Yasmin Perez

1a. One major concern is that the documentation does not stay consistent. The patient is charted as “non-directable” while also being listed as “sedated,” which does not logically align and makes it unclear what the patient’s actual condition was. The same behaviors and interventions are repeated at multiple times with no clear evidence that a new assessment was performed. This gives the impression that information may have been copied forward instead of updated. There is also very little detail describing the patient’s actual behavior or how they responded to interventions. IM medications are documented, but there is no clear explanation of why they were necessary at those specific times

1b The nurse should have documented specific behaviors observed and explained how the patient responded to each intervention. Each entry should reflect a true reassessment rather than repeating the same information. When IM medications were given, the nurse should have clearly documented the reason for giving them and the patient’s response afterward. Documentation should clearly support the clinical decision-making and show why the interventions were need.

1c If this documentation were reviewed in court, I would explain that the patient required ongoing monitoring and interventions to maintain safety. I would also acknowledge that the documentation does not clearly show changes in the patient’s condition or fully explain the reasoning behind certain interventions. While the care was provided with the patient’s safety in mind, the documentation could have been more detailed to accurately reflect the assessments and decisions that were made.

1d In my practice, I will make sure to document in real time and avoid repeating the same information without reassessing the patient. I will clearly describe patient behaviors, explain the reasons for medications or restraints, and document how the patient responds to interventions. I will also review my documentation for clarity and consistency so it accurately reflects the care provided.

2a. My first priority would be to stay with the patient to prevent a fall and ensure safety, as the patient has been attempting to climb out of bed and remove medical devices. I would make sure the oxygen and pulse oximeter remain in place since the patient’s oxygen saturation drops into the low 80s when oxygen is removed, which can worsen hypoxia and confusion. I would use least-restrictive interventions such as lowering the bed, activating the bed alarm, and providing calm, frequent reorientation. I would notify the charge nurse and provider about the continued agitation and repeated removal of oxygen. Because the patient calms when staff are present, I would request a sitter to provide continuous observation and maintain safety. Restraints would only be considered if all other interventions fail.

b.The Quality Department would review fall risk prevention, management of hypoxia, use of least-restrictive interventions, communication with the provider, and documentation related to sitter or restraint use to ensure patient safety policies were followed.

3a My next action would be to activate a Rapid Response. The patient is showing signs of worsening respiratory distress, including a rising respiratory rate, increasing oxygen needs, use of accessory muscles, cyanosis, diaphoresis, and a drop in oxygen saturation to 84% on 2L NC. The patient is also becoming hypotensive and tachycardic, indicating poor perfusion. Waiting for the physician to call back places the patient at risk for respiratory failure, so immediate escalation of care is necessary.

3b. If I were the Quality Department nurse, I would review the timeliness of escalation of care, including when Rapid Response was activated, as well as any delays in provider response. I would also review recognition and documentation of patient deterioration, oxygen therapy

management, communication among staff, and adherence to hospital policies for managing respiratory distress and patient deterioration.