Firelands Regional Medical Center School of Nursing

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

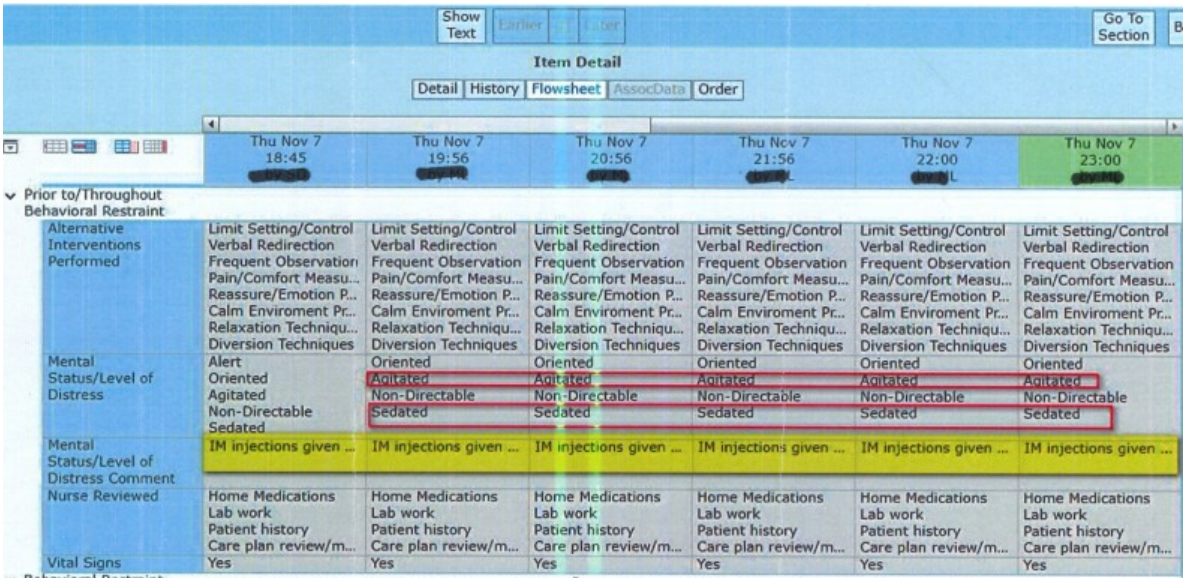
1) Review every patient who expires in the hospital.
   a. The focus is more on inpatients as we can't prevent the ED/ Code Blue situations.

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.
The concerns I have with this documentation are under mental status they are reporting under oriented that the patient was agitated and the patient was sedated. The nurse is documenting about every hour, so they are checking on the patient. As for the nurse they have been sedating the patient for about 6 hours without trying a sedation vacation to see how the patients mental status is or to identify the patient's behavior off sedation. This could be a big risk for delirium when they remove sedation on the patient as well as it can be harder to wake the patient and take longer periods of time for patient waking.

b. What should the nurse have done differently with this documentation?
The nurse should have documented the reason for the restraints and sedation, As well as the certain behaviors that patient presented to need the restraints. Nurse should have also changed what was documented instead of the same exact documentation every hour for 6 hours.

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?
I would explain that over the hours there was no change in the patient's status. I would also explain the reason for the restraints needed. I would also explain every hour checks on the patient for the patient's safety. I would explain my reasoning for sedating the patient and how the patient reacted with the sedation.

d. How will you as the RN prevent this type of issue from happening in your practice?

I would prevent this from happening by trying to reduce the sedation after so long to see the patients behavior and give trial runs on how the patient will react. I will also add notes to my documentation to provide more explanation on my patients current status so it does look like Im just copying documentation to complete the documentation.

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)

- Monitor patients oxygen levels every hour
  - This will help patients remain safe as O2 level drop severely low.
- Provide patient with frequent checks to reorient the patient and provide familiar items.
  - This may provide him comfort knowing the patient is not alone in an unfamiliar place.
- Provide patient with a distraction as needed
  - To help the patient with his fidgeting to see if this can help maintain safety before more extreme measures
- Call family to see if anyone could come stay with him
  - It might provide comfort to patient and help reorient and calm the patient down.
- Put patient on 24hr tele sitter to provide supervisor.

- Using tele sitter can help patient remain safe and can redirect him as needed.

b. Following eventual discharge, what would the Quality Department review related to this patient?

The quality department will review education to the family on patient safety, education on patients oxygen needs, what resources where used. The use of tele sitter, the resource used to maintain safety, and communication between healthcare team. This will help determine what went right and what mistakes happened to identify better patient outcomes.

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.
The next action would be to go to a high staff to report patient decline in health so intervention could be doen to help provide patient with comfort and care. If the healthcare provider doesn't respond and patient consistently gets worse it is important to notify someone on high power so the nurse can start intervention before the patient declines to bad. It is most important to provide patient care in adequate time even if you have to go to higher power.

b. If you were the Quality Department nurse, what part(s) of this case would you review and monitor? Explain.
If I was the Quality Department nurse the parts of the case that I would review if the communication between staff. I would also review what the nurse did in the time the healthcare provider did not answer and who the nurse went to. I would monitor the healthcare providers communication with staff overtime to make sure there is no errors or issues cause a decline in patient treatment or care for the hospital overall. I would also look into when the healthcare provider was finally reach and what happened from there.