DAY 12 · NCLEX-RN 2026 · MANAGEMENT OF CARE

Quality Improvement, Incident Reports, Near Misses & Safety Systems

How a safe, entry-level RN recognizes errors before they reach the client, reports them honestly, drives system change through QI, and never confuses an incident report with a chart entry.

FRAMEWORK: NGN CLINICAL JUDGMENT MEASUREMENT MODEL

CATEGORY: SAFE & EFFECTIVE CARE ENVIRONMENT

ACTIVITY: PARTICIPATE IN PI & QI PROCESSES · ACKNOWLEDGE ERRORS & NEAR MISSES

SECTION 01

OVERVIEW High-Yield Concepts

Quality improvement (QI) is a **system-level** activity. It is not about blaming one nurse — it is about asking, "*Why did the system let this happen, and how do we stop the next event?*" The NCLEX expects you to think like a nurse who reports honestly, participates in change, and protects future clients.

The Three "Errors" You MUST Distinguish

NEAR MISS	ADVERSE EVENT	SENTINEL EVENT	NEVER EVENT
Error caught *before* reaching the client. "Good catch." Still report → system learning.	Error reached the client and caused harm — but harm may be temporary/recoverable.	A safety event resulting in *death, permanent harm, or severe temporary harm*. Triggers a Root Cause Analysis (RCA).	Should never occur, ever (wrong-site surgery, retained object, mismatched blood). CMS will not reimburse.

The QI Cycle — PDSA

P	D	S	A
PLAN	**DO**	**STUDY**	**ACT**
Identify a problem. Form a question. Predict an outcome.	Implement the change on a small scale (one unit, one	Analyze data. Did the change reduce the error rate?	Adopt, adapt, or abandon. Spread successful changes

Plan a small test of change.	shift, a few clients).	Compare predicted vs actual.	house-wide.

Just Culture (Not Blame Culture)

CORE CONCEPT

Just Culture recognizes that humans err. It separates **human error** (slip/mistake → console & coach) from **at-risk behavior** (drift from policy → coach & counsel) from **reckless behavior** (conscious disregard → discipline). On NCLEX, the nurse who reports a near miss is *not* "in trouble" — they are protecting future clients.

The Six Aims of Quality Care (STEEEP — IOM)

STEEEP

- **S**afe — avoid harm
- **T**imely — reduce delays
- **E**ffective — evidence-based
- **E**fficient — avoid waste
- **E**quitable — care regardless of personal characteristics
- **P**atient-centered — respect values & preferences

HACS (CMS) — HIGH-YIELD

- **CAUTI** — catheter-associated UTI
- **CLABSI** — central line BSI
- **SSI** — surgical site infection
- **HAPI** — pressure injury (stage 3, 4, unstageable)
- **VAP** — ventilator-associated pneumonia
- **Falls with injury, blood incompatibility, wrong-site surgery**

Incident Report — What It IS & What It IS NOT

IT IS ✔	IT IS NOT ✘
An internal QI / risk management tool	Part of the client's legal medical record
Objective, factual, completed by the person who discovered or was involved in the event	A place to assign blame, speculate cause, or write opinions
Filed immediately, regardless of harm — including near misses	Charted in the client's EHR (NEVER write "incident report filed" in the nurse's note)
Protected (in most jurisdictions) under peer-review / QI privilege	Discoverable in court if mishandled — keep it strictly factual
Used to identify trends, drive RCA, and prevent the next event	A reason to delay assessing the client or notifying the provider

Root Cause Analysis (RCA) & FMEA

- **RCA** = *retrospective*. Performed **after** a sentinel event. Uses the "5 Whys" to trace the failure to system roots (not individuals).
- **FMEA** (Failure Mode & Effects Analysis) = *prospective*. Performed **before** implementing a new process to predict what could go wrong.
- **Sentinel events** are reported to The Joint Commission; an RCA must occur within a defined period (typically 45 days).

SECTION 02

10 RULES Must-Know NCLEX Rules

01 **Assess the client first.** Whenever an error or near miss is identified, the nurse's *first* action is always to check the client's status — never to file paperwork first.

02 **Notify the provider** after assessing the client and before completing the incident report so the provider can give correcting orders.

03 **Incident reports are never charted in the EHR.** Document only the objective clinical facts and the client's response in the nurse's note — never "incident report completed."

04 **Near misses are always reported.** They protect future clients and are the strongest source of system learning.

05 **Document objectively.** Only what you saw, did, found, and what the client said — in their own words, in quotation marks. No opinions, no blame, no speculation.

06 **Use facility variance / incident reporting systems** for events involving clients, visitors, AND staff (sharps injuries, slips, etc.).

07 **The Joint Commission** sets National Patient Safety Goals (NPSGs) — two client identifiers, time-out for invasive procedures, hand hygiene, medication labeling, and improved alarm/communication safety.

08 **Sentinel events require an RCA** — a system-level review, not punishment of one nurse.

09 **Evidence-based practice (EBP)** uses the best research + clinical expertise + client preferences. When two interventions exist, choose the one supported by current evidence and your facility policy.

10 **Cost-effective care is still safe care.** The RN advocates for the right level of care (rehab vs SNF vs home health), uses supplies wisely, and prevents complications that drive HACs.

SECTION 03

DECISION TABLE RN Safety Decisions in QI & Reporting

SITUATION	BEST RN ACTION	WHY IT IS SAFEST	COMMON NCLEX TRAP
Nurse realizes the wrong dose of furosemide was just given.	Assess the client (VS, K^+ risk, hydration), notify provider, then complete the incident report.	Client safety always precedes paperwork; the provider can order labs/treatment to mitigate harm.	"Document in the chart that an incident report was filed" — never do this.
UAP reports a client found on the floor.	RN goes to the client, performs neuro & injury assessment, obtains VS, notifies provider, then completes a fall variance report.	RN cannot delegate the post-fall assessment. Provider notification supports orders for imaging.	Choosing "have UAP take vitals first" — UAP collects data but the RN performs the assessment.
A nurse catches a heparin bag programmed at 10× the ordered rate before infusion starts.	Stop & correct the pump, verify order, file a near-miss report.	Near misses are the highest-value QI data — they reveal failures without harm.	"No harm occurred, so no report needed." Wrong — near misses must still be reported.
A coworker tells the nurse, "Just don't file anything, the patient is fine."	File the report; if pressured, escalate to charge nurse / supervisor.	Suppressing reports violates Just Culture and facility policy and risks future harm.	Choosing "discuss privately with the coworker only" — that is collusion, not advocacy.
The new ICU central-line policy seems to be reducing CLABSI rates.	Continue collecting outcome data; participate in the PDSA cycle.	QI requires ongoing measurement before adopting a change house-wide.	Picking "immediately roll out to every unit" — must *Study* before *Act*.
RN suspects an indwelling urinary catheter is no longer indicated.	Reassess indication using facility CAUTI bundle & recommend discontinuation to provider.	Prompt catheter removal is the single strongest CAUTI prevention measure (EBP).	"Continue catheter because the client prefers it." Convenience ≠ medical necessity.
RN witnesses a colleague pocket leftover hydromorphone.	Report immediately to the nurse manager / supervisor; document factual observations.	Mandatory reporting protects clients from impaired-practice harm; also a Board of Nursing duty.	"Confront the colleague first." Impaired-practice reporting goes to leadership, not the impaired nurse.
Client falls; family asks the RN, "What is going to happen now?"	Answer honestly — disclose the event factually (transparency) and explain next steps.	Open disclosure is required ethically and is part of National Patient Safety Goals.	Saying "I can't talk about that, it's under review" — that's evasion, not disclosure.
RN identifies repeated medication mislabeling on	Submit a quality concern through the unit-based safety	Trends require system fixes (FMEA), not one-by-one	Only telling the pharmacist directly — that misses the

SITUATION	BEST RN ACTION	WHY IT IS SAFEST	COMMON NCLEX TRAP
the unit.	council / QI committee.	corrections.	system pattern.
Client received the wrong unit of blood; develops fever, back pain, hematuria.	Stop transfusion immediately, maintain IV with NS, notify provider & blood bank, send blood/tubing back, file sentinel-event report.	Mismatched blood = Never Event; rapid stop prevents acute hemolytic crisis death.	"Slow the transfusion and observe" — never slow, ALWAYS stop.

SECTION 04

DELEGATION QI & Safety: RN vs LPN/VN vs UAP

TASK	RN	LPN/VN	UAP	CAN RN DELEGATE?	WHY / WHY NOT
Completing the incident / variance report for an event the RN witnessed	✔	✘	✘	NO	Must be completed by the person who discovered/was involved. Requires clinical judgment about facts.
Initial assessment of a client who just fell	✔	✘	✘	NO	Assessment is RN-only; LPN may *reassess stable data points* after the RN.
Obtaining vitals on a client after a fall, once cleared	✔	✔	✔	YES	Collecting data is within UAP scope after RN-driven plan is set.
Teaching client about fall-prevention measures at home	✔	✘	✘	NO	Initial teaching is RN's responsibility. LPN may reinforce.
Stocking sharps containers / monitoring fill levels	✔	✔	✔	YES	Environmental safety task, no clinical judgment required.
Auditing handwashing compliance on a shift	✔	✔	✔	YES (with training)	Data collection only; analysis remains with RN/QI team.
Reviewing a near-miss medication trend & designing a PDSA cycle	✔	✘	✘	NO	QI design requires clinical reasoning and EBP literature review.

TASK	RN	LPN/VN	UAP	CAN RN DELEGATE?	WHY / WHY NOT
Repositioning a high-risk client every 2 h to prevent HAPI	✔	✔	✔	**YES**	Established turning schedule; UAP reports skin changes back to RN.
Performing a daily CAUTI bundle review & recommending catheter removal	✔	partial	✘	**RN leads; LPN may complete checklist items**	Clinical decision to remove is RN/provider; LPN can document bundle elements.
Reporting a coworker for substance misuse	✔	✔	✔	**YES (everyone is mandated to report)**	Reporting impaired practice is everyone's duty — not a delegated task.

SECTION 05

RED FLAGS Cues That Demand Action

IMMEDIATE ASSESSMENT

- Client found on floor / post-fall
- Wrong med, wrong dose, or wrong client recognized
- Transfusion reaction signs (fever, back pain, chills, hematuria, hypotension)
- Pump alarm + medication infusing at unexpected rate
- Client states "this doesn't look like my regular pill"

PROVIDER NOTIFICATION

- Medication error reached the client
- Post-fall neuro change or new pain
- Allergic reaction after med administration
- New HAC suspected (CAUTI signs, CLABSI fever)
- Anticoagulation dose given to a client with active bleeding

RAPID RESPONSE

- Acute hemolytic transfusion reaction
- Anaphylaxis after medication error
- Respiratory depression after opioid overdose
- Severe hypoglycemia after insulin error
- New unresponsiveness post-fall

CHAIN OF COMMAND

- Manager pressures staff not to file a report
- Provider refuses to acknowledge a near miss
- Unsafe staffing pattern causing repeated errors
- Repeated equipment failures unaddressed
- Same med error recurs despite reporting

MANDATORY REPORTING

- Suspected impaired colleague (substance, diversion)
- Suspected abuse / neglect (including elder & child)
- Communicable disease (TB, measles, certain STIs, COVID per local rules)
- Sentinel events to The Joint Commission
- Unsafe staff practice that endangers clients

HOLD DELEGATION & REASSESS

- UAP returns abnormal VS — RN must assess
- LPN reports new bleeding / change in LOC
- Tasks initially delegated now require clinical judgment
- Client suddenly unstable mid-task
- Equipment failure during delegated task

SECTION 06

NGN PRACTICE 12 Advanced Questions With Rationales

Q 01 · Multiple Choice

INCIDENT REPORT | CJMM: TAKE ACTION

A nurse administers acetaminophen 1,000 mg orally to the wrong client. The client is alert, oriented, and reports no symptoms. Which action should the nurse take **first**?

A. Complete an incident report immediately.

B. Notify the prescribing provider.

C. Assess the client and obtain vital signs.

D. Notify the nurse manager.

Correct: C. The first action is always direct client assessment after any error reaches a client. Even when the client "feels fine," objective data (VS, mental status, signs of toxicity) must be obtained before any other step.

Why not A: Reports come AFTER client safety is confirmed.
Why not B: The provider needs assessment data to direct further orders.
Why not D: Notifying the manager does not address the client first.

NCLEX TRAP: Choosing the report or the phone call. Assessment ALWAYS precedes documentation and notification in error scenarios.

Q 02 · SATA

REPORTING | CJMM: RECOGNIZE CUES

Which events **require** completion of an incident/variance report? Select all that apply.

A. **A nurse catches a wrong-dose IV bag before it is hung.**

B. **A visitor slips on a wet floor and reports no injury.**

C. **A client refuses a scheduled medication after teaching is provided.**

D. **A staff member sustains a needlestick injury.**

E. A client experiences expected post-op pain rated 4/10.

F. **A client's IV infiltrates and causes a small area of redness.**

Correct: A, B, D, F — all are events involving clients, visitors, or staff that fall outside the expected course of care.
C is more nuanced: a documented informed refusal after teaching is generally charted in the EHR — not an incident report. However, if refusal endangers the client (e.g., refused critical anticoagulant after stroke) and conflicts arise, some facilities do require a variance. NCLEX favors the EHR-only documentation pathway for informed refusal.
Why not E: Expected post-op pain is normal and is charted in the EHR; not a variance.

NCLEX TRAP: Thinking "no harm = no report." Near misses and visitor/staff events are ALL reportable.

Q 03 · Drop-Down / Cloze

JUST CULTURE | CJMM: ANALYZE CUES

Complete the statement.

An RN intentionally bypasses two-nurse verification for an insulin drip because "it takes too long." This represents **[reckless behavior]**, which Just Culture addresses with **[discipline and remediation]**. A different nurse who forgets verification because a code is in progress in the next room represents **[human error]**, which is addressed with **[console and coach]**.

Reckless behavior = conscious disregard of known risk → discipline (Just Culture differentiates this from human error and at-risk behavior).
Human error = an inadvertent slip → consoling and supportive coaching. The nurse is not "blamed" — the system is examined.
Just Culture is a key NPSG-aligned framework for QI.

NCLEX TRAP: Treating all errors equally. Reckless behavior gets discipline; human error gets support.

Q 04 · Matrix / Grid

DOCUMENTATION | CJMM: TAKE ACTION

For each statement, indicate whether it should be documented in the **EHR (nurse's note)** or kept ONLY in the **Incident Report**.

STATEMENT	EHR	INCIDENT REPORT ONLY
"Client states, 'I tried to get to the bathroom on my own.'"	✔	
"Speculation that the night shift left the bed rail down."		✔ (and even there should be objective only)
"Incident report completed."	✘ NEVER	
"Client found on the floor at 0420. VS: BP 132/78, HR 88. Provider Dr. K notified at 0428."	✔	
"Skin intact, no ecchymosis, AOx4."	✔	
"This fall could have been prevented if the UAP responded faster."	✘ NEVER (opinion / blame)	✘ (still inappropriate — even reports stay objective)

Charts contain **objective clinical facts** and **provider notification**. The incident report is a separate QI tool. Speculation, blame, and assigning cause never belong in either.

NCLEX TRAP: Writing "incident report filed" in the EHR. This creates legal discoverability and turns a protected QI tool into evidence.

Q 05 · Bow-Tie

CLABSI PREVENTION | CJMM: GENERATE SOLUTIONS

A nurse is caring for a client with a central venous catheter for chemotherapy. Identify **2 actions to prevent**, the **condition**, and **2 cues to monitor**.

Actions to take (preventive):
✔ Daily CHG bathing
✔ Sterile dressing change weekly & PRN with chlorhexidine prep
✘ Routine line replacement to "refresh"
✘ Allow the line to remain after indication ends

CLABSI

Cues to monitor:
✔ Fever > 38°C, chills
✔ Redness, warmth, drainage at insertion site
✘ Mild bruising 1 cm from site
✘ Routine 2nd-day soreness at site

Correct preventive actions: CHG bathing + sterile dressing technique are evidence-based bundle elements.
Correct cues: systemic fever and local infection signs are the earliest CLABSI red flags.
Routine line replacement is no longer evidence-based; leaving an unnecessary line increases risk.

NCLEX TRAP: Confusing "more interventions" with "better care." EBP bundles are specific — added steps without evidence can increase risk.

Q 06 · Ordered Response

TRANSFUSION REACTION | CJMM: PRIORITIZE HYPOTHESES

A client develops fever, back pain, and dark urine 15 minutes into a PRBC transfusion. Place the nurse's actions in correct order.

1. **STOP the transfusion immediately.**
2. **Maintain IV access with 0.9% normal saline using new tubing.**
3. **Assess vital signs and oxygen saturation.**
4. **Notify the provider and the blood bank.**
5. **Send the blood unit, tubing, and a post-transfusion blood/urine sample per protocol.**
6. **Complete the transfusion reaction / variance report and document objectively.**

Stop is always FIRST — even before assessment in this scenario, because the offending agent must be removed. New tubing prevents continued exposure. Saline keeps a line for emergency drugs. Provider + blood bank are simultaneous. Sending the unit closes the chain of evidence. Reports come last.

NCLEX TRAP: "Slow the transfusion to half rate and observe." NEVER slow — always STOP. Mismatched blood is a Never Event.

Q 07 · Prioritization

FIRST ACTION | CJMM: TAKE ACTION

Which client should the charge nurse **assess first**?

A. A post-op day 2 client with a Foley catheter requesting pain medication.

B. A client who just received an IM antibiotic and now reports itching of the throat.

C. A client whose family is upset that a near-miss medication event occurred earlier in the shift.

D. A client who was found on the floor 2 hours ago, now reassessed AOx4 and asymptomatic.

Correct: B. Throat itching after IM antibiotic = early anaphylaxis. ABC threat overrides every other concern.
A: Pain is real but stable.
C: Family concerns matter but are not immediately life-threatening.
D: Reassessed, asymptomatic, and 2 hours stable.

NCLEX TRAP: Picking the family in distress (emotional pull) or the post-fall client (recency). Always select the client with the airway/circulatory threat.

Q 08 · Delegation Scenario

QI AUDIT TASKS | CJMM: GENERATE SOLUTIONS

The unit is launching a CAUTI-reduction PDSA project. Which task is **most appropriate** to delegate to a trained UAP?

A. Reviewing each client chart for catheter indication daily.

B. Performing weekly perineal care audits using a standardized checklist.

C. Determining when to recommend catheter removal to the provider.

D. Teaching clients about CAUTI prevention before discharge.

Correct: B. Standardized checklist data collection is within UAP scope and supports QI data.
A & C: Require nursing judgment — RN only.
D: Initial teaching is an RN function.

NCLEX TRAP: "Trained UAP" doesn't mean they can do assessment or teaching — just standardized, observable tasks.

Q 09 · SATA

SENTINEL EVENTS | CJMM: RECOGNIZE CUES

Which events meet The Joint Commission definition of a **sentinel event**? Select all that apply.

A. A surgical procedure performed on the wrong side of the body.

B. Suicide of an inpatient during admission.

C. Death of a client from a hemolytic transfusion reaction.

D. A client falls but sustains no injury.

E. Retained surgical sponge requiring reoperation.

F. A medication error caught and corrected before reaching the client.

Sentinel events = death, permanent harm, or severe temporary harm. A, B, C, E all qualify. D and F are reportable but are *not* sentinel events because no severe harm reached the client.

NCLEX TRAP: Equating "reportable" with "sentinel." All sentinel events are reportable, but not all reportable events are sentinel.

Q 10 · Case-Style MCQ

RCA | CJMM: EVALUATE OUTCOMES

After a sentinel event involving a wrong-site surgery, the facility convenes an RCA. The RN representing the OR should expect the team to focus primarily on:

A. Disciplining the surgeon and circulating nurse involved.

B. Identifying system-level failures (communication, time-out, marking) and proposing redesign.

C. Determining financial liability for the facility.

D. Issuing a press release detailing the names of the staff involved.

Correct: B. RCA is a system-focused, non-blaming process. The "5 Whys" trace causes back to system roots so future events are prevented. Discipline (if any) is handled separately.
A, C, D all reflect punitive or non-QI activity, which would actually suppress future reporting.

NCLEX TRAP: Believing RCA = punishment. RCA is QI's most important learning tool.

Q 11 · Handoff / SBAR

COMMUNICATION SAFETY | CJMM: TAKE ACTION

An RN is giving handoff after a near-miss medication event was identified and resolved earlier in the shift. Which inclusion is **most appropriate** in SBAR?

A. "Don't write this down, but earlier there was almost a med error — it's been handled."

B. "During my shift, a 10× heparin programming error was identified at 1100 and corrected before infusion. Client status remains unchanged; a variance has been filed. Please continue heparin per current order and monitor PTT at 1800."

C. "The pump was set wrong but the patient is fine, so nothing else to report."

D. "I'll write it in the chart so the next shift can read about it later."

Correct: B. Transparent SBAR keeps the receiving nurse informed of system risk and pending labs. The variance is mentioned (Just Culture) — but the EHR documentation focuses on facts and care plan, not on the report itself.

NCLEX TRAP: Verbal "off-the-record" handoff. Safe handoff is honest, documented in the care plan, and protects the next shift.

Q 12 · Multiple Choice

EBP & COST | CJMM: EVALUATE OUTCOMES

A unit-based QI team finds that switching from routine 72-hour peripheral IV site replacement to *clinically indicated* replacement reduces phlebitis rates and supply costs without increasing infections. The team should next:

A. Continue routine 72-hour replacement because "that's how it has always been done."

B. Adopt clinically indicated replacement, update policy, and educate staff while continuing surveillance.

C. Stop monitoring outcomes since the data already favor the change.

D. Wait for an external audit before changing policy.

Correct: B. The "Act" phase of PDSA adopts an evidence-supported change AND continues monitoring (sustainability). This is EBP + cost-effective care = quality.
A: Tradition over evidence.
C: Surveillance must continue — gains can erode.
D: Internal QI does not require external permission.

NCLEX TRAP: Believing cost-effective = lower quality. Evidence-based, well-monitored change is both safer AND more efficient.

SECTION 07

CASE STUDY Unfolding NGN Case

CASE FILE

Setting: 32-bed medical unit, 0700 shift change. Client: 74-year-old woman, post-op day 1 hip ORIF.

NURSE'S NOTES — 0710 (OFF-GOING RN)

"Client awake, AOx4, denies pain at this time. Encouraged to use call light before ambulating. Bed in low position, brakes locked, two side rails up. Voided in bedpan ×1 overnight. Anticoagulation per protocol given at 0600. Plan: PT consult at 1000, transfer to rehab planning."

VITAL SIGNS — 0700

Temp 37.1°C · HR 84 · BP 132/78 · RR 16 · SpO₂ 97% on RA · Pain 3/10

PROVIDER ORDERS

- Enoxaparin 40 mg SubQ daily
- Oxycodone 5 mg PO Q4H PRN pain
- Ambulate with PT today; bedrest until PT clears
- Discontinue Foley if not contraindicated
- Fall precautions; bed alarm on

HEALTH CARE TEAM NOTE — 0815 (UAP)

"Found Mrs. M. on floor next to bed at 0810. No bed alarm sounded. Client states, 'I tried to go to the bathroom myself, I didn't want to bother anyone.' She is moaning and grabbing her right hip."

FAMILY STATEMENT — 0830

Daughter: "She fell last admission too. Why does this keep happening here? What are you going to do?"

CJMM STEP 1 · RECOGNIZE CUES

Which findings are *most concerning*? Select 3.

✔ Bed alarm did not sound

✔ Client moaning and grabbing operative hip

✔ Recent enoxaparin administration

VS at 0700 within normal range

PT consult ordered for 1000

Rationale: A failed bed alarm is a system safety failure. Anticoagulation + acute trauma raises bleeding risk. Pain at the operative site signals possible re-injury / dislocation. Normal vitals and a planned consult are background context, not red flags.

CJMM STEP 2 · ANALYZE CUES

What is the likely combined problem?

Anxiety-related restlessness

Mechanical/equipment failure + at-risk client behavior leading to post-op fall with anticoagulant exposure

Routine post-op pain

Family conflict driving care confusion

Connecting cues: the alarm failure + the client's verbalized rationale ("didn't want to bother anyone") + recent anticoagulant + operative hip = mechanism for a high-risk adverse event with hemorrhage potential and possible hardware compromise.

CJMM STEP 3 · PRIORITIZE HYPOTHESES

Rank from highest to lowest priority hypothesis:

1. Hip dislocation / hardware displacement with bleeding risk (acute, ABC/circulation-linked)

2. Head injury from unwitnessed fall in elderly anticoagulated client

3. System safety failure — alarm not functioning

4. Family communication / disclosure

5. Need for QI review and PDSA on bed-alarm reliability

Highest priorities address physical harm. System and communication issues are critical but follow stabilization.

CJMM STEP 4 · GENERATE SOLUTIONS

Which interventions are appropriate? Select all that apply.

✔ Do NOT move the client until full neuro and hip assessment

✔ Obtain VS and neurological assessment

✔ Notify the provider STAT — anticipate imaging order & possible hold on enoxaparin

✔ Activate post-fall protocol

✔ Complete factual variance report; tag bed alarm for biomed evaluation

Send the client back to surgery without imaging

Document "incident report completed" in the EHR

Movement before assessment risks worsening dislocation or bleed. Imaging guides surgical decisions. The variance report and biomed referral are essential QI/system actions.

CJMM STEP 5 · TAKE ACTION

Place these actions in correct order:

1. Direct the UAP to remain with the client and not to move her; call for help.

2. Perform focused assessment (neuro, hip, skin, VS).

3. Notify the provider with SBAR; obtain imaging orders.

4. Hold/clarify enoxaparin until provider input.

5. Disclose factually to family; document objective EHR note.

6. Complete variance report; submit equipment for biomed inspection; refer to QI/safety committee.

Client first, then provider, then system. Each step is sequenced for safety and legal protection.

CJMM STEP 6 · EVALUATE OUTCOMES

Which outcomes indicate that interventions were effective? Select all that apply.

✔ Imaging shows no hardware displacement or intracranial bleed; client stabilized.

✔ Variance report submitted; bed alarm replaced; unit-based QI launches PDSA on call-light response times.

✔ Family expresses understanding after transparent disclosure.

✔ Fall-with-injury rate trended on unit dashboard; staff education completed.

Documentation includes "incident report filed" in EHR.

Manager identifies the off-going RN as the sole cause and removes her from the schedule.

Outcomes reflect both individual client safety AND system learning. Outcomes that reflect blame or improper documentation are red flags, not signs of success.

SECTION 08

PRIORITIZE "What Should the Nurse Do First?"

1. A nurse realizes 30 minutes after the fact that the wrong antibiotic was infused.
FIRST → Assess the client for allergic/adverse reaction, obtain VS, then notify provider, then complete variance.
Rationale: assessment precedes notification and paperwork.

2. A client just received the second unit of PRBCs and now reports back pain and chills.
FIRST → STOP the transfusion. Maintain IV with NS via new tubing, then VS, then provider/blood bank.
Rationale: remove the offending agent before any further data collection.

3. A coworker is observed slurring speech and unsteady on the unit.
FIRST → Remove the coworker from client assignments and escalate to the charge nurse/supervisor

immediately.
Rationale: client safety is protected by removing the potentially impaired provider; investigation/report follows.

4. The nurse witnesses a pump alarm being silenced repeatedly without re-checking the infusion.
FIRST → Stop the pump, verify infusion settings, assess the client. Then re-educate or file a near-miss.
Rationale: alarm fatigue is a sentinel-event risk; immediate verification protects the client.

5. A family member asks, "Why does my mother have new bruising and no one told us?"
FIRST → Assess the client (skin, neuro, pain). Then disclose objectively, notify provider, document, and file variance.
Rationale: Transparent disclosure is required, but assessment for an unrecognized event comes first.

SECTION 09

DELEGATE? "Can This Be Delegated?"

1. Counting opened-but-unused narcotic doses at end of shift.
RN with another licensed nurse (RN or LPN). Controlled substance count is a licensed nurse duty per facility & DEA-aligned policy. NO UAP

2. Collecting hand-hygiene audit data using a simple checklist.
Trained UAP. Standardized observation without clinical interpretation. YES

3. Notifying a provider about a post-fall change in mental status.
RN ONLY. Requires clinical judgment + SBAR + interpretation. NO

4. Removing an unnecessary indwelling urinary catheter per a CAUTI bundle order.
RN or LPN/VN. Catheter removal is a licensed task following protocol. YES (LICENSED)

5. Initial assessment of a coworker the RN suspects is impaired.
RN reports up the chain of command (charge nurse / supervisor / manager). "Initial assessment" of suspected impaired staff is leadership's role with HR/EAP. The RN's duty is to report and protect clients.

REPORT

SECTION 10

REFER "Who Should the Nurse Contact?"

1. A post-op client has a stage 3 sacral pressure injury developing on POD 5.
→ **Wound/Ostomy/Continence Nurse (WOCN) + provider.** This is a hospital-acquired condition (HAPI) — escalate for advanced wound care & surveillance.

2. The unit's CLABSI rate has risen above target for 3 months in a row.
→ **Infection Preventionist + Unit-Based QI Committee.** Trends require system review, not single-event handling.

3. A client suffers a serious medication error and the family wants answers and emotional support.
→ **Provider for disclosure + Risk Management/Patient Safety Officer + Social Work/Chaplain.** Disclosure is a team effort.

4. Repeated mislabeling of look-alike medications has been identified.
→ **Pharmacist + Medication Safety Committee.** System-level fix requires medication-safety expertise.

5. A nurse is experiencing moral distress after a serious event involving a colleague.
→ **Employee Assistance Program (EAP) + Nurse Manager + Peer Support team.** Moral distress is real; resources support staff well-being.

SECTION 11

LEGAL / ETHICAL Trap Scenarios

1. Consent / Disclosure. After a wrong-site biopsy, a manager tells the RN, "Don't mention this to the family until legal reviews it."
Trap: Withholding factual disclosure violates ethical principles of veracity and transparent communication. The provider performs formal disclosure; the nurse never lies, never withholds clinical facts, and never tells the family the event didn't happen.

2. Confidentiality. A nurse posts on a private social media group: "Crazy shift — lady fell after we forgot the alarm. Don't worry, no names."
Trap: HIPAA violation even without names if details could identify the client. Also violates incident report confidentiality.

3. Refusal. A client refuses enoxaparin after teaching about VTE risk.
Trap: Honor refusal AFTER documented teaching. Chart in EHR (not incident report). Notify provider. Refusal alone is not a "variance event."

4. Mandatory Reporting. A nurse notices a peer's documented narcotic waste does not match the EHR removal records.
Trap: Diversion = mandatory report to manager & (per state) Board of Nursing. Not "I'll watch them next shift."

5. End-of-Life. A client with a DNR/DNI receives accidental intubation during a code blue.
Trap: Honor the directive — initiate provider-led withdrawal once confirmed; this is a sentinel-level safety event requiring RCA. NEVER hide the event from family or ethics committee.

SECTION 12

QUICK REVIEW End-of-Day Power-Up

10 MUST-REMEMBER ONE-LINERS

1. Assess the client BEFORE filing the incident report.
2. Never write "incident report filed" in the EHR.
3. Near misses ARE reportable — they are QI gold.
4. Sentinel events trigger an RCA.
5. RCA = retrospective; FMEA = prospective.
6. Just Culture treats human error with support, not punishment.

7. Quality follows STEEEP: Safe, Timely, Effective, Efficient, Equitable, Patient-centered.
8. Six HAC bundles: CAUTI · CLABSI · SSI · HAPI · VAP · Falls.
9. STOP (don't slow) a transfusion reaction.
10. Open, factual disclosure is required — but the provider leads it.

5 "NEVER DO THIS" RULES

- NEVER chart "incident report completed."
- NEVER record opinions, speculation, or blame in the incident report.
- NEVER slow a transfusion reaction; STOP it.
- NEVER confront an impaired coworker alone — report up the chain.
- NEVER post any clinical details on social media, even "anonymized."

5 COMMON NCLEX TRAPS

- Choosing "report" over "assess" as the first action.
- Calling near misses non-reportable.
- Confusing RCA with disciplinary review.
- Documenting incident report references in the EHR.
- Equating cost-effective care with cutting safety.

5 SAFETY-FIRST PHRASES TO RECOGNIZE ON NCLEX

- "Assess the client first."
- "Notify the provider after assessment."
- "Complete an objective variance report."
- "Initiate a root cause analysis."
- "Apply evidence-based practice and current policy."

SECTION 13

INFOGRAPHIC Standalone Screenshot Summary

Day 12 · QI, Incident Reports, Near Misses & Safety Systems

Print, save, or screenshot — your full-day pocket reference.

1 · ERROR TYPES

- **Near miss** — caught before harm
- **Adverse event** — reached the client
- **Sentinel event** — death / severe harm
- **Never event** — wrong-site, retained object, blood mismatch

2 · THE PDSA CYCLE

- **P** Plan a small test
- **D** Do it on a small scale
- **S** Study the data
- **A** Adopt, adapt, or abandon

3 · THE SIX AIMS (STEEEP)

- Safe
- Timely
- Effective
- Efficient
- Equitable
- Patient-centered

▼

4 · INCIDENT REPORT — RULES

- Filed by the discoverer
- Objective only — no blame
- Includes near misses
- NOT charted in EHR
- Used for QI / RCA

5 · RCA VS FMEA

- **RCA** — retrospective, after sentinel event, 5 Whys, 45 days
- **FMEA** — prospective, before new process, predicts failure modes

6 · HOSPITAL-ACQUIRED CONDITIONS

- CAUTI · CLABSI · SSI
- HAPI (stages 3, 4, unstageable)
- VAP · Falls with injury
- Blood incompatibility (Never Event)

▼

7 · JUST CULTURE CATEGORIES

- **Human Error** → console & coach
- **At-Risk Behavior** → coach & counsel
- **Reckless Behavior** → discipline

8 · TRANSFUSION REACTION

- STOP transfusion
- NS via new tubing
- VS & SpO_2
- Provider & blood bank
- Send unit/tubing/samples

9 · TOP QI / NPSG GOALS

- Two identifiers
- Time-out before procedures
- Hand hygiene
- Medication labeling
- Improve communication / alarms

▼

THE DAY 12 MANTRA · "ASSESS-NOTIFY-REPORT-LEARN"

A · Assess the client first.

N · Notify the provider with SBAR.

R · Report — file the variance OBJECTIVELY (never in the chart).

L · Learn — participate in PDSA, RCA, and ongoing surveillance.

FINAL ANCHOR

"Errors are not failures of nurses — they are failures of systems. A safe entry-level RN reports honestly, documents factually, and builds a culture where the next nurse will report just as honestly."

End of Day 12 — Quality Improvement, Incident Reports, Near Misses & Safety Systems

TOMORROW → DAY 13: RESOURCE MANAGEMENT, TIME MANAGEMENT & SAFE STAFFING