

Name of Facility
Critical Access Hospital
Quality Assurance and Performance Improvement Committee Meeting
Date of Meeting:

	<i>Print Name</i>	<i>Signature</i>
Chairman		
Administrator		
CCO		
QM		
Respiratory		
Drug Room Supervisor		
Physical Therapy		
Dietary		
Case Management		
HIM		
BOM		
Infection Control		
Radiology		
Plant Operations		
Materials Management		
Environmental Services		
Lab		
Human Resources		
Other		
Other		

QUALITY CARE

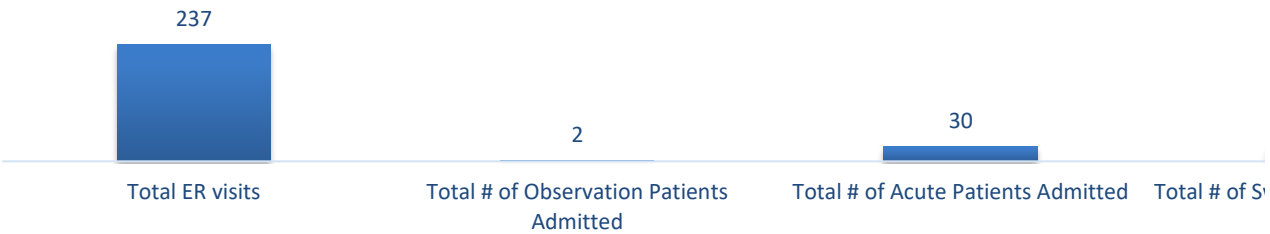
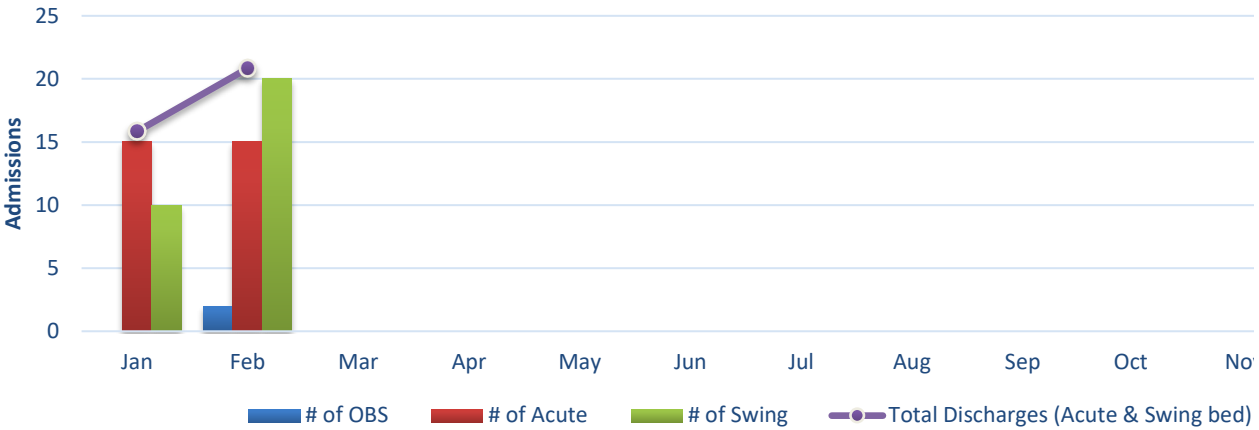
Name of Facility

*QUALITY ASSURANCE &
PERFORMANCE IMPROVEMENT
REPORT*

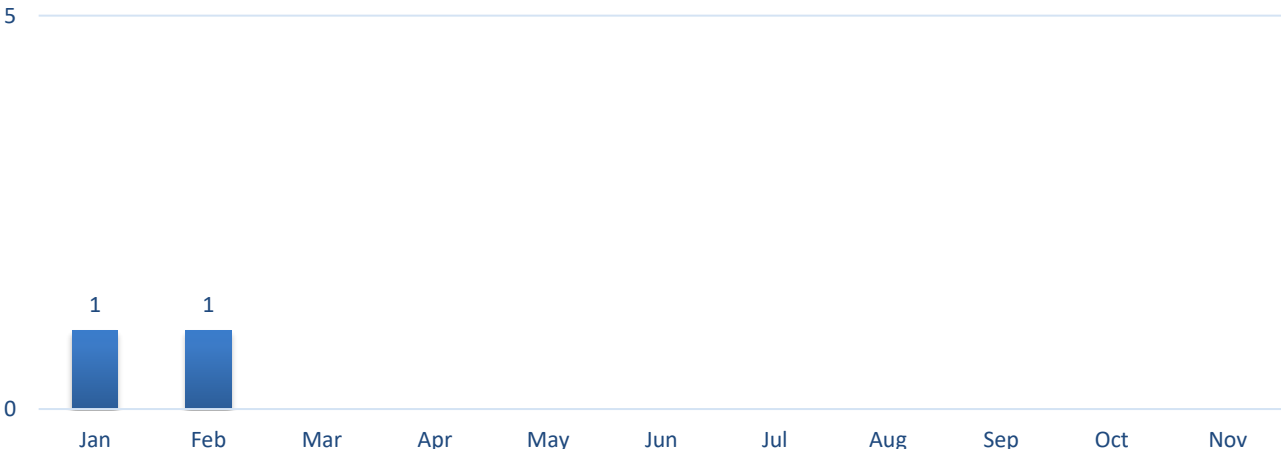
REPORTING PERIOD

Date: Revised 2021

Census - Acute & Swing



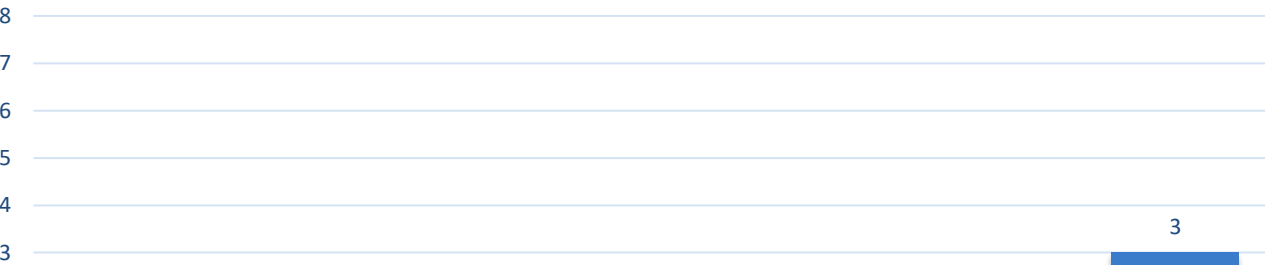
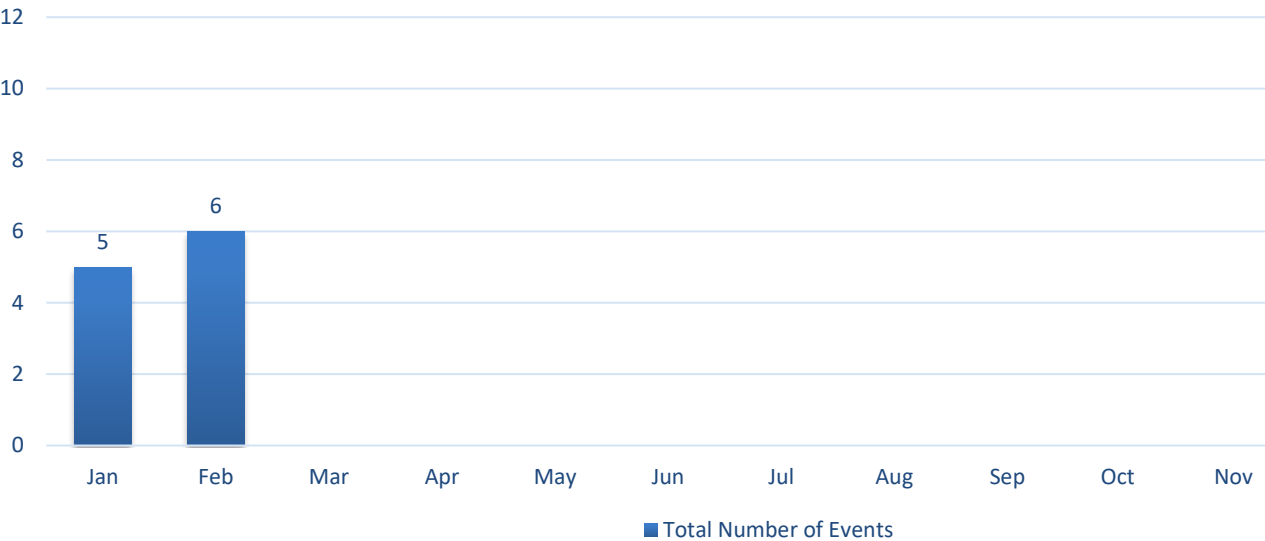
Transfers

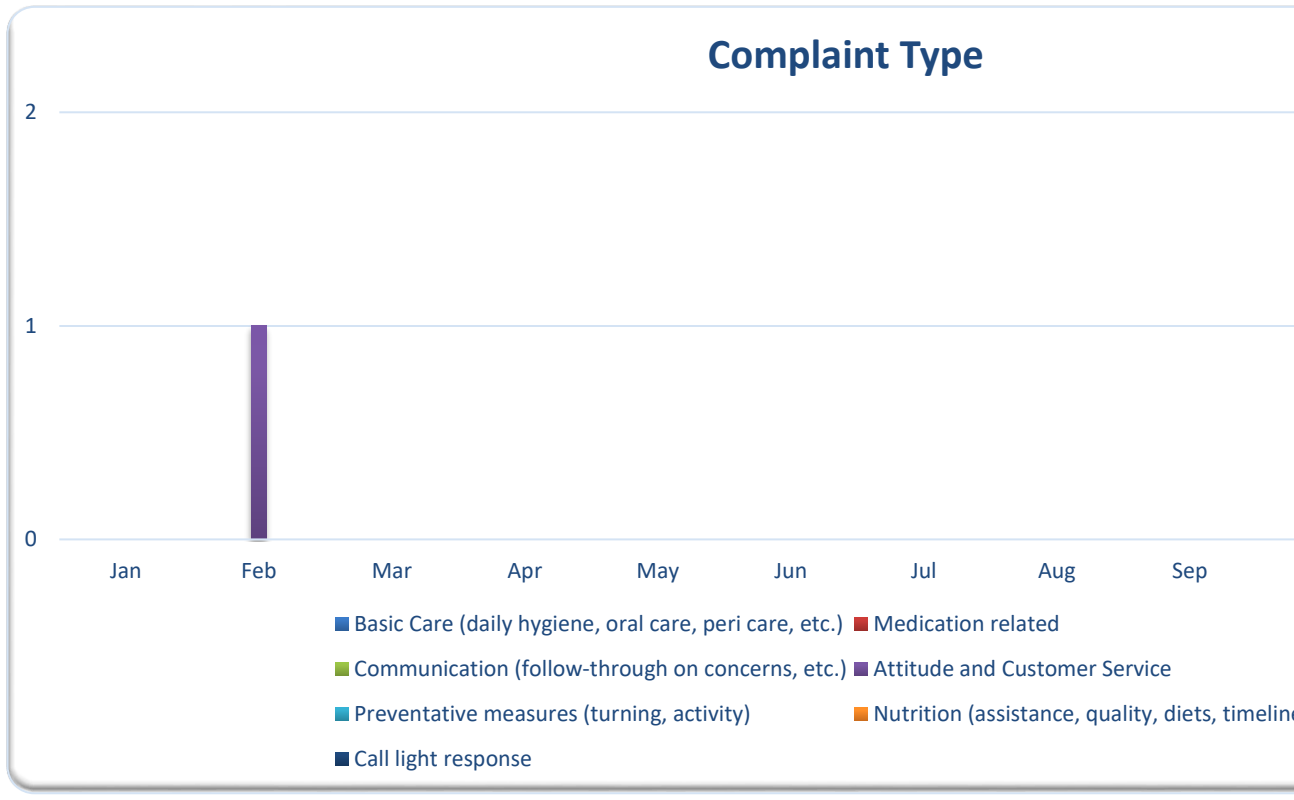
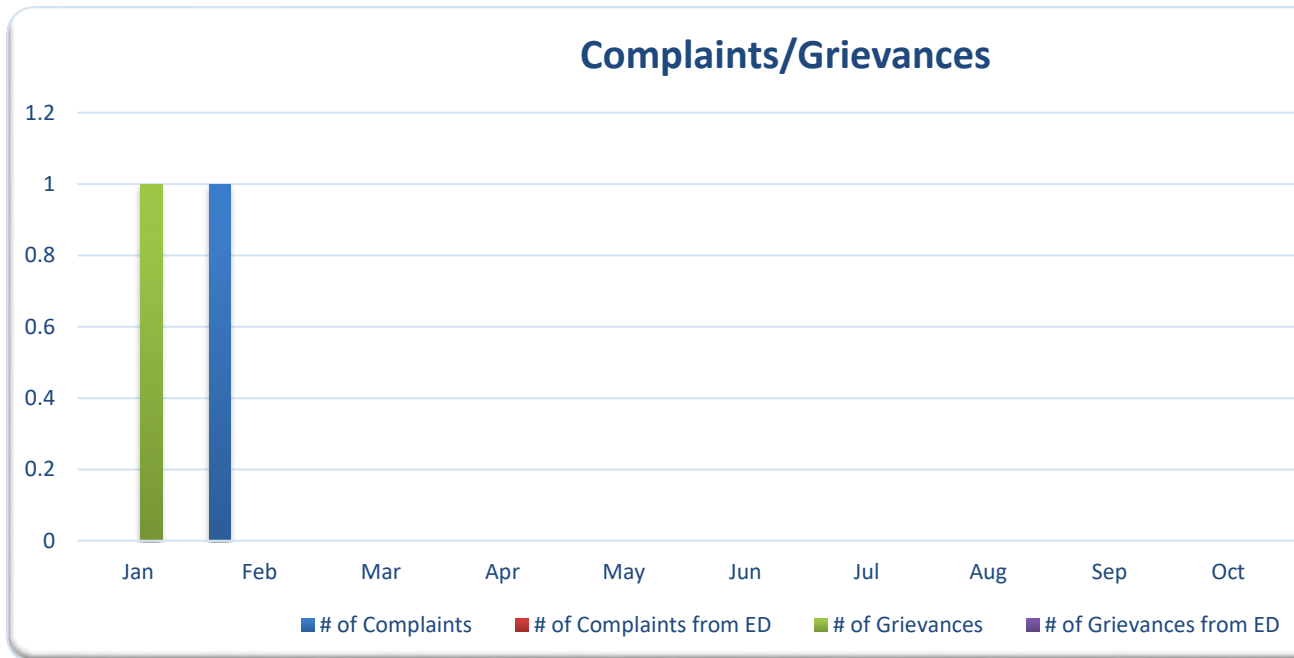
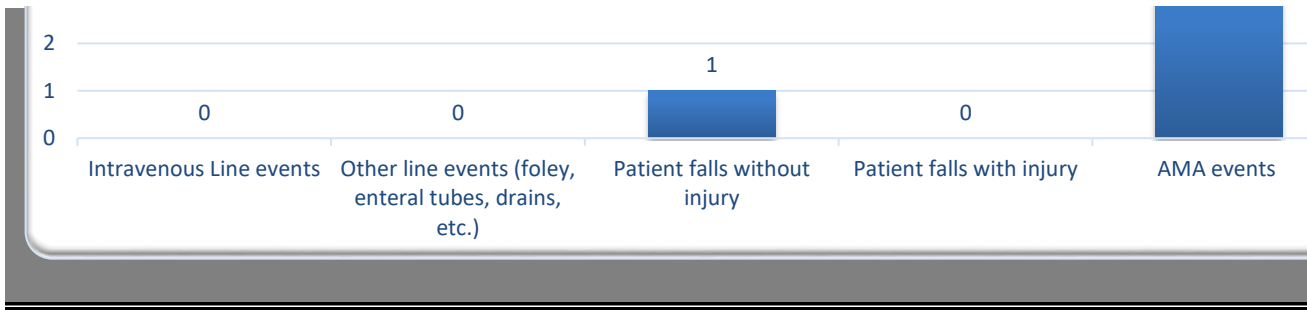


■ # of patients transferred to tertiary facility

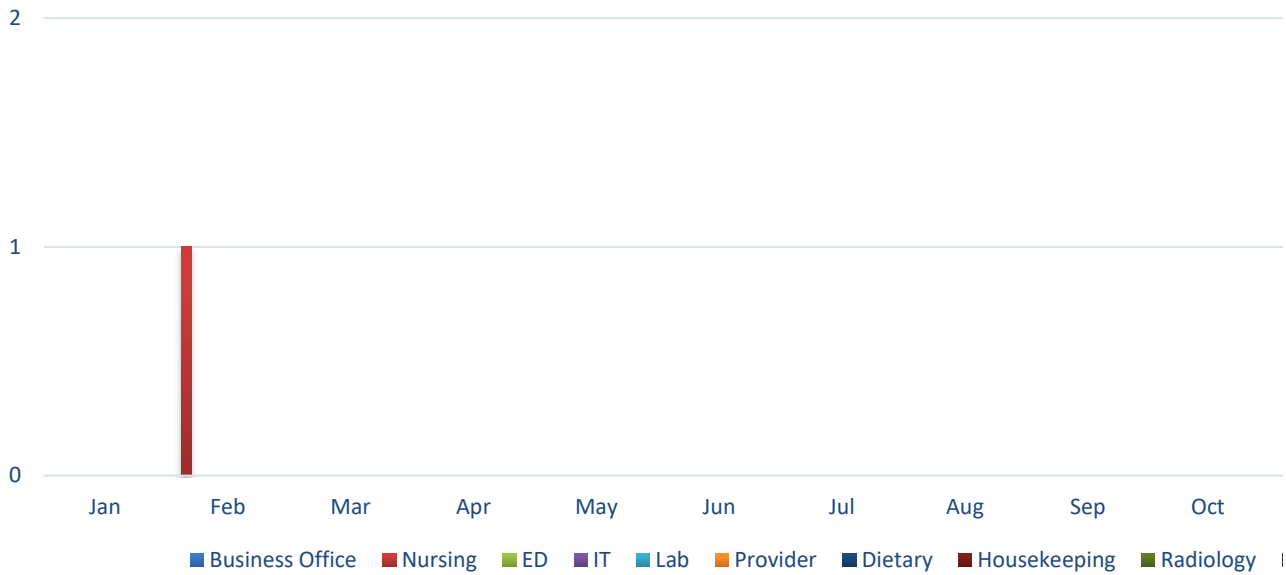


Incident Reports



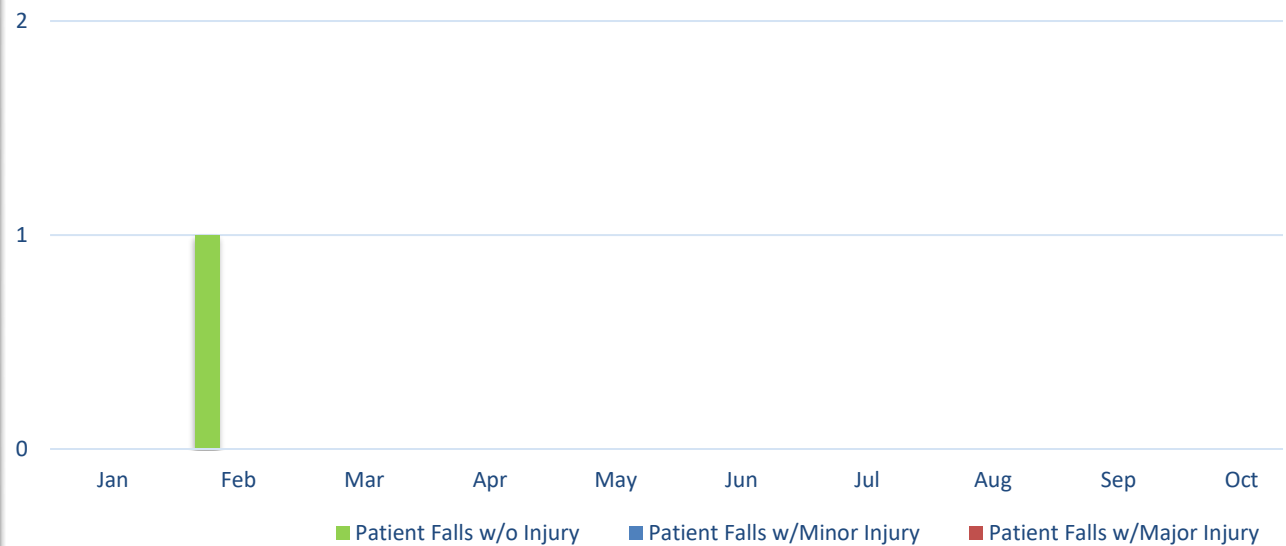


Complaint by Department



[D. Patient Falls](#)

Patient Falls

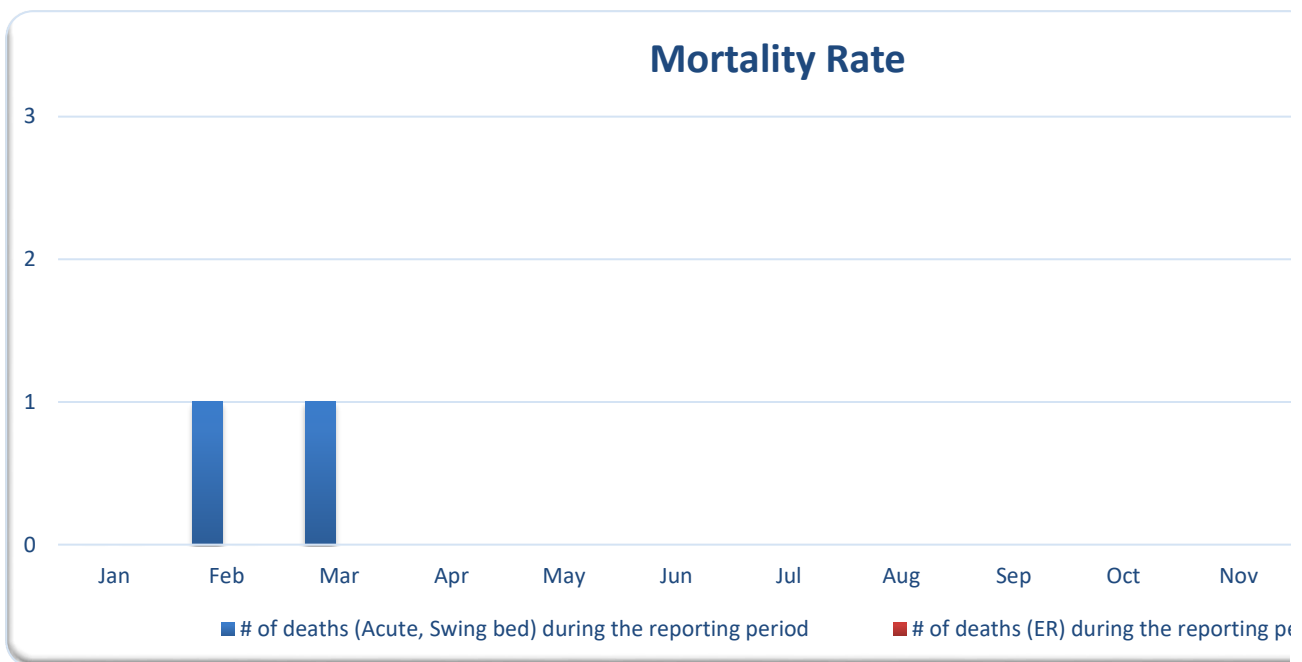


ER Patient Falls

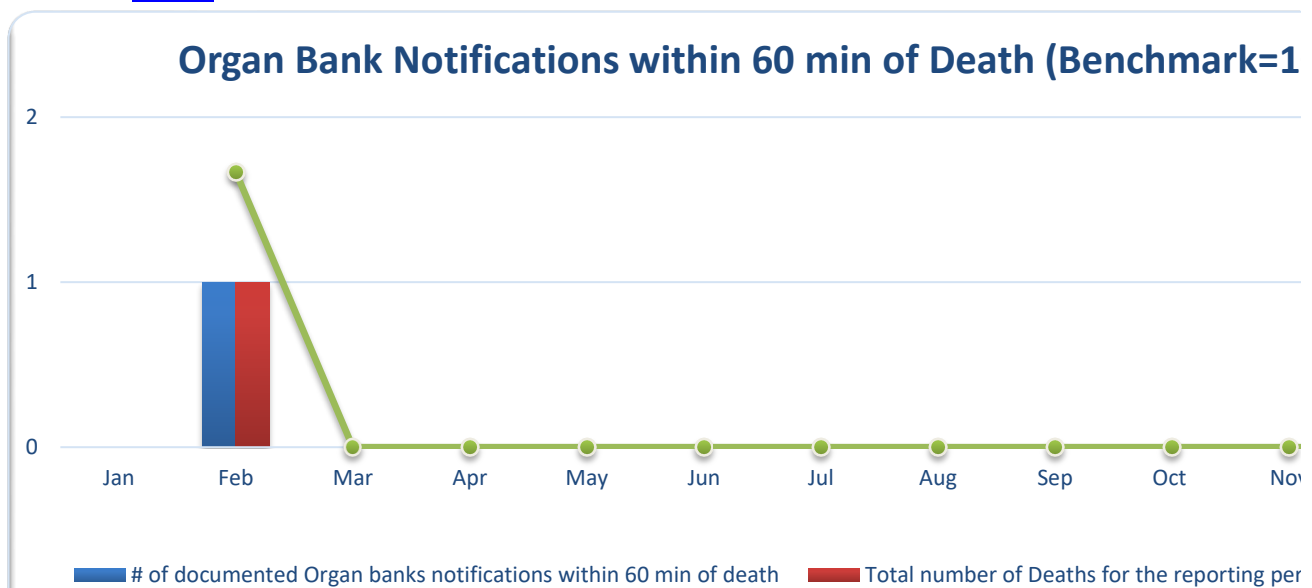




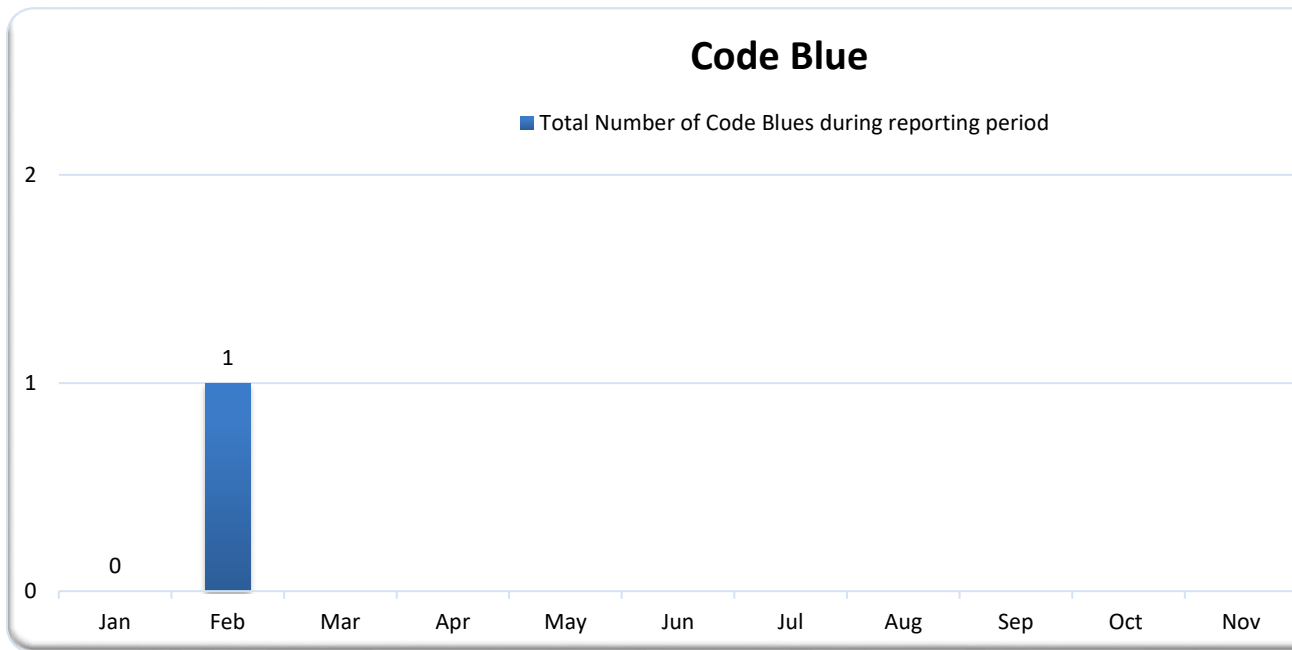
[G. Mortality Rate](#)



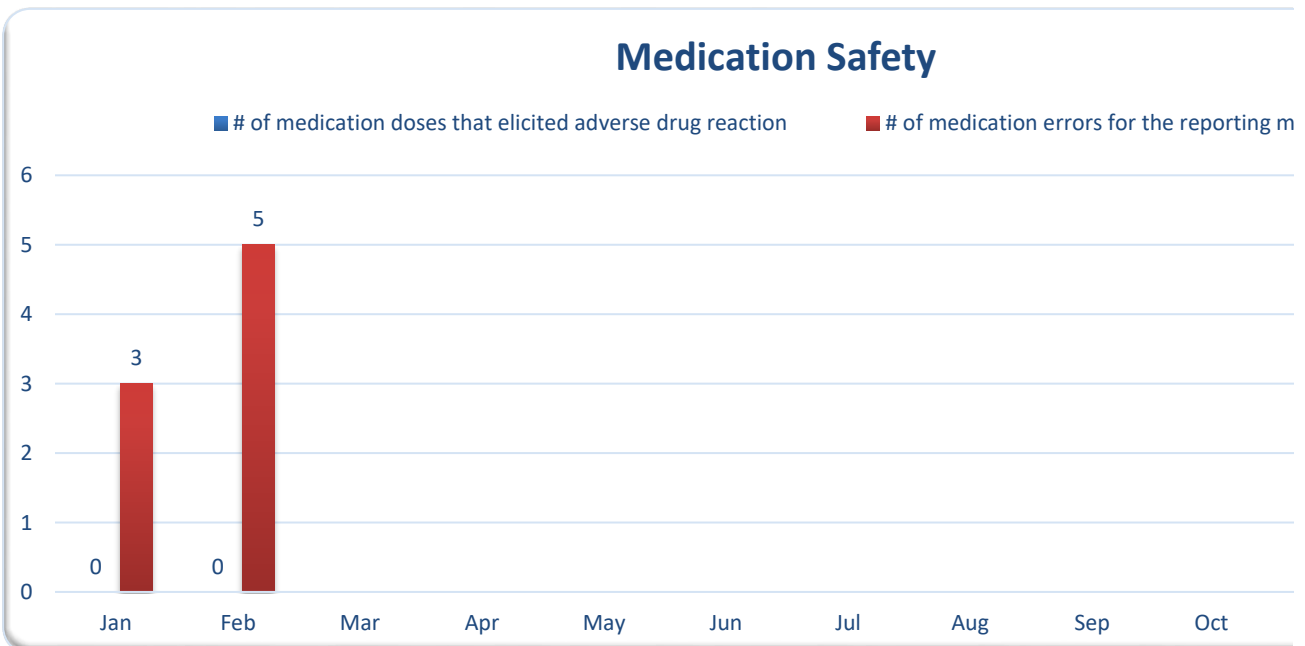
[I. OPO](#)



J. Code Blue Intervention

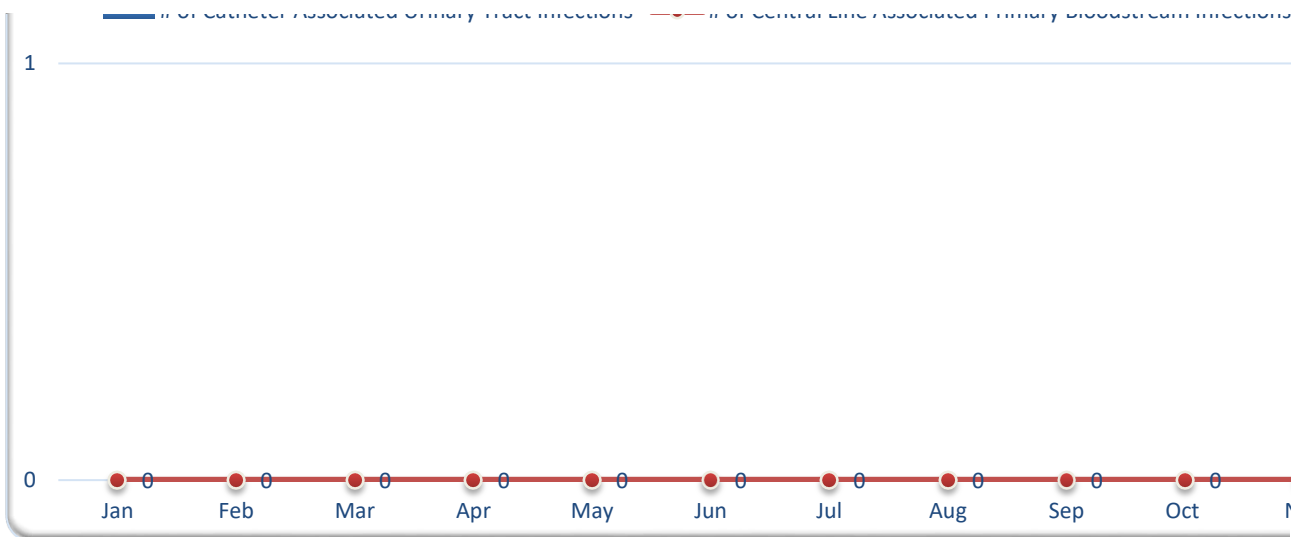


B. Med Errors



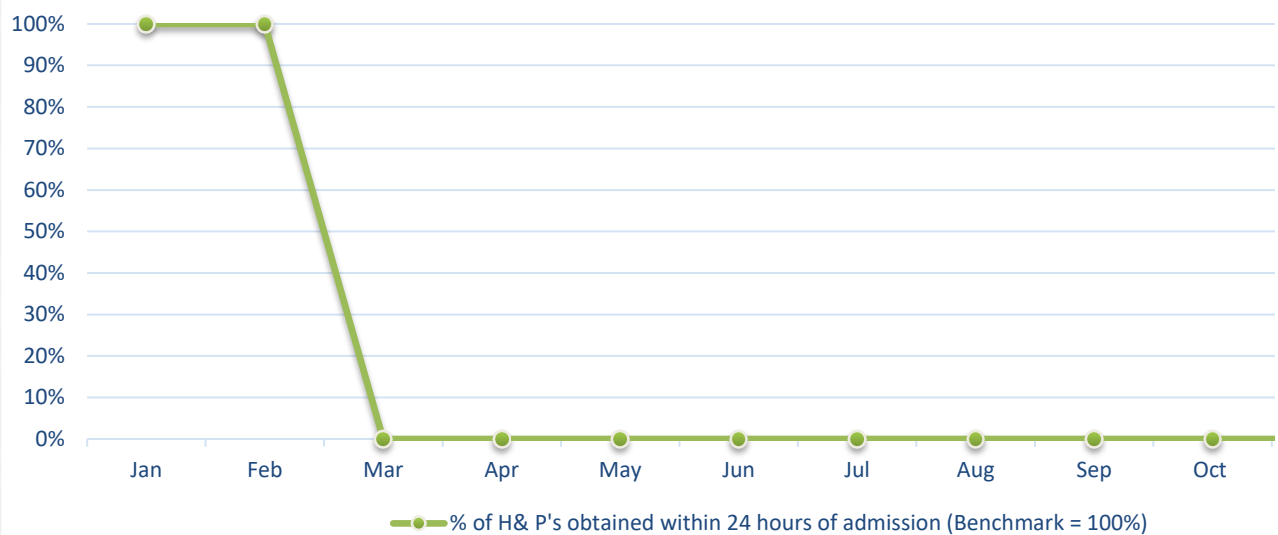
XIII. Infection Control & Prevention



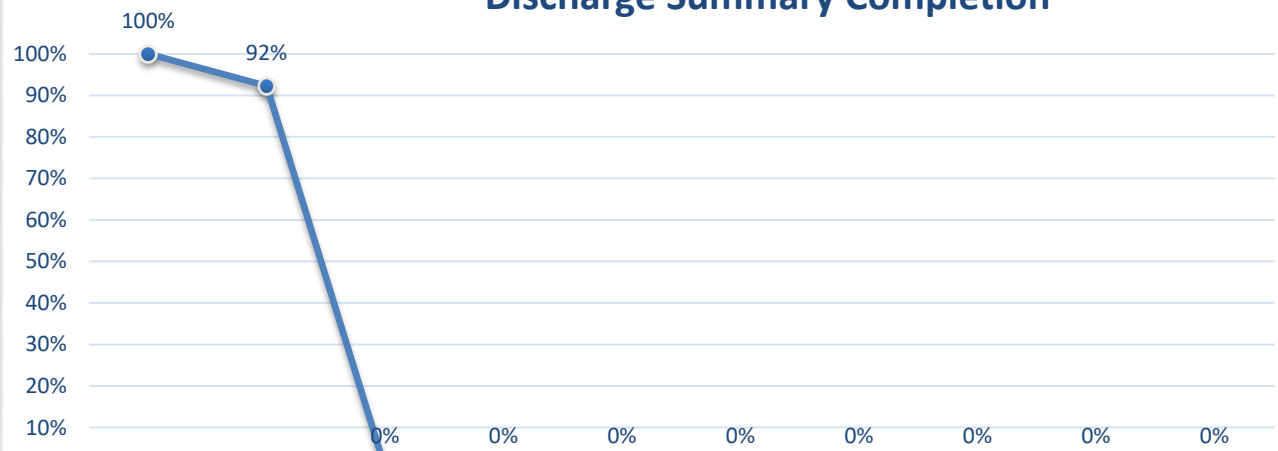


XIV. HIM

History and Physicals Completion

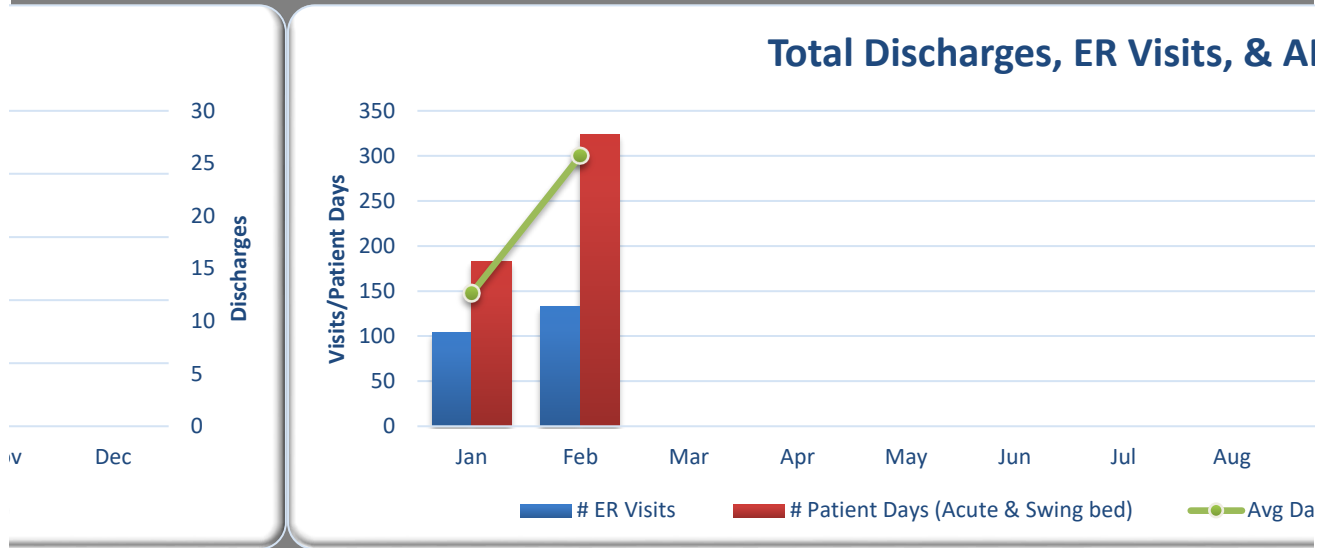


Discharge Summary Completion

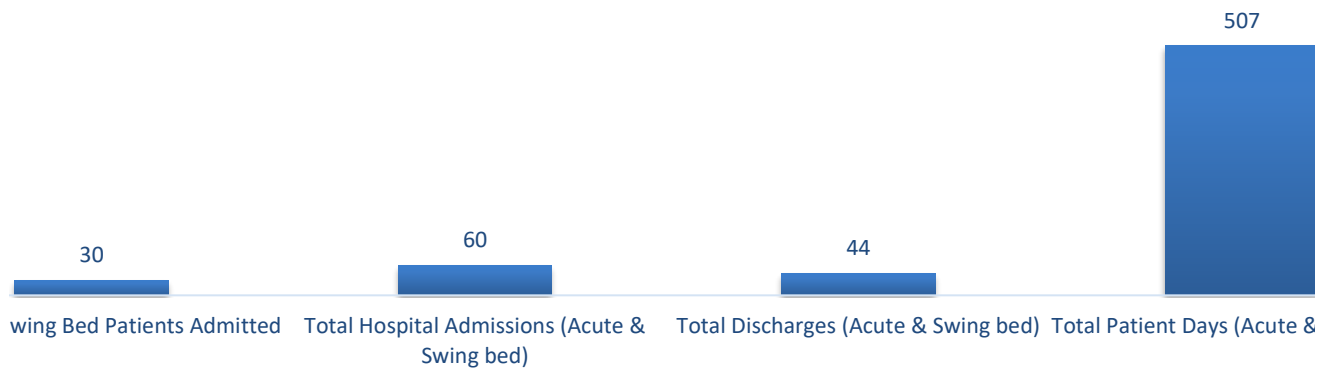




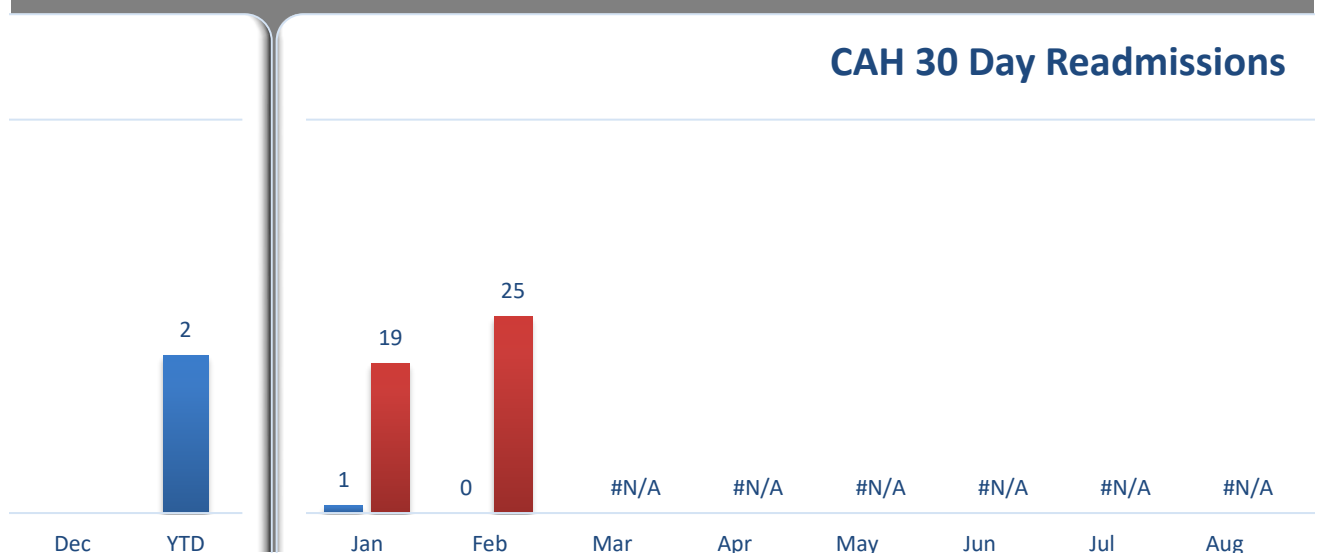
I. Volume & Utilization



Hospital Activity YTD



II. Care Management



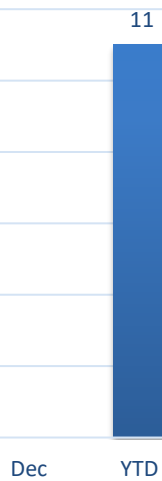
■ Total Number of Readmits (Acute & SWB) Within 30 days of discharge ■ Total

Hospital Activity AMA/LWBS

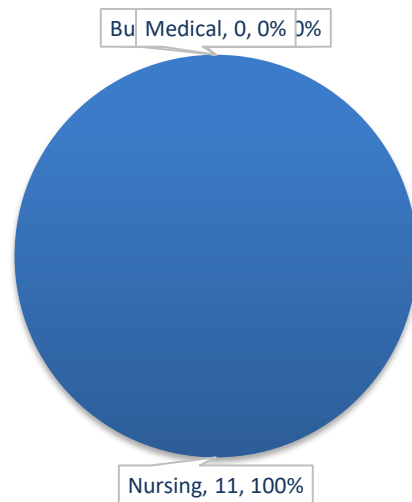
Jun Jul Aug Sep Oct

■ ED patients left without being seen ● Average Wait Time/Minutes (LWBS)

III. Risk Management



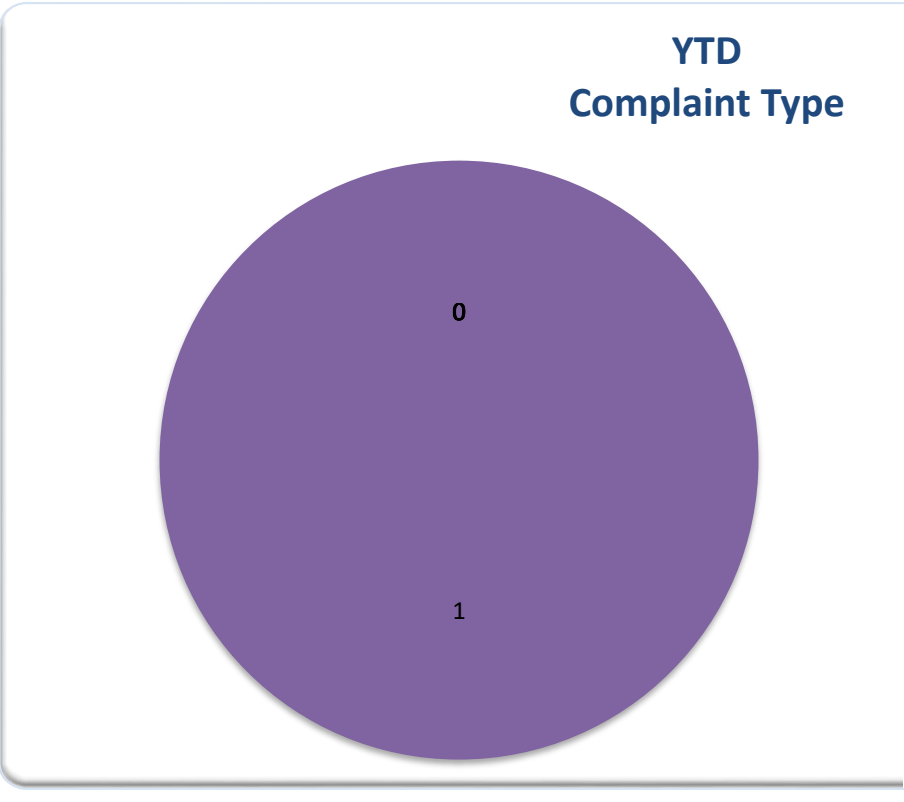
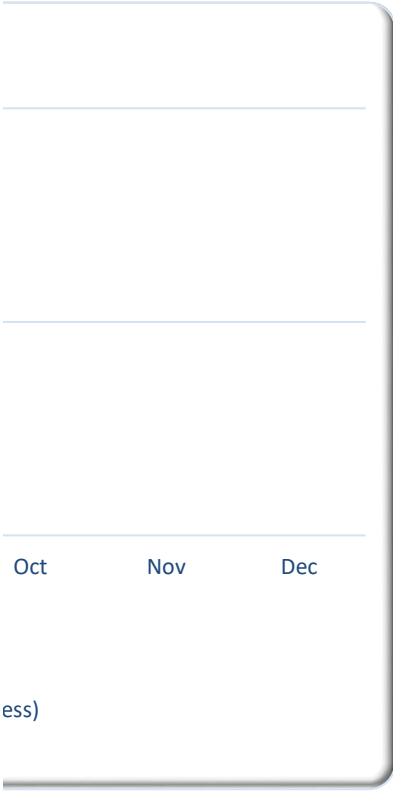
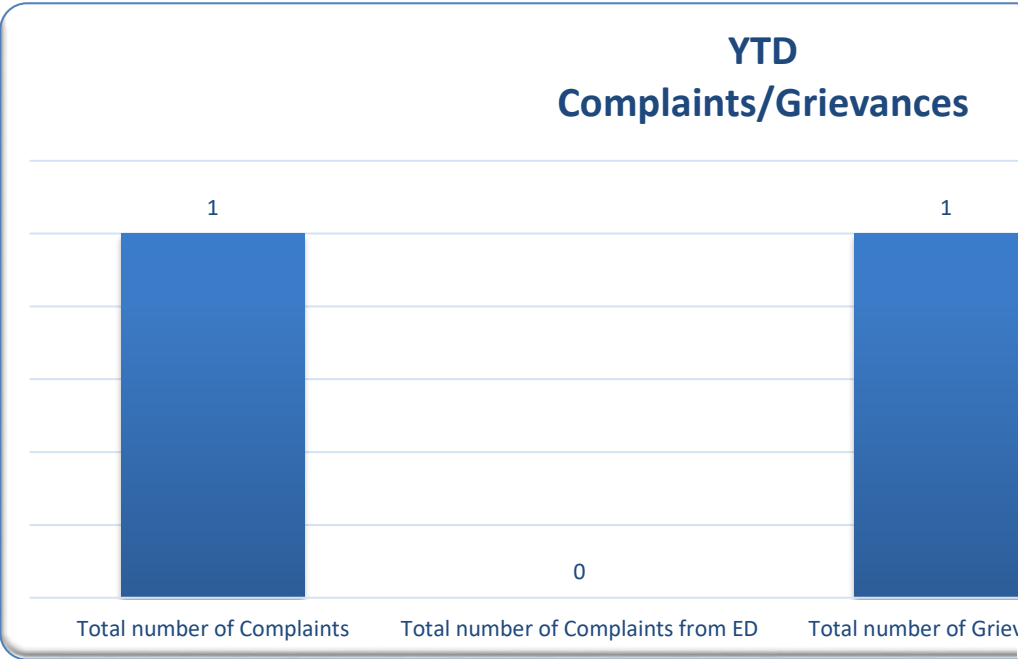
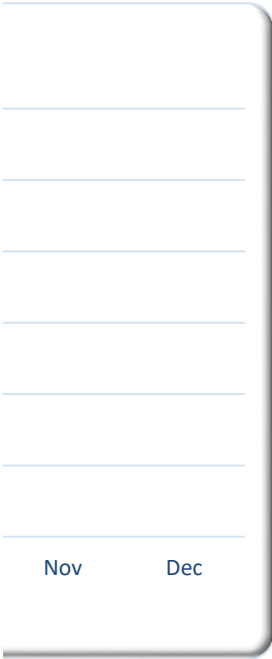
YTD Incident by Department

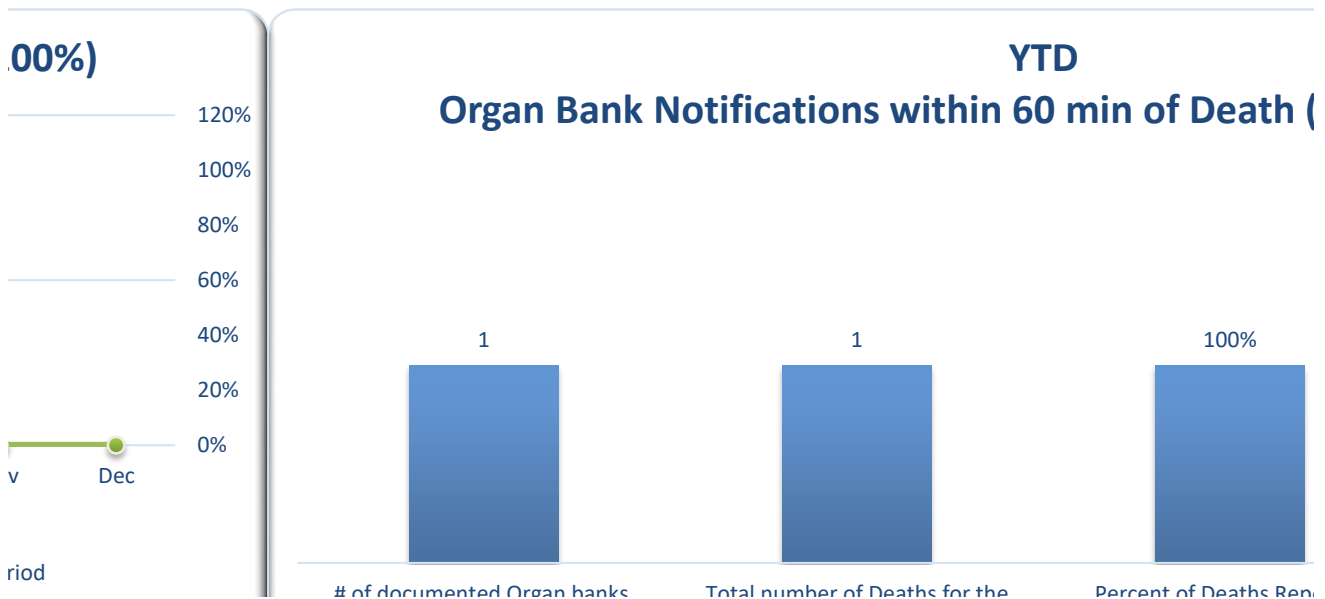
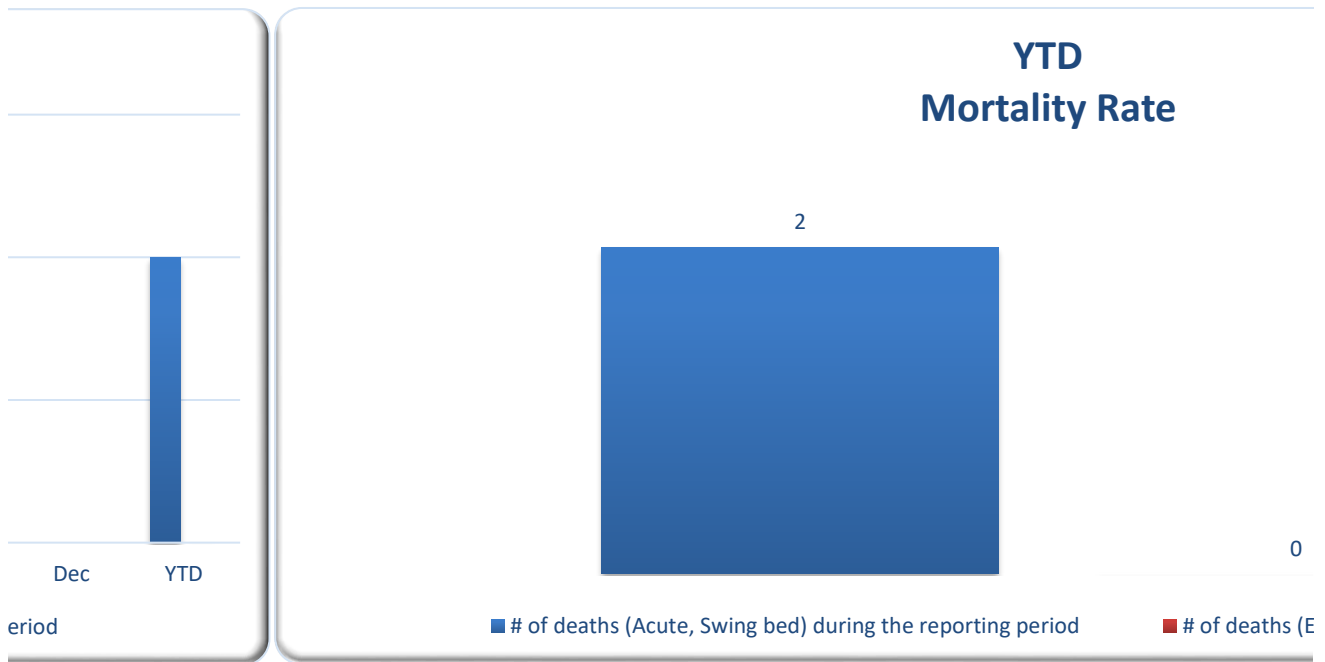
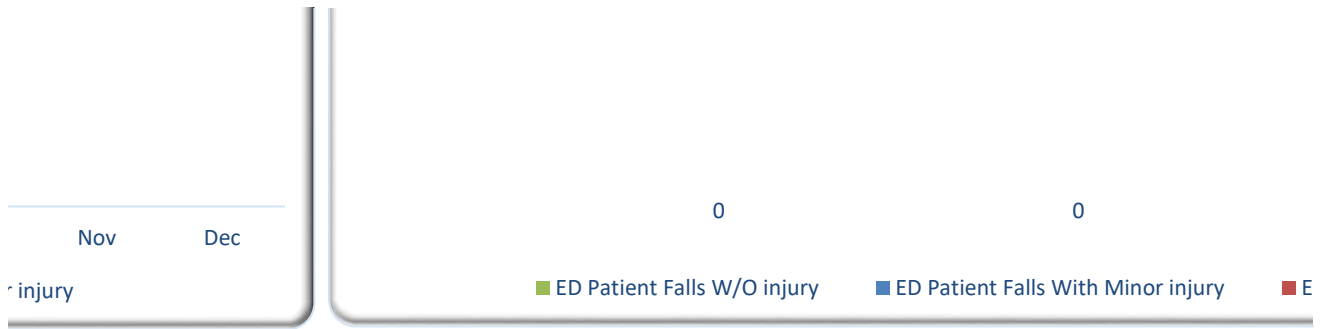


YTD Incident Report Categories

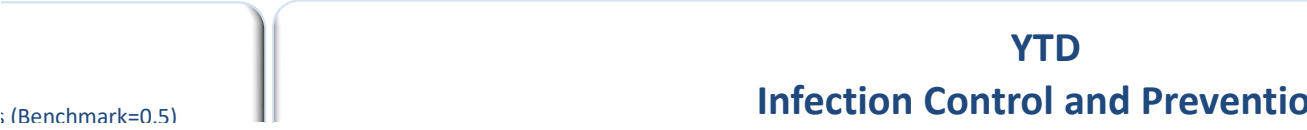
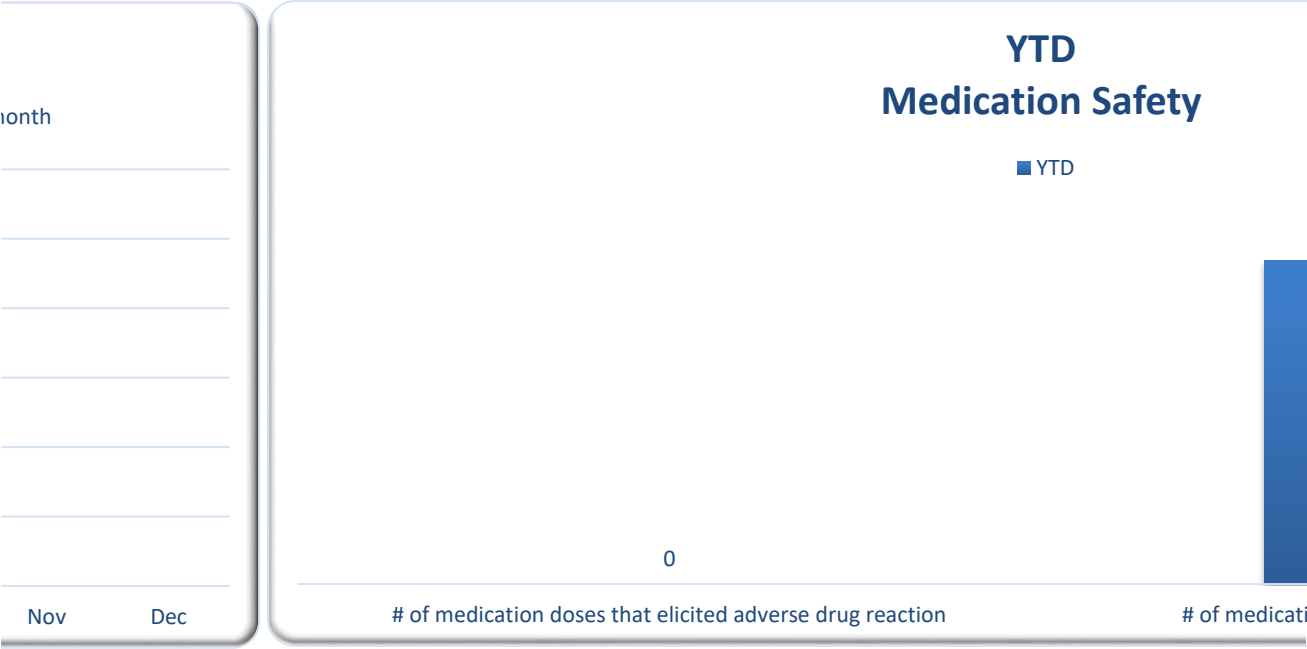
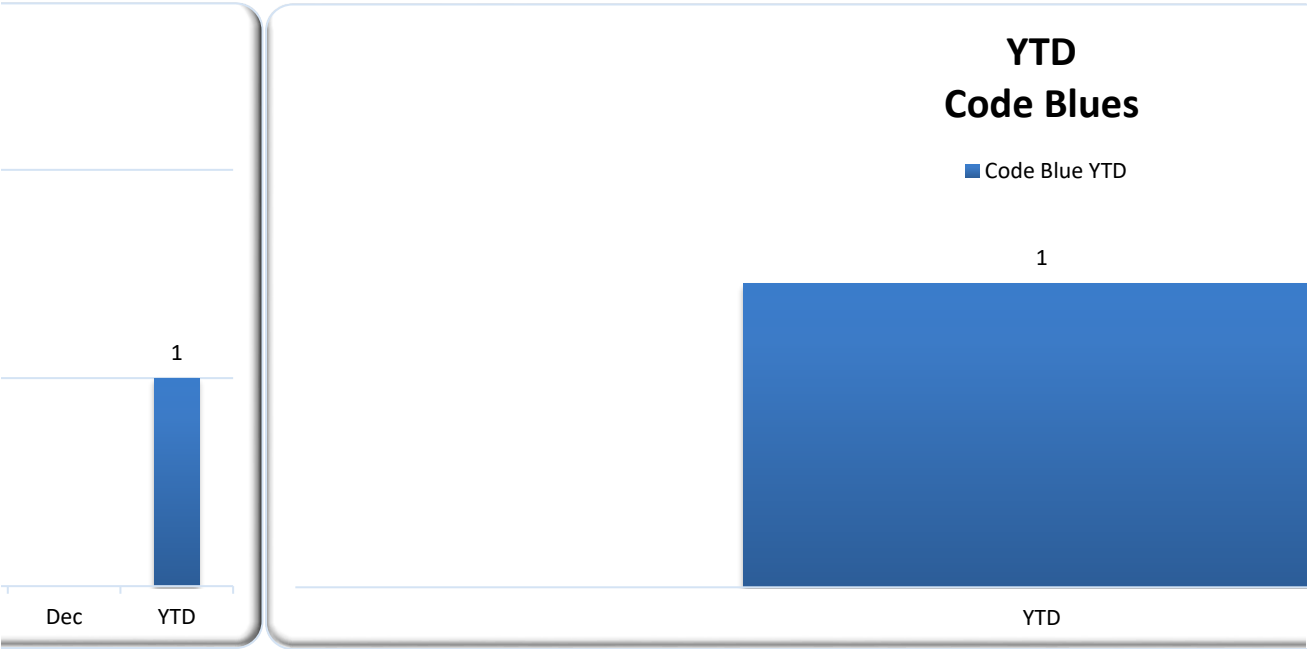
7

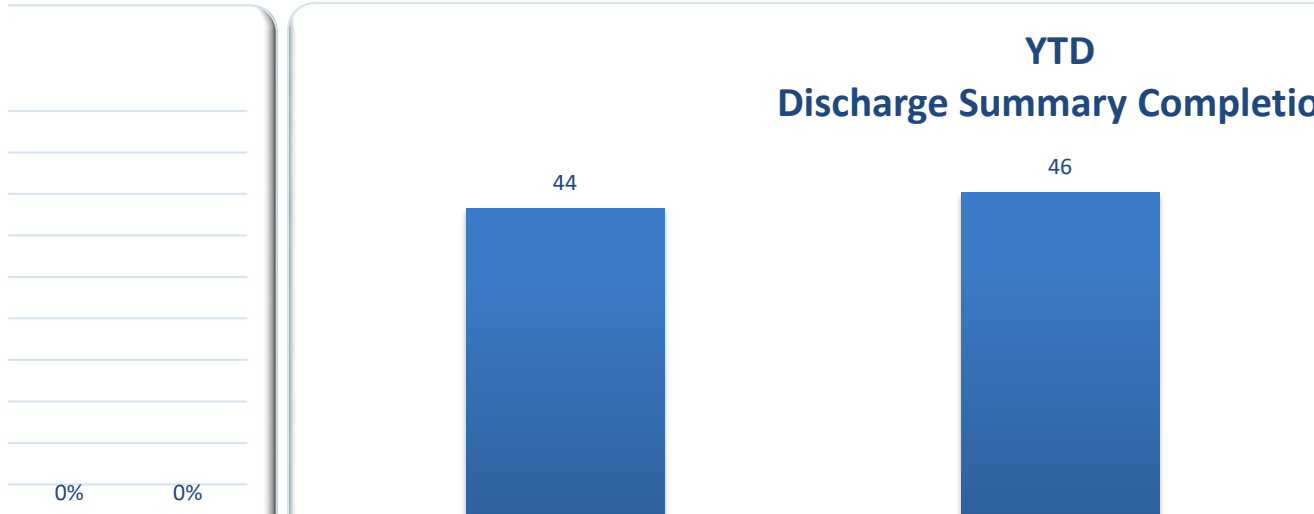
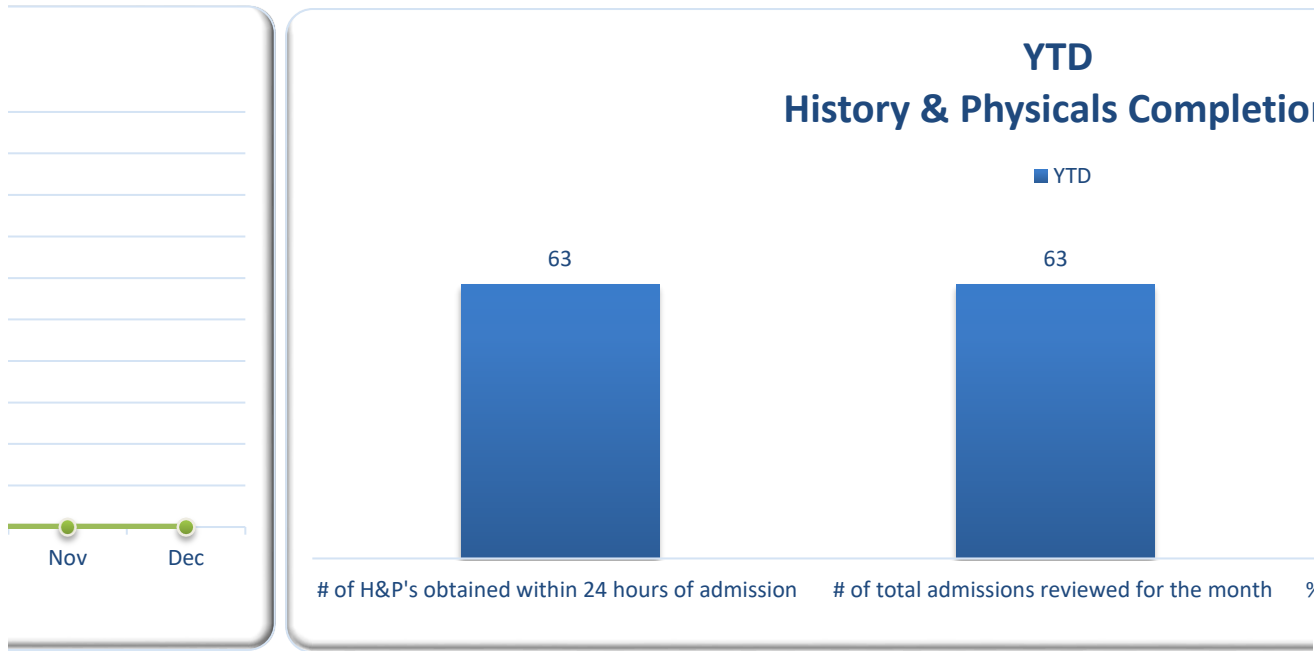
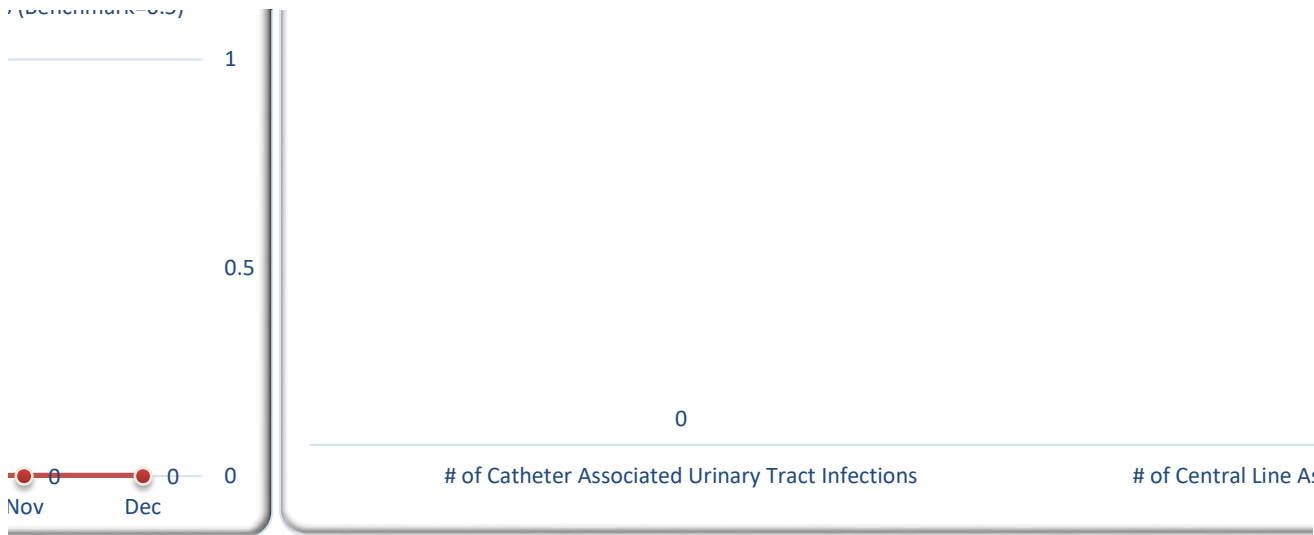


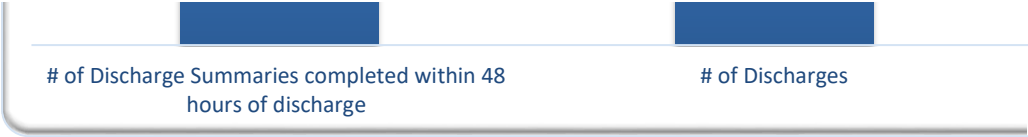




# of documented Organ Banks notifications within 60 min of death	Total number of Deaths for the reporting period	Percent of Deaths rep (Benchmark = 100%
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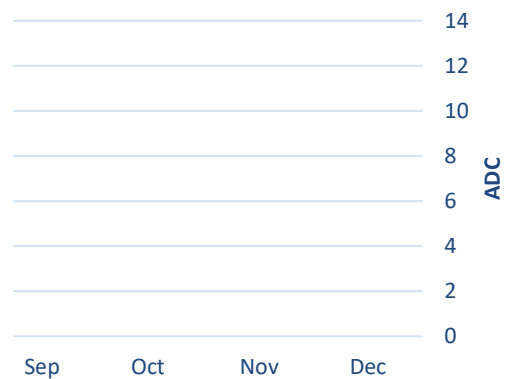




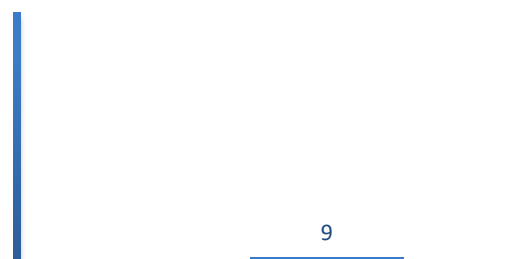


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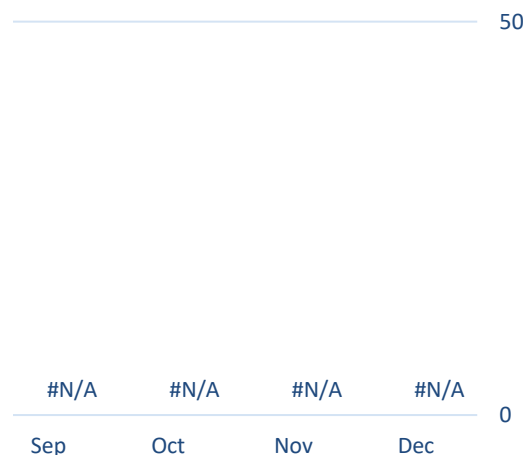
DC



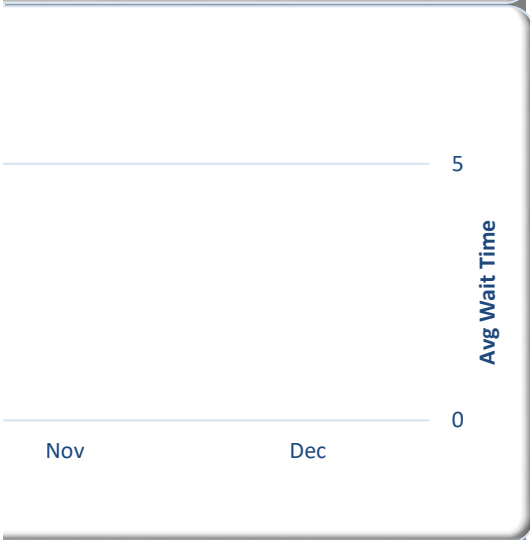
Family Census (Acute & Swing bed)



Swing bed) Average Daily Census (Acute & Swing bed)



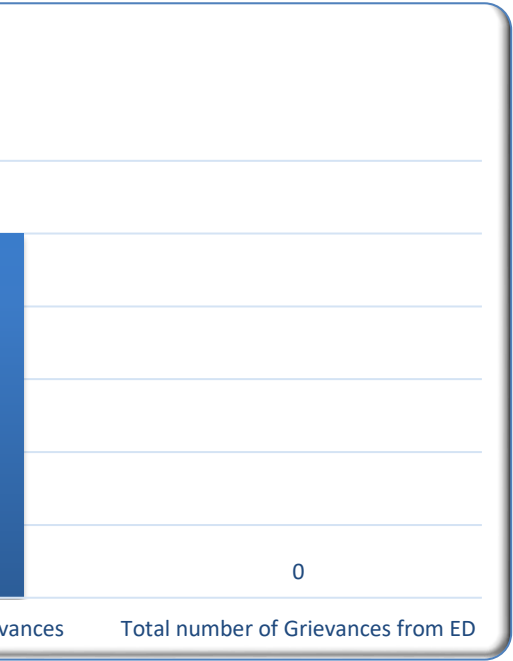
Discharges for the reporting month



- Nursing
- Respiratory
- Radiology
- Lab
- Therapy
- Business Office
- Dietary
- Medical

[illegible]

0	0
Process incidents	Visitor incidents



- Basic Care (daily hygiene, oral care, peri care, etc.)
- Medication related
- Communication (follow-through on concerns, etc.)
- Attitude and Customer Service
- Preventative measures (turning, activity)
- Nutrition (assistance, quality, diets, timeliness)
- Call light response

	Housekeeping	Radiology	Other
0	0	0	0

0

ient Falls w/Major Injury

0

D Patient Falls With Major injury

ER) during the reporting period

(Benchmark=100%)

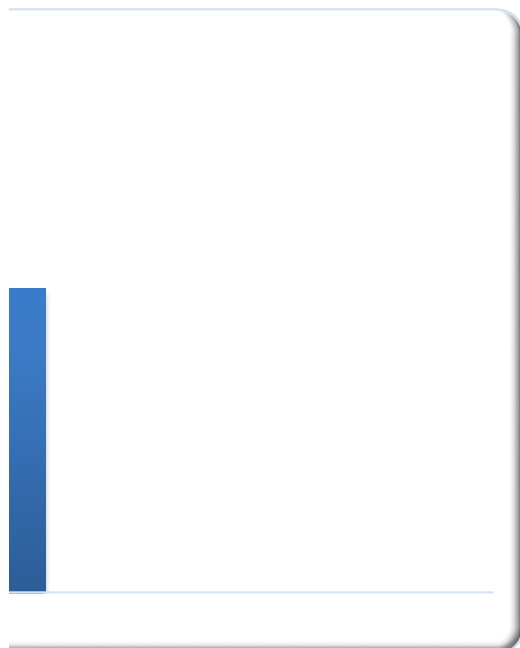
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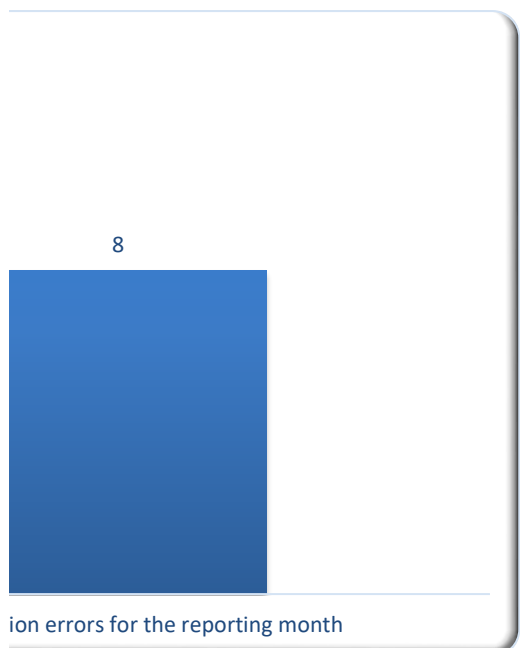
orted

Tissue Donations

ected
%)

ISSUE DONATIONS





on

0

ssociated Primary Bloodstream Infections
(Benchmark=0.5)

n

100%

% of H& P's obtained within 24 hours of admission
(Benchmark = 100%)

on

96%

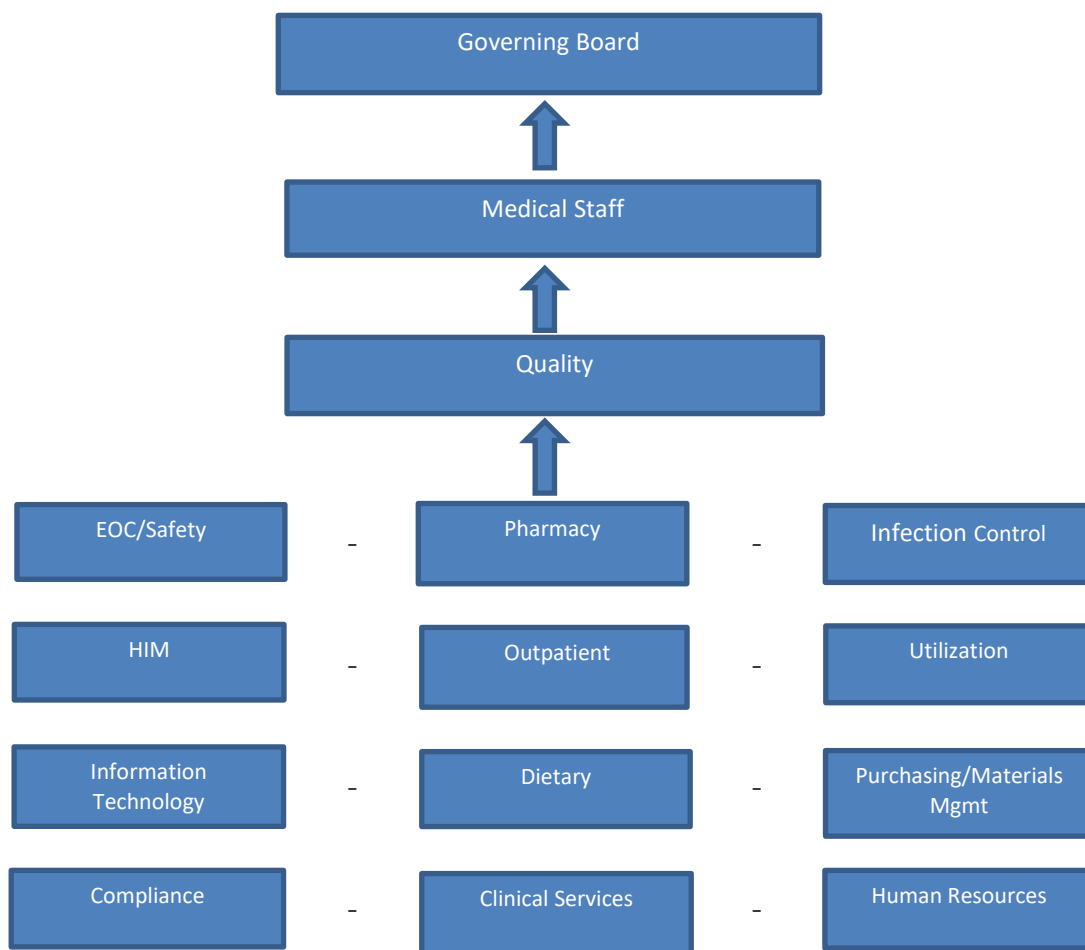
% of Discharge Summaries completed within 48
hours of discharge (Benchmark=100%)

Overview

The Hospital Quality Assurance and Performance Improvement Committee is the central coordinating body for all performance improvement and patient safety activities within the hospital. The Quality Committee meets on a routine scheduled basis. The Quality Committee coordinates the performance improvement process by establishing a planned, systematic, organization-wide approach to performance measurement, analysis and improvement. Membership includes representation from both leadership and staff levels.

The hospital quality indicators are a set of measures that provide a perspective on hospital quality of care using hospital data. These indicators reflect quality of care inside the hospital. The quality indicators can be used to help the hospital identify potential problem areas that might need further study; provide the opportunity to assess quality of care inside the hospital using collected data and implement improvement processes.

Reporting Hierarchy



Name of Facility
Hospital Meeting Calendar/Meeting Frequency

<i>Title of Meeting</i>	<i>Frequency of Meeting</i>	<i>Attendees</i>
Quality Assurance & Performance Improvement Committee	Monthly	Administrator, CCO, QM/RM, IP, Dept. Leads
Environment of Care (EOC) & Safety Committee	Monthly	Administrator, CCO, QM/RM, IP, Dept. Leads
Infection Prevention & Control Committee	Monthly	Physician, Administrator, CCO, QM/RM, IP, Pharmacy, ES, EHN
Pharmacy & Therapeutics Committee	Monthly	Administrator, Pharmacist, DRN, CCO, QM, IP
Health Information Management (HIM) & Credentialing Committee	Monthly	HIM, CCO, QM, Registration Clerk, Credentialer
Utilization Review Committee	Monthly	Administrator, CCO, QM, IP, CM
Compliance Committee	Monthly	Administrator, CCO, QM, BOM, CO, Physician, HR, Nurse Managers, CM
Medical Executive Committee	Monthly	Medical Staff, Administrator, CCO, QM
Governing Board	Monthly	Administrator, CCO, Medical Staff, Governing Board Members

MANUGM REGIONAL MEDICAL CENTER

Quality Assurance & Performance Improvement

Agenda

Date: 4/15/2021

CONFIDENTIALITY STATEMENT: This meeting contains privileged and confidential information. Distribution, reproduction, or any other use of this information by any party other than the intended recipient is strictly prohibited.

- I. Call to Order

- II. Review of Minutes

- III. Review of Committee Meetings
 - A. EOC/Patient Safety Committee
 - B. Infection Control Committee
 - C. Pharmacy & Therapeutics Committee
 - D. HIM/Credentialing Committees
 - E. Utilization Review Committee
 - F. Compliance Committee

- IV. Old Business

- V. New Business

- VI. **Quality Assurance/Performance Improvement**
 - I. Volume & Utilization
 - A. Hospital Activity
 - B. Blood Utilization
 - II. Care Management
 - A. CAH Re-Admits
 - B. Acute Transfers
 - C. Transition of Care
 - D. Discharge Follow-Up Phone Calls
 - E. Patient Safety Discharge Checklist
 - III. **Risk Management**
 - A. Incidents
 - B. Reported Complaints
 - C. Reported Grievances
 - D. Patient Falls Without Injury
 - E. Patient Falls With Minor Injury
 - F. Patient Falls With Major Injury
 - G. Mortality Rate
 - H. Deaths Within 24 Hours of Admit
 - I. OPO Notification/Tissue Donation
 - J. Patient Identifiers

IV. Nursing

- A. Critical Tests/Labs
- B. Restraints
- C. RN Assessments
- D. Code

V. Emergency Department

- A. ER Log & Visits
- B. Medical Screening Exam
- C. Provider ER Response Time
- D. ED RN Assessments (Initial)
- E. ED Readmissions
- F. EMTALA Transfer Form
- G. ED Transfers
- H. Stroke Care
- I. Suicide Management
- J. Triage
- K. STEMI Care
- L. ED Nursing Assessment (Discharge/Transfer)

VI. Pharmacy & Med Safety

- A. Pharmacy Utilization
- B. After Hours Access
- C. Adverse Drug Reaction
- D. Medication Errors

VII. Respiratory Care Services

- A. Ventilator Days
- B. Ventilator Wean Rate
- C. Patient Self-Decannulation Rate
- D. Respiratory Care Equipment

VIII. Wound Care Services

- A. Development of Pressure Ulcer
- B. Wound Healing Improvement
- C. Wound Care Documentation
- D. Debridement/Wound Care Procedures
- E. Wound VAC

IX. Radiology

- A. Radiology Films
- B. Imaging
- C. Radiation Dosimeter Report
- D. Physicist's Report

X. Lab

- A. Lab Reports
- B. Blood Culture Contaminants

XI. Infection Control & Employee Health

- A. CAUTI Infections
- B. CLABSI Infections

- C. Hospital Acquired MDROs
- D. Hospital Acquired C. diff
- E. Hospital Acquired Infections By Source
- F. Hand Hygiene/PPE & Isolation Surveillance
- G. Public Health Reporting
- H. Patient Vaccinations
- I. Ventilator Associated Events
- J. Employee Health Summary

XII. HIM

- A. H&P's
- B. Discharge Summaries
- C. Progress Notes (Swingbed & Acute)
- D. Consent to Treat
- E. Swingbed Indicators
- G. E-prescribing System
- H. Legibility of Records

XIII. Dietary

- A. Food Test Tray Evaluation
- B. Dietary Checklist Audit

XIV. Therapy

- A. Therapy Indicators
- B. Therapy Visits
- C. Standardized Assessment Outcomes

XV. Human Resources

- A. Compliance

XVI. Resgistration Services

XVII. Environmental Services

- A. Terminal Room Cleans

XVIII. Materials Management

- A. Materials Management Indicators

XIX. Plant Ops

- A. Fire Safety Management

XX. Information Technology (IT)

- A. IT Indicators

XXI. Outpatient Services

- A. Orders and Assessments
- B. Outpatient Therapy Services
- C. Outpatient Wound Services

XXII. Strong Mind Services

- A. Record Compliance
- B. Client Satisfaction Survey
- C. Master Treatment Plan
- D. Suicidal Ideation
- E. Scheduled Appointments

VII. Contract Services

VIII. Regulatory & Compliance

- A. OSDH & CMS updates
- B. Surveys
- C. Product Recalls
- D. Failure Mode Effect Analysis (FMEA)
- E. Root Cause Analysis (RCA)

IX. Policy & Procedure Review

X. Standing Agenda

- A. Annual Approval of Strategic Quality Plan
- B. Annual Appointment of Infection Preventionist
- C. Annual Appointment of Risk Manager
- D. Annual Appointment of Safety Officer
- E. Annual Appointment of Security Officer
- F. Annual Appointment of Compliance Officer
- G. Annual Review of ICRA
- H. Annual Review of HVA

XI. Credentialing/New Appointment Updates

XII. Chief Clinical Officer Report

XIII. Administrator Report

XIV. Education & Training

XV. Performance Improvement Project

XVI. Department Reports

XIX. Other

XX. Adjournment

Quality Workbook Contents

<i>Topic</i>	<i>Responsible Party</i>
I. Hospital Volume & Utilization	
A. Hospital Activity	
B. Blood Utilization	
II. Care Management	
A. CAH/ER Re-Admits	
B. Acute Transfers	
C. Transition of Care	
D. Discharge Follow-Up Phone Calls	
E. Patient Discharge Safety Checklist	
III. Risk Management	
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B. Reported Complaints	
C. Reported Grievances	
D. Patient Falls Without Injury	
E. Patient Falls With Minor Injury	
F. Patient Falls With Major Injury	
G. Mortality Rate	
H. Deaths Within 24 Hours of Admission	
I. OPO/Tissue Donation	
J. Patient Identifiers	
IV. Nursing	
A. Critical Tests/Labs	
B. Restraints	
C. RN Assessments	
D. Code Blue	
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A. ER Log & Visits	
B. Medical Screening Exam	
C. Provider Response Time	
D. ED RN Assessment (Initial)	
E. ED Readmissions	
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C. Adverse Drug Reaction	
D. Medication Error Rate	
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A. Ventilator Days	
B. Ventilator Wean Rate	
C. Patient Unplanned Decannulation Rate	
D. Respiratory Care Equipment	
VIII. Wound Care	
A. Development of Pressure Ulcer	
B. Wound Healing Improvement	
C. Wound Care Documentation	
D. Debridement/Wound Care Procedure	
E. Wound Vac Application	
IX. Radiology	
A. Radiology Films	
B. Imaging	
C. Radiation Dosimeter Reports	
D. Physicist's Report	
X. Laboratory	
A. Lab Reports	
B. Blood Culture Contaminations	
XI. Infection Control & Employee Health	
A. CAUTI Infections	
B. CLABSI Infections	
C. Hospital Acquired MDROs	
D. Hospital Acquired C.diff	
E. Hospital Acquired Infections By Source	
F. Hand Hygiene/PPE & Isolation Surveillance	
G. Public Health Reporting	

- H. Patient Vaccinations
- I. Ventilator Associated Events
- J. Employee Health Summary

XII. Health Information Management (HIM)

- A. History & Physical Completion
- B. Discharge Summary Completion
- C. Progress Notes (Swingbed & Acute)
- D. Consent to Treat
- E. Swingbed Indicators
- G. E-prescribing System
- H. Legibility of Records

XIII. Dietary

- A. Food Test Tray Evaluation
- B. Dietary Checklist Audit

XIV. Therapy Services

- A. Therapy Swingbed Services
- B. Therapy Visits
- C. Standardized Assessment Outcomes

XV. Human Resources

- A. Employee Compliance

XVI. Registration Services

XVII. Environmental Services

- A. Terminal Room Cleans

XVIII. Materials Management/Purchasing Services

- A. Materials Management Indicators

XIX. Plant Operations

- A. Fire Safety Management

XX. Information Technology (IT)

- A. IT Indicators

XXI. Outpatient Services

- A. Outpatient Orders and Assessments
- B. Outpatient Therapy Services
- C. Outpatient Wound Services

XXII. Strong Mind Services

- A. Record Compliance
- B. Client Satisfaction Survey
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- D. Suicidal Ideation
- E. Scheduled Appointments

Hospital Volume & Utilization Data

A. [Hospital Activity](#)

Indicator	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Total ER visits	104	133											237
Total # of Observation Patients Admitted	0	2											2
Total # of Acute Patients Admitted	15	15											30
Total # of Swing Bed Patients Admitted	10	20											30
Total Hospital Admissions (Acute & Swing bed)	25	35	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	60
Total Discharges (Acute & Swing bed)	19	25											44
Total Patient Days (Acute & Swing bed)	183	324											507
Average Daily Census (Acute & Swing bed)	6	12											9
January													
Summary of Findings				Plan of Action									
N/A				N/A									
February													
Summary of Findings				Plan of Action									
March													
Summary of Findings				Plan of Action									
April													
Summary of Findings				Plan of Action									
May													
Summary of Findings				Plan of Action									
June													
Summary of Findings				Plan of Action									
July													
Summary of Findings				Plan of Action									
August													
Summary of Findings				Plan of Action									
September													
Summary of Findings				Plan of Action									

Hospital Volume & Utilization Data

October	
Summary of Findings	Plan of Action
November	
Summary of Findings	Plan of Action
December	
Summary of Findings	Plan of Action

B. Blood Utilization

Function: Outcome & Process Measure

Rationale: High Risk, Problem Prone

Data Source: Medical Record/Lab Reports/Blood Log

Sample Size: All episodes of blood/blood product administration

Methodology: Audit Log, PDSA

Inclusion Criteria: All patients receiving blood/blood products during reporting period

Indicator	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Total Units of Blood / Blood Products Administered	4	1											5
Total Number of Transfusion Episodes	2	1											3
Appropriateness for transfusion (per criteria)	4	1											5
Total number of transfusion reactions	0	0											0
Patient identification using 2 identifiers (total # of units with 2 patient identifiers/total units infused) (Benchmark=100%)	4	1											5
Signed Informed Consent (total # of episodes with signed Informed Consent/total episodes) (Benchmark=100%)	4	1											5
Vital signs monitor and document per protocol for each transfusion occurrence													0
Total # of transfusion occurrence													0

January

Summary of Findings	Plan of Action
All blood products were administered without problems	no action needed

February

Summary of Findings	Plan of Action
---------------------	----------------

Hospital Volume & Utilization Data

All blood products were administered without problems. All paperwork completed.	no action needed
March	
Summary of Findings	Plan of Action
April	
Summary of Findings	Plan of Action
May	
Summary of Findings	Plan of Action
June	
Summary of Findings	Plan of Action
July	
Summary of Findings	Plan of Action
August	
Summary of Findings	Plan of Action
September	
Summary of Findings	Plan of Action
October	
Summary of Findings	Plan of Action
November	
Summary of Findings	Plan of Action
December	
Summary of Findings	Plan of Action

Hospital Volume & Utilization Data

CAH Re-Admits

Function: Outcome & Process Measure													
Rationale: High Risk, Problem Prone													
Data Source: Patient Records													
Sample Size: All acute & SWB patients readmitted to CAH													
Methodology: Medical records, Discharge reports, PDSA													
Inclusion Criteria: All acute & SWB patients readmitted to CAH within 30 days of discharge													
Exclusion Criteria: Patients who are transferred to a higher level of care and then readmitted back to CAH													
Indicator	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Total Number of Readmits (Acute & SWB) Within 30 days of discharge	1	0											1
Total Discharges for the reporting month	19	25	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	44
CAH Readmission Rate per 100 patient discharges	5%	---	---	---	---	---	---	---	---	---	---	---	2%
January													
Summary of Findings				Plan of Action									
1 re-admit to acute within 30 days. Patient was admitted to acute care on 1-3-20 with CHF, COPD exacerbation and shortness of breath. She was started on IV Rocephin and Zithromax for CXR that showed mediastinal opacity. Neb treatments were ordered routinely. She received DVT and stress ulcer prophylaxis and has improved. She has no dyspnea with exertion and on room air is oxygenating at 95%. She insists she go home, though it was suggested a few more days of IV antibiotics would be beneficial, and sputum culture results would be available. She states she has family that will be staying with her and she 'really needs' to go home. CXR shows improving opacity. She was discharged on Nicotine patch, increase in Lasix to 40 mg BID for one week, then once daily, Metoprolol 50 mg BID and Prednisone 20 mg daily for 5 days, along with Levaquin 500 mg once daily. She has received order for outpatient ultrasound of LLE for mild, chronic edema, worse on left. F/U in one week with PCP. Patient readmitted next day for c/o DOE, for breathing treatments and supplemental O2 prn, Levaquin 750 mg IVDD daily, LLE worsens LSC.													
February													
Summary of Findings				Plan of Action									
No re-admits for February				Will continue to monitor									
March													
Summary of Findings				Plan of Action									
April													
Summary of Findings				Plan of Action									
May													

Care Management

Summary of Findings	Plan of Action
June	
Summary of Findings	Plan of Action
July	
Summary of Findings	Plan of Action
August	
Summary of Findings	Plan of Action
September	
Summary of Findings	Plan of Action
October	
Summary of Findings	Plan of Action
November	
Summary of Findings	Plan of Action
December	
Summary of Findings	Plan of Action

D. Discharge Follow-Up Phone Calls

Function: Outcome Measure Rationale: Problem Prone Data Source: Discharge List Sample Size: All discharged acute & SWB patients to home during the reporting period Methodology: PDSA, Patient Records Inclusion Criteria: All discharged acute & SWB patients to home during the reporting period													
Indicator	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD

Care Management

Total number of Discharge Follow-Up calls completed within 48 hours; excluding holidays & weekends)													
	19	25											44
# of Discharge Follow-Up calls required during the reporting	19	25											44
Percentage of Compliance	100%	100%	---	---	---	---	---	---	---	---	---	---	100%
January													
Summary of Findings				Plan of Action									
February													
Summary of Findings				Plan of Action									
March													
Summary of Findings				Plan of Action									
April													
Summary of Findings				Plan of Action									
May													
Summary of Findings				Plan of Action									
June													
Summary of Findings				Plan of Action									
July													
Summary of Findings				Plan of Action									
August													
Summary of Findings				Plan of Action									
September													
Summary of Findings				Plan of Action									
October													
Summary of Findings				Plan of Action									
November													
Summary of Findings				Plan of Action									

Care Management

December	
Summary of Findings	Plan of Action

E. Patient Discharge Safety Checklist

Function: Outcome Measure Rationale: Problem Prone Data Source: Patient Records Sample Size: All inpatients discharged to home during the reporting period Methodology: PDSA, Patient Records

Risk Management

A. Incidents

Function: Outcome & Process Measure													
Rationale: High Risk, Problem Prone													
Data Source: Patient Records, Incident Reports													
Sample Size: All patients/visitors/facility with unplanned events/incidents													
Methodology: Incident reports, patient records, PDSA													
Inclusion Criteria: All patients/visitors/facility with unplanned events/incidents													
Indicators	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Intravenous Line events	0	0											0
Other line events (foley, enteral tubes, drains, etc.)	0	0											0
Patient falls without injury	0	1											1
Patient falls with injury	0	0											0
AMA events	2	1											3
ED patients left without being seen	0	0											0
Average Wait Time/Minutes (LWBS)	0	0											0
Notifications to Police/Law for Disruptive Events	0	0											0
Violent/Disruptive Events	0	0											0
Suicide/Self Harm During Hospital Stay	0	0											0
Other events	3	4											7
Process incidents	0	0											0
Visitor incidents	0	0											0
Total Number of Events	5	6	0	0	0	0	0	0	0	0	0	0	11
January													
Summary of Findings					Plan of Action								

Risk Management

OTHER EVENTS: 1. On 1/31/21 drug room tech identified FSBS omission while doing QA checks of MARS. FSBS omitted by LPN. CCO interviewed LPN, LPN had inaccurate FSBS data. LPN given opportunity to correct the omission. LPN entered inaccurate data into EMR documented that she had completed a finger stick on a patient. 2. On 1/8/21 CNA was assisting patient with shower when patient had inappropriate behavior towards CNA. CNA let the patient know that it is not acceptable. No findings of confusion, AMS or dementia. 3. On 1/11 @ 1700 it was found by LPN that the RMS was in the vagina instead of the rectum. RMS was removed and cleaned and properly placed into the rectum. AMA - 1. Patient presented @ 20:30 by EMS with CP. Patient was triaged upon arrival. Provider notified, and EKG was done. Pt did not like that her S.O. could not come in ED. RN & lab at bedside for IV & blood draw. Pt is relaxed & calm, states “I am feeling better, and want to go home” Pt now denies CP or SHOB. RN discussed what tests are ordered & why – pt remains pleasant with staff & further declines any testing, and wants to go home. NP at bedside to discuss risks of leaving and benefits of staying. Pt comprehends again states she “wants to go home.” Agrees to sign AMA form. Pt ambulated to car w/out difficulty. 2. AMA ED - Patient presented to ED @ 11:50 with hyperglycemia and CP. Patient became angry about NPO order. He cursed at nursing staff. Patient stated “If I don’t get a heater and more blankets and some food, I am leaving and I am not signing any paperwork” Provider notified of pt behavior. Provider advised pt to stay to receive further treatment, pt refused further treatment and refused to sign AMA form. Patient was informed that refusal of further treatment has serious consequences to his health, possibly even death. Patient dressed himself, got out of bed, and refused to sit. Patient stated “I don’t like the way I’m being treated, and my stress levels are through the roof. I just need to go.” Patient also stated “my health doesn’t matter.” Patient refused to wait for his sister to come and get him.	OTHER EVENTS: 1. CCO met with LPN involved. LPN's agency contacted. Agency and CCO agree to cancel contract.LPN will not return to MRMC. 2. Charge nurse notified. It was also noted in chart. Care plan was reviewed and updated which included, but was not limited to socially inappropriate behavior. CCO told staff to use "buddy system" for patient hygiene needs. 3. CCL and QM interviewed all staff members one by one that take care of said patient. None of the staff members interviewed knew how it was misplaced. CCO reminded each staff member to take time and make sure of insertion. AMA - 1. RN involved counseled and reminded that an incident report is to be filled out on each AMA. Also, that CCO and QM must be notified about incident. AMA -ED 2. QM spoke with RN and several warm blankets were given to pt. Patient was NPO and could not have food or drink administered to him. Nursing staff walked with patient off the property and also called the Police Department to let them know the patient had left the hospital and asked if the PD would check on him.
February	
Summary of Findings	Plan of Action

Risk Management

FALL W/O INJ 1. On 2/24/21 At Patient was found on floor due to an unassisted fall while walking. Patient stated "I needed to use restroom" She then said she got out of bed w/out hitting call light. At 0153 call light went off and nursing staff found patient on the floor by bed in a sitting position. Patient stated "I fell on my bottom and crawled back toward bed to hit call light." Patient was assessed for injuries. No apparent injuries, and patient denies pain anywhere. Vitals taken and patient was assisted to commode and then back to bed. Bed alarm was turned on. Patient was instructed to use call light if needing to get out of bed. Patient verbalized understanding. Patients socks were changed to grip socks. Patient had put her own personal socks on. patient call light was w/in reach, bed was in low position. Provider and patient's family was informed of the fall. AMA 2/8/21 Patient presented to the ED @ 15:15 with a PMH of Hep C, diabetes II, hypertension, chronic neck pain and chronic substance-abuse with complaint of lower extremity swelling for the last month that has not improved. She reports gradual increase in swelling to lower extremities that has continued to worsen and become painful. Patient was triaged and seen by Provider. Patient left prior to lab review. Patient left AMA because her house was getting broken into. Patient was informed of risks of leaving and the benefits of staying before signing AMA. OTHER EVENTS: 1. On 2/9/21 @ 0053 Patient was reaching for something on his bedside table. His hand slipped and the table went up under his fingernail and pulled it completely off. Patient stated "Oh, this happens all the time." 2. On 2/21/20 @ 1830 Staff noticed an odor of cigarettes in patients room. Patient admitted she was smoking cigarette in her room so she could get kicked out and go back to the Nursing home. Patient does not use oxygen and hasn't for several days. 3. On 2/22/20 @ 10:10 a.m. Nursing staff smelled cigarette smoke and went into patient room to find patient watching tv. Smoke smell was strong. Nurse made CCO aware of incident, then CCO went to patients room and with nurse. Patient approved CCO and nurse to look in her purse. Findings were 2 partially smoked cigarettes. Patient is requesting to go back to nursing home so she can smoke freely. 4. On 2/21/21 at 10:22 ED Patient presented from EMS nonresponsive, will open eyes but no other response. Provider assessed patient and patient was triaged immediately. Provider ordered a "stat" CT of the brain @ 10:22 RN failed to inform Radiology of the CT patient. At approximately 12:00 Provider noticed no CT was	FALL W/O INJ 1. On 2/24/21 Changed patients personal socks to non skid socks. Made sure appropriate railing up. Bed alarm was turned on. AMA 2/8/21 1. Staff did explain to patient the risks of leaving and the benefits of staying. Patient was being treated but had emergency. OTHER EVENTS: 2/9/21 1. RN assessed finger. Cleaned the wound, and applied 2X2 with medical tape. Provider was notified of patient injury. Also, CCO communicated with patient regarding safety with furniture during repositioning. Patient verbalized understanding. 2. Patient's lighter was confiscated by nursing staff and lighter was also educated on risks to herself, staff and other patients. It was explained to the patient that she could cause a fire/explosion from smoking around oxygen. 3. Patient gave CCO verbal consent to search purse. Removed cigarettes and lighter from purse and took it to the ward clerk to be stored for patient. CCO communicated the risks associated with smoking in the hospital. CCO also visted with patient about going back to Nursing home. Patient wanted to be d/c'd back to nursing home. CCO spoke with CM and provider. CM approved the d/c back to Nursing home. 4. Immediate action taken, CCO informed CEO that he would remove the RN off the schedule in the ED unless shorthanded. 2nd QM reviewed the chart and interviewed staff involved. 3rd action is to educate RN and Provider individually. 4th CCO will get Dr. C involved and do an immediate read and sign. Also, CCO is doing a global response to nursing when he introduces new policies and procedures on 3/9/2021. Future education is also coming when Cohesive rolls out video training on new policies and procedures in near future. No exact date is set. 5th QM also spoke with the Radiology Director about the event. Director said she will remind her staff that all stroke patients are to be done first and immediately.
March	
Summary of Findings	Plan of Action
April	
Summary of Findings	Plan of Action
May	
Summary of Findings	Plan of Action

Risk Management

June	
Summary of Findings	Plan of Action
July	
Summary of Findings	Plan of Action
August	
Summary of Findings	Plan of Action
September	
Summary of Findings	Plan of Action
October	
Summary of Findings	Plan of Action
November	
Summary of Findings	Plan of Action
December	
Summary of Findings	Plan of Action

[illegible]

Risk Management

B. Reported Complaints

Function: Outcome Measure													
Rationale: High Risk, Problem Prone													
Data Source: Patient, Family, Visitor													
Sample Size: All Complaints													
Methodology: Report (Verbal), PDSA													
Inclusion Criteria: All complaints													
Documentation Indicator	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Total number of Complaints	0	1											1
Total number of Patient Days	183	324	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	507
Rate per 1000 patient days	---	3.1	---	---	---	---	---	---	---	---	---	---	2.0
Total number of Complaints from ED	0	0											0
Total number of ED Visits	104	133	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	237
Percentage of ED Complaints	---	---	---	---	---	---	---	---	---	---	---	---	---
January													
Summary of Findings				Plan of Action									
No complaints for January				Will continue to monitor									
February													
Summary of Findings				Plan of Action									
On 2/4/21 Patient spoke with the charge nurse about staff member upsetting her when helping her to the bed side commode. She said the LPN that came in to help her said she needs to finish and empty her bladder this time. She also said that LPN used her hurt arm to help assist her. Patient said she stated "that is my hurt arm" LPN then let go of her arm. QM and CCO spoke with the patient the morning of 2/5 and patient felt nurse was irritated at how many times she goes to the bathroom. QM spoke with LPN about the matter. She said when the patient got off of the commode to quickly she was afraid the patient would fall so she grabbed her arm without thinking of her arm injury. She immediately let go when the patient said that is her hurt arm.				2/5/21 QM and CCO assured patient that we all love taking care of her. CCO asked patient if he made it where the LPN would not assist in her care anymore would that help her to feel more comfortable with her stay here at MRMC? Patient said "yes" Also, CCO asked if patient wanted any further action taken on this matter? Patient stated " no, I am fine with that" Further actions taken was CCO had LPN read and sign education on empathy and human connection. QM also reviewed chart. QM was approved by patient to call her sister and let her know what actions were taken and how her sister was doing. The sister was happy with the process.									
March													
Summary of Findings				Plan of Action									
April													
Summary of Findings				Plan of Action									
May													
Summary of Findings				Plan of Action									

Risk Management

June	
Summary of Findings	Plan of Action
July	
Summary of Findings	Plan of Action
August	
Summary of Findings	Plan of Action
September	
Summary of Findings	Plan of Action
October	
Summary of Findings	Plan of Action
November	
Summary of Findings	Plan of Action
December	
Summary of Findings	Plan of Action

C. Reported Grievances

Function: Outcome Measure													
Rationale: High Risk, Problem Prone													
Data Source: Patient, Family, Visitor													
Sample Size: All Complaints													
Methodology: Report (Verbal, Written), PDSA													
Inclusion Criteria: All grievances													
Documentation Indicator	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Total number of Grievances	1	0											1
Total number of Patient Days	183	324	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	507
Rate per 1000 patient days	5.5	---	---	---	---	---	---	---	---	---	---	---	2.0
Total number of Grievances from ED	0	0											0
Total number of ED Visits	104	133	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	237
Percentage of ED Grievances	---	---	---	---	---	---	---	---	---	---	---	---	---
January													
Summary of Findings					Plan of Action								

Risk Management

On 1/12/21 Patient's husband wanted video footage reviewed of his wife's room entrance 1/9/21 between 11:30 a.m. - 7:30 p.m. He wanted to make sure only the allowable staff was entering his wife's room. Patient's husband didn't want to file a grievance, but we followed policy.	1/13/21 QM reviewed video footage, interviewed staff and reviewed the chart. After review found only the allowed staff were entering room. Date issue was closed and letter sent 1/18/21.
February	
Summary of Findings	Plan of Action
No grievances for the month of February	Will continue to monitor
March	
Summary of Findings	Plan of Action
April	
Summary of Findings	Plan of Action
May	
Summary of Findings	Plan of Action
June	
Summary of Findings	Plan of Action
July	
Summary of Findings	Plan of Action
August	
Summary of Findings	Plan of Action
September	
Summary of Findings	Plan of Action
October	
Summary of Findings	Plan of Action
November	
Summary of Findings	Plan of Action
December	
Summary of Findings	Plan of Action

Risk Management

[illegible][illegible]

Risk Management

D. Patient Falls Without Injury

Function: Outcome and Process Measure													
Rationale: High Risk, Problem Prone													
Data Source: Patient Records, Incident Reports													
Sample Size: All patients with falls													
Methodology: Patient Records, Incident Reports, PDSA													
Inclusion Criteria: All patients with falls													
Indicator	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Patient Falls W/O injury	0	1	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	1
Total number of Patient Days	183	324	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	507
Rate per 1000 patient days (Benchmark = 5 or less)	---	3.1	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	2.0
Indicator	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
ED Patient Falls W/O injury	0												0
Total number of ED Visits	104	133	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	237
Percent of Total ED Patient Falls (Benchmark = 5 or less)	---	---	---	---	---	---	---	---	---	---	---	---	---
January													
Summary of Findings					Plan of Action								
No falls w/o inj for Januray					Will continue to monitor								
February													
Summary of Findings					Plan of Action								
See summary of findings under Risk Management Incident tab													
March													
Summary of Findings					Plan of Action								
April													
Summary of Findings					Plan of Action								
May													
Summary of Findings					Plan of Action								
June													
Summary of Findings					Plan of Action								
July													
Summary of Findings					Plan of Action								
August													

Risk Management

Summary of Findings	Plan of Action
September	
Summary of Findings	Plan of Action
October	
Summary of Findings	Plan of Action
November	
Summary of Findings	Plan of Action
December	
Summary of Findings	Plan of Action

E. Patient Falls with Minor Injury

Function: Outcome and Process Measure

Rationale: High Risk, Problem Prone

Data Source: Patient Records, Incident Reports

Sample Size: All patients with falls (minor cuts, minor bleeding, skin abrasions/contusions/tears, swelling, pain)

Methodology: Patient Records, Incident Reports, PDSA

Inclusion Criteria: All patients with falls

[illegible]

January

Summary of Findings	Plan of Action
No falls for January	Will continue to monitor

February

Summary of Findings	Plan of Action
No falls for February	Will continue to monitor

March

Risk Management

Summary of Findings	Plan of Action
April	
Summary of Findings	Plan of Action
May	
Summary of Findings	Plan of Action
June	
Summary of Findings	Plan of Action
July	
Summary of Findings	Plan of Action
August	
Summary of Findings	Plan of Action
September	
Summary of Findings	Plan of Action
October	
Summary of Findings	Plan of Action
November	
Summary of Findings	Plan of Action
December	
Summary of Findings	Plan of Action

F. Falls with Major Injury

Function: Outcome and Process Measure														
Rationale: High Risk, Problem Prone														
Data Source: Patient Records, Incident Reports														
Sample Size: All patients with falls (fractures, subdural hematomas, other major head trauma, cardiac arrest, excessive bleeding, lacerations requiring sutures, loss of consciousness)														
Methodology: Patient Records, Incident Reports, PDSA														
Inclusion Criteria: All patients with falls														
Indicator	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD	

Risk Management

Patient Falls with Major Injury	0	0											0
Total number of Patient Days	183	324	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	507
Rate per 1000 patient days (Benchmark = 0.5 or less)	---	---	---	---	---	---	---	---	---	---	---	---	---
Indicator	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
ED Patient Falls With Major injury	0	0											0
Total number of ED Visits	104	133	0	0	0	0	0	0	0	0	0	0	237
Percent of Total ED Patient Falls (Benchmark = 0.5 or less)	---	---	---	---	---	---	---	---	---	---	---	---	---
January													
Summary of Findings				Plan of Action									
No falls this month				Will continue to monitor									
February													
Summary of Findings				Plan of Action									
No falls with major injury for February				Will continue to monitor									
March													
Summary of Findings				Plan of Action									
April													
Summary of Findings				Plan of Action									
May													
Summary of Findings				Plan of Action									
June													
Summary of Findings				Plan of Action									
July													
Summary of Findings				Plan of Action									
August													
Summary of Findings				Plan of Action									
September													
Summary of Findings				Plan of Action									
October													
Summary of Findings				Plan of Action									

Risk Management

November	
Summary of Findings	Plan of Action
December	
Summary of Findings	Plan of Action

Mortality Rate

Function: Outcome & Process Measure													
Rationale: High Risk, Problem Prone													
Data Source: Patient Records, Discharge Report													
Sample Size: All patient expirations during reporting period													
Methodology: Patient Records, Discharge Report, PDSA													
Inclusion Criteria: All patient expirations during reporting period													
Indicator	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
# of deaths (Acute, Swing bed) during the reporting period	0	1	1										2
Total number of patient discharges	19	25	0	0	0	0	0	0	0	0	0	0	44
Percent of Total Discharges (Benchmark=10%)	---	4%	#DIV/0!	---	---	---	---	---	---	---	---	---	5%
Indicator													
# of deaths (observation) during reporting period	0	0											0
Indicator													
# of deaths (ER) during the reporting period	0	0											0
Total number of ER patient discharges	104	133	0	0	0	0	0	0	0	0	0	0	237
Percent of Total Discharges	---	---	---	---	---	---	---	---	---	---	---	---	---
January													
Summary of Findings				Plan of Action									
No deaths for MRMC in January				Will continue to monitor									
February													
Summary of Findings				Plan of Action									
One patient death in reporting period. 1. Patient was admitted for CHF and AKI. During stay patient became unresponsive. ACLS protocols administered. No ROSC noted. Death called.				Continue operating capacities for this CAH.									
March													
Summary of Findings				Plan of Action									
April													
Summary of Findings				Plan of Action									
May													
Summary of Findings				Plan of Action									
June													
Summary of Findings				Plan of Action									

Risk Management

July	
Summary of Findings	Plan of Action
August	
Summary of Findings	Plan of Action
September	
Summary of Findings	Plan of Action
October	
Summary of Findings	Plan of Action
November	
Summary of Findings	Plan of Action
December	
Summary of Findings	Plan of Action

H. Deaths within 24 hours of Admit

Function: Outcome & Process Measure														
Rationale: High Risk, Problem Prone														
Data Source: Patient Records, Discharge Report														
Sample Size: All patient expirations during reporting period														
Methodology: Patient Records, Discharge Report, PDSA														
Inclusion Criteria: All patient expirations during reporting period														
Indicator	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD	
# of deaths within 24 hours of admit	0	0											0	
# of deaths during the reporting period	0	0											0	
Percentage of deaths within 24 hours	#N/A	---	---	---	---	---	---	---	---	---	---	---	---	
January														
Summary of Findings					Plan of Action									
No deaths w/in 24 hours of admit					No action required at this time									
February														
Summary of Findings					Plan of Action									
No deaths w/in 24 hours of admit					No action required at this time									
March														

Risk Management

Summary of Findings	Plan of Action
April	
Summary of Findings	Plan of Action
May	
Summary of Findings	Plan of Action
June	
Summary of Findings	Plan of Action
July	
Summary of Findings	Plan of Action
August	
Summary of Findings	Plan of Action
September	
Summary of Findings	Plan of Action
October	
Summary of Findings	Plan of Action
November	
Summary of Findings	Plan of Action
December	
Summary of Findings	Plan of Action

I. [Organ Procurement Organization Notification/Tissue Donation](#)

Function: Outcome & Process Measure

Rationale: High Risk, Problem Prone

Data Source: Patient Records, Discharge Report

Sample Size: All patient deaths

Methodology: Patient Records, Discharge Report, PDSA

Inclusion Criteria: All patient expirations during reporting period

Risk Management

Indicator	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
# of documented Organ banks notifications within 60 min of death	0	1											1
Total number of Deaths for the reporting period	0	1											1
Percent of Deaths Reported (Benchmark = 100%)	#N/A	100%	---	---	---	---	---	---	---	---	---	---	100%
Tissue Donations	0												0
January													
Summary of Findings				Plan of Action									
No deaths				NO action required at this time									
February													
Summary of Findings				Plan of Action									
LifeShare notified within 60 minutes of death.				No action required at this time									
March													
Summary of Findings				Plan of Action									
April													
Summary of Findings				Plan of Action									
May													
Summary of Findings				Plan of Action									
June													
Summary of Findings				Plan of Action									
July													
Summary of Findings				Plan of Action									
August													
Summary of Findings				Plan of Action									
September													
Summary of Findings				Plan of Action									
October													
Summary of Findings				Plan of Action									
November													

Risk Management

Summary of Findings	Plan of Action
December	
Summary of Findings	Plan of Action

J. Patient Identifiers

Function: Outcome & Process Measure
Rationale: High Risk, Problem Prone
Data Source: Tracking Tool

Nursing Services

A. Critical Tests / Labs

Function: Outcome & Process Measure													
Rationale: High Risk, High Volume, Problem Prone													
Data Source: Lab reports, Patient Records													
Sample Size: All critical labs for Reporting Period													
Methodology: Audit Tool, Patient Records, PDSA													
Indicator	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Critical results with documented MD/LIP contact within 1 hour (from RN notification to provider) (Benchmark=90%)	11	27											38
Total critical results logged during reporting period	16	27											43
Percentage of Critical Lab Results Completed (Benchmark = 90%)	69%	100%	---	---	---	---	---	---	---	---	---	---	88%
January													
Summary of Findings				Plan of Action									
31% below benchmark				CCO has instructed Lab staff to call critical results to nurse. Nurse will promptly log and report results to provider. Additionally, lab staff will accompany their call with a faxed reults and request signed acknowledgment from the receiving nursing. Staff were educated on the updated process via read and sign inservice by CCO.									
February													
Summary of Findings				Plan of Action									
no remarkable findings				no action required at thsi time									
March													
Summary of Findings				Plan of Action									
April													
Summary of Findings				Plan of Action									
May													
Summary of Findings				Plan of Action									
June													
Summary of Findings				Plan of Action									
July													
Summary of Findings				Plan of Action									
August													

Nursing Services

Summary of Findings	Plan of Action
September	
Summary of Findings	Plan of Action
October	
Summary of Findings	Plan of Action
November	
Summary of Findings	Plan of Action
December	
Summary of Findings	Plan of Action
December	

B. Restraint Use

Rationale: High Risk, Problem Prone													
Data Source: Patient Records, Audit Log													
Sample Size: All episodes of restraint Use During Reporting Period													
Methodology: Patient Records, Audit Log, PDSA													
Indicator	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Number of restraint days during reporting period	0	0											0
Total patient days during reporting period	183	324	0	0	0	0	0	0	0	0	0	0	507
Rate per 1000 patient days	---	---											
January													
Summary of Findings				Plan of Action									
No restraint use in January				No action required at thsi time									
February													
Summary of Findings				Plan of Action									
No restraint use in February				No action required at thsi time									
March													
Summary of Findings				Plan of Action									
April													
Summary of Findings				Plan of Action									

Nursing Services

May	
Summary of Findings	Plan of Action
June	
Summary of Findings	Plan of Action
July	
Summary of Findings	Plan of Action
August	
Summary of Findings	Plan of Action
September	
Summary of Findings	Plan of Action
October	
Summary of Findings	Plan of Action
November	
Summary of Findings	Plan of Action
December	
Summary of Findings	Plan of Action
December	

Nursing Services

Summary of Findings	Plan of Action

C. RN Assessments

Rational: High Risk, Problem Prone													
Data Source: Patient Records													
Sample Size: Quarterly Random Sample (20 records) of Discharged Patients (Acute & SWB)													
Methodology: Patient Records, PDSA													
Inclusion Criteria: Discharged patients (Acute & Swing) during a quarterly period													
Indicators	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Total Number of RN assessments completed q24 hours	19	20											39
Total Number of assessments reviewed	19	20											39
Percent of Compliance (Benchmark = 100%)		1000	---	---	---	---	---	---	---	---	---	---	1000
January													
Summary of Findings				Plan of Action									
				No action required at this time									
February													
Summary of Findings				Plan of Action									
No remarkable findings				No action required at this time									
March													
Summary of Findings				Plan of Action									
April													
Summary of Findings				Plan of Action									
May													
Summary of Findings				Plan of Action									
June													
Summary of Findings				Plan of Action									
July													
Summary of Findings				Plan of Action									
August													
Summary of Findings				Plan of Action									

Nursing Services

September	
Summary of Findings	Plan of Action
October	
Summary of Findings	Plan of Action
November	
Summary of Findings	Plan of Action
December	
Summary of Findings	Plan of Action

ER Log & Visits

Rationale: High Risk, Problem Prone

Sample Size: All ER patients During Reporting Period

Inclusion Criteria: All ER Patients During Reporting Period

January											
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no remarkable findings	No action required at this time.
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Summary of Findings		Plan of Action
1. Findings: The audit identified several areas of concern, including inadequate documentation of internal controls, insufficient segregation of duties, and a lack of timely reconciliation of accounts. 2. Recommendations: Management is advised to implement the following corrective actions: - Enhance documentation of internal controls. - Strengthen segregation of duties to reduce the risk of error or fraud. - Establish a schedule for regular reconciliation of accounts.		1. Management Response: Management acknowledges the findings and has committed to implementing the recommended actions. 2. Timeline: The corrective actions are expected to be completed within the next six months.

NO remarkable findings	NO action required at this time.
March	

Summary of Findings	Plan of Action

[illegible]

Summary of Findings	Plan of Action
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June	
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Summary of Findings		Plan of Action
1. Findings: The audit identified several areas of concern, including inadequate documentation of internal controls, insufficient segregation of duties, and a lack of timely reconciliation of accounts. 2. Recommendations: Management is advised to implement the following corrective actions: - Enhance documentation of internal controls. - Strengthen segregation of duties to reduce the risk of errors or fraud. - Establish a schedule for regular reconciliation of accounts.		1. Management Response: Management acknowledges the findings and has committed to implementing the recommended actions. 2. Timeline: The corrective actions are expected to be completed within the next 90 days.

	August

Summary of Findings	Plan of Action
September	
Summary of Findings	Plan of Action
October	
Summary of Findings	Plan of Action
November	
Summary of Findings	Plan of Action
December	
Summary of Findings	Plan of Action

B. Medical Screening Exams

Function: Outcome & Process Measure Rationale: High Risk, Problem Prone, Compliance Data Source: Patient Records Sample Size: Quarterly Random Sample of 20 Discharged Patients Methodology: Patient Records, PDSA Inclusion Criteria: ED Records													
Indicator	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Total # of Medical Screening Exams Completed (Benchmark=100%)	20	20											40
Total # of Medical Exam Screenings Reviewed	20	20											40
Compliance Percentage (Benchmark = 100%)	100%	100%	---	---	---	---	---	---	---	---	---	---	100%
January													
Summary of Findings				Plan of Action									
No remarkable findings				No action required at this time.									
February													
Summary of Findings				Plan of Action									
no remarkable findings				No action required at this time.									
March													
Summary of Findings				Plan of Action									
April													
Summary of Findings				Plan of Action									

May	
Summary of Findings	Plan of Action
June	
Summary of Findings	Plan of Action
July	
Summary of Findings	Plan of Action
August	
Summary of Findings	Plan of Action
September	
Summary of Findings	Plan of Action
October	
Summary of Findings	Plan of Action
November	
Summary of Findings	Plan of Action
December	
Summary of Findings	Plan of Action

C. Provider ER Response Time

Function: Outcome & Process Measure Rationale: High Risk, Problem Prone, Compliance Data Source: Patient Records Sample Size: Quarterly Random Sample of 20 Discharged Patients Methodology: Patient Records, PDSA Inclusion Criteria: ED Records													
Indicator	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Total number of ER response times within 20 minutes (time of provider notification to provider arrival time)	20	20											40
Total number of ER visits reviewed	20	20											40
ER Provider Response Time (Benchmark=90%)	100%	100%	---	---	---	---	---	---	---	---	---	---	100%
January													

Summary of Findings	Plan of Action
No remarkable findings	No action required at this time.
February	
Summary of Findings	Plan of Action
No remarkable findings	No action required at this time.
March	
Summary of Findings	Plan of Action
April	
Summary of Findings	Plan of Action
May	
Summary of Findings	Plan of Action
June	
Summary of Findings	Plan of Action
July	
Summary of Findings	Plan of Action
August	
Summary of Findings	Plan of Action
September	
Summary of Findings	Plan of Action
October	
Summary of Findings	Plan of Action
November	
Summary of Findings	Plan of Action
December	
Summary of Findings	Plan of Action

D. ED RN Assessment (Initial)

Function: Outcome & Process Measure Rationale: High Risk, Problem Prone, Compliance Data Source: Patient Records

Sample Size: Quarterly Random Sample of 20 Discharged ED Patients

Methodology: Patient Records, PDSA

Inclusion Criteria: ED Records

Indicator	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Total # of ED RN assessments (Initial) completed	20	20											40
Total # of ED RN assessments reviewed	20	20											40
ED RN Assessment Percent of completion (Benchmark=100%)	100%	100%	---	---	---	---	---	---	---	---	---	---	100%

January

Summary of Findings	Plan of Action
no remarkable findings	No action required at this time.

February

Summary of Findings	Plan of Action
no remarkable findings	No action required at this time.

March

Summary of Findings	Plan of Action

April

Summary of Findings	Plan of Action

May

Summary of Findings	Plan of Action

June

Summary of Findings	Plan of Action

July

Summary of Findings	Plan of Action

August

Summary of Findings	Plan of Action

September

Summary of Findings	Plan of Action

October

Summary of Findings	Plan of Action

November

Summary of Findings	Plan of Action
December	
Summary of Findings	Plan of Action

E. ED Readmissions

Function: Outcome & Process Measure Rationale: High Risk, Problem Prone Data Source: Patient Records Sample Size: All ED Readmissions within 72 hours of discharge Methodology: Medical records, Discharge reports, PDSA Inclusion Criteria: All ED Readmissions within 72 hours of discharge													
Indicator	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
# of patients readmitted to ED within 72 hours	1	3											4
Total # of ED discharges	104	133											237
ER Re-Admits Rate per 100 patient discharges (Benchmark=2.5%)	1	2	---	---	---	---	---	---	---	---	---	---	2
January													
Summary of Findings				Plan of Action									
1 readmit to acute: Patient was admitted to acute care on 1-3-20 with CHF, COPD exacerbation and shortness of breath. She was started on IV Rocephin and Zithromax for CXR that showed mediastinal opacity. Neb treatments were ordered routinely. She received DVT and stress ulcer prophylaxis and has improved. She has no dyspnea with exertion and on room air is oxygenating at 95%. She insists she go home, though it was suggested a few more days of IV antibiotics would be beneficial, and sputum culture results would be available. She states she has family that will be staying with her and she 'really needs' to go home.				no action required at this time.									
February													
Summary of Findings				Plan of Action									

3 patients readmitted to ER within 72 hours. 1) First admission patient c/o n/v. NS bolus given in ER and phenergan given for home use. When patient came back within 24 hours was for c/o heart palpitations. Provider determined from phenergan use and patient was told to stop using the phenergan. 2) first admission was for laceration to left long finger and pinky. Laceration repair done with Dermabond and Steri-Strips. Patient came back within 24 hours due to a Steri-Strip falling off and then proceeding to remove the rest of the Steri-strips. Laceration repair done again with Dermabond and Steri-Strips and covered with bandage. 3) First admssion with c/o anxiety and out of medications until appointment in three days with PCP. Ativan given and patient discharged. Patient returned within 48 hours with same c/o. Ativan given. Patient stated had appointment with PCP the following day for medication refills.	No action required at this time.
March	
Summary of Findings	Plan of Action
April	
Summary of Findings	Plan of Action
May	
Summary of Findings	Plan of Action
June	
Summary of Findings	Plan of Action
July	
Summary of Findings	Plan of Action
August	
Summary of Findings	Plan of Action
September	
Summary of Findings	Plan of Action
October	
Summary of Findings	Plan of Action
November	
Summary of Findings	Plan of Action

[illegible]

F. EMTALA Transfer Form

Function: Outcome & Process Measure													
Rationale: High Risk, Problem Prone													
Data Source: Patient Records													
Sample Size: All ED Transfers													
Methodology: Medical records, Discharge reports, PDSA													
Inclusion Criteria: All patients transferred from ED													
Indicator	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
# of patients with EMTALA Transfer Form Completed	n/a	n/a											0
Total # of ED discharge reviews													0
ER Re-Admits Rate per 100 patient discharges (Benchmark = 100%)	#####	#####	---	---	---	---	---	---	---	---	---	---	---
January													
Summary of Findings				Plan of Action									
Corporate is working towards getting us the correct EMTALA paperwork for													
February													
Summary of Findings				Plan of Action									
March													
Summary of Findings				Plan of Action									
April													
Summary of Findings				Plan of Action									
May													
Summary of Findings				Plan of Action									
June													
Summary of Findings				Plan of Action									
July													
Summary of Findings				Plan of Action									
August													

Summary of Findings	Plan of Action
September	
Summary of Findings	Plan of Action
October	
Summary of Findings	Plan of Action
November	
Summary of Findings	Plan of Action
December	
Summary of Findings	Plan of Action

G. ED Transfers

Function: Outcome & Process Measure Rationale: High Risk, Problem Prone Sample Size: All acute transfers from ED to tertiary facility Methodology: Medical records, Discharge reports, ED Log, PDSA Inclusion Criteria: All ED transfers from ED to tertiary facility													
Indicator	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
# of ED patients transferred to tertiary facility	7	10											17
January													
Summary of Findings							Plan of Action						
7 ER Transfers: 1) Patient had elevated troponin, obstructive uropathy, AKI vs CRF vs acute on chronic renal failure, severe bilateral hydronephrosis, metabolic acidosis, anemia, UTI, hyperphosphatemia. 2) Patient had dizziness, bradycardia, patient transferred for pacemaker placement per cardiologist Dr. Chanrda 3) 8 yr old with a dog bit to the face with avulsion injury, Transferred to OU Children's 4) Patient had hypovolemic shock with endoorgan dysfunction, large abdominal wall hematoma s/p AAA surgery on 1/11/21, anemia. 5) Patient had hypoxia, CHF exacerbation, large right pleural effusion, A-fib 6) Patient had RLQ abdominal pain, RLQ abdominal Spigelian hernia with possible obstruction, probable incarcerated hernia 7) Patient has minimally displaced subcapital right femoral neck fracture s/p fall, syncope, bilateral pleural effusions and right basilar opacity							Continue operations at capacities appropriate for this CAH.						
February													
Summary of Findings							Plan of Action						

10 ER Transfers: 1. Patient presented with rhabdomyolysis and acute respiratory failure. 2. Presented with acute thrombotic stroke and right hemiparesis. 3. Presented with left sided weakness and noted NSTEMI on EKG. 4. Presented with right subdural hematoma with midline shift secondary to head injury with LOC. 5. Presented with right hip fracture. 6. Presented with RLQ pain, Right ovarian cyst, possible intermittent Right ovarian Torsion. 7. Presented with left femoral neck fracture. 8. Presented with Covid + and Shortness of Breath. 9. Presented with UTI, Nephrolithiasis, and Sepsis. 10. Presented with Exacerbation of COPD and AKI.	1) Higher level of care needed. 2) Higher level of care needed. 3) Higher level of care needed. 4) Higher level of care needed. 5) Surgical repair needed. 6) Higher level of care needed. 7) Surgical repair needed. 8) Inability to keep at facility due to inability to heat Covid rooms at time of presentation. 9) Higher level of care needed. 10) Inability to keep at facility due to inability to heat Covid rooms at time of presentation. Continue operations at capacities appropriate for this CAH
March	
Summary of Findings	Plan of Action
April	
Summary of Findings	Plan of Action
May	
Summary of Findings	Plan of Action
June	
Summary of Findings	Plan of Action
July	
Summary of Findings	Plan of Action
August	
Summary of Findings	Plan of Action
September	
Summary of Findings	Plan of Action
October	
Summary of Findings	Plan of Action
November	
Summary of Findings	Plan of Action
December	
Summary of Findings	Plan of Action

H. Stroke Care

Stroke Care													
Function: Outcome & Process Measure													
Rationale: High Risk, Problem Prone													
Sample Size: All stroke alerts during reporting period													
Methodology: Medical records, Discharge reports, ED Log, PDSA													
Inclusion Criteria: All stroke alerts during reporting period													
Indicator	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Stroke Log Completed	0%	%											0%
Door to EMS/Air Evac Notification < 15 Minutes	0	0											0
Total # of Stroke Alerts	0	2											2
Percentage of Compliance (Benchmark = 80%)	---	---	---	---	---	---	---	---	---	---	---	---	---
Door to Patient Transfer < 60 minutes	0	0											0
Total # of Stroke Alerts	0	2											2
Percentage of Compliance (Benchmark = 80%)	---	---	---	---	---	---	---	---	---	---	---	---	---
Door to Provider Evaluation < 15 minutes	0	2											2
Total # of Stroke Alerts	0	2											2
Percentage of Compliance (Benchmark = 80%)	---	100%	---	---	---	---	---	---	---	---	---	---	100%
Door to Stroke Center Notification < 20 minutes	0	0											0
Total # of Stroke Alerts	0	2											2
Percentage of Compliance (Benchmark = 80%)	---	---	---	---	---	---	---	---	---	---	---	---	---
Vital Signs Documented Every 15 minutes	0	1											1
Total # of Stroke Alerts	0	2											2
Percentage of Compliance (Benchmark = 80%)	---	50%	---	---	---	---	---	---	---	---	---	---	50%
Neurological Checks Documented Every 15 minutes	0	0											0
Total # of Stroke Alerts	0	2											2
Percentage of Compliance (Benchmark = 80%)	---	---	---	---	---	---	---	---	---	---	---	---	---
Total # of Stroke Patients	0	2											2
Total # of Acute Stroke Patients	0	2											2
Total # of Stroke Patients Eligible for Thrombolytics	0	1											1
January													
Summary of Findings				Plan of Action									
No strokes noted for January				No action required at this time.									
February													

Summary of Findings	Plan of Action
1. No TPA in building. Vital signs and neuro checks not done every 15 minutes until stable. Inclement weather and pandemic (lack of bed) delayed transport. 2. No clinical signs for TPA. No neuro checks noted every 15 minutes until stable. Inclement weather and pandemic (lack of beds) delayed transport. (Wasn't this patient admitted?) This patient was not admitted, but was tranfered to a higher level of care.	Continue operations at capacities for this CAH. No other action required at this time. ER RN's re-educated on stroke protocols for vital signs and neuro checks.
March	
Summary of Findings	Plan of Action
April	
Summary of Findings	Plan of Action
May	
Summary of Findings	Plan of Action
June	
Summary of Findings	Plan of Action
July	
Summary of Findings	Plan of Action
August	
Summary of Findings	Plan of Action
September	
Summary of Findings	Plan of Action
October	
Summary of Findings	Plan of Action
November	
Summary of Findings	Plan of Action
December	
Summary of Findings	Plan of Action

I. Suicide Management

Function: Outcome & Process Measure

Rationale: High Risk, Problem Prone

Sample Size: All ED patients during reporting period

Methodology: Medical records, Discharge reports, ED Log, PDSA

Inclusion Criteria: All patients with suicidal/homicidal ideations, suicide attempt, self-harming behaviors, intentional overdose, etc.

	Indicator	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
1	Total # of Suicide Screenings Documented on Admission/Triage	2	2											4
	Total # of Suicide Screenings Required	2	2											4
	Percentage of Compliance (Benchmark = 80%)	100%	100%	---	---	---	---	---	---	---	---	---	---	100%
2	Completion of Environmental Patient Safety Checklist	2	1											3
	Total # of Environmental Patient Safety Checklists Required	2	2											4
	Percentage of Compliance (Benchmark = 80%)	100%	50%	---	---	---	---	---	---	---	---	---	---	75%

January

Summary of Findings	Plan of Action
1. Patient presented on 1/13 w/suicidal ideations. QM can not find Psych paperwork in the chart. Patient came in with thoughts of self harm, depression and anxiety. Patient was told by Red Rock to come in and get an eval. Patient was triaged and evaluated. Had virtual meeting with Red Rock. Patient was transferred from ED to Red Rock facility by MPD. 2. Patient presented on 1/12 w/chronic depression and auditory hallucinations. Patient wanted to be transfereed to Red Rock. Patient was triaged and evaluated. Had virtual meeting with Red Rock. Patient was transferred from ED to Red Rock facility by MPD	QM spoke with CCO and QA Nurse about not being able to find Psych paperwork. QA Nurse is reassessing the chart. CCO will re-educate the RN involved in the care of that patient about Psyc paperwork that is required to be done.

February

Summary of Findings	Plan of Action
1. Patient presented on 2/17 with thoughts of self harm. Patient was triaged and evaluated. Red Rock held virtual meeting with patient and safety plan was implemented. Patient allowed to discharge home with safety plan. No ED psych paper work noted. 2. Patient presented on 2/24 with suicidal ideations. Patient was triaged and evaluated. Patient had virtual meeting with Red Rock Crisis team and crisis plan/safety plan was implemented. Patient was allowed to discharge home with parents with crisis/safety plan.	ER RN re-educated on Psych paperwork that is required for such patients.

March

Summary of Findings	Plan of Action
April	
Summary of Findings	Plan of Action
May	
Summary of Findings	Plan of Action
June	
Summary of Findings	Plan of Action
July	
Summary of Findings	Plan of Action
August	
Summary of Findings	Plan of Action
September	
Summary of Findings	Plan of Action
October	
Summary of Findings	Plan of Action
November	
Summary of Findings	Plan of Action
December	
Summary of Findings	Plan of Action

J. Triage

[illegible]

Percentage of Compliance (Benchmark = 85%)	100%	100%	---	---	---	---	---	---	---	---	---	---	100%
January													
Summary of Findings				Plan of Action									
				No action required at this time									
February													
Summary of Findings				Plan of Action									
No remarkable findings				No action required at this time									
March													
Summary of Findings				Plan of Action									
April													
Summary of Findings				Plan of Action									
May													
Summary of Findings				Plan of Action									
June													
Summary of Findings				Plan of Action									
July													
Summary of Findings				Plan of Action									
August													
Summary of Findings				Plan of Action									
September													
Summary of Findings				Plan of Action									
October													
Summary of Findings				Plan of Action									
November													
Summary of Findings				Plan of Action									
December													
Summary of Findings				Plan of Action									
				No action required at this time									

K. STEMI Care

Function: Outcome & Process Measure													
Rationale: High Risk, Problem Prone													
Sample Size: All cardiac patients during reporting period													
Methodology: Medical records, Discharge reports, ED Log, PDSA													
Inclusion Criteria: All patients reporting chest pain, chest discomfort or other symptoms based on ECG screening criteria													
Indicator	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Door to ECG < 5 Minutes Met	0	1											2
Total # of Cardiac Patients	0	1											2
Percentage of Compliance (Benchmark = 80%)	100%	---	---	---	---	---	---	---	---	---	---	---	100%
Door to Provider Evaluation < 15 minutes	0	1											2
Total # of Cardiac Patients	0	1											2
Percentage of Compliance (Benchmark = 80%)	100%	---	---	---	---	---	---	---	---	---	---	---	100%
Door to Chest X-ray < 30 minutes	0	1											0
Total # of Cardiac Patients	0	1											2
Percentage of Compliance (Benchmark = 80%)	---	---	---	---	---	---	---	---	---	---	---	---	---
Door to EMS/Air Evacuation Notification < 20 minutes	0	0											0
Total # of Cardiac Patients	0	1											2
Percentage of Compliance (Benchmark = 80%)	---	---	---	---	---	---	---	---	---	---	---	---	---
Door to Patient Transfer < 60 minutes	0	0											0
Total # of Cardiac Patients	0	1											2
Percentage of Compliance (Benchmark = 80%)	---	---	---	---	---	---	---	---	---	---	---	---	---
Door to Fibrinolytic Therapy < 30 minutes	0	0											0
Total # of Cardiac Patients	0	1											2
Percentage of Compliance (Benchmark = 80%)	---	---	---	---	---	---	---	---	---	---	---	---	---
January													
Summary of Findings				Plan of Action									
No STEMI/NSTEMI noted for January				No action required at this time									
February													
Summary of Findings				Plan of Action									

One patient noted for reporting period. 1) Patient presented to ER with Stroke like symptoms. Upon evaluation during ER visit, it was noted patient had a NSTEMI per EKG. Patient was delayed transfer due to inclement weather and pandemic (lack of beds). Thrombolytic therapy was not indicated for patient.	CCO re-educated ED RN on cardiac protocols. DATE??? Continue operating capacities for this CAH. No action required at this time.
March	
Summary of Findings	Plan of Action
April	
Summary of Findings	Plan of Action
May	
Summary of Findings	Plan of Action
June	
Summary of Findings	Plan of Action
July	
Summary of Findings	Plan of Action
August	
Summary of Findings	Plan of Action
September	
Summary of Findings	Plan of Action
October	
Summary of Findings	Plan of Action
November	
Summary of Findings	Plan of Action
December	
Summary of Findings	Plan of Action

I. ED Nursing Assessment (Discharge/Transfer)

Inclusion Criteria: All ED patients

Summary of Findings	Plan of Action
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November	
Summary of Findings	Plan of Action
December	
Summary of Findings	Plan of Action

Pharmacy and Medication Safety

A. Pharmacy Utilization

Drug Costs	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Total Drug Costs for reporting month	\$9,525	\$18,552											\$28,078
High Cost Medications (Medications that cost more than \$100 per dose)	\$709.92	4177.88											4888
January													
Summary of Findings				Plan of Action									
High Cost Medications: \$709.92 (Advair, Santyl, Cathflo); Antibiotics: \$817.19; Radiology: \$1383.87 (Optiray); Vaccines: \$832.07 (Adacel, Tubersol); COVID-19 Meds: \$131.24 (ProAir)													
February													
Summary of Findings				Plan of Action									
High Cost Medications: \$4177.88 (Symbicort, Lantus, Combivent); Antibiotics: \$2057.90; Vaccines: \$243.85 (Adacel); Nutrition/IV fluids: \$2721.42; COVID-19 Medications: \$2243.25 (Combivent inhalers)													
March													
Summary of Findings				Plan of Action									
April													
Summary of Findings				Plan of Action									
May													
Summary of Findings				Plan of Action									
June													
Summary of Findings				Plan of Action									
July													
Summary of Findings				Plan of Action									
August													
Summary of Findings				Plan of Action									
September													
Summary of Findings				Plan of Action									
October													

Pharmacy and Medication Safety

Summary of Findings	Plan of Action
November	
Summary of Findings	Plan of Action
December	
Summary of Findings	Plan of Action

B. After Hours Access

Rationale: High Risk, Problem Prone

Data Source: Med Dispense & Patient Records

Sample Size: All After Access Hours Occurrences

Methodology: Pharmacy Logs, PDSA

Quality Control Monitoring	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Total # of after hours access to pharmacy for narcotics	0	0											0
Total # of after hours access to pharmacy for narcotics (Benchmark = < 50)	104	133											237
January													
Summary of Findings				Plan of Action									
DR accessed 104 times: 41 times for refrigerated medications; 11 times for ER patient medications; 3 times to restock RT box; 25 times for IV fluids not stocked in MedDispense; 4 times for inhalers/topicals that are kept in DR to capture charges; 1 time for a vaccine; 1 time for Bamlanivimab therapy; 5 times to restock MedDispense; and 12 times for no need when medications were actually in MedDispense				Refrigerator and MedDispense locking system has been purchased for nursing station. Awaiting installation. Will dramatically decrease the amount of times DR is accessed after hours. We still are looking at options for adding additional automated dispensing systems to increase storage capabilities at the nursing station.									
February													
Summary of Findings				Plan of Action									
Dr accessed 133 times: 3 times for refrigerated medications; 21 times for inhalers/topicals that are kept in DR to capture charges; 12 times for ER patient medications; 7 times for bulk medications; 5 times for vaccines; 31 times for IV fluids not stocked in MedDispense; 13 times to restock RT box; 5 times for Remdesivir or other COVID-19 medications; 9 times to restock MedDispense; and 22 times for no need when medications actually stocked in MedDispense.				Refrigerator and MedDispense locking system has been purchased for nursing station. Awaiting installation. Will dramatically decrease the amount of times DR is accessed after hours. We still are looking at options for adding additional automated dispensing systems to increase storage capabilities at the nursing station.									
March													
Summary of Findings				Plan of Action									

Pharmacy and Medication Safety

April	
Summary of Findings	Plan of Action
May	
Summary of Findings	Plan of Action
June	
Summary of Findings	Plan of Action
July	
Summary of Findings	Plan of Action
August	
Summary of Findings	Plan of Action
September	
Summary of Findings	Plan of Action
October	
Summary of Findings	Plan of Action
November	
Summary of Findings	Plan of Action
December	
Summary of Findings	Plan of Action

C. Adverse Drug Reactions

Definition per The American Society of Health-System Pharmacists (ASHP):

"Any unexpected, unintended, undesired, or excessive response to a drug that: 1) requires discontinuing the drug (therapeutic or diagnostic) 2) requires changing the drug therapy 3) requires modifying the dose (except for minor dose adjustments) 4) necessitates hospital admission 5) prolongs stay in a health care facility 6) necessitates supportive 7) significantly complicates diagnosis 8) negatively affects prognosis 9) results in temporary or permanent harm, disability, or death 10) an allergic reaction (an immunologic hypersensitivity occurring as the result of unusual sensitivity to a drug) and idiosyncratic reaction (an abnormal susceptibility to a drug that is peculiar to the individual)"

Function: Outcome & Process Measure

Rationale: High Risk, High Volume, Problem Prone

Data Source: Patient Records, Incident Reports

Sample Size: All Incidences with a Reported/Suspected ADR During Reporting Period

Methodology: Patient Records, Incident Reports, PDSA

Pharmacy and Medication Safety

Indicator	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
# of medication doses that elicited adverse drug reaction	0	0											0
# of medication doses dispensed from pharmacy during reporting period	5,874	TBD											5874
ADR Rate per 1000 medications dispensed	---	---	---	---	---	---	---	---	---	---	---	---	---
January													

Respiratory Care Services

A. Ventilator Days

Function: Process Measure														
Rationale: High Risk, Problem Prone														
Data Source: Patient Records														
Sample Size: All Inhouse Ventilator Patients During Reporting Period														
Methodology: Patient Records, PDSA														
Inclusion Criteria: All Inhouse Ventilator Patients During Reporting Period														
Indicator	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD	
Total Ventilator Days	0	10											10	
January														
Summary of Findings				Plan of Action										
Benchmark met				No action required										
February														
Summary of Findings				Plan of Action										
Benchmark met				No action required										
March														
Summary of Findings				Plan of Action										
April														
Summary of Findings				Plan of Action										
May														
Summary of Findings				Plan of Action										
June														
Summary of Findings				Plan of Action										
July														
Summary of Findings				Plan of Action										
August														
Summary of Findings				Plan of Action										
September														
Summary of Findings				Plan of Action										
October														
Summary of Findings				Plan of Action										

Respiratory Care Services

November	
Summary of Findings	Plan of Action
December	
Summary of Findings	Plan of Action
December	
Summary of Findings	Plan of Action

B. Ventilator Wean

Rationale: High Risk, Problem Prone													
Data Source: Patient Records													
Sample Size: All Inhouse Ventilator Patients On Weaning Program													
Methodology: Patient Records, PDSA													
Inclusion Criteria: All Inhouse Ventilator Patients On Weaning Program													
Indicator	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
# of patients on a ventilator at least 7 days, in the weaning program and weaned from the ventilator at least 2 days prior to discharge and at time of discharge	0	0											0
# of ventilator patients discharged during the reporting month that had a physician order to wean, were on a vent > 7 days, and were NOT a terminal wean.	0	0											0
Percent of discharged patients successfully weaned from the ventilator prior to discharge	---	---	---	---	---	---	---	---	---	---	---	---	---
January													
Summary of Findings				Plan of Action									
Benchmark met				No action required									
February													
Summary of Findings				Plan of Action									
Benchmark met				No action required									
March													
Summary of Findings				Plan of Action									
April													
Summary of Findings				Plan of Action									

Respiratory Care Services

May	
Summary of Findings	Plan of Action
June	
Summary of Findings	Plan of Action
July	
Summary of Findings	Plan of Action
August	
Summary of Findings	Plan of Action
September	
Summary of Findings	Plan of Action
October	
Summary of Findings	Plan of Action
November	
Summary of Findings	Plan of Action
December	
Summary of Findings	Plan of Action

C. Unplanned Trach Decannulations

Rationale: High Risk, Problem Prone													
Data Source: Patient Records, Incident Reports													
Sample Size: All Patients with Unplanned Trach Decannulations													
Methodology: Patient Records, Incident Reports, PDSA													
Inclusion Criteria: All Patients with Unplanned Trach Decannulations													
Indicator	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Total Number of Unplanned Patient Decannulations	0	0											0
Total Trach Days	0	10											10
Self Decannulation Rate per 1000 Trach Days	#DIV/0!	0	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	0.0
January													
Summary of Findings					Plan of Action								

Respiratory Care Services

Benchmark met	No action required
February	
Summary of Findings	Plan of Action
Benchmark met	No action required
March	
Summary of Findings	Plan of Action
April	
Summary of Findings	Plan of Action
May	
Summary of Findings	Plan of Action
June	
Summary of Findings	Plan of Action
July	
Summary of Findings	Plan of Action
August	
Summary of Findings	Plan of Action
September	
Summary of Findings	Plan of Action
October	
Summary of Findings	Plan of Action
November	
Summary of Findings	Plan of Action
December	
Summary of Findings	Plan of Action

D. Respiratory Care Equipment

Rationale: High Risk, Problem Prone

Data Source: Patient Records, Log

Respiratory Care Services

Sample Size: All Patients with Respiratory Care Equipment

Methodology: Patient Records, Log, PDSA

(Benchmark = 100%)

Inclusion Criteria: All Patients with Respiratory Care Equipment

Indicator	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
HME's Changed Every Shift & PRN	0	3											3
Total Due To Change	0	3											3
Percentage of Compliance	---	100%	---	---	---	---	---	---	---	---	---	---	100%
Inner Cannulas Changed Every Shift & PRN	0	19											19
Total Due To Change	0	19											19
Percentage of Compliance	---	100%	---	---	---	---	---	---	---	---	---	---	100%
Suction Set-Ups Changed Every 7 Days & PRN	0	1											1
Total Due To Change	0	1											1
Percentage of Compliance	---	100%	---	---	---	---	---	---	---	---	---	---	100%
Nebulizer & Masks Changed Every 7 Days & PRN	10	21											31
Total Due To Change	10	21											31
Percentage of Compliance	100%	100%	---	---	---	---	---	---	---	---	---	---	100%
Trach Collars & Tubing Changed Every 7 Days & PRN	0	2											2
Total Due To Change	0	2											2
Percentage of Compliance	---	100%	---	---	---	---	---	---	---	---	---	---	100%
Vent Circuits Changed Every 30 Days & PRN	0	0											0
Total Due To Change	0	0											0
Percentage of Compliance	---	---	---	---	---	---	---	---	---	---	---	---	---
Trach Changed Every 30 Days & PRN	0	0											0
Total Due To Change	0	0											0
Percentage of Compliance	---	---	---	---	---	---	---	---	---	---	---	---	---
Closed Suction Kits Changed Every 3 Days & PRN	0	3											3
Total Due To Change	0	3											3
Percentage of Compliance	---	100%	---	---	---	---	---	---	---	---	---	---	100%

January

Summary of Findings	Plan of Action
Benchmark met	No action required

February

Summary of Findings	Plan of Action
Benchmark met	No action required

March

Summary of Findings	Plan of Action

April

Summary of Findings	Plan of Action

Respiratory Care Services

May	
Summary of Findings	Plan of Action
June	
Summary of Findings	Plan of Action
July	
Summary of Findings	Plan of Action
August	
Summary of Findings	Plan of Action
September	
Summary of Findings	Plan of Action
October	
Summary of Findings	Plan of Action
November	
Summary of Findings	Plan of Action
December	
Summary of Findings	Plan of Action

Wound Care

A. Development of Pressure Ulcers

Function: Outcome & Process Measure Rationale: High Risk, Problem Prone Data Source: Patient Records Sample Size: All Patients who Develop a Stage II PU or > Methodology: Patient Records, Incident Reports, PDSA Inclusion Criteria: All Patients who Develop a Stage II PU or > Exclusion Criteria: Kennedy Ulcers Formula: All patients who develop Stage II PU or > (Count on Discharge)/Total # of Discharges for the Month													
Indicator	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
# of patients that develop hospital acquired pressure ulcers during the stay: Stage II or higher, including eschar	0	0											0
Total number of patients discharged during the reporting period	19	10											29
Percent of patients developing 1 or more pressure ulcers during reporting period (Benchmark = 2% or less)	0%	0%	---	---	---	---	---	---	---	---	---	---	0%
January													
Summary of Findings				Plan of Action									
N/A				N/A									
February													
Summary of Findings				Plan of Action									
N/A				N/A									
March													
Summary of Findings				Plan of Action									
April													
Summary of Findings				Plan of Action									
May													
Summary of Findings				Plan of Action									
June													
Summary of Findings				Plan of Action									
July													
Summary of Findings				Plan of Action									
August													
Summary of Findings				Plan of Action									
September													

Wound Care

Summary of Findings	Plan of Action
October	
Summary of Findings	Plan of Action
November	
Summary of Findings	Plan of Action
December	
Summary of Findings	Plan of Action

B. Wound Healing Rate

Rationale: High Risk, Problem Prone

Data Source: Patient Records

Sample Size: All Discharged Patients Receiving Wound Care for PU During Reporting Period

Methodology: Patient Records, PDSA

Formula: Total sum of admission wound scores minus total sum of discharged wound scores

# of wounds that showed improvement	1	0											1
# of total wounds	1	0											1
Wound Healing Rate	100%	---	---	---	---	---	---	---	---	---	---	---	100.0%

January	
Summary of Findings	Plan of Action
1 patient discharged with a PU and her wound showed improvement	N/A
February	
Summary of Findings	Plan of Action
No patient discharged with PU's for the month of February	N/A
March	
Summary of Findings	Plan of Action
April	
Summary of Findings	Plan of Action
May	
Summary of Findings	Plan of Action
June	
Summary of Findings	Plan of Action
July	
Summary of Findings	Plan of Action

Wound Care

August	
Summary of Findings	Plan of Action
September	
Summary of Findings	Plan of Action
October	
Summary of Findings	Plan of Action
November	
Summary of Findings	Plan of Action
December	
Summary of Findings	Plan of Action

C. Wound Care Documentation

Function: Outcome & Process Measure													
Rationale: High Risk, Problem Prone													
Data Source: Patient Records													
Indicators	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
# of Initial wound patients with assessment/pictures completed within 24 hours of admission	2	3											5
# of wound care patients admitted during the reporting period	2	3											5
Total of Completed Wound Care Admission Assessments/Pictures (Benchmark=95%)	100%	100%	---	---	---	---	---	---	---	---	---	---	100%
# of discharged wound patients with assessment/pictures completed at discharge	3	1											4
# of wound care patients discharged during the reporting period	3	1											4
Total of Completed Wound Care Discharge Assessments/Pictures (Benchmark=95%)	100%	100%	---	---	---	---	---	---	---	---	---	---	100%
January													
Summary of Findings				Plan of Action									
N/A				N/A									
February													
Summary of Findings				Plan of Action									
N/A				N/A									
March													
Summary of Findings				Plan of Action									

Wound Care

April	
Summary of Findings	Plan of Action
May	
Summary of Findings	Plan of Action
June	
Summary of Findings	Plan of Action
July	
Summary of Findings	Plan of Action
August	
Summary of Findings	Plan of Action
September	
Summary of Findings	Plan of Action
October	
Summary of Findings	Plan of Action
November	
Summary of Findings	Plan of Action
December	
Summary of Findings	Plan of Action

D. Wound Debridement/Wound Procedures

Medical Wound Debridement/Wound Procedures	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
# of patients with consents completed prior to the procedure	1	3											4
# of patients with wound debridement's/wound procedures performed during reporting period	1	3											4
Percent of patients receiving documented informed consent (Benchmark=100%)	100%	100%	---	---	---	---	---	---	---	---	---	---	100%
Total number of debridements	3	8											11
January													
Summary of Findings	Plan of Action												

Wound Care

N/A	None
February	
Summary of Findings	Plan of Action
N/A	N/A
March	
Summary of Findings	Plan of Action
April	
Summary of Findings	Plan of Action
May	
Summary of Findings	Plan of Action
June	
Summary of Findings	Plan of Action
July	
Summary of Findings	Plan of Action
August	
Summary of Findings	Plan of Action
September	
Summary of Findings	Plan of Action
October	
Summary of Findings	Plan of Action
November	
Summary of Findings	Plan of Action
December	
Summary of Findings	Plan of Action

E. Wound Vac Application**Function: Outcome & Process Measure****Rationale: High Risk, Problem Prone****Data Source: Patient Records****Sample Size: All Discharged Patients Receiving Wound Vac Treatment During Reporting Period****Methodology: Patient Records, PDSA**

Wound Care

Indicators	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
# of consents completed prior to application of first wound vac	1	0											1
# of patients initiating wound vac therapy during the reporting period	1	0											1
Percent of patients receiving consent for wound vac intervention prior to first treatment (Benchmark=100%)	100%	---	---	---	---	---	---	---	---	---	---	---	100%
January													
Summary of Findings				Plan of Action									
Only 1 patient had a wound vac for January and consent was signed				N/A									
February													
Summary of Findings				Plan of Action									
N/A				N/A									
March													
Summary of Findings				Plan of Action									
April													
Summary of Findings				Plan of Action									
May													
Summary of Findings				Plan of Action									
June													
Summary of Findings				Plan of Action									
July													
Summary of Findings				Plan of Action									
August													
Summary of Findings				Plan of Action									
September													
Summary of Findings				Plan of Action									
October													
Summary of Findings				Plan of Action									
November													
Summary of Findings				Plan of Action									
December													

Wound Care

Summary of Findings	Plan of Action

Radiology/Imaging Services

A. Radiology Films

Function: Outcome & Process Measure													
Rationale: High Risk, High Volume, Problem Prone													
Data Source: Patient Records													
Sample Size: All Radiology Performed During Reporting Period													
Methodology: Patient Records, PDSA													
Inclusion Criteria: All Radiology Reports Performed During Reporting Period													
Indicators	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Number of films repeated	5	9											14
Total Number of films completed	103	149											252
Percentage of films repeated	5%	6%	---	---	---	---	---	---	---	---	---	---	6%
Poor preparation	1	0											1
Technical Error	4	9											13
Equipment Failure	0	0											0
January													
Summary of Findings				Plan of Action									
Did not make sure the bucky and tube were lined up, There was patient motion. The tech				No action needed.									
February													
Summary of Findings				Plan of Action									
Clipped anatomy in some, the technique was incorrect in the others.				no action needed.									
March													
Summary of Findings				Plan of Action									
April													
Summary of Findings				Plan of Action									
May													
Summary of Findings				Plan of Action									
June													
Summary of Findings				Plan of Action									
July													
Summary of Findings				Plan of Action									
August													
Summary of Findings				Plan of Action									

Radiology/Imaging Services

September	
Summary of Findings	Plan of Action
October	
Summary of Findings	Plan of Action
November	
Summary of Findings	Plan of Action
December	
Summary of Findings	Plan of Action

Imaging

Function

Rationale: High Risk, High Volume, Problem Prone

Rationale: High Risk, High Volume, Problem Prone

Data Source: Patient Records

Sample Size: All CT Imaging Performed During Reporting Period

Methodology: Patient Records, PDSA

Inclusion Criteria: All CT Imaging Performed During Reporting Period

January	
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	
11	
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13	
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15	
16	
17	
18	
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20	
21	
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23	
24	
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26	
27	
28	
29	
30	
31	

Summary of Findings

Plan of Action

no action needed.

Summary of Findings

Plan of Action

No action needed.

[illegible]

Plan of Action

Summary of Findings

Plan of Action

Summary of Findings

Plan of Action

Summary of Findings

Plan of Action

Radiology/Imaging Services

Summary of Findings	Plan of Action
August	
Summary of Findings	Plan of Action
September	
Summary of Findings	Plan of Action
October	
Summary of Findings	Plan of Action
November	
Summary of Findings	Plan of Action
December	
Summary of Findings	Plan of Action

Radiology/Imaging Services

C. Radiation Dosimeter Report

Function: Outcome Measure													
Rationale: Safety & Compliance													
Data Source: Dosimeter Reports (Quarterly Report)													
Sample Size: All Radiology Personnel													
Methodology: Dosimeter Reports, PDSA													
Inclusion Criteria: All Radiology Personnel													
Indicators	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Total Number of Radiology Personnel Monitored	6	6											12
Total Number of Radiology Personnel	6	6											12
Percentage of Compliant Personnel	100%	100%	---	---	---	---	---	---	---	---	---	---	100%
Total Number of Radiology Personnel with out of range results	0	0											0
Total Number of Radiology Personnel	6	6											12
Percentage of out of range Personnel	0%	0%	---	---	---	---	---	---	---	---	---	---	---
January													
Summary of Findings				Plan of Action									
Reports come in quarterly. All techs within range.				No action needed.									
February													
Summary of Findings				Plan of Action									
Reports were received this month. All techs within range.				No action needed.									
March													
Summary of Findings				Plan of Action									
April													
Summary of Findings				Plan of Action									
May													
Summary of Findings				Plan of Action									
June													
Summary of Findings				Plan of Action									
July													
Summary of Findings				Plan of Action									
August													

Radiology/Imaging Services

Summary of Findings	Plan of Action
September	
Summary of Findings	Plan of Action
October	
Summary of Findings	Plan of Action
November	
Summary of Findings	Plan of Action
December	
Summary of Findings	Plan of Action

D. Physicist's Report

Function: Outcome Measure														
Rationale: Safety & Compliance														
Data Source: Physicist Report														
Methodology: Physicist Report, PDSA														
Indicators	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD	
Physicist Report Completed	X	X	X	X	X	X							0	

Laboratory

A. Lab Reports

Function: Outcome & Process Measure													
Rationale: High Risk, High Volume, Problem Prone													
Data Source: Lab Reports													
Sample Size: All Lab Reports Performed During Reporting Period													
Methodology: Lab Reports, PDSA													
Inclusion Criteria: All Lab Reports Performed During Reporting Period													
Indicators	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Number of labs repeated or rejected	2	1											3
Total Number of labs completed	2140	2286											4426
Percentage of labs repeated	0%	0%	---	---	---	---	---	---	---	---	---	---	0%
Processing Specimen Error	2	1											3
Specimen Collection Procedure/Technique Error	0	0											0
Equipment Failure	0	0											0
Specimen Identification Error	0	1											1
January													
Summary of Findings				Plan of Action									
2 specimens from the nursing home was misplaced when brought in from the nursing home				Lab tech contacted the nursing home and had the patients specimens resent and the correction for the problem had been established, when the specimens are checked in at the laboratory the specimens are ran by the tech that is in that department that day. Instead of several different techs handling the specimens.									
February													
Summary of Findings				Plan of Action									
Sputum specimen recieved in laboratory with wrong label and the laboratory notified Respiratory Therapy about the mistake and Respiratory came to lab and labeled the specimen with the correct label the resspiratory therapist was the person that had collected the specimen and was certain that the specimen was collected from the patient				The respiratory stated that they would make sure the correct label would be applied before the specimen was collected.									
March													
Summary of Findings				Plan of Action									
April													
Summary of Findings				Plan of Action									
May													
Summary of Findings				Plan of Action									
June													
Summary of Findings				Plan of Action									
July													
Summary of Findings				Plan of Action									

August	
Summary of Findings	Plan of Action
September	
Summary of Findings	Plan of Action
October	
Summary of Findings	Plan of Action
November	
Summary of Findings	Plan of Action
December	
Summary of Findings	Plan of Action

Function: Outcome & Process Measure														
Rationale: High Risk, High Volume, Problem Prone														
Data Source: Lab Reports														
Sample Size: All Blood Culture Lab Reports Performed During Reporting Period														
Methodology: Lab Reports, PDSA														
Inclusion Criteria: All Blood Culture Lab Reports Performed During Reporting Period														
Indicators	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD	
Number of contaminated blood cultures	0	0											0	
Total number of blood cultures obtained	18	34											52	
Percentage of contaminated blood cultures	0%	---	---	---	---	---	---	---	---	---	---	---	---	
January														
Summary of Findings				Plan of Action										
No contaminated blood cultures				no action needed										
February														
Summary of Findings				Plan of Action										
No contaminated blood cultures				no action needed										
March														
Summary of Findings				Plan of Action										
April														
Summary of Findings				Plan of Action										
May														
Summary of Findings				Plan of Action										

Laboratory

June	
Summary of Findings	Plan of Action
July	
Summary of Findings	Plan of Action
August	
Summary of Findings	Plan of Action
September	
Summary of Findings	Plan of Action

Infection Control and Prevention

A. [Catheter Associated Urinary Tract Infections \(CAUTI's\)](#)

Function: Outcome Measure													
Rationale: High Risk, Problem Prone													
Data Source: Patient Records, Lab Reports													
Sample Size: All Patients with Indwelling Urinary Catheters During Reporting Period													
Methodology: Patient Records, Lab Reports, PDSA													
Inclusion Criteria: All Patients with Indwelling Urinary Catheters During Reporting Period													
Catheter Associated Urinary Tract Infections (CAUTI's)	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
# of Catheter Associated Urinary Tract Infections	0	0											0
Total # of Urinary Catheter Days During the Reporting Period	71	100											171
Infection Rate per 1000 foley catheter days (Benchmark=1)	0.0	0.0	---	---	---	---	---	---	---	---	---	---	---
CAUTI Bundle Compliance (Benchmark=90%)	100%	100%											100%
January													
Summary of Findings				Plan of Action									
0 CAUTI'S for the month of January. 71 total catheter days between 7 patients.				IP will continue to monitor CAUTI bundles and maintain surveillance of Foley catheter usage for appropriate usage, intitiation, and maintenace.									
February													
Summary of Findings				Plan of Action									
0 CAUTI'S for the month of February. 100 total catheter days between 11 patients.				IP will continue to monitor CAUTI bundles and maintain surveillance of Foley catheter usage for appropriate usage, intitiation, and maintenace.									
March													
Summary of Findings				Plan of Action									
April													
Summary of Findings				Plan of Action									
May													
Summary of Findings				Plan of Action									
June													
Summary of Findings				Plan of Action									
July													
Summary of Findings				Plan of Action									
August													
Summary of Findings				Plan of Action									

Infection Control and Prevention

September	
Summary of Findings	Plan of Action
October	
Summary of Findings	Plan of Action
November	
Summary of Findings	Plan of Action
December	
Summary of Findings	Plan of Action

B. [Central Line Associated Bloodstream Infections \(CLABSI's\)](#)

Function: Outcome Measure													
Rationale: High Risk, Problem Prone													
Data Source: Patient Records, Lab Reports													
Sample Size: All Patients with Indwelling Central Venous Catheters During Reporting Period													
Methodology: Patient Records, Lab Reports, PDSA													
Inclusion Criteria: All Patients with Indwelling Central Venous Catheters During Reporting Period													
Indicator	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
# of Central Line Associated Primary Bloodstream Infections	0	0											0
# of Total Central Line Days During the Reporting Period	58	127											185
Infection Rate per 1000 central line days (Benchmark = 0.5)	0.0	0.0	---	---	---	---	---	---	---	---	---	---	---
CLABSI Bundle Compliance (Benchmark=90%)	100%	100%											100%
January													
Summary of Findings				Plan of Action									
0 CLABSI's for the month of January. 58 total CVL days between 6 patients.				Nursing and IP will reinforce rationale for placement and maintenance of central lines. IP will reinforce hand hygiene and sterile technique to nursing staff when performing dressing changes and proper technique for utilization when administering medications.									
February													
Summary of Findings				Plan of Action									

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0 CLABSI's for the month of February. 127 total CVL days between 11 patients.	Nursing and IP will reinforce rationale for placement and maintenance of central lines. IP will reinforce hand hygiene and sterile technique to nursing staff when performing dressing changes and proper technique for utilization when administering medications.
March	
Summary of Findings	Plan of Action
April	
Summary of Findings	Plan of Action
May	
Summary of Findings	Plan of Action
June	
Summary of Findings	Plan of Action
July	
Summary of Findings	Plan of Action
August	
Summary of Findings	Plan of Action
September	
Summary of Findings	Plan of Action
October	
Summary of Findings	Plan of Action
November	
Summary of Findings	Plan of Action
December	
Summary of Findings	Plan of Action

Infection Control and Prevention

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C. Hospital Acquired MDRO

Function: Outcome Measure														
Rationale: High Risk, Problem Prone														
Data Source: Patient Records, Lab Reports														
Sample Size: All Patients who Develop HA MDRO														
Methodology: Patient Records, Lab Reports, PDSA														
Inclusion Criteria: All Patients who Develop HA MDRO														
Indicator	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD	
Total # of MDRO identified >24 hours after admission	0	0											0	
Total # of Patient Admissions	25	35	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	60	
Hospital Acquired MDRO Rate per 1000 patient admissions	0.0	---	---	---	---	---	---	---	---	---	---	---	---	
January														
Summary of Findings				Plan of Action										
0 Hospital-acquired MDRO's for the month of January.				IP will continue to reinforce prompt recognition of need and collection for cultures within 3 days of admission through ongoing training and upon orientation of new nursing staff.										
February														
Summary of Findings				Plan of Action										
0 Hospital-acquired MDRO's for the month of February				IP will continue to reinforce prompt recognition of need and collection for cultures within 3 days of admission through ongoing training and upon orientation of new nursing staff.										
March														
Summary of Findings				Plan of Action										
April														
Summary of Findings				Plan of Action										
May														
Summary of Findings				Plan of Action										
June														
Summary of Findings				Plan of Action										
July														
Summary of Findings				Plan of Action										

Infection Control and Prevention

August	
Summary of Findings	Plan of Action
September	
Summary of Findings	Plan of Action
October	
Summary of Findings	Plan of Action
November	
Summary of Findings	Plan of Action
December	
Summary of Findings	Plan of Action

Infection Control and Prevention

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D. Hospital Acquired C-diff

Function: Outcome Measure													
Rationale: High Risk, Problem Prone													
Data Source: Patient Records, Lab Reports													
Sample Size: All Patients who Develop C. diff > days After Admission													
Methodology: Patient Records, Lab Reports, PDSA													
Inclusion Criteria: All Patients who Develop C. diff > days After Admission													
Indicator	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Total # of LAB ID EVENT C. diff (Hospital Onset identified > 3 days after admission)	0	0											0
Total # of Patient Days (Excludes observation patients)	183	324											507
LAB ID EVENT C. Diff Rate	0.0	---	---	---	---	---	---	---	---	---	---	---	---
Total number of admissions	25	35	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	60
Total # of LAB ID EVENT C. diff (Community Onset identified within 3 days of admission)	0	0											0
January													
Summary of Findings				Plan of Action									
No C-Diff findings for the month of January				Continue to monitor for C-Diff with ABX surveillance and stewardship.									
February													
Summary of Findings				Plan of Action									
No C-Diff findings for the month of February.				Continue to monitor for C-Diff with ABX surveillance and stewardship.									
March													
Summary of Findings				Plan of Action									
April													
Summary of Findings				Plan of Correction									
May													
Summary of Findings				Plan of Action									
June													
Summary of Findings				Plan of Action									

Infection Control and Prevention

July	
Summary of Findings	Plan of Action
August	
Summary of Findings	Plan of Action
September	
Summary of Findings	Plan of Action
October	
Summary of Findings	Plan of Action
November	
Summary of Findings	Plan of Action
December	
Summary of Findings	Plan of Action

Infection Control and Prevention

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E. Hospital Acquired Infections by Source

Source	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Blood with CVC (central venous catheter)	0	0											0
Blood without CVC	0	0											0
Urine with indwelling catheter	0	0											0
Urine without indwelling catheter	0	0											0
HAI with artificial airway device	0	0											0
HAI without artificial airway device	0	0											0
Stool	0	0											0
Wound	0	0											0
Total Acquired Infection Sources	0	0	0	0	0	0	0	0	0	0	0	0	0
January													
Summary of Findings				Plan of Action									
0 HAI for January				IP will continue infection control surveillance, increase education and emphasize importance of hand hygiene and PPE usage. Prompt recognition and collection of cultures within 3 days of admission, or less than 24 hrs if possible, will be initiated by nursing and IP.									
February													
Summary of Findings				Plan of Action									
0 HAI for February				IP will continue infection control surveillance, increase education and emphasize importance of hand hygiene and PPE usage. Prompt recognition and collection of cultures within 3 days of admission, or less than 24 hrs if possible, will be initiated by nursing and IP.									
March													
Summary of Findings				Plan of Action									
April													
Summary of Findings				Plan of Action									
May													
Summary of Findings				Plan of Action									
June													
Summary of Findings				Plan of Action									
July													

Infection Control and Prevention

Summary of Findings	Plan of Action
August	
Summary of Findings	Plan of Action
September	
Summary of Findings	Plan of Action
October	
Summary of Findings	Plan of Action
November	
Summary of Findings	Plan of Action
December	
Summary of Findings	Plan of Action

F. Hand Hygiene/PPE & Isolation Surveillance

Function: Outcome & Process Measure														
Rationale: High Risk, High Volume, Problem Prone														
Data Source: Observation														
Sample Size: 20 observations/month														
Methodology: All Staff, PDSA														
Inclusion Criteria: All Staff														
% of Hand Hygiene Compliance (Benchmark=80%)	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD	
Nursing (RN, LPN, Tech)	100%	100%											100%	
Radiology/Imaging Staff	100%	100%											100%	
Lab	100%	100%											100%	
Respiratory	100%	100%											100%	
Therapy	100%	100%											100%	
Housekeeping/Dietary	100%	100%											100%	
Medical Staff (MD/DO, NP, PA)	100%	100%											100%	
% of PPE Compliance (Benchmark=80%)	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD	
Nursing (RN, LPN, Tech)	100%	100%											100%	
Radiology/Imaging Staff	100%	100%											100%	
Lab	100%	100%											100%	

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Respiratory	100%	100%												100%
Therapy	100%	100%												100%
Housekeeping/Dietary	100%	100%												100%
Medical Staff (MD/DO, NP, PA)	100%	100%												100%
Isolation	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD	
Total number of patients in isolation	20	22												42
Total number of isolation patient days	122	92												214
January														
Summary of Findings					Plan of Action									
100% compliance with hand hygiene and PPE measures monitored for the month of January. A total of 122 isolation days between 20 patients in January. Each PUI in airborne/contact/droplet isolation pending COVID-19 swab results and screening history. 18 PUI patients for a total of 70 isolation days. 1 on contact and 1 on airborne/droplet, outside of the PUI isolation, for a total of 52 days.					IP will continue to promote and survey hand hygiene and PPE techniques and usage with all staff. Nursing will have continued diligence with COVID-19 PUI status, unless and until swab results with screening history indicate patient can be transferred to "regular" room. IP will continue monitoring appropriate PPE donning & doffing and supply count to be able to protect patients and staff and educate as needed.									
February														
Summary of Findings					Plan of Action									
100% compliance with hand hygiene and PPE measures monitored for the month of February. A total of 92 isolation days between 22 patients in February. Each PUI in airborne/contact/droplet isolation pending COVID-19 swab results and screening history. 18 PUI patients for a total of 49 isolation days. 4 on contact, outside of the PUI isolation, for a total of 43 days.					IP will continue to promote and survey hand hygiene and PPE techniques and usage with all staff. Nursing will have continued diligence with COVID-19 PUI status, unless and until swab results with screening history indicate patient can be transferred to "regular" room. IP will continue monitoring appropriate PPE donning & doffing and supply count to be able to protect patients and staff and educate as needed.									
March														
Summary of Findings					Plan of Action									
April														
Summary of Findings					Plan of Action									
May														
Summary of Findings					Plan of Action									
June														
Summary of Findings					Plan of Action									
July														
Summary of Findings					Plan of Action									
August														

Infection Control and Prevention

Summary of Findings	Plan of Action
September	
Summary of Findings	Plan of Action
October	
Summary of Findings	Plan of Action
November	
Summary of Findings	Plan of Action
December	
Summary of Findings	Plan of Action

G. Public Health Reporting

Function: Outcome Measure														
Rationale: Regulatory Compliance														
Data Source: Patient Records, Lab Records														
Sample Size: All Inhouse Patients with A Reportable Disease Condition														
Methodology: Patient Records, Lab Records, PDSA														
Inclusion Criteria: All Inhouse Patients with A Reportable Disease Condition														
Indicator	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD	
Reports to the Health Department	0	9											9	
January														
Summary of Findings				Plan of Action										
114 COVID-19 swabs obtained for month of January. 115 results negative, 3 positive. 4 IGG/IGM Serological Antibody tests performed with 2 negative results. Guidance on reporting indicated not to report unless In-House tests were completed and positive. No other issues reported for the month of January.				IP will continue to survey results of all COVID-19 swabs and antibody testing completed by MRMC. No In-House testing to be completed and utilized for official results at this time. Nursing will continue with isolation measures for each patient admitted regarding PUI status.										
February														
Summary of Findings				Plan of Action										

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132 COVID-19 PCR swabs obtained for month of February. 118 results negative, 14 positive. 12 IGG/IGM Serological Antibody tests performed with 3 negative results, 9 positive. 8 resulted Positive Rapid Swabs. Guidance on reporting indicated not to report unless In-House tests were completed and positive. 1 Chlamydia STI reported.	IP will continue to survey results of all COVID-19 swabs and antibody testing completed by MRMC. In-House Covid-19 Rapid Tests to be completed by lab and reported by lab to PHIDDO within 24 hours of results. Ordering physicians to give the results to the patients or a resulted paper with result disclosure by lab tech. Nursing will continue with isolation measures for each patient admitted regarding PUI status. All other indicated positive results reported by IP to PHIDDO.
March	
Summary of Findings	Plan of Action
April	
Summary of Findings	Plan of Action
May	
Summary of Findings	Plan of Action
June	
Summary of Findings	Plan of Action
July	
Summary of Findings	Plan of Action
August	
Summary of Findings	Plan of Action
September	
Summary of Findings	Plan of Action
October	
Summary of Findings	Plan of Action
November	
Summary of Findings	Plan of Action
December	
Summary of Findings	Plan of Action

Infection Control and Prevention

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H. Patient Vaccinations

Function: Process Measure													
Rationale: High Risk, Problem Prone													
Data Source: Patient Records													
Sample Size: All Inhouse Patients (Swing bed)													
Methodology: Patient Records, PDSA													
Indicator	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Total number of eligible patients receiving influenza vaccination	3	0											3
Total number of eligible patients inhouse and/or admitted during reporting period that meet criteria for vaccination	3	0											3
Percentage of Compliance	100%	100% %	---	---	---	---	---	---	---	---	---	---	100%
Total number of eligible patients receiving pneumococcal	4	0											4
Total number of eligible patients inhouse and/or admitted during reporting period that meet criteria for vaccination	4	0											4
Percentage of Compliance	100%	100% %	---	---	---	---	---	---	---	---	---	---	100%
January													
Summary of Findings				Plan of Action									
3 patient influenza vaccines given in January. We had 4 patients receive pneumococcal vaccine. All vaccination assessments completed for the month of January except one who was transferred.				IP will continue to monitor patient assessments and documentation regarding vaccination status. Each admission gets a review of any immunizations logged into OSIIS and reported to charge nurse. IP will continue to educate and reinforce policy regarding Flu/Pneumo assessments with nursing staff and to document vaccinations under Immunizations in CPSI. IP will record vaccinations given into OSIIS database. At each IDT, IP will review upcoming discharges with primary nurse for review and administration of vaccines if appropriate.									
February													
Summary of Findings				Plan of Action									
0 patient influenza vaccines given in February. We had 0 patients receive pneumococcal vaccine. 9 vaccination assessments via "blue sheet" completed for the month of February out of 13, two transfers, 2 missed.				IP will continue to monitor patient assessments and documentation regarding vaccination status. Each admission gets a review of any immunizations logged into OSIIS and reported to charge nurse. IP will continue to educate and reinforce policy regarding Flu/Pneumo assessments with nursing staff and to document vaccinations under Immunizations in CPSI. IP will record vaccinations given into OSIIS database. At each IDT, IP will review upcoming discharges with primary nurse for review and administration of vaccines if appropriate.									
March													
Summary of Findings				Plan of Action									

Infection Control and Prevention

April	
Summary of Findings	Plan of Action
May	
Summary of Findings	Plan of Action
June	
Summary of Findings	Plan of Action
July	
Summary of Findings	Plan of Action
August	
Summary of Findings	Plan of Action
September	
Summary of Findings	Plan of Action
October	
Summary of Findings	Plan of Action
November	
Summary of Findings	Plan of Action
December	
Summary of Findings	Plan of Action

I. Ventilator Associated Event

Function: Outcome Measure

Rationale: High Risk, Problem Prone

Data Source: Patient Records, Lab Reports

Sample Size: All Patients with Ventilators During Reporting Period

Health Information Management (HIM)

A. History and Physicals Completion

Function: Outcome & Process Measure													
Rationale: High Risk, Problem Prone Compliance													
Data Source: Patient Records													
Sample Size: All patient admissions for reporting month if less than 20													
Methodology: Patient Records, PDSA													
Inclusion Criteria: All Patient Admissions													
Indicator	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
# of H&P's obtained within 24 hours of admission	25	38											63
# of total admissions reviewed for the month	25	38											63
% of H& P's obtained within 24 hours of admission (Benchmark = 100%)	100%	100%	---	---	---	---	---	---	---	---	---	---	100%
January													
Summary of Findings				Plan of Action									
Met benchmark				Will continue to monitor									
Summary of Findings				Plan of Action									
Met benchmark				Will continue to monitor									
March													
Summary of Findings				Plan of Action									
April													
Summary of Findings				Plan of Action									
May													
Summary of Findings				Plan of Action									
June													
Summary of Findings				Plan of Action									
July													
Summary of Findings				Plan of Action									
August													
Summary of Findings				Plan of Action									
September													
Summary of Findings				Plan of Action									
October													
Summary of Findings				Plan of Action									

November	
Summary of Findings	Plan of Action
December	
Summary of Findings	Plan of Action

B. Discharge Summary Completion

Function: Outcome & Process Measure													
Rationale: High Risk, Problem Prone, Compliance													
Data Source: Patient Records													
Sample Size: All discharged patients for reporting month if less than 20													
Methodology: Patient Records, PDSA													
Inclusion Criteria: Patient Discharges (Acute, SWB patients) Exclusion Criteria: Observation Patient Discharges													
Indicator	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
# of Discharge Summaries completed within 48 hours of discharge	20	24											44
# of Discharges	20	26	0	0	0	0	0	0	0	0	0	0	46
% of Discharge Summaries completed within 48 hours of discharge (Benchmark=100%)	100%	92%	---	---	---	---	---	---	---	---	---	---	96%
January													
Summary of Findings							Plan of Action						
Met benchmark							Will continue to monitor						
February													
Summary of Findings							Plan of Action						
Missing one d/c from swingbed and one for an acute chart.							HIM put these in the dr.'s boxes to be done. HIM sent out an email to both physicians letting them know that these are missing on 3/5/21. 3/9/21 Sent out an email to Marie-CEO and Kaye-Credentialing and they are going to send the message along to get these matters completed.						
March													
Summary of Findings							Plan of Action						
April													
Summary of Findings							Plan of Action						
May													
Summary of Findings							Plan of Action						
June													
Summary of Findings							Plan of Action						
July													
Summary of Findings							Plan of Correction						

August	
Summary of Findings	Plan of Action
September	
Summary of Findings	Plan of Action
October	
Summary of Findings	Plan of Action
November	
Summary of Findings	Plan of Action
December	
Summary of Findings	Plan of Action

C. Progress Notes (Swing bed & Acute)

Function: Outcome & Process Measure													
Rationale: High Risk, Problem Prone, Compliance													
Data Source: Patient Records													
Sample Size: All discharged patients for reporting month if less than 20													
Methodology: Patient Records, PDSA													
Inclusion Criteria: All Swing bed Patients													
Indicator	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Total # of complete weekly SWB progress notes	32	23											55
Total # of progress notes audited	32	23											55
Weekly Progress Note Percent of completion (Benchmark=100%)	100%	100%	---	---	---	---	---	---	---	---	---	---	100%
Indicator	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Total # of complete daily acute progress notes	40	46											86
Total # of progress notes audited	40	46											86
Daily Progress Note Percent of completion (Benchmark=100%)	100%	100%	---	---	---	---	---	---	---	---	---	---	100%
January													
Summary of Findings				Plan of Action									
Met benchmark.				Will continue to monitor									
February													
Summary of Findings				Plan of Action									
Met benchmark				Will continue to monitor									
March													
Summary of Findings				Plan of Action									
April													
Summary of Findings				Plan of Action									

May	
Summary of Findings	Plan of Action
June	
Summary of Findings	Plan of Action
July	
Summary of Findings	Plan of Action
August	
Summary of Findings	Plan of Action
September	
Summary of Findings	Plan of Action
October	
Summary of Findings	Plan of Action
November	
Summary of Findings	Plan of Action
December	
Summary of Findings	Plan of Action

D. Consent to Treat

Function: Outcome & Process Measure													
Rationale: High Risk, Problem Prone, Compliance													
Data Source: Patient Records													
Sample Size: All discharged patients for reporting month if less than 20													
Methodology: Patient Records, PDSA													
Inclusion Criteria: Patient Records													
Indicator	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Total number of consent to treat completed	128	165											293
Total number of records reviewed	129	172											301
Consent To Treat Percent of completion (Benchmark=100%)	99%	96%	---	---	---	---	---	---	---	---	---	---	97%
January													
Summary of Findings						Plan of Action							
One swingbed is missing the consent.						Jessica with registration checks on them and sends out emails for them to get done when she comes across them. I will run a daily report for the charts to check the consents. if the consents are not scanned in, I will let Daniel in. We will have a sheet that the ward clerks will have to							
February													
Summary of Findings						Plan of Action							

There is 1 er, 1 obs, 3 acute and 2 swb that are missing consents.	HIM sent out emails to RCM-Kasi, CCO-Daniel, Ward Clerks-Desiree & Krystle letting them know about some of the charts that were missing consents on 2/11/21. Kasi followed up with me and i let her know that four of them had gotten done, but the other 7 had not. Kasi-RCM manager also followed up with HIM via email on 2/25/21 about consents and they still were not
March	
Summary of Findings	Plan of Action
April	
Summary of Findings	Plan of Action
May	
Summary of Findings	Plan of Action
June	
Summary of Findings	Plan of Action
July	
Summary of Findings	Plan of Action
August	
Summary of Findings	Plan of Action
September	
Summary of Findings	Plan of Action
October	
Summary of Findings	Plan of Action
November	
Summary of Findings	Plan of Action
December	
Summary of Findings	Plan of Action

E. Swing bed

Function: Outcome & Process Measure													
Rationale: High Risk, Problem Prone, Compliance													
Data Source: Patient Records													
Sample Size: All patient admissions for reporting month if less than 20													
Methodology: Patient Records, PDSA													
Inclusion Criteria: Swing bed Records													
Indicator	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Transition of Care to Swing bed Completed	10	20											30
Total number of swing bed admissions	10	20	0	0	0	0	0	0	0	0	0	0	30
Percent of completion (Benchmark=95%)	100%	100%	---	---	---	---	---	---	---	---	---	---	100%
Social History completed within 24 hours or first business day post admission	10	20											30
Total number of swing bed admissions	10	20	0	0	0	0	0	0	0	0	0	0	30
Percent of completion (Benchmark=95%)	100%	100%	---	---	---	---	---	---	---	---	---	---	100%
January													
Summary of Findings				Plan of Action									
There are two swingbeds missing the Social History.				2/08/21 HIM Manager sent SWB Director an email about the 2 missing. I am waiting on her response. Candy emailed me back and stated that she would get them done. 2/10/21 i checked and they are complete.									
February													
Summary of Findings				Plan of Action									
Met benchmark				Will continue to monitor									
March													
Summary of Findings				Plan of Action									
April													
Summary of Findings				Plan of Action									
May													
Summary of Findings				Plan of Action									
June													
Summary of Findings				Plan of Action									
July													
Summary of Findings				Plan of Action									
August													
Summary of Findings				Plan of Action									
September													
Summary of Findings				Plan of Action									

October	
Summary of Findings	Plan of Action
November	
Summary of Findings	Plan of Action
December	
Summary of Findings	Plan of Action

F. Electronic Prescribing

Function: Outcome & Process Measure													
Rationale: High Risk, High Volume, Problem Prone													
Data Source: Patient Food Trays													
Sample Size: 3 Trays/Month													
Methodology: Food Trays, PDSA													
Formula: # of Food Trays Meeting Goal/# of Food Trays Evaluated													
Indicators	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Food Test Tray Evaluation (Composite Score)	100	100											200
Total Score Possible (Composite Score)	100	100											200
Percentage of Compliance	100%	100%	---	---	---	---	---	---	---	---	---	---	100%
January													
Summary of Findings				Plan of Action									
February													
Summary of Findings				Plan of Action									
March													
Summary of Findings				Plan of Action									
April													
Summary of Findings				Plan of Action									
May													
Summary of Findings				Plan of Action									
June													
Summary of Findings				Plan of Action									
July													
Summary of Findings				Plan of Action									
August													
Summary of Findings				Plan of Action									
September													
Summary of Findings				Plan of Action									
October													

Dietary Department

Summary of Findings	Plan of Action
November	
Summary of Findings	Plan of Action
December	
Summary of Findings	Plan of Action

B. Quality Checks

Function: Outcome & Process Measure

Therapy

A. Therapy Indicators

Function: Process, Outcome Measure Rationale: High Risk, Problem Prone Data Source: Patient Records Sample Size: All patients on therapy services Methodology: Patient records; PDSA Inclusions: Swing bed patients receiving rehab services during reporting period													
Indicators	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Physician Signature on Evaluation Within 7 Days of Initial Evaluation	7	13											20
Total Number of Evaluations (Benchmark = 95%)	7	13											20
Percentage of Compliance	100%	100%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	100%
Physician Signature & Date on Recertification Within 7 Days of Completion	2	1											3
Total Number of Recertifications (Benchmark = 95%)	2	1											3
Percentage of Compliance	100%	100%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	100%
30-Day Progress Notes Present & On Time	2	1											3
Total Progress Notes Due (Benchmark = 80%)	2	1											3
Percentage of Compliance	100%	100%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	100%
Discharge Note Present Within 72 Hours of Discharge (PT/OT/ST) (exclude weekends & holidays)	5	7											12
Total Number of Discharge Patients With Therapy Services (Benchmark = 75%)	5	7											12
Percentage of Compliance	100%	100%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	100%
Number of Patients With Assistive Equipment Needs (Evaluation & Recommendations By Therapy)	5	13											18
Total Number of Discharge Patients With Identified Assistive Equipment Needs (Benchmark = 95%)	5	13											18
Percentage of Compliance	100%	100%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	100%
January													
Summary of Findings				Plan of Action									
All paperwork completed on time.				No changes needed.									
February													
Summary of Findings				Plan of Action									
All paperwork completed on time.				No changes needed.									
March													
Summary of Findings				Plan of Action									
April													
Summary of Findings				Plan of Action									

May	
Summary of Findings	Plan of Action
June	
Summary of Findings	Plan of Action
July	
Summary of Findings	Plan of Action
August	
Summary of Findings	Plan of Action
September	
Summary of Findings	Plan of Action
October	
Summary of Findings	Plan of Action
November	
Summary of Findings	Plan of Action
December	
Summary of Findings	Plan of Action

B. Therapy Visits

Function: Outcome Measure

Rationale: High Risk, Problem Prone

Data Source: Patient Records

Sample Size: All patients receiving therapy services

Methodology: Patient records; PDSA

Inclusions: Swing bed patients receiving rehab services during reporting period

Formula: # of treatments sessions completed/# of planned treatment sessions

[illegible]

Treatment Compliance (Benchmark = 85%)	2400%	90%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	137%
Indicators	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Total number of ST treatment sessions performed	5	0											5
Total # of planned treatment sessions	5	0											5
Treatment Compliance (Benchmark = 85%)	100%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	100%
January													
Summary of Findings				Plan of Action									
Good participation from patients this month.				Continue seeing patients that are well enough to participate.									
February													
Summary of Findings				Plan of Action									
Good participation from patients this month.				Continue seeing patients that are well enough to participate and offer those refusing treatment alternative options for therapy.									
March													
Summary of Findings				Plan of Action									
April													
Summary of Findings				Plan of Action									
May													
Summary of Findings				Plan of Action									
June													
Summary of Findings				Plan of Action									
July													
Summary of Findings				Plan of Action									
August													
Summary of Findings				Plan of Action									
September													
Summary of Findings				Plan of Action									
October													
Summary of Findings				Plan of Action									
November													
Summary of Findings				Plan of Action									
December													

Summary of Findings	Plan of Action

C. **Standardized Assessment Improvement Outcomes**

Function: Outcome Measure
Rationale: Problem Prone
Data Source: Patient Records
Sample Size: All discharged patients in the therapy program for reporting month
Methodology: Patient records; PDCA
Inclusions: All swing bed patients admitted to therapy services to improve functional mobility
Exclusions: Deaths, patients who cannot tolerate therapy & unplanned facility discharges
Formula: total number of patients discharged with improved standardized assessment score/ total number of patients with documented standardized assessment score on admission

Indicators	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Total # of patients discharged with improved standardized assessment scores (Benchmark=80%)	5	4											9
Total # patients with documented standardized assessment score on admission	5	4											9
% of Functional Improvement	100%	100%	---	---	---	---	---	---	---	---	---	---	100%
Total # of discharges with full return to documented PLOF	3	4											7
Total # therapy patient discharges for the month	5	4											9
% of Home Discharges	60%	100%	---	---	---	---	---	---	---	---	---	---	78%

January

Summary of Findings	Plan of Action
2 patient's were discharged below PLOF. 1 Patient had increased debility from stroke suffered prior to admission, and the other patient was given the OK from ortho to discharge home, although it was not recommended by Therapy staff.	Continue providing quality care suitable to each patient's needs.

February

Summary of Findings	Plan of Action
All patients discharged at PLOF.	No changes needed.

March

Summary of Findings	Plan of Action

April

Summary of Findings	Plan of Action

May

Summary of Findings	Plan of Action

June

Summary of Findings	Plan of Action

July

Summary of Findings	Plan of Action
August	
Summary of Findings	Plan of Action
September	
Summary of Findings	Plan of Action
October	
Summary of Findings	Plan of Action
November	
Summary of Findings	Plan of Action
February	
Summary of Findings	Plan of Action

Compliance

Function: Process & Outcome Measure													
Rationale: High Risk, Problem Prone, Regulatory Compliance													
Data Source: Employee Records													
Sample Size: All Employees as Applicable													
Methodology: Employee Records, PDSA													
Inclusion Criteria: All Employees													
Indicators	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
90-Day Staff Competency Check-Off Completed	100%	100%											100%
New Hire Orientation Compliance	100%	100%											100%
Background Check Completed	100%	100%											100%
Annual Licensure Check for Governing Board Action	100%	100%											100%
CPR Certification Compliance	100%	100%											100%
ACLS Certification Compliance	100%	100%											100%
PALS Certification Compliance	100%	100%											100%
Annual Education Compliance	100%	100%											100%
January													
Summary of Findings				Plan of Action									
Monitored closley				Continue to monitor									
Summary of Findings				Plan of Action									
Monitored closley				Continue to monitor									
March													
Summary of Findings				Plan of Action									
April													
Summary of Findings				Plan of Action									
May													
Summary of Findings				Plan of Action									
June													
Summary of Findings				Plan of Action									
July													
Summary of Findings				Plan of Action									

August	
Summary of Findings	Plan of Action
September	
Summary of Findings	Plan of Action
October	
Summary of Findings	Plan of Action
November	
Summary of Findings	Plan of Action
December	
Summary of Findings	Plan of Action

A. Registration Services

[illegible]

August	
Summary of Findings	Plan of Action
September	
Summary of Findings	Plan of Action
October	
Summary of Findings	Plan of Action
November	
Summary of Findings	Plan of Action
December	
Summary of Findings	Plan of Action

Environmental Services

A. Terminal Room Cleans

Function: Process & Outcome Measure													
Rational: High Risk, Problem Prone													
Data Source: Observation, EOC rounds report, incident reports													
Sample Size: Ten per month or all whichever is greater													
Methodology: Observation, EOC rounds report, incident reports, PDSA													
Indicators	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Terminal Room Cleans Meeting Inspection Standards	8	8											16
Total Number of Rooms Inspected	8	8											16
Percent of Compliance (Benchmark=100%)	100%	100%	---	---	---	---	---	---	---	---	---	---	100%
January													
Summary of Findings				Plan of Action									
Compliant				No action needed									
February													
Summary of Findings				Plan of Action									
Compliant				No action needed									
March													
Summary of Findings				Plan of Action									
April													
Summary of Findings				Plan of Action									
May													
Summary of Findings				Plan of Action									
June													
Summary of Findings				Plan of Action									
July													
Summary of Findings				Plan of Action									
August													
Summary of Findings				Plan of Action									
September													
Summary of Findings				Plan of Action									

October	
Summary of Findings	Plan of Action
November	
Summary of Findings	Plan of Action
December	
Summary of Findings	Plan of Action

Materials Management

A. Materials Management Indicators

Function: Process & Outcome Measure Rational: High Risk, Problem Prone Data Source: Order Sheets, Invoices, Audits Methodology: Order Sheets, Invoices, Audits PDSA Sample Size: All Orders and All Recalls													
Indicators	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Total Number of Back Orders by Vendors	1	3											4
Total Number of Orders Placed to Vendors by Hospital	30	32											62
Percentage of Back Orders	3%	9%	---	---	---	---	---	---	---	---	---	---	6%
Total Number of Late Orders due to Vendor(s) Issues	0	1											1
Total Number of Orders Placed to Vendors by Hospital	30	32											62
Percentage of Late Orders	---	3%	---	---	---	---	---	---	---	---	---	---	2%
Total Number of Recalls (Items utilized by the hospital)	2	1											3
Total Number of Items Checked Out Properly	712	981											1693
Total Number of Items Checked Out	721	984											1705
Percentage of Compliance	99%	100%	---	---	---	---	---	---	---	---	---	---	99%
January													
Summary of Findings				Plan of Action									
recalls feb particulate respirator and surgical mask													
RECALLS: (1) Dermabond Advanced™ Topical Skin Adhesive, (2) Strata II™, Delta™, and CSF-Flow Control™ Valves and Shunts				Materials Manager checked stock, did not have affected product. No action needed.									
February													
Summary of Findings				Plan of Action									
RECALLS: 3M PARTICULATE RESPIRATOR AND SURGICAL MASK				This is an update to a safety notice posted on 2/3/2021 to include additional lot numbers. Due to increasing reports of fraud. This is a counterfeit notification not a product recal. No action needed.									
Summary of Findings				Plan of Action									
April													
Summary of Findings				Plan of Action									
May													
Summary of Findings				Plan of Action									

June	
Summary of Findings	Plan of Action
July	
Summary of Findings	Plan of Action
August	
Summary of Findings	Plan of Action
September	
Summary of Findings	Plan of Action
October	
Summary of Findings	Plan of Action
November	
Summary of Findings	Plan of Action
December	
Summary of Findings	Plan of Action

B. Materials Management Indicators

Function: Process & Outcome Measure**Rational: High Risk, Problem Prone**

Data Source: Order Sheets, Invoices, Audits

Methodology: Order Sheets, Invoices, Audits PDSA

Sample Size: Ten Items Per Month with a sampling of 20 "eaches" or all if less than 20 "eaches" for each item

[illegible]

Process: For each reporting month a total of 10 separate "chargeable items" are reviewed for correct labeling, expiration date/within use date, & correct inventory information.

Utilize the Audit Tool to gather and compile data. At the end of the month when the data is entered for all 10 items, a value will be autocalculated for a composite score. These are the values that will be entered into the Quality Report.

[illegible]

January

Summary of Findings	Plan of Action
Met benchmark.	Continue to monitor

February	
Summary of Findings	Plan of Action
Found 2 expired products. Still within benchmark.	Continue to monitor
March	
Summary of Findings	Plan of Action
April	
Summary of Findings	Plan of Action
May	
Summary of Findings	Plan of Action
June	
Summary of Findings	Plan of Action
July	
Summary of Findings	Plan of Action
August	
Summary of Findings	Plan of Action
September	
Summary of Findings	Plan of Action
October	
Summary of Findings	Plan of Action
November	
Summary of Findings	Plan of Action
December	
Summary of Findings	Plan of Action

Plant Operations

A. Fire Safety Management

Function: Process & Outcome Measure														
Rationale: High Risk, Problem Prone														
Data Source: Fire Drill Reports, Audit														
Methodology: Fire Drill Reports, Audits														
Note: Fire drills must be conducted at least quarterly but may be conducted more frequently.														
Note: Fire extinguisher checks must be performed monthly														
Indicators	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD	
	Q1			Q2			Q3			Q4				
Total Number of Fire Drills Completed													0	
Total Number of Fire Drills													0	
Percentage of Compliance	---			---			---			---			---	
Monthly Fire Extinguisher Checks Completed	24	24											48	
Total Number of Fire Extinguishers	24	24											48	
Percentage of Compliance	100%	100%	---	---	---	---	---	---	---	---	---	---	100%	
January														
Summary of Findings				Plan of Action										
Compliant				No action needed										
February														
Summary of Findings				Plan of Action										
Compliant				No action needed										
March														
Summary of Findings				Plan of Action										
April														
Summary of Findings				Plan of Action										
May														
Summary of Findings				Plan of Action										
June														
Summary of Findings				Plan of Action										
July														
Summary of Findings				Plan of Action										
August														
Summary of Findings				Plan of Action										
September														
Summary of Findings				Plan of Action										

October	
Summary of Findings	Plan of Action
November	
Summary of Findings	Plan of Action
December	
Summary of Findings	Plan of Action

Information Technology

A. IT Incidents

Function: Process & Outcome Measure													
Rational: High Risk, Problem Prone													
Data Source: Work Reports													
Methodology: Work Reports, PDSA													
Indicators	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Equipment Malfunction/Issue	2	0											2
EHR System Shutdown	0	0											0
Power/Electrical Failure	0	0											0
Internet Outage	0	0											0
Interface Issue	0	0											0
Server Outage	0	0											0
Planned Changes	0	0											0
Other (Include in findings)	58	68											126
January													
Summary of Findings				Plan of Action									
this month was quiet, usual password resets and such. we do have 2 COW units down on the floor that need new pc's installed in them				IT will replace the PCs in the COW units and deliver back to the floor. WHEN? when i got the parts, at the time i did not know when the new units would arrive, and so instead of guessing, i chose not to make mention of a date.									
February													
Summary of Findings				Plan of Action									
it was a pretty quiet month again, only 68 tickets, mostly tv remotes and													
March													
Summary of Findings				Plan of Action									
April													
Summary of Findings				Plan of Action									
May													
Summary of Findings				Plan of Action									
June													
Summary of Findings				Plan of Action									
July													
Summary of Findings				Plan of Action									
August													

Summary of Findings	Plan of Action
September	
Summary of Findings	Plan of Action
October	
Summary of Findings	Plan of Action
November	
Summary of Findings	Plan of Action
December	
Summary of Findings	Plan of Action

Outpatient Services

A. Outpatient Orders & Assessments

Function: Process & Outcome Measure Rational: High Risk, Problem Prone Data Source: Patient Records Sample Size: 10 randomized records per month Methodology: Patient Records, PDSA Inclusion Criteria: All patients receiving outpatient services													
Indicators	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Scheduled Appointment for Outpatient Services	10	0											10
Correct Order On Chart	10	0											10
Total number of orders	10	0											10
Percentage of correct orders (Benchmark=100%)	100%	---	---	---	---	---	---	---	---	---	---	---	100%
RN assessments completed	4	0											4
Total number of RN assessments required & completed	4	0											4
Percentage of RN assessments required & completed (Benchmark=100%)	100%	---	---	---	---	---	---	---	---	---	---	---	100%
January													
Summary of Findings				Plan of Action									
No OP noted for the month of February				No plan of action needed.									

B. Outpatient Therapy Services

[illegible]

Summary of Findings	Plan of Action
April	
Summary of Findings	Plan of Action
May	
Summary of Findings	Plan of Action
June	
Summary of Findings	Plan of Action
July	
Summary of Findings	Plan of Action
August	
Summary of Findings	Plan of Action
September	
Summary of Findings	Plan of Action
October	
Summary of Findings	Plan of Action
November	
Summary of Findings	Plan of Action
December	
Summary of Findings	Plan of Action

Strong Mind Services

A. Record Compliance

Function: Compliance Measure Rationale: High Risk, Problem Prone Data Source: Client Records Sample Size: All clients in program Methodology: Client records; PDCA Inclusions: All clients in program during reporting month Formula: # of complete charts/# of charts audited													
Indicators	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Total number of records meeting compliance													0
Total number of records audited													0
Percentage of Compliance (Benchmark=95%)	---	---	---	---	---	---	---	---	---	---	---	---	#DIV/0!
January													
Summary of Findings				Plan of Action									

B. Client Satisfaction Surveys

[illegible]

Total number of surveys distributed (discharged clients)													0
Return Rate (Benchmark=80%)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Satisfaction Score Results (composite score/discharged clients)													0
Total Score													0
Percentage of satisfaction (Benchmark=80%)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
January													
Summary of Findings				Plan of Action									

C. Master Treatment Plans

Function: Process & Outcome Measure													
Rationale: High Risk, Problem Prone													
Data Source: Client Files													
Sample Size: All clients in program													
Methodology: Client records; PDCA													
Inclusions: All clients in program during reporting month													
Formula: # of master treatment plans completed within 5 days/# of master treatment plans													
Indicators	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Total number of master treatment plans completed													0
Total number of master treatment plans required													0
Master Treatment Plans Completed (Benchmark=100%)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
January													
Summary of Findings				Plan of Action									

D. Suicidal Ideation

Function: Process & Outcome Measure Rationale: High Risk, Problem Prone Data Source: Client Files Sample Size: All clients in program Methodology: Client records; PDCA Inclusions: All clients in program during reporting month Formula: # of clients with suicidal ideation/# of clients with treatment plan
--

[illegible]

E. Scheduled Appointments

Function: Process & Outcome Measure**Rationale: High Risk, Problem Prone**

Data Source: Client Files

Sample Size: All clients in program

Methodology: Client records; PDCA

Inclusions: All clients in program during reporting month

Formula: # of missed appointments/total number of scheduled appointments

[illegible]

Contract Services

Date	Name	Service	Date of Review	Renewed	Discontinued
01/14/21	Life Share Contract/Log	Tissue donation	02/23/21	Yes	
01/14/21	OGA Business	Insurance for Strong Minds	02/23/21	Yes	
01/14/21	Press Ganey Contract	HCAHPS	02/23/21		
01/14/21	Space Labs	Telemetry system	02/23/21	Yes	
01/14/21	Press Ganey Contract	HCAHPS	02/23/21	Yes	
02/10/21	Wolters Kluwer Health,	Education/train ing/resources	3/1/2021 - 03/02/2022	Yes	
02/10/21	OFMQ Agreement	Peer review	2/23/2021 -	Yes	

[illegible]

Education & Training

Date	Main Objectives	Audience	Compliance
01/25/21	Provider time study 2/15-2/28	Providers	
03/04/21	ACLS		
03/18/21	BLS	All Staff	

Performance Improvement Projects

Date	Title	Goals	Status	Progress
01/25/21				

Surveys

Date	Type of Survey	Results of Survey	Actions Taken
01/25/21			

Product Recalls

Date	Product/Equipment	Action Taken
01/01/21	Derma bond	Did not have product
01/01/21	Strata	Did not have product
02/01/21	No Recalls for MRMC	

FMEA

Date	Project Title	Actions Taken
01/25/21		

RCA

Date	Type of Event	Outcome of Event	Actions Taken
01/25/21			

Blood Utilization

Date	# of Transfusion Episodes	# of Blood Products	Transfusion Reaction
01/25/21	4	18	No
02/01/21	1		No

HIPAA Breaches

Date	Event	Action Taken
01/01/21	None for Janu	No action needed
02/01/21	None for Febr	No action needed

Facility/Equipment Issues/Concerns/PM Reports

Date	Brief Description of Issue	Actions Taken	PM Report Summary
01/25/21			

Emergency Preparedness

Date	Type of Drill	Emergency Disaster Event	After Action Summary
01/01/21		No drills for January	No summary needed
02/27/21	Water Supply	No water to the facility	Maintenance is doing summary

Mandatory or Routine Inspections

Date	Inspection Type	Inspection Date	Results
01/25/21			

Policy & Procedure Review and Approval

Date	Name of Policy	MEC/GB Approval
02/23/21	Respiratory P & P	Yes
02/23/21	Drug Room P & P	Yes
02/23/21	Emergency Department	Yes
02/23/21	Clinical P & P	Yes
02/23/21	Wound Care P & P	Yes
02/23/21	Hospital Rehab P & P	Yes
02/23/21	(Form) Patient Discharge Sa	Yes
02/23/21	(Form) HR Performance Eva	Yes
02/23/21	(Form) Blood Transfusion O	Yes

Staffing

Date	New Employee	Voluntary Separations	Involuntary Separations
01/31/21	3	2	
2/28/2021	0	1	

Open Positions

Credentialing & New Appointments

Date	Credential Update	New Appointments
02/23/21	John Chiaffitell, DO	Active Privileges-Re-Credentialing
02/23/21	Terrie Gibson, MD	Courtesy Privileges-Re-Credentialing
02/23/21	Pathologists w/Heartland	Courtesy Privileges
02/23/21	Dr. Steven Snail	Voluntary removal
02/23/21	Dr. Riley Winham	Voluntary removal
02/23/21	OSU Telehealth removed as contract termed 1/1/21	
02/23/21	Sara McDade, APRN	Couresty Privileges
02/23/21	Dave Spear, MD	Courtesy Privileges
02/23/21	Mary Barnes, APRN	Courtesy Privileges-Re-Credentialing
02/23/21	Mary Homboe, MD	Courtesy Privileges-Re-Credetailing
02/23/21	Ruth Oneson, MD	Courtesy Privileges-Re-Credentialing
02/23/21	Ricky Reaves, MD	Courtesy Privileges-Re-Credentialing
02/23/21	Barry Rockler, MD	Courtesy Privileges-Re-Credentialing
02/23/21	Sherrita Wilson, MD	Courtesy Privileges-Re-Credentialing

**Mangum Regional Medical Center
Quality Committee Meeting Minutes**

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Date: 5/13/2021	Time: 11:49	Recorder: Melissa Tunstall		Reporting Period Discussed: APRIL 2021			
Members Present via Teams Meeting							
Chairperson:		CEO: Dale Clayton			Medical Representative: Dr. Chiaffitelli		
Name	Title	Name	Title	Name	Title	Name	Title
Jennifer Waxell	Respiratory	Josey Kenmore	Materials Management	Chelsea Church	Pharmacy	Evan	Lab Manager
Sarah Dillahunty	Dietary	Daniel Coffin	CCO	Kaye Hamilton	Credentialing	Karli Bowles	Infection
Linda James	Pharmacy	Pamela Esparza	Radiology Manager	Jennifer Dreyer	HIM	Kasi Hilley	Business/RCM Director
Ivy Bowden	Corporate Infection						
TOPIC	FINDINGS/CONCLUSIONS			ACTIONS/RECOMMENDATIONS			FOLLOW-UP
Call to Order	Melissa Tunstall and Pam Esparza						
Review of Minutes	Candy Denny and Pam Esparza						
Review of Committee Meetings							
A. EOC/Patient Safety Committee	April - Nurses break room tile needs to get finished, but the tile isn't being made any more and will take more time to locate more tile. New suction head wall is approved and pending verification. Covered peg boards are still not complete.Continue replacing 15 amp for 20 amp. Repaired xray ceiling on 27th of April. Doctors sleep room is starting the remodel. Stretcher in ER 1 head supports were located and will be repaired						
B. Infection Control Committee	Vaccines are going at the Clinic. TB Risk Assessment is complete. No Covid cases for the month. No CLABSI, CAUDIA, HAI. 100% hand			Will continue to monitor			
C. Pharmacy & Therapeutics Committee	TPA was taken off formulary. TNK was kept in house. Tesivimab in stock.						
D. HIM/Credentials Committee	Missing 1 discharge summary. Missing 2 consents			Discharges IT is working on getting Provider access . Consent are improving. Reports are printed and emailed to CCO and QA Nurse.			
E. Utilization Review Committee	143 ER visits Total days 281 ADC 9 1 Readmit April-SWB had to send to Oklahoma Heart for cardiac window. Came back after stable for						
F. Compliance Committee	No meetings started as of this time						
Old Business	Roof repair over OR2 is completed.						

New Business	Policies that were previously approved: 1.Employee Health Program Manual 2. HIM 3. HIPPA 4. Infection Control Policy and Procedure. New Patient slogan: Is there anything else I can do for you? I have the time.		
Quality Assurance/Performance Improvement			
Volume & Utilization			
A. Hospital Activity			
B. Blood Utilization	Product was administered without problems	Will continue to monitor	
Care Management			
A. CAH/ER Re-Admits			
B. Acute Transfers			
C. Transition of Care			
D. Discharge Follow-Up Phone Calls			
E. Patient Discharge Safety Checklist			
Risk Management			
A. Incidents	1. Needle stick of nursing staff. 2. Falls W/O Injury. (Both patients had attempted to get up without using the call light. Both patients were	1. Needle stick protocols were followed. No negative outcome. AMA - 4 were explained benefits of staying and the risks of leaving and	
B. Reported Complaints	One complaint reported for May. Patient was dissatisfied with attitude of nursing staff member.	Charge Nurse took care of the complaint at bedside. Patient was satisfied with the outcome.	
C. Reported Grievances			
D. Patient Falls Without Injury			
E. Patient Falls With Minor Injury			
F. Patient Falls With Major Injury			
G. Mortality Rate	2 Deaths in the ED 1.) CPR performed per ACLS guidlines. ROSC was never obtained. TOD was called. 2) PT to ED via EMS in full cardiac arrest. CPR was done in route and in ED per ACLS guidlines. TOD was called.		
H. Deaths Within 24 Hours of Admit			
I. OPO Notification/Tissue Donation	Lifeshare was called within the 60 minute time frame.		

J. Patient Identifiers			
Nursing			
A. Critical Tests/Labs			
B. Restraints	1 Patient was restrained due to overdose.		
C. RN Assessments			
D. Code Blue	2 Code Blue		
E. Acute Transfers	ACUTE/SWING 3 Transfers - 3 patients for reporting period transferred to tertiary facilities. 1) One patient to higher level of care for surgical consult for development of cholecystitis. 2) One patient to higher level of care for cardiac treatment for development of large pericardial effusion. 3) One patient to higher level of care for cardiac treatment due to NSTEMI.		
Emergency Department			
A. ER Log & Visits			
B. MSE			
C. Provider ER Response Time			
D. ED RN Assessment (Initial)			
E. ED Readmissions	2 Readsmissions		
F. EMTALA Transfer Form			
G. ED Transfers	5 (4) were transferred due to higher level of care needed. (1) was		
H. Stroke Care			
I. Suicide Management			
J. Triage			

K. Stemi Care	1		
L. ED Nursing Assessment (Discharge/Transfer)	was at 76% CCO said it should be 100% and would check on it and let us know.		
Pharmacy & Medication Safety			
A. Pharmacy Utilization			
B. After Hours Access	114		
C. Adverse Drug Reactions			
D. Medication Errors	2 Medication Errors. Nurse failed to administer IV Steroid.		
Respiratory Care Services			
A. Ventilator Days	30		
B. Ventilator Wean Rate			
C. Patient Self-Decannulation Rate	30		
D. Respiratory Care Equipment			
Wound Care Services			
A. Development of Pressure Ulcer			
B. Wound Healing Improvement			
C. Wound Care Documentation			
D. Debridement/Wound Care Procedures			

E. Wound Vac Application			
Radiology			
A. Radiology Films			
B. Imaging			
C. Radiation Dosimeter Report			
D. Physicist's Report			
Lab			
A. Lab Reports			
B. Blood Culture Contaminants			
Infection Control & Employee Health			
A. CAUTI's	0		
B. CLABSI'S	0		
C. HA MDROs	0		
D. HA C. diff	0		
E. Hospital Acquired Infections By Source	0		
F. Hand Hygiene/PPE & Isolation Surveillance	100%		
G. Public Health Reporting	2		
H. Patient Vaccinations			
I. Ventilator Associated Events			

J. Employee Health Summary			
HIM			
A. H&P's			
B. Discharge Summaries	95%		
C. Progress Notes (Swing bed & Acute)			
D. Consent to Treat	99%		
E. Swing bed Indicators			
F. E-prescribing System			
G. Legibility of Records	Still pending on accuracy		
Dietary			
A. Food Test Tray Eval			
B. Dietary Checklist Audit			
Therapy			
A. Therapy Indicators			
B. Therapy Visits			
C. Standardized Assessment Outcomes	75% Did not meet benchmarks in these categories due to two patients DC to nursing home secondary to decreased medical status.		
Human Resources			
A. Compliance			
Registration Services			
Registration Services			

Environmental Services			
A. Terminal Room Cleans			
Materials Management			
A. Materials Management Indicators			
Plant Operations			
A. Fire Safety Management			
Information Technology			
A. IT Indicators			
Outpatient Services			
A. Outpatient Orders and Assessments			
B. Outpatient Therapy Services			
C. Outpatient Wound Services			
Contract Services			
Contract Services	1. Sizewise mattress 2. MiMedx ammendment to a contract already signed and approved.		
A. OSDH & CMS Updates			
B. Surveys			
C. Product Recalls			
D. FMEA			
E. RCA			
Policy & Procedure Review			
Policy & Procedure	1. Standing orders for Bamlanivimab. Etesevimab and Casirivimab.lemdevimab. 2. Emergency Preparedness Plan	1. Approved by: Melissa Tunstall and Candy Denny 2. Emergency Preparedness Plan appoved by Melissa Tunstall, QM and Daniel Coffin, CCO 3. Building Risk assessment approved by: Daniel Coffin, CCO and Candy Denny 4. Safety Hazard and Risk Assessment Approved by Pam	
Standing Agenda			

A. Annual Approval of Strategic Quality Plan			
B. Annual Appointment of Infection Preventionist	Karli Bowles		
C. Annual Appointment of Risk Manager			
D. Annual Appointment of Safety Officer			
E. Annual Appointment of Security Officer			
F. Annual Appointment of Compliance Officer			
G. Annual Review of Infection Control Risk Assessment (ICRA)			
H. Annual Review of Hazard Vulnerability Analysis (HVA)	May 13th		
Credentialing/New Appointments			
A. Credentialing/New Appointment Updates			
Education & Training			
A. Education & Training	Neutropenic Education 4/20 Infection Prevention puzzle on 4/26 Dry suction and chest tube education on 4/28 Care for the immunocompromised patient. CT Warm up education for nursing staff for decrease stroke door to transfer time. HQIC On board assessment completed 4/2 by QM. MOU meeting with Comanche County by phone		
Performance Improvement Projects			
A. Performance Improvement Projects	Stroke door to transfer time decrease. ROADI.		

Department Reports			
A. Department			
Other			
A. Other	Emergency Preparedness		
Adjournment			
A. Adjournment		Kim Houston and Kaye Hamilton	