Mangum Regional Medical Center
Quality Assurance & Performance Improvement Committee Meeting

Meeting Minutes					
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Date: 07/13/2023	**T 1303 i m e :**	**Recorder: D. Jackson**	**Reporting Period: June 2023**		
Members Present					
Chairperson: Dr. C		CEO: Kelly Martinez		dical Representative:	
Name	**Title**	**Name**	**Title**	**Name**	**Title**
Daniel	CNO	Danielle	Bus Office		Lab
	HR	Kaye via Teams	Credentialing		IT
Jennifer	HIM		Maintenace/EOC	Marla	Dietary
	PT		Radiology	Claudia Collard	IP
TOPIC	**FINDINGS – CONCLUSIONS**		**ACTIONS – RECOMMENDATIONS**		**FOLLOW-UP**
I. CALL TO ORDER					
Call to Order	The hospital will develop, implement, and maintain a performance improvement program that reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors.		This meeting was called to order on 07/13/2023 by Josey Kenmore/Kelly Martinez		
II. REVIEW OF MINUTES					
A. Quality Council Committee	06/15/2023		Committee reviewed listed minutes A-F. Motion to approve minutes as distributed made by Kelly Martinez 2nd by Chelsea Church Minutes A-F approved. Present a copy of the MeetingMinutes at the next Medical Executive Committee and Governing Board meeting.		
B. EOC/ Patient Safety Committee	05/09/2023				
C. Infection Control Committee	05/08/2023				
D. Pharmacy & Therapeutics Committee	03/30/2023				
E. HIM/Credentialing Committee	05/04/2023				

F. Utilization Review Committee	05/08/2023		
III. REVIEW OF COMMITTEE MEETINGS			
A. EOC/Patient Safety	06/13/2023		
B. Infection Control	06/07/2023		
C. Pharmacy & Therapeutics	06/15/2023 - Next meeting 09/2023		
D. HIM-Credentials	06/13/2023		
E. Utilization Review	06/07/2023		
F. Compliance	07/12/2023		
IV. OLD BUSINESS			
A. Old Business	Employee Health Standing Orders Employee Occupational Illness and Injury Policy Employee Health Manuel TOC Signing of a Death Certificate Policy Mortality Review Tool Scanning Documents into the EHR Policy OBS Audit Sheet Access Maintenace EHR Policy Swing Bed Audit Sheet Discharge Summary Discharge Content Management Policy DC Record Reconciliation and Scanning Policy Incomplete Records Policy Clinical Records Requirement, Standard and Content Policy Location Security Maintenace and Destruction of Medical Records Policy INP Audit Sheet Employee/VIP Discount Policy HIPPA Security Officer Appointment – Jared Ballard HIPPA Privacy Officer Appointment – Jennifer Dreyer	All Approved June 2023 by Quality/Med Staff/Board	
V. NEW BUSINESS			
A. New Business	340B Drug Policy (updated) First Quarter 2023 Compliance Committee Meeting Minutes	First Approval – Kelly Second Approval – Chelsea	
VI. QUALITY ASSURANCE/PERFORMANCE IMPROVEMENT			

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A. Volume & Utilization			
1. Hospital Activity	Total ER – 130 Total OBS pt - 1 Total Acute pt - 12 Total SWB - 7 Total Hospital Admits (Acute/SWB) - 19 Total Hospital DC (Acute/SWB) - 24 Total pt days - 317 Average Daily Census - 11		
2. Blood Utilization	4 total units administered without reaction		
B. Care Management			
1. CAH Readmissions	1 for the reporting period - 1.) admitted with primary dx, d/c and returned with continuing issues and readmitted with different dx		
2. IDT Meeting Documentation	10/10 (100%)		
3. Insurance Denials	0 for the reporting period		
4. IMM Notice	18/18 (100%)		
C. Risk Management			

1. Incidents	AMA 4 - 1.) er pt in for c/o, pt was agreeable to transfer to higher level of care however pt would only transport via private vehicle. Risks/benefits explained, pt signed AMA. 2.) ER pt in for c/o, advised there would be a wait time for testing due to high volume at the time of the visit. pt did not want to wait and left AMA, did not sign AMA form. 1.) In pt admitted for wound care, pt became upset and did not want to have to wait on wound eval/treatment. Wanted to leave facility, risks/benefits discussed, pt signed AMA. 2.) inpt admitted for resp dx, pt decided that there were things at home to deal with and could no longer remain in patient for treatment, risks/benefits discussed. pt signed AMA		
2. Reported Complaints	None for reporting period		
3. Reported Grievances	None for reporting period		
4. Patient Falls without Injury	0 for the reporting period		
5. Patient Falls with Minor Injury	1 for reporting period – 1 inpt fall with minor injury. Precautions in place prior to fall per fall rick assessment. Pt attempted to transfer self from restroom without assist, pt had fall with abrasion noted post fall. Nursing provided BSC for restroom use to allow better supervision, pt educated on calling for assist with transfers and		

	use of BSC		
6. Patient Falls with Major Injury	None for reporting period		
7. Fall Risk Assessment	1 completed for the reporting period		
8. Mortality Rate	1 SWB- pt for the reporting period		
9. Deaths Within 24 Hours of Admission	None for the reporting period		
10. Organ Procurement Organization Notification	1 for the reporting period, no tissue donations for the month		
D. Nursing			
1. Critical Tests/Labs	25 for the reporting period		
2. Restraint Use	None for reporting period		
3. Code Blue	None for reporting period		
4. Acute Transfers	1 for reporting period – neuro/ICU		
5. Inpatient Transfer Forms	1 for the reporting period		
E. Emergency Department			
1. ED Nursing DC/ Transfer Assessment	20/20 (100%)		
2. ED Readmissions	2 for the reporting period - 1.) pt to the ED for primary c/o, returned for continued symptoms d/t non-compliance and additional tx w/i 72 hrs. 2.) pt to the ED for primary c/o returned with-in 72 hrs for different c/o and dx		
3. ER Log & Visits	130 (100%)		
4. MSE	20/20 (100%)		
5. EMTALA Transfer Form	9/9 (100%)		
6. Triage	19/20 (100%)		

7. ESI Triage Accuracy	20/20 (100%)		
8. ED Transfers	9 for the reporting period - Patients transferred to Higher Level of Care for: 1.) GI Bleed – ICU 2.) Trauma/FXs – Trauma/ER/ICU 3.) SH – in-pt psych 4.) 2nd-3rd degree Burns – Burn Unit 5.) Appendicitis – Gen. Surgery 6.) NSTEMI – Cardiology 7.) Trauma – Trauma/Poss Surgical Services 8.) Trauma/FXs – Trauma/Neuro 9.) Bowel Obstruction – Surgical Services/Specialty Unit	All ER transfers for the reporting period appropriate for higher level of care	
9. Stroke Management	None for reporting period		
10. Brain CT Scan – Stroke (OP-23)	None for reporting period		
11. Suicide Management	1 for the reporting period		
12. STEMI Care	pt presented with no cardiac symptoms, complete work up resulted in NSTEMI dx. Accepting hospital secured, however there was delay in transportation due to transports unavailable due to weather/staff shortage		
13. Chest Pain	2/6 EKG (33%) 4/6 Xray (67%) - 1 ekg complete in 7 min, 1 complete in 9 min, 2 ekg preformed on old machine with time stamp cut off. 2 xrays completed in greater than 30 min - met with RT director about issues noted in the month of June. CEO/QM have identified outlier, addressed issue individually.		
14. ED Departure - (OP-18)	83 min		

F. Pharmacy & Medication Safety			
1. After Hours Access	67 for the reporting period		
2. Adverse Drug Reactions	None for reporting period		
3. Medication Errors	1: Nurse failed to document administered dose of antibiotic. CCO allowed team members to review the variance then reeducated nurse regarding six rights of medication administration.		
4. Medication Overrides	50 for the reporting period		
5. Controlled Drug Discrepancies	10 for the reporting period		

G. Respiratory Care Services			
1. Ventilator Days	0 for the reporting period		
2. Ventilator Wean	0 for the reporting period		
3. Unplanned Trach Decannulations	None for the reporting period		
4. Respiratory Care Equipment	20 nebs and mask changes for the reporting period, 0 HME, 0 inner cannula, 0 trach collars/tubing, 0 closed suction kit, 0 suction set ups, 0 vent circuit, 0 trach		
H. Wound Care Services			
1. Development of Pressure Ulcer	None for the reporting period		
2. Wound Healing Improvement	7 for the reporting period		
3. Wound Care Documentation	100%		
I. Radiology			

1. Radiology Films	1 film repeated due to technical error – 120 total for the reporting period		
2. Imaging	28 for the reporting period		
3. Radiation Dosimeter Report	5		
J. Laboratory			
1. Lab Reports	20 repeated /1802 total for the reporting period		
2. Blood Culture Contaminations	None for the reporting period		
K. Infection Control and Employee Health			
1. Line Events	1 for the reporting period, picc incidentally removed with patient care. No adverse outcome noted.		
2. CAUTI's	0 for the reporting period		
3. CLABSI's	None for the reporting period		
4. Hospital Acquired MDRO's	0 for the reporting period		
5. Hospital Acquired C-diff	None for the reporting period		
6. HAI by Source	0 for the reporting period		
7. Hand Hygiene/ PPE & Isolation Surveillance	100%		
8. Patient Vaccinations	0 received influenza vaccine / 0 received pneumococcal vaccine		
9. VAE	None for the reporting period		
10. Employee Health Summary	2 employee event/injury, 75 employee health encounters (vaccines/testing) 6 reports of		

	employee illness/injury		
11. Staff COVID19 Vaccine Compliance	100%		
L. Health Information Management (HIM)			
1. History and Physicals Completion	20/20 (100%)		
2. Discharge Summary Completion	20/20 (100%)		
3. Progress Notes (Swing bed & Acute)	SWB – 20/20 (100%) Acute – 20/20 (100%)		
4. Swing Bed Indicators	7/7 (100%)		
5. E-prescribing System	102/102 (100%)		
6. Legibility of Records	20/20 (100%)		
7. Transition of Care	Obs to acute – none for the reporting period, Acute to SWB – 5/5 (100%)		
8. Discharge Instructions	20/20 (100%)		
9. Transfer Forms	10/10 (100%)		
M. Dietary			
1. Weekly Cleaning Schedules	50/50 (100%)		

2. Daily Cleaning Schedules	390/390 (100%)		
3. Wash Temperature	90/90 (100%)		
4. Rinse Temperature	90/90 (100%)		
N. Therapy			
1. Discharge Documentation	24/24 (100%)		
2. Equipment Needs	12/12 (100%)		
3. Therapy Visits	PT 149 – OT 142– ST 0		
4. Supervisory Log	1 completed for June		
5. Functional Improvement Outcomes	PT 10/10 (100%) – OT 10/10 (100%) – ST 0/0 (100%)		
O. Human Resources			
1. Compliance	100 %		
2. Staffing	Hired – 2, Termed - 2		
P. Registration Services			
1. Compliance	13/13 indicators above benchmark for the reporting period		
Q. Environmental Services			
1. Terminal Room Cleans	8/8 (100%)		
R. Materials Management			
1. Materials Management Indicators	8 – Back orders, 0 – Late orders, 2 – Recalls, 725 items checked out properly		
S. Life Safety			

1. Fire Safety Management	1 fire drills for the reporting period – 24 fire extinguishers checked		
2. Range Hood	(100%)		
3. Biomedical Equipment	(100%)		
T. Emergency Preparedness			
1. Orientation to EP Plan	2/2 (100%)		
U. Information Technology			
A. IT Incidents	76 events for the reporting period		
V. Outpatient			
1. Therapy Visits	56/72 (78%) 3 no show/no call missed visits, 4 missed visits due to patient illness, 9 visits which patients called and cancelled.		
2. Discharge Documentation	5/5 (100%)		
3. Functional Improvement Outcomes	5/4 (80%) 1 patient d/c for surgical intervention		
4. Outpatient Wound Services	(100%)		
W. Strong Mind Services			
1. Record Compliance	N/A	N/A	N/A
2. Client Satisfaction Survey	N/A	N/A	N/A
3. Master Treatment Plan	N/A	N/A	N/A
4. Suicidal Ideation	N/A	N/A	N/A
5. Scheduled Appointments	N/A	N/A	N/A
VII. POLICY AND PROCEDURE REVIEW			

1. Review and Retire	None for this reporting period		
2. Review and Approve	340B Drug Policy (updated) First Quarter 2023 Compliance Committee Meeting Minutes	First Approval – Kelly Second Approval – Chelsea	
VIII. CONTRACT EVALUATIONS			
1. Contract Services			
IX. REGULATORY AND COMPLIANCE			
A. OSDH & CMS Updates	None for this reporting period		
B. Surveys	None for this reporting period		
C. Product Recalls	None for this reporting period		
D. Failure Mode Effect Analysis (FMEA)	Water Line Break – Final at Corporate for approval		
E. Root Cause Analysis (RCA)	None for this reporting period		
X. PERFORMANCE IMPROVEMENT PROJECTS			
A. PIP	Proposed – STROKE; The Emergency Department will decrease the door to transfer time to < 60 minutes for all stroke patients who present to the Emergency Department at least 65% of the time or greater by December 2023. Proposed –STEMI/CP; The Emergency Department will decrease the door to transfer time to < 60 minutes for all STEMI patients who present to the Emergency Department at least 80% of the time or greater by December		

	2023.		
XI. CREDENTIALING/NEW APPOINTMENT UPDATES			
A. Credentialing/New Appointment Updates	None		
XII. EDUCATION/TRAINING			
A. Education/ Training	Sepsis Care & Management for the Adult Patient Dynamic Access PICC education ACLS/PALS Electronic Device Policy (read & Sign) Lunch and Learn: UTI and Treatment with Dr Rumsey		
XIII. ADMINISTRATOR REPORT			
A. Administrator Report			
XIV. CCO REPORT			
A. CCO Report			
XV. STANDING AGENDA			
A. Annual Approval of Strategic Quality Plan	Approved 04/2023		
B. Annual Appointment of Infection Preventionist	Approved 02/2023	Approved 02/2023	
C. Annual Appointment of Risk Manager	Approved 02/2023	Approved 02/2023	
D. Annual Appointment of Security Officer	Approved 04/2023	Approved 04/2023	
E. Annual Appointment of Compliance Officer	Approved 02/2023	Approved 02/2023	
F. Annual Review of Infection Control Risk Assessment (ICRA)	Approved 02/2023	Approved 02/2023	
G. Annual Review of Hazard Vulnerability Analysis (HVA)	N/A		
Department Reports			
A. Department reports			
Other			

A. Other	None		
Adjournment			
A. Adjournment	There being no further business, meeting adjourned by Chasity seconded by Josey at 13:38.	The next QAPI meeting will be – tentatively scheduled for 8/10/2023	