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

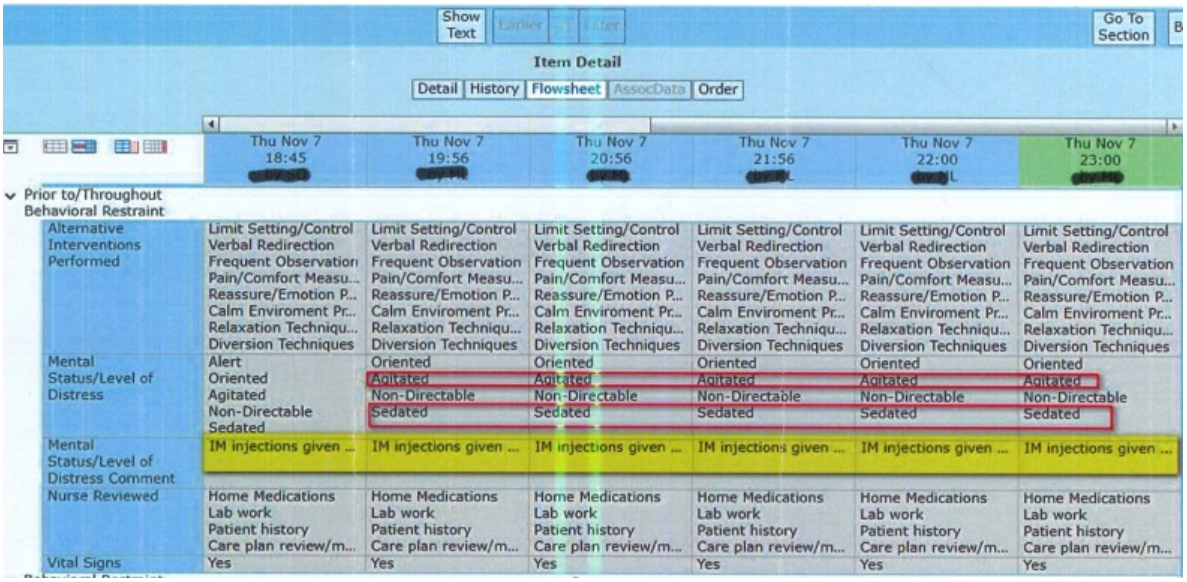
1) Review every patient who expires in the hospital.
   a. The focus is more on inpatients as we can't prevent the ED/ Code Blue situations.

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.

I am concerned with this documentation because it seems that it has just been copied from previous documentation. It is documented that the patient is agitated but also that the patient is sedated. If the patient is under sedation, how are they showing signs of being agitated? It is unknown if the assessment for the restraints were done because of this. It is also being documented that the patient is being given an IM injection during every restraint check. This is unsafe because the patient would not need the injections this frequently. This documentation shows that the patient is being over medicated. This also shows that the nurse may not be double-checking their documentation before submitting it, which can cause a lot of errors.

b. What should the nurse have done differently with this documentation?

The nurse should have documented their own assessment instead of just copying the assessment of the previous nurse.

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 the documentation was not double checked and not completed accurately. I would take accountability in the fact that I could have just either been lazy with my documentation at the time or that I did not document as soon as I had don't the assessment.

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

I will make sure that I am always documenting my own personal assessment. I will make sure that I am taking my time with my documentation as well so that it is being done correctly and I will always double check my documentation so that if I have made any errors, I am able to correct them before submitting my documentation for said assessment or intervention.

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)

Place O2 back on patient. This is important because the patient has been hypoxic and isn't getting the adequate amount of oxygen so making sure that the patient's O2 is on them is a priority.

Redirect the patient to stay in bed. Because the patient is confused getting out of bed can cause a huge safety issue.

Continue to attempt to talk down the patient and remind them that pulling on the cords and tubes could hurt them. This is because you should always start with the least invasive measure. It would possibly help calm them down as well as educate them on the possible outcome of their behavior and actions.

I would then attempt to create a quiet and comforting environment for the patient. I would close the door and dim the lights and possibly put on white noise or calming music for them. This would be another noninvasive attempt at calming the patient's agitation without having to restrain or sedate them immediately.

Have a staff member who is available, like a UAP sit in the room with the patient for a while. The patient is noted to calm down but gets fidgety as soon as staff leaves the room so maybe having someone in the room with them makes them less agitated and less likely to do the unsafe activities that were a problem before.

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

The quality department would review how the team responded to this patient as well as how they handled the situation and if they did things effectively and safely.

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.

I would make sure the head of the bed is raised to at least 45 degrees and if it is not I would raise it and then I would increase the patient's oxygen and see if that would help while we are waiting to hear back from the physician. I would raise the head of the bed because it would help the airway to be more open than when laying flat. Increasing the amount of oxygen, they are receiving through the NC will help them intake more oxygen.

b. If you were the Quality Department nurse, what part(s) of this case would you review and monitor? Explain.

If I were the Quality Department I would review and monitor whether they had attempted to improve oxygenation on their own by raising the head of the bed and increasing the oxygen level to greater than 2L before calling the physician. I would also review and monitor how many times they attempted to reach the physician since the time they had originally been paged.