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

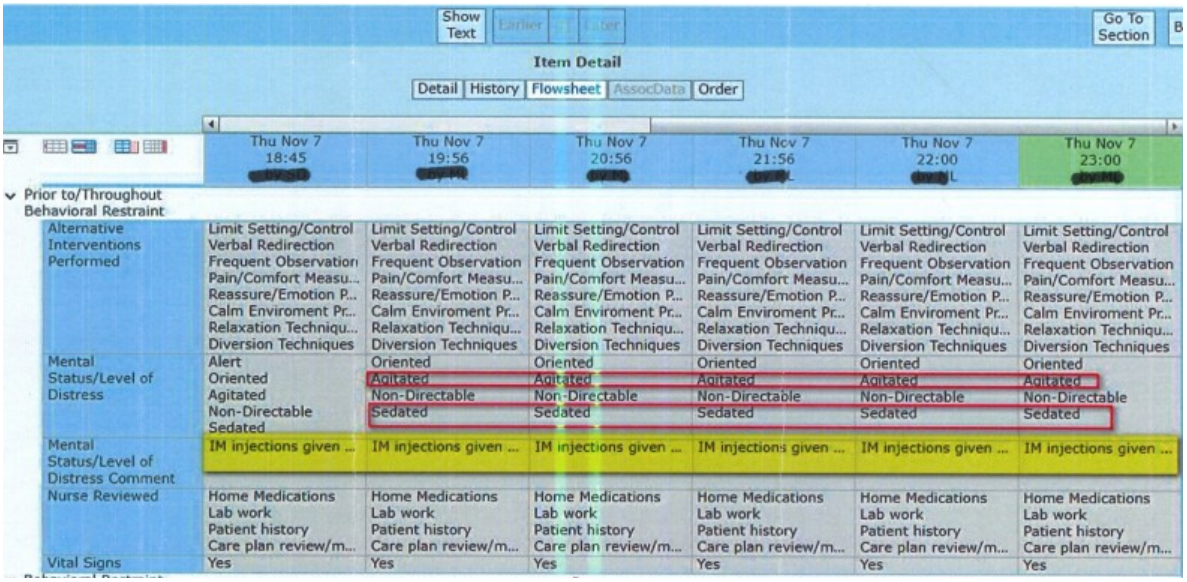
1) Review every patient who expires in the hospital.
   a. The focus is more on inpatients as we can't prevent the ED/ Code Blue situations.

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.
   There are a few concerns I have with this documentation. Firstly, the charting is not done every hour consistently, it seems like in one area of charting, there is a 4-minute timespan between the next documentation, instead of hourly. Secondly, it seems that all the information is exactly the same, and it seems that they copied the information from the last time of documentation, with no new changes except from the first excerpt to the second. Third, it states the patient is alert, however they are sedated, this seems contraindicated.
b. What should the nurse have done differently with this documentation?
   The nurse should have deleted or corrected the 4-minute documentation difference, as it may cause incorrect statistics when reviewing the chart. The nurse should also not have copied the documentation directly from the last, and to show actual changes that accurately show they were doing assessments on the patients.
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?
   If I were the RN in a court of law, I would explain that I made a mistake in the time of charting. I would also explain that I did assess the patient every hour, and the status had remained the same over the course of the time shown.
d. How will you as the RN prevent this type of issue from happening in your practice?
   If I were the RN, I would double check that I am not double charting on the same intervention in Meditech. I would also rewrite new documentation every hour, so it reflects that I had actually gone into the patient room to look at the patient.

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)

1. Secure airway device on patient ASAP
   Rationale: Airway is the #1 priority, we need to stabilize oxygen immediately to allow proper perfusion and oxygenation.
2. Complete a confusion/mental status assessment ASAP
   Rationale: Doing a focused assessment for mental confusion may point us to factors such as delirium, for which we have preventative measures we can implement to help this patient.
3. Reorient the patient when showing signs of confusion
   Rationale: We should reorient the patient to remind them of where they are, place familiar objects at bedside, and have clocks and calendars in the room as this may decrease confusion.

4. 1-1 sitter in the room as needed
   Rationale: It seems this patient may be a danger to himself and seems to increase anxiousness when left alone. Having a constant presence in the room may help his restlessness + pulling at equipment.
5. Encourage family to visit during visiting hours as needed
   Rationale: Having family members talk and visit the patient may provide a sense of calm and reorientation.

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

The Quality Department may review that non-invasive measures were used first to calm and reorient the patient before any restrictive measures are taken towards the patient. If the patient happens to have delirium, the Quality Department would track documentation to make sure the protocol is followed with proper measures regarding the patients' care. They also may see if these interventions aren't working, what steps are they taking next?

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 100.3^{o}F, 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 99.8^{o}F. 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 call a rapid response team. I would do this as this patient's condition is concerning and showing no signs of improvement, and no physician has called back or placed new orders. This is concerning as the vital signs are not stable, and patient is showing signs poor oxygenation.
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 how long the page sat before the new actions were taken, I'd review the decreasing patient status documentation, I would check to make sure the charge nurse is aware, if this situation could have been avoided, and if a rapid response team was called + what actions occurred after. I would look at these parts of this case because changes

in protocol can be made to improve patient care and outcomes if we can avoid situations like this in the future by reviewing documentation and actions preformed.