Firelands Regional Medical Center School of Nursing Jess Bower

AMSN 2026

Quality Assurance/Core Measures (**1H**)

Review this information and utilize the information provided on January 8, 2026. Answer the questions that follow. You must complete this assignment completely to be satisfactory.

This completed document is due in the "Quality Assurance/Core Measures" Dropbox by January 23, 2026 at 0800. The CDG for this assignment is also due at that time. You will evaluate yourself for this observation experience on the Clinical Tool for Week 3.

The Quality Department is responsible for monitoring many safety and standardization items, including the following:

CODES:

1) Quality Department members continually monitor/review to be sure **safe quality** care was rendered.
2) Monitor the response of the team.
3) Was proper treatment rendered? ACLS protocol followed?
4) Could the code have been avoided?
    a. Code Blue
        i. **ED**-
            1. Mostly checking that ACLS protocol was done. Looking at EMS to ED transfer of care.
            2. The hospital can't prevent these codes.
            3. Assure there is documentation on the code blue record that supports the treatment rendered.
        ii. **Inpatient**-
            1. Was this impending (expected) or not expected?
            2. Monitor these more closely when they occur outside of the ED or 4C. Why did it occur?
                a. Abnormal lab values?
                b. Did prior assessments show a trend:
                    i. Were the changes in condition reported? Timely reported?
                    ii. Review vital sign trends.
                    iii. *Clinical Judgment*: how is my assessment different from the prior one?
                    iv. Importance of notifying charge nurse/ physician with significant changes.
                c. Was the patient at the correct level of care to begin with?
                d. Was the physician made aware of abnormal labs? Was treatment being done? (i.e. low/high K+; Na+; glucose, etc.)
                e. **Could this have been avoided**?

f. Were nursing assessments done completely and timely?

b. MET
   i. Often see deterioration in condition over the previous 8-12 hrs.
   ii. *Clinical Judgment*: Initiate an intervention before it converts to a code blue.
   iii. *Clinical Judgment*: Do more frequent assessments, vital signs. Don't wait until the next scheduled time.
   iv. Don't be afraid to call a MET. Charge nurse should be aware of the changes in condition that you have reported to them prior. (unless it's a sudden hemorrhage, etc.)
   v. With sudden changes in BP and patient is stable.
      1. Example: 0600 NIBP 125/71. One hr. later: NIBP 98/60. Patient looks a bit more lethargic. First thing: Take a **manual BP.** Can't rely on the machine. It may be wrong. Always know where your manual BP cuff is on your unit. Depending on the patient's condition, things can change fast especially in sepsis, cardiogenic shock, etc.
      2. Confused patients: Medications? UTI? Importance of doing/documenting the focused assessment and passing those changes along to the charge nurse/physician as needed.

c. Code Violet
   i. Monitoring for signs the patient was escalating.
   ii. Could PRN meds have been given? Would like to see that staff tried other less aggressive measures.
   iii. Was the team's response appropriate?
      1. Nursing needs to maintain clinical control. This is **your** patient. Security too rough ? Unnecessary aggression on part of staff?
      2. Often the patient is given medication or they are restrained. This becomes a patient safety issue. Try to prevent these situations.
   iv. Documentation of event.

d. Code Pink
   i. These are either called as a Stand by or an Alert. The Quality Department only review the Alerts.
   ii. When should a Code Pink be called?
      1. Anticipation of a possible problem that may occur.
         a. Twins.
         b. Young gestational age (<36weeks).
         c. Maternal IV insulin or another high-risk condition.
         d. Mother with no prenatal care.

MORTALITIES

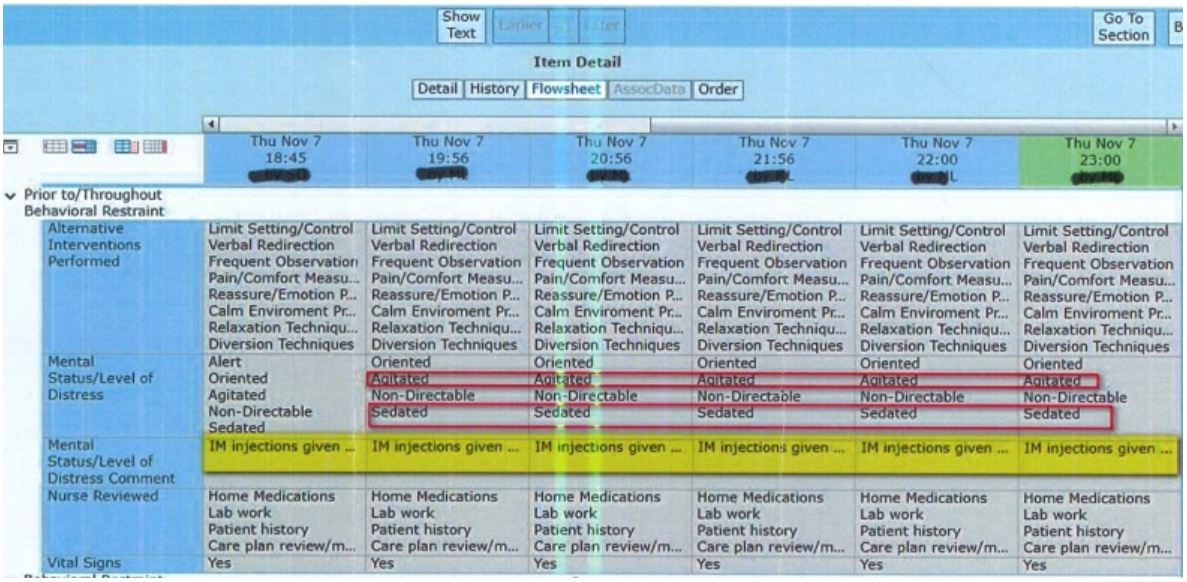
1) Review every patient who expires in the hospital.
   a. The focus is more on inpatients as we can't prevent the ED/ Code Blue situations.

b. Key points the Quality Department reviews:
    i. Did the death occur on a med/ surg unit?
    ii. Was this expected/not expected?
    iii. Code Blue or MET prior?
    iv. Hospice patient?
    v. Was this a terminal extubation?
    vi. DNR?
        1. Did we help the family realize or cope with the fact their loved one was dying?
        2. Are we having those discussions and are they documented?
            a. This shows compassion.

RESTRAINTS:

1) Always use the least invasive method first.
2) Try Sitters; 1:1 etc.
3) Frequent rounding. Checking for toilet, food, pain, repositioning, distraction
4) Monitor use to assure patient's rights are not being violated.
5) Restraints are being used most often on 4C for patients on the vent, trying to prevent extubation.
    a. *Clinical Judgment*: Assure they are being used appropriately (i.e. flaccid extremities should not be restrained).
6) Restraint use is closely monitored on med/surg units.
    a. To assure they are not being used for fall prevention.

Documentation of Restraint example (drag and drop used by nursing)



Answer the following

1. Review the restraint documentation above.

a. What concerns do you have with this documentation? Provide specific examples and explain each.
One concern I have is that it lists that the patient is “Alert” and “Oriented” but also “Sedated”. I also see that IM injections were given, I assume for the sedation but again the charting shows “Agitated” but then also “Sedated”. I am also wondering what type of IM injections are being given it appears every hour and then again 4 minutes later. I also feel over the span of what appears to be 4.5 hours the patient’s condition did not change at all even with all the interventions of the IM injections.

b. What should the nurse have done differently with this documentation?
I feel the nurse should have made a nurses note to document in what way the patient was still agitated, every hour that the patient was allegedly assessed. I feel it’s almost if it was just copy and pasted for each hour and perhaps a check was not really done.

c. If this documentation was presented in a court of law, and you were the RN who provided the care to this patient, how would you explain this situation?
It is hard to say because I do not feel the documentation is correct and therefore, I cannot justify why it was done that way. Had I had a patient in this similar situation I would have explained the need for any restraints and/or the sedation. However, if this was my documentation, I would of acknowledged that the documentation does not fully reflect the assessments that were conducted and lacked detail. It is hard because what is priority here is patient safety and staff safety and sedation and restraints should only be used for a short period of time.

d. How will you as the RN prevent this type of issue from happening in your practice?
I feel to prevent this, proper training on documentation and the importance of being detailed and accurate in a timely manner that is patient specific is crucial. Nurses notes as well as reassessments are important. This clearly looks like copy and pasting and I feel with a patient such as this, interventions and assessments should show some sort or change in over 4 hours.

2. You are caring for an older aged patient on 3Tower who is confused. The patient was admitted at 1930 for hypoxia. The admitting SpO2 was 74% on RA, and the patient is currently on 5L NC.

- At 2100 you enter the patient’s room.
  - No family is present.
  - The patient has been very agitated for the past 30-45 minutes, and has attempting to climb out of bed several times.
  - Pulling at Foley, taking off pulse ox, pulling O2 off.
  - Has been reminded several times of the importance of not pulling at tubes.
  - SpO2 is 94-95% on 5L NC, but drops to low 80’s when the oxygen is pulled off.
  - The patient calms down quickly but gets fidgety as soon as staff leaves the room.

a. What are your next actions, in order of **priority**? (include at least 5 interventions, and provide a rationale for each)
SAFETY- Since the patient is actively attempting to climb out of bed and pulling out the Foley, pulse ox and pulling the O2 off it is important to interventions to help protect the patient for falling but also reducing the risk of a breathing or respiratory issue such as hypoxia because of the low O2 and he is now pulling off the oxygen. He appears to be agitated so that can increase the work of breathing.
RESPIRATORY STATUS – The patient was admitted because of 74% SpO2 on RA. He was on 5L NC and then dripped quick back into the 80s. Keeping his oxygenated is crucial to prevent hypoxia or any other change in mental status due to lack of oxygen.

NEURO ASSESSMENT – Due to the sudden confusion and agitation this could because the patient may already be experiencing hypoxia. A focused neuro assessment is needed to see any possible other effects low oxygen could have caused.
POSSIBLE 1:1 – Due to this patient's state, and having no family present, it would be recommended they are put on a teleasitter or a 1:1 sitter to ensure and maintain patient safety.
NOTIFY PROVIDER – it is important to update the HCP and maybe get new orders for possible restraints if needed or perhaps look into any medication changes that could help the patient relax.

b. Following eventual discharge, what would the Quality Department review related to this patient?
They would review the trend in vitals' signs, such as oxygen and periods of decreasing level of SpO2. They would need to see the documentation of the progression of the confusion, agitation and behavior issues and what interventions were done and if they were appropriate for said situation.

3. You are caring for an older aged patient who presented to the ED with dyspnea, and was admitted with a diagnosis of pneumonia. PMH: CHF. COPD.

- **0630** - Nursing note from prior RN:
  - In to check on patient. Appears more relaxed. BP 112/62. HR 97. RR remains in mid 30s. SpO2 94% on 2L NC. Audible wheezes heard. Steroid inhaler given on schedule. No improvement with breathing.
- **0650:** Respiratory in to administer PRN breathing treatment.
- **0730**: Your assessment:
  - RR still in high 30s.
  - Audible wheezes still heard. Lung sounds are "tight". Now diaphoretic and clammy. Linens wet.
  - VS: Temp 100.3ºF, HR 120, RR 38 and SpO90% on 2L NC. Respirations shallow, using accessory muscles.
  - Hands and feet are cool to touch with slow capillary refill. Fingertips cyanotic. Charge nurse aware. Physician paged.
- **0745**: Assessment unchanged. Awaiting physician call back.
- **0800**: VS : Temp 99.8ºF. BP 98/50. HR 122. RR 40 and SpO2 84% on 2L NC. No other change in assessment. Still awaiting physician call back.

a. What is your **next** action? Explain and provide a rationale.
Active a MET – due to this patient's worsening progression in less than a 2 hours this warrants us to active a MET. The patients has worsening hypoxia, audible wheezes, lungs are "tight" and the patient is now diaphoretic and clammy. RR are 40 and Sp02 is 84% on 2L NC. The patient is experiencing tachycardia and new onset hypotension. Even though we are waiting on physician call back, this patient is declining rapidly.

b. If you were the Quality Department nurse, what part(s) of this case would you review and monitor? Explain.
With any case, the decline in progression would be looked at. When did the patient first start declining to when the MET was called and why. I would also look at if all the correct interventions were done and in a timely manner based on this situation, such as calling for a MET

even though they were still waiting to hear from the physician. Documentation would be looked at closely to determine accuracy and consistently with all assessments.