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

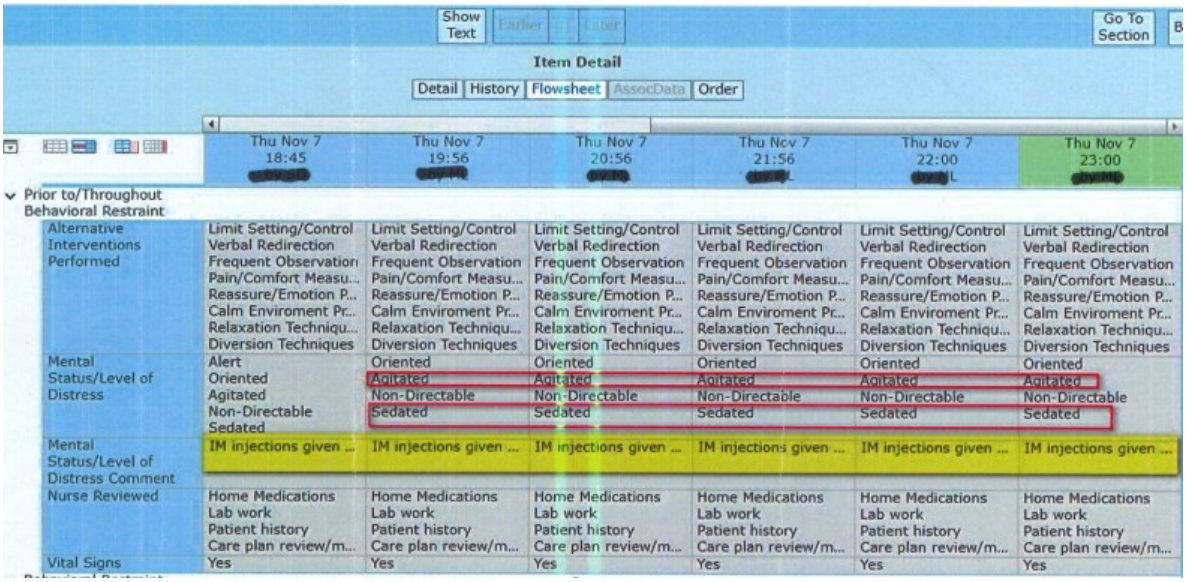
1) Review every patient who expires in the hospital.
   a. The focus is more on inpatients as we can't prevent the ED/ Code Blue situations.

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 have concerns regarding improper charting, unclear level of consciousness, improper medication documentation, and the unclear need for sedation. The chart shows repeated identical selections across multiple time frames. Showing no patient progression, improvement, or worsening which does not support accurate status. While the patient's condition may have remained unchanged, this is not acceptable documentation. The interventions that are being documented require immense accurate detail. The patient being documented as sedated but agitated and non-directable suggests inaccurate documentation and unclear patient level of consciousness. Within the comment section of mental status, mediation administration is charted. This is not documented properly under any circumstance and is an unsafe practice.

b. **What should the nurse have done differently with this documentation?**
The nurse should have done their own reassessment on the patient and gathered all data. Clearly identifying the patient's level of consciousness and need for sedation. Once the patient is fully assessed all assessment data should be documented into the electronic medical record accordingly. Not going off previously charted data or repeating documentation. If the patient requires sedation, restraints, or medication it would be documented appropriately within their own interventions and complete per hospital policy. If the patient's condition did not change and charting repeated itself from previous time frames, I would ensure that I add details of the assessment data, plan of care, and all interventions within the comment sections or by adding a nursing note.

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 this documentation was presented in a court of law, I would acknowledge the inconsistencies within the charting and take accountability for inaccurate documentation. Stating that the patient demonstrated agitation and the inability to direct which led to the administration of medication which led to sedation. Since the patient's condition did not change from the time of documentation the charting repeated itself.

d. **How will you as the RN prevent this type of issue from happening in your practice?**
As the RN I would prevent this type of issue from occurring within my practice by ensuring to complete all interventions individually and document findings accordingly. I would not look back at previous charting to use for myself and would add detailed comments and nurses notes as needed to provide an accurate reflection of patient condition and care. Nurse notes would also cover any communication and events regarding patients care. Ensuring to follow policy while ensuring that the patient's current condition is reflected. For additional interventions including medications and restraints, frequent assessments for those interventions are needed to determine the need. Practicing this way ensures patient safety, which is the number one priority along with staying professional and having no possible risk of legal issues.

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)

- Ensure patient safety: patient is climbing out of bed, removing equipment, and are agitated putting them at risk for injury. Prevent harm and promote safety.
- Ensure patent airways and oxygenation: ensure NC 5L is on and hooked up appropriately to ensure proper oxygenation. Ensure patent airway and continuously monitor SPO2 to prevent hypoxia associated complications.
- Implement therapeutic non-pharmacological de-escalation techniques: use least invasive calming techniques first. Implementing a calm environment, redirection, and therapeutic communication. Preventing the use of excess medication or the need for restraints.
- Reassess vital signs: assess patient stability and current status.
- Assess mental status: assessing mental status indicates patients' status. Assessing possible causes of agitation.
- Notifying: collaborate with all team members including family and update on patients' status and plan of care. Especially updates when a significant event has taken place and/or assistance is needed.
- Document: timely and accurate documentation is essential throughout patient care. Not only for the well-being of the patient but also for legal protection and quality reviews. Additional documentation like a nurse's note may be necessary.

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

Following discharge of this patient the Quality Department would review patient safety, respiratory status, delirium screening/management, collaboration, medication administration, assessments, and documentation. Ensuring that the patient received safe high-quality care. In addition, to safe and quality care it is important that the least invasive intervention is performed first and documentation is per policy. Preventative measures should have also been placed to possibly reduce the event of delirium, aggression, and agitation, leading to negative patient and staff 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.**
My next action as the nurse would be to call the medical emergency team (MET). The reason I would do this is because of the patient’s rapid change in condition. Between 0630 and 0800 the patient went from slight distress correlating with PMH and diagnosis. To interventions being ineffective and overall declining rapidly. Not only did the patients’ vital signs worsen but their physical assessment findings did as well. While the charge nurse was aware and the physician was notified. This needed immediate attention and we could not wait for others to get there when pleased. The assessment findings at 0800 were life changing, needing immediate attention from many staff members.

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 nurse I would review/monitor all documentation, response to patient status timely, appropriate implementation of interventions, communication processes, ongoing assessments, collaboration between staff, and adherence to policies and procedures. All these factors would be monitored to promote quality patient care and ensure safety. Ensuring timely responses, proper implementation, intervention completion, collaboration, and assessments all contribute to keeping the patient safe. If these are monitored for multiple patients, the department can see where improvements are needed so we can implement change. Overall, putting the patients first with a positive impact.