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

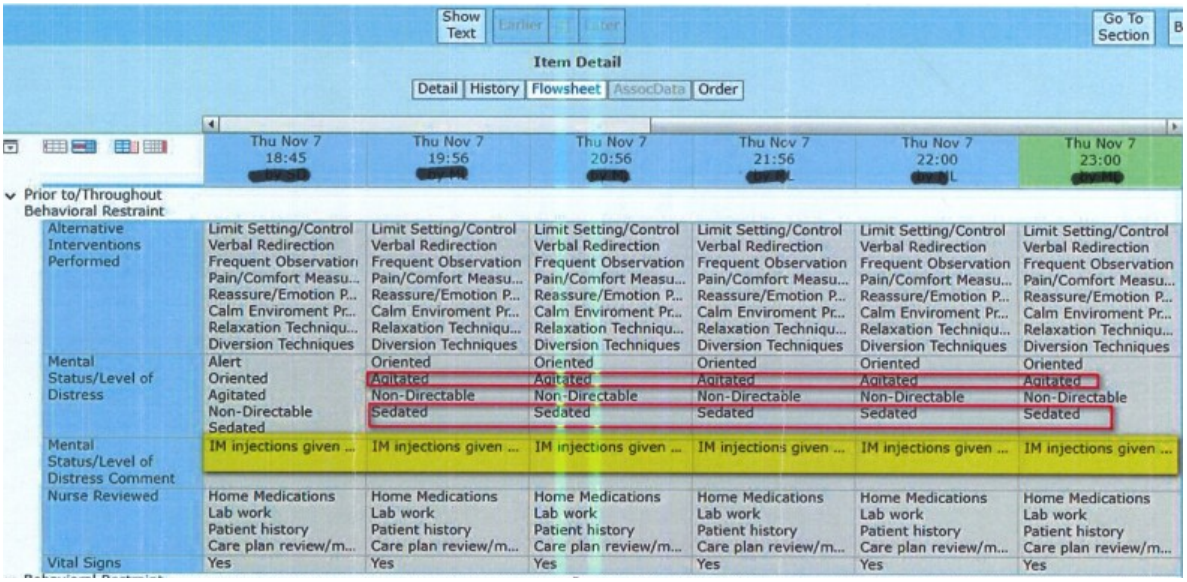
1) Review every patient who expires in the hospital.
   a. The focus is more on inpatients as we can't prevent the ED/ Code Blue situations.

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 patient is sedated and it looked like their condition has not changed in the 6 hours since first being documented on. The documentation has not changed since being first documented on.

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

-Ensure that there is no change in condition such as level of distress noted or alternative interventions used at that specific time. The way this is documented is that every single hour the nurse was going through each intervention listed, and reviewed all things listed, as well as the patient has not had a change in mental status at all, and that the patient was given an IM injection every hour to reduce the patients stress.

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?

-Either justify the need for the continued restraint or comment on there being an error in documentation, and that patient care was prioritized in place of documenting. Acknowledge the error, not justify it, and say there is a plan for you to improve documentation for the future.

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

-I will read through my documentation thoroughly, avoid copy/paste features and autofill when charting, be clear and concise, follow policies, and be especially mindful when documenting on sedation and restraints.

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)

- Reapply oxygen frequently and monitor pulse ox frequently, ensure saturation has returned to 90s prior to leaving room. Oxygen and airway are high priority to prevent further issues. Ensure fall precautions are in place prior to exiting room like bed alarms, lower the bed, untangle cords, keep call light within reach, frequently check on the patient and offer the restroom often, and keep and pain controlled if they are having any. Assess the patient overall, for possible delirium, hypoxia, medication reactions, infections (UTI), pain, etc. The signs/symptoms listed could potentially be causing the confusion and agitation. Possibly request a 1:1 sitter for the patient if needed to help keep the patient oriented. Contact the provider because possibly medications can be given to assist the patient in relaxing or reducing anxiety of being in the hospital,

preventing agitation, falls, and lines being pulled out. Also contacting the family may be helpful as well, if someone is planning a visit, it's helpful in orienting the patient and helping reduce anxiety.

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

- Fall risk and prevention protocols, oxygen therapy/ monitoring of O2, delirium management/ recognition, foley management and assessment, IV assessment use of board device/ additional securement devices used, medications given and ordered during this time, and staffing/ use of 1:1.

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.
   - First I would increase the oxygen and call a rapid response to get the physician there faster for assessment, RT at bedside to help oxygenate the patient, stay with the patient and prepare to give SBAR to those coming. I would continue to monitor the patient and keep pulse ox on, calm the patient as best as possible, elevate the head of the bed if not already done, and ensure IV access. Continuing to monitor the patient is important, as well as bringing in the entire care team to provide care faster

b. If you were the Quality Department nurse, what part(s) of this case would you review and monitor? Explain.
   - I would ensure that the change in condition was charted as well as the appropriate interventions being carried out in a timely manner. To ensure the warning signs were recognized as well as the rapid response initiated timely. Was the entire event documented appropriately, was communication appropriate, and what were the patient outcomes following these interventions.