fully informed; provider must re-disclose.

5. ED brings an unresponsive client with dementia and no advance directive on file; next-of-kin is in the parking lot.

FIRST → Begin emergency treatment under implied consent. Identify surrogate per state law as they arrive. Do not delay life-saving care.

SECTION 09 · "CAN THIS BE DELEGATED?"

Five delegation drills.

1. Witnessing a consent signature for a bone-marrow biopsy.

RN ONLY. Requires capacity & voluntariness verification.

2. Reinforcing post-op care instructions taught yesterday.

LPN/VN. Stable, previously taught content is within LPN scope.

3. Placing a copy of the living will into the chart binder.

UAP (CLERICAL). Filing is delegable; RN verifies it's the correct document.

4. Asking on admission whether the client has an advance directive.

RN. Admission assessment, education, and integration = RN.

5. Conducting the initial advance-directive education for a new admission.

RN. PSDA-required teaching is RN responsibility.

SECTION 10 · "WHO SHOULD THE NURSE CONTACT?"

Five collaboration drills.

1. Client wants to create a living will but doesn't know how.

`SOCIAL WORKER / CASE MANAGER` — they navigate facility advance-directive resources and forms.

2. Spanish-speaking client needs to give surgical consent.

`QUALIFIED MEDICAL INTERPRETER` (in-person or facility-certified phone/video). Never family, never "the bilingual nurse."

3. Family is in conflict with the client's DNR wishes.

`CHAPLAIN · SOCIAL WORK · PALLIATIVE CARE` first. If unresolved, **ethics committee**.

4. Client refuses life-sustaining dialysis; provider is insisting.

`CHAIN OF COMMAND` — charge nurse → nursing supervisor → ethics committee. Document refusal verbatim.

5. Transgender client's consent form/EHR uses the wrong name.

`PROVIDER + EHR SUPPORT + CHARGE NURSE` — correct documentation, update orders, and advocate for affirming care.

SECTION 11 · LEGAL / ETHICAL TRAP SCENARIOS

Five traps. The right move every time.

1. The provider says, "Just have her sign — I'll explain it later."

`TRAP:` Cooperating to keep the schedule. **Correct:** Refuse. The provider must explain first. Document and escalate if needed.

2. The wife of a competent client asks the nurse to withhold the cancer diagnosis from her husband.

`TRAP:` "Family knows best." **Correct:** The client is the decision-maker. Offer a family meeting with the provider; truth-telling belongs to the client.

3. The nurse discovers a "Do Not Resuscitate" tattoo on a client's chest with no chart documentation.

`TRAP:` Treating the tattoo as the order. **Correct:** A tattoo is not a legal directive. Initiate CPR until a written DNR is verified; investigate immediately.

4. A 17-year-old (non-emancipated) comes to the ED with a sprained ankle; parents are unreachable.

`TRAP:` Withholding all care. **Correct:** Emergency care for minors does not require parental consent when delay would cause harm. Provide care; document attempts to reach parents.

5. A coworker witnessed consent without verifying the client was alert (post-IV opioid).

`TRAP:` Staying silent to avoid conflict. **Correct:** Address with coworker, document the safety event, and escalate to charge nurse/supervisor. Patient safety > collegial silence.

SECTION 12 · END-OF-DAY QUICK REVIEW

The shortest review that still works.

10 MUST-REMEMBER POINTS

1. Provider explains. Nurse witnesses, verifies, advocates.
2. V + I + C = valid consent. Lose one, stop.
3. "I don't understand" → call the provider, every time.
4. Sedation cancels capacity. Sign before medicating.
5. Living will = *what*. DPOA-HC = *who*.
6. The DPOA-HC speaks only when the client cannot.
7. A DNR must be a written provider order to be honored.
8. Family wishes never override a competent client.
9. Use qualified medical interpreters — not family, not yourself.
10. Emergency implied consent = life/limb threat + no decision-maker.

5 COMMON NCLEX TRAPS

1. "Have the family member sign instead." → No.
2. "Reinforce the surgeon's explanation." → Not for new questions.
3. "Withhold information at the family's request." → No — the client decides.
4. "Honor a verbal DNR until the order is written." → No — full code.
5. "Use the bilingual nephew to interpret." → No — qualified interpreter only.

5 "NEVER DO THIS" RULES

1. Never have a sedated client sign consent.
2. Never let a UAP witness a consent.
3. Never proceed when a client says "I don't understand."
4. Never delegate the advance-directive admission discussion.
5. Never honor a non-documented DNR.

5 SAFETY-FIRST PHRASES TO RECOGNIZE

- "Stop and notify the provider."
- "Honor the client's documented wishes."
- "Verify decision-making capacity."
- "Use a qualified medical interpreter."
- "Document the client's words verbatim."

SECTION 13 · ONE-PAGE VISUAL SUMMARY

Screenshot this. It's the whole day.

DAY 4 · ONE-PAGE SUMMARY

Informed Consent & Advance Directives

THE CONSENT DECISION TREE

Provider explains procedure → Nurse verifies V-I-C (Voluntary · Informed · Capacity) → Any element missing? → STOP · Notify provider

All three present? → Nurse witnesses signature → Document in EHR → Proceed

LIVING WILL

- **What** the client wants
- Refusals: intubation, CPR, tube feedings, dialysis
- Activated when client *cannot* speak
- Place on chart at admission

DPOA-HC / PROXY

- **Who** speaks for the client
- Dormant while client has capacity
- Cannot override the client's living will
- Document contact info in EHR

WHO DOES WHAT

- **Provider** · Explains, obtains, signs as practitioner
- **RN** · Witnesses, verifies, advocates
- **LPN** · Reinforces stable teaching
- **UAP** · Files paperwork · Vital signs

STOP SIGNALS

- "I don't understand"
- Sedation / intoxication / acute confusion
- Coercion ("They said I have to")
- Withdrawal of consent
- Form ≠ scheduled procedure

DNR TRUTH

- Must be a **written provider order**
- Tattoo ≠ order
- Family statement ≠ order
- Until written → **full code**
- POLST/MOLST travels with client

MINOR EXCEPTIONS

- Emancipated minors
- STI testing & treatment
- Contraception
- Pregnancy care
- Mental health · Substance use
- Emergencies (always)

ESCALATION LADDER WHEN THE CLIENT IS OVERRULED

Charge Nurse → Nursing Supervisor → Provider / Hospitalist → Risk / Patient Advocate → Ethics Committee

IF YOU SEE…	DO THIS
Client received IV opioid + needs to sign	Hold consent. Sign before sedation next time.
Family says "Don't tell Dad"	Client is the decision-maker. Notify provider; offer family meeting.
DNR tattoo, no order	Full code. Investigate the directive.
Wife disagrees with client's DNR	Honor client. Support wife with chaplain/social work/palliative.
Spanish-speaking client + English form	Qualified medical interpreter. Never family.
Unconscious, unknown, life threat	Implied consent. Treat.
Client says "I changed my mind"	Stop. Notify provider. Document. Support decision.