Management of Care

National Council Licensure Examination for Registered Nurses (NCLEX-RN)

15 to 21% of the exam · 25 activity statements · 2026 NCLEX-RN Test Plan

Management of Care is the largest category on the NCLEX-RN: how the nurse coordinates, directs and protects the care a client receives from the whole team. Items ask you to choose which client to see first, what to delegate and to whom, how to handle orders, consent, confidentiality, advance directives and mandatory reports, and how to act within scope, ethics and the law. Most items are priority and judgment decisions, not recall.

You should be able to: You can decide which client to see first, what to delegate and to whom, how to carry out or question an order, and how to protect a client's rights, privacy and wishes within the law, scope and the code of ethics.

Every activity statement: the key point and the trap

1. Carry out admissions, transfers and discharges safely

On admission, the RN completes the initial assessment, identifies the client with two identifiers, orients the client to the room and call light, and starts the plan of care; AP may collect height, weight and routine vital signs.

Trap: Choosing to transfer or discharge a client whose condition has just changed, or delegating the admission assessment or discharge teaching to AP or an LPN/VN.

2. Give and take report on the clients you are assigned

Handoff is a structured, two-way exchange; a standard format such as SBAR (situation, background, assessment, recommendation) or I-PASS reduces omissions.

Trap: Leaving out a recent change, a pending result or code status, or treating report as a one-way recital with no questions or read-back.

3. Assign tasks to other staff and oversee the care they give

The five rights of delegation: the right task, the right circumstance, the right person, the right direction and communication, and the right supervision and evaluation.

Trap: Delegating a task that needs assessment, teaching or judgment (the first ambulation after surgery, a newly admitted client, teaching insulin use) or assigning an unstable client to AP or an LPN/VN.

4. Speak up for what clients need and are entitled to

Advocacy means protecting the client's right to make informed decisions and speaking up when care does not meet the client's needs or wishes.

Trap: Choosing an answer that pressures the client toward what the team or family prefers, or that dismisses a stated wish instead of acting on it.

5. Decide the order of care by how sick each client is

See first the client with a threat to airway, breathing or circulation, then other physiological needs, then safety, then psychosocial needs (ABCs, then Maslow).

Trap: Picking the client with the most alarming diagnosis or the abnormal but expected finding, instead of the client whose condition is new, acute and threatening the ABCs.

6. Take part in quality and performance improvement work

Quality improvement is the ongoing, data-driven work of making care safer and better; every nurse takes part.

Trap: Documenting in the chart that an incident report was filed, or treating an error as a matter for individual blame instead of reporting it for system review.

7. Work with other disciplines, such as therapists or social workers, on care

Know each discipline's role: physical therapy (mobility, gait, strength), occupational therapy (activities of daily living, adaptive equipment), speech-language pathology (swallowing and communication), dietitian (nutrition), social work and case management (resources, discharge, finances), respiratory therapy, pharmacy, chaplain or spiritual care.

Trap: Matching the problem to the wrong discipline, such as sending a swallowing problem to the dietitian or a dressing problem to physical therapy.

8. Take, check and carry out orders from prescribers

A complete order or prescription includes the client's name, date and time, the drug or treatment, dose, route, frequency, and the prescriber's signature.

Trap: Carrying out an incomplete or unsafe order because a provider wrote it, or accepting a telephone order without reading it back.

9. Build the client's advance directives into the care plan

Advance directives include a living will (wishes about life-sustaining treatment) and a durable power of attorney for health care (a named substitute decision maker); names differ by jurisdiction.

Trap: Assuming DNR means withdrawing other care, or following a relative's wishes over a valid directive or the client's own stated choice.

10. Give fair care with equal access for every client, whatever their background or identity

Every client receives the same standard of care regardless of culture, ethnicity, race, religion, sexual orientation, gender identity or gender expression.

Trap: Choosing an answer that assumes a client's beliefs, family structure or needs from a group stereotype instead of asking the client.

11. Confirm the client has been taught and has consented before care or procedures

Informed consent is the duty of the primary health care provider performing the procedure: the provider explains the nature, risks, benefits and alternatives.

Trap: Choosing an answer in which the nurse obtains consent by explaining the risks, or witnesses a signature for a client who is sedated or does not understand.

12. Teach clients and staff what clients' rights and responsibilities are

Client rights include respectful care, information about their condition and care, privacy, refusal of treatment, access to their own record, and a way to raise complaints.

Trap: Treating a client's refusal or complaint as a behavior problem rather than an exercise of a right.

13. Judge when a referral is needed and get the orders for it

Assess for referral needs from the first contact: mobility, self-care, nutrition, finances, home safety, mental health, substance use and social support.

Trap: Choosing the referral that does not match the need, or arranging a service that needs an order without obtaining one.

14. Start, review and revise the client's care plan

The RN builds the plan of care from assessment data: nursing diagnoses or problems, measurable client-centred goals, interventions and evaluation.

Trap: Continuing an unchanged plan after evaluation shows the goal was not met, or writing a goal that cannot be measured.

15. Protect client privacy and information, including online and in disclosures

Share client information only with those involved in the client's care and with a need to know, or with the client's permission; HIPAA in the US and provincial health privacy laws in Canada set the rules.

Trap: Thinking a post or a chart lookup is acceptable because the client is not named or because the nurse is curious about a person she knows.

16. Know the limits of your own and others' skills and seek help

Accept only assignments you are competent to do safely; tell the charge nurse before starting care if a task or client is beyond your training.

Trap: Choosing to attempt an unfamiliar procedure alone, or to refuse an assignment outright, instead of speaking up and asking for help or a change.

17. Make legally required reports, such as suspected abuse or reportable infections

Nurses are mandatory reporters of suspected child abuse or neglect, and in most jurisdictions of abuse of older or dependent adults; the duty applies to reasonable suspicion, not proof.

Trap: Waiting for proof before reporting, confronting the suspected abuser, or assuming someone else will report.

18. Resolve disagreements between clients and staff

Address conflict early, privately and directly, focusing on the issue and client safety, not on personalities.

Trap: Choosing an answer that settles a conflict in front of clients, takes sides without hearing both, or ignores the conflict in the hope it will pass.

19. Draw on evidence, technology and policies to improve care quality

Evidence-based practice combines the best research evidence, clinical expertise and the client's values and preferences.

Trap: Choosing a workaround that bypasses a safety technology or policy because it saves time.

20. Notice ethical dilemmas and bring them forward

An ethical dilemma is a choice between two options that both have moral reasons and drawbacks, such as respecting autonomy versus preventing harm.

Trap: Choosing an answer where the nurse resolves the dilemma alone, or overrides a competent client's choice for the sake of beneficence.

21. Document care using accepted terms

Documentation is factual, objective, accurate, timely and in chronological order, and uses approved terminology and abbreviations.

Trap: Choosing an entry that records opinions or labels rather than observable findings, or that uses a "Do Not Use" abbreviation.

22. Plan your workload so time is used well

Plan the shift after report: list each client's priorities and time-critical tasks (medications, treatments, tests, discharges).

Trap: Choosing to finish a routine task in order instead of stopping to respond to a client whose condition has changed.

23. Act in line with the nursing code of ethics

Nursing codes of ethics (the ANA Code of Ethics in the US, the CNA Code of Ethics in Canada) state the profession's values: respect for dignity, commitment to the client, accountability, and advocacy.

Trap: Choosing an answer that becomes too personal with a client (sharing personal problems, accepting a valuable gift, meeting outside work) because it seems kind.

24. Stay within the legal limits of nursing practice

Scope of practice is set by the jurisdiction's nurse practice act or nursing legislation, and is narrowed further by employer policy and the nurse's own competence.

Trap: Choosing an action that falls outside RN scope (changing a dose, interpreting a test as a diagnosis) because a provider asked or because it would save time.

25. Deliver and promote care that is both high quality and cost effective

Quality and cost-effective care avoid waste without cutting what the client needs: right care, right place, right time.

Trap: Choosing an answer that saves money by withholding needed care, or that keeps a device or test in place out of habit when it is no longer indicated.

Key terms

Delegation: Giving a delegatee the authority to perform a specific task for a client while the RN keeps accountability for the outcome.

Five rights of delegation: Right task, right circumstance, right person, right direction and communication, right supervision and evaluation.

Assignment: Distributing clients or tasks among staff according to each person's scope and competence.

Acuity: How sick or unstable a client is and how much nursing care the client needs.

Handoff (report): The structured transfer of information and responsibility for a client between caregivers.

SBAR: Situation, background, assessment, recommendation: a format for clear clinical communication.

Informed consent: A competent client's voluntary agreement after the provider explains the nature, risks, benefits and alternatives; the nurse verifies and witnesses.

Advance directive: A written statement of a client's wishes for care, or of who decides for them, if they cannot decide themselves.

Durable power of attorney for health care: A person the client names to make health care decisions when the client cannot.

Mandatory reporting: The legal duty to report suspected abuse or neglect and certain conditions to the authority the law names.

Scope of practice: The activities a nurse is legally permitted to perform, set by the jurisdiction's nursing law.

Chain of command: The line of authority a nurse follows to resolve a safety or practice concern that is not settled at the first level.

Incident (occurrence) report: A confidential quality document recording an error, near miss or unsafe event; not part of the client record.

Autonomy: The client's right to make their own decisions about care.

Negligence: Failure to meet the standard of care a reasonably prudent nurse would provide, causing harm.

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