2024

Annual Review & Evaluation 2023

Mangum Regional Medical Center

Mangum Regional Medical Center

Denise Jackson RN/Quality Manager

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2024 Quality Program Annual Review & Evaluation

EXECUTIVE SUMMARY

This program review and evaluation provides a comprehensive overview of the Mangum Regional Medical Center Quality Program for 2023.

Our Medical Staff and Hospital staff are committed to providing safe, high-quality care and exceptional service for every patient, every time. We look for ways to improve the patient care experience from beginning to end.

We use data to help us optimize outcomes of care and make improvements as needed to ensure the quality of care rendered to our patients is exceptional. The Quality Committee meets monthly to review and analyze the service and performance of the Hospital and its day-to-day operations. The annual quality and performance program plan shall strive to set clearly defined goals to achieve optimal outcomes. The Quality Department utilizes a system of indicators and benchmarks to measure and evaluate the effectiveness of our outcomes. This allows us to rapidly adjust, analyze, plan, and continuously improve our performance.

The governance work is accomplished through a series of committees that interact. The Hospital has established department level committees including the following: Utilization Review, Infection Control, Health Information Management, Pharmacy and Therapeutics, Environment of Care, and Compliance. These formally report through the Hospital's Quality Committee (QC) which in turn reports through the Medical Staff Committee (MS) and the Governing Board (GB).

The Hospital has a Governing Body that assumes full legal responsibility for determining, implementing, and monitoring policies and programs governing the Hospital's total operation and for ensuring that those policies and programs are administered to provide quality health care in a safe environment.

SCOPE

The Quality Assurance and Performance Improvement Program shall apply Hospital-wide and to any contracted services. It is the responsibility of all Hospital staff, including leadership who provide and support care in the Hospital to ensure an environment where care is safe, effective and centered on the patient's needs. Leaders foster performance improvement through planning, educating, setting priorities, and providing time and resources. Leaders play a major role in creating an environment where staff feel safe and free to engage in performance improvement and understand it is their responsibility to not only report quality and safety issues and concerns, but to participate in developing solutions and to ensure the right thing gets done.

The Hospital strives to meet the needs of the community and surrounding areas. Mangum Regional Medical Center is a 18-bed hospital that provides emergency care, observation, acute, and swing bed services.

The annual review and evaluation of the Quality Program includes an evaluation of the prior year's activities and includes recommendations for the next year. A periodic evaluation of the Hospital's Quality Program provides a mechanism to use the information collected to make informed decisions about changes and improvements. The Quality Manager retains oversight over the review and evaluation in conjunction with the Quality Committee, department leaders, and key leadership. Results of the annual review and evaluation are submitted to the Quality Committee, Medical Staff Committee, and Governing Board for review and approval.

Annual Items Completed in 2023

1. Annual Review & Approval of Quality Plan
    a. Approved on April 25, 2023
2. Appointment of Infection Preventionist
    a. Claudia Collard
        i. February 28, 2023
    b. Meghan Smith
        i. September 21, 2023 (IP Approval only)
3. Appointment of Risk Manager
    a. Denise Jackson
        i. Approved on February 28, 2023
4. Appointment of Compliance Officer
    a. Denise Jackson
        i. Approved on February 28, 2023
5. Annual Review of the Infection Control Risk Assessment & Evaluation
    a. Approved on February 28, 2023
    b. ICRA for MRMC 2023
6. Annual Review of the Hazard Vulnerability Assessment (HVA)
    a. Approved on October 2023
    b. HVA for MRMC 2023
7. Annual Review of the TB Risk Assessment
    a. Approved on April 25, 2023
    b. Risk Assessment for MRMC 2023

Annual Review Evaluation & Summary of Key Hospital Indicators

The program evaluation reporting period compares performance measures of calendar year 2022 to calendar year 2023. The Hospital Quality Program used benchmarks for 89 quality measures: AMA, LWBS, transfers, readmissions, medication errors, CAUTI, CLABSI, complaints, grievances, falls, mortality, OPO, code blue, and documentation. These benchmarks indicate the performance expectation for the corresponding quality measure.

Volume & Utilization

Total ED visits and transfers to higher levels of care numbers were down for the 2023 reporting year. All other areas are up from 2022. More patients were admitted to OBS due to payer source. Acute/SWB days up over all reflecting a higher discharge number and higher average daily census, due to higher acuity of patients admitted during 2023. Higher numbers for AMA due to numerous patients refusing in-patient admission, no provider follow up prior to inpatient discharging home and higher number of patients in the ER refusing treatment. Higher blood utilization for 2023 due to higher acuity of patients admitted inpatient and in the ER requiring blood products for treatment.

Criteria	2022	Benchmark	2023	CY/PY
Total ED Visits	1852	----------	1758	1758/1852
Total Observation Patients	6	----------	22	22/6
Total Acute Patients	169	----------	183	183/169
Total Swing Bed Patients	111	----------	131	131/111
Total Discharges (Acute & SWB)	263	----------	314	314/263
Total Patient Days (Acute & SWB)	3612	----------	4129	4129/3612
Average Daily Census	10	----------	11.3	11.3/10
AMA	38	<2	52	52/38
ED LWBS	2	<1	3	3/2
Transfers to a Tertiary Facility (Inpatient & ED)	132	<12	115	115/132
Blood Utilizations	53	----------	60	60/53

Case Management

The goal of the Case Management Department is to help coordinate the care for patients and families from Hospital admission to discharge. The Case Management Department shall be responsible for ensuring care coordination is multi-disciplinary, focuses on safe, high quality, cost-effective care, and promotion of optimal outcomes throughout the patient's hospitalization. To ensure these outcomes are sustained the Case Management Department measures quality indicators including CAH readmissions, IDT meeting documentation and Case Management assessments and reports these indicators to Quality Committee on a reoccurring basis.

CAH readmissions down by one for 2023, Case Manager working diligently with patients for care required at discharge. IDT numbers have significantly improved with EMR system improvements during the year.

Criteria	2022	Benchmark	2023	CY/PY

CAH Readmissions	18	<2	17	17/18
IDT Meeting Documentation	33%	85%	85%	85%/33%
Case Management Assessment	97%	95%	99%	99%/97%

Infection Control

The Hospital continues to care for patients with increased susceptibility to infections with increased risk to healthcare associated infections. The Hospital focuses on several infection control quality measures annually as part of the quality program. Of primary focus are CAUTIs (5th most common type of healthcare associate infection) and CLABSI (>85,000 preventable infections and >10,000 preventable deaths yearly). Hand hygiene and PPE are also of primary importance as they are both a simple and cost-effective way to prevent infections. Therefore, the Hospital has conducted monitoring activities on these measures in an effort to identify and address patient safety risks.

Two CAUTIs for the reporting period, two patients with high infection risk admitted inpatient and found to have CAUTI prior to discharge. One CLASBI infection in patient admitted with infection, during admit infection found in central line as well. HH/PPE numbers up for 2023 with continued education for all staff.

Criteria	2022	Benchmark	2023	CY/PY
CAUTI	1	≤1	2	2/1
CLABSI	0	0.5%	0.89	0.89/0
Hand Hygiene Compliance	97%	80%	100%	100% / 97%
PPE Compliance	92%	80%	99%	99% / 92%

Risk Management

The Hospital is committed to a culture of safety in an environment that promotes reporting of adverse events that includes but is not limited to sentinel events, near misses, and infrastructure events to take appropriate steps to mitigate the risk of such events and strive to continuously improve the quality and safety of patient care.

Events down overall for 2023. Complaints/Grievances up for 2023, likely due to routine rounding by administrative staff for all patients admitted to MRMC. Increase in ED mortality rate due to severity of cases in ED. Decline in OPO notification due to nurse lacking proper notification protocol, nurse provided individual education with no further issues.

Criteria	2022	Benchmark	2023	CY/PY	Summary
Total Number of Events	79	----------	25	25/79	Events decreased overall for 2023 due to fall precautions put in place for prevention
Total Inpatient Complaints	0	----------	4	4/0	Complaints up likely due to administration rounding on patients
Total ED Complaints	0	----------	1	1/0	Complaints up likely due to administration rounding on patients

Total Inpatient Grievances	1	----------	1	1/1	Grievances remained the same
Total ED Grievances	0	----------	1	1/0	Grievances up likely due to administration rounding on patients
Fall w/o Injury Rate (Inpatient)	6.1	≤5	0	0/6.1	Falls down due to precautions initiated on admit
Fall w/o Injury (Inpatient)	22	----------	13	13/22	Falls down due to precautions initiated on admit
Fall w/o Injury Rate (ED)	0	≤5	0	0/0	No change from 2022
Fall w/o Injury (ED)	3	----------	0	0/3	Falls down due to precautions initiated on admit
Fall w/ Minor Injury Rate (Inpatient)	1.4	≤5	0	0/1.4	Falls down due to precautions initiated on admit
Fall w/ Minor Injury (Inpatient)	5	----------	6	6/5	Falls with minor injury up, these make up any bruising/skin tears or abrasions
Fall w/ Minor Injury Rate (ED)	0	≤5	0	0/0	No change from 2022
Fall w/ Minor Injury (ED)	0	----------	0	0/0	No change from 2022
Fall w/ Major Injury Rate (Inpatient)	0.3	0.5%	0	0/0.3	Falls down due to precautions initiated on admit
Fall w/ Major Injury (Inpatient)	1	----------	0	0/1	Falls down due to precautions initiated on admit
Fall w/ Major Injury Rate (ED)	0	0.5%	0	0/0	No change from 2022
Fall w/ Major Injury (ED)	0	----------	0	0/0	No change from 2022
Mortality Rate	6%	10%	0	0/6%	Mortality rate down due to overall to less than 10%, less full code patients during the year
ED Mortality Rate	9	----------	14	14/9	Increase in ED mortality rate, increase in patients presenting to the ED requiring Full Code services, very high acuity cases with unsuccessful outcome
OPO Notifications	95%	100%	93%	93%/95%	Notifications down, one new nurse unaware of exact reporting requirements. Education was provided with no further issues in reporting times

Nursing

The Hospital has a well-organized nursing staff that strives to provide quality patient care. The quality program evaluates nursing quality measures on an annual basis and has standardized quality measures that includes critical tests/labs and Code Blue due to the risk to patient safety that are analyzed and reported to the Quality Committee monthly.

Critical Lab reporting process adjusted and monitored closely for improved reporting process during 2023. Code Blue numbers down for 2023.

Criteria	2022	Benchmark	2023	CY/PY
Critical Tests/Labs	90%	90%	97%	97%/90%
Code Blue	12	----------	6	6/12

Emergency Department

The Hospital's Emergency Department (ED) is focused on delivering safe and effective healthcare to those patients who present to the ED seeking emergency medical services. To ensure high quality services are provided to ED patients the Hospital performs an analysis and evaluation of quality measures that include but are not limited to low volume high risk conditions such as Stroke and STEMI, EMTALA indicators, and regulatory measures (MBQIP and EDTC).

MSE, Median time to transfers, and medical record documentation elements improved in 2023 with continued nursing education. ED readmissions increased likely due to patient compliance and lack of outpatient care follow-ups. Median ED arrival and departure time increased due to acuity of care and limited transfer mode resources.

Criteria	2022	Benchmark	2023	CY/PY
Medical Screening Examination (MSE)	99%	100%	100%	100%/99%
ED Readmission	1	2.5%	2.45%	2.45%/1
Median Time to Transfer to Another Facility for Acute Coronary Intervention (OP-3)	220 (3hr 40 min)	----------	178 min (2hr 58 min)	178/220
ED AMI Patients with ST-Segment Elevation on ECG who received Fibrinolytic Therapy (OP-2)	1	----------	0	0/1
Median Time from ED Arrival to ED Departure for Discharged ED Patients (OP-18)	89.75 min (1hr 29.75 min)	----------	105 min (1hr 45 min)	105 min / 89.75 min
Total # of patients transferred to another facility whose medical record documentation indicates all applicable 8 elements were documented and communicated to the receiving hospital in a timely manner	71%	100%	89%	89%/71%

Pharmacy

The Hospital's pharmacy staff including the Pharmacist in Charge, Drug Room Supervisor (DRS), providers and nursing staff are committed to providing the highest level of healthcare possible to the patients who are admitted to the Hospital. Pharmacy staff strive to meet the health needs of the community and surrounding area and provide cost-effective services necessary to enhance the quality of life for patients. By understanding the constant and dramatic changes in the healthcare industry, the Pharmacy Department will continue to strive to achieve excellence through the assessment of quality metrics. The Pharmacy Department analyzes and reports quality measures that include the measurement of the non-authorized accesses after hours, Adverse Drug Reactions (ADR), Medication Errors, Medication Overrides and Controlled Drug Discrepancies to the Quality Committee monthly.

Authorized access to pharmacy, medication overrides and controlled drug discrepancies were new indicators for 2023. Medication errors up by one in 2023, continued education to nursing staff as needed for errors as well as EMR system improvements for better medication error prevention aid.

Criteria	2022	Benchmark	2023	CY/PY
Number of authorized accesses to pharmacy after hours	N/A	90%	1091	1091/ NA
Adverse Drug Reactions (ADR)	0	0	0	0/0
Medication Errors	43	----------	44	44/43
Medication Overrides	N/A	----------	924	924/ NA
Controlled Drug Discrepancies Resolved	N/A	100%	98%	98% /NA

Radiology

The Radiology Department is responsible for the acquisition of diagnostic imaging of the human body for the purposes of studying the anatomical structures and physiological processes and performance of therapeutic procedures. The Radiology Department strives to provide cost effective, efficient, and appropriate care for all patients in need of radiologic procedures. Primary goals of the Radiology Department are to improve the quality of care through the performance of routine quality measurement and continual evaluation and improvement of key processes. To ensure sustainable patient outcomes the Radiology Department performs review and evaluation of quality measures that include but are not limited to repeated films, contrast CT scans with reaction, monitoring of radiology personnel and those personnel with out-of-range results.

Decrease in number of repeated films for the 2023 year.

Criteria	2022	Benchmark	2023	CY/PY
Number of Films repeated	68	----------	39	39/68
Number of Contrast CT scans completed with ***reaction***	0	----------	0	0/0
Number of Radiology Personnel Monitored	5	----------	5	5/5
Number of Radiology Personnel without out of range results	0	----------	0	0/0

Laboratory

The primary responsibility of the Laboratory Department is the provision of reliable and timely laboratory services, assistance to providers and nursing staff on the appropriate use of laboratory procedures, and the presentation of results within a timely manner to facilitate quality patient care. To achieve this the Laboratory Department routinely measures the number of labs repeated or rejected and the number of contaminated blood cultures for quality purposes, and continually evaluates laboratory processes for areas of improvement.

Repeated labs at 1% for the year, education provided when appropriate for draw errors. Blood contaminates down for the 2023 reporting period.

Criteria	2022	Benchmark	2023	CY/PY
Number of labs repeated or rejected	0%	<10%	1%	1% / 0%
Number of contaminated blood cultures	4%	<5%	1%	1% / 4%

Therapy

The Rehabilitation Therapy team is an integral part of the interdisciplinary team and is primarily focused on assisting patients to maximize their potential to the extent that it enables them to return to a lower level of care or achieve their most practical level of functional independence. Through evaluations and patient specific plans of treatment/care the Rehabilitation Therapy team works to achieve these goals. As part of the quality program the Rehabilitation Therapy team focuses on reporting the following quality measures including but not limited to discharge notes, PT/OT treatment sessions, improvement standardized assessment scores and discharges with full return to documented PLOF (previous level of function).

Discharge notes discharged patients with improved assessment scores and full return to PLOF increased for 2023. PT/OT sessions completed down due to patient refusal; education provided to patients regarding the need for therapy services with refusals.

Criteria	2022	Benchmark	2023	CY/PY
Number of Discharge Notes Present within 72 hours of Discharge (except weekends & holidays	96%	75%	100%	100% / 96%
Number of PT treatment sessions performed	96%	85%	93%	93% / 96%
Number of OT treatment sessions performed	92%	85%	89%	89 % / 92%
Number of patients discharged with improved standardized assessment scores	82%	80%	PT – 96%, OT - 98%, ST - 100% (98%)	98% / 82%
Number of discharges with full return to documented PLOF	73%	80%	84%	84% / 73 %

Wound Care

The Hospital's Wound Care team goals include maintaining the integrity of the patient's skin which is a significant factor of the patient's health, minimizing the risks and prevention of the occurrence of skin breakdown, provision of early detection and intervention of all breakdowns evident upon admission to the Hospital and the promotion of prompt evaluation and intervention of any changes in the patient's skin integrity during their hospitalization. The Wound Care team have been uniquely trained to assist the Quality team to measure quality and patient safety measures that are related to wound care including but not limited to hospital acquired pressure ulcers and wound healing rates.

There were no patients with hospital acquired pressure ulcers for 2023 and a lower number of wounds showing improvement for 2023 due to the overall lower number in wounds for the reporting period.

Criteria	2022	Benchmark	2023	CY/PY
Number of patients that developed hospital acquired pressure ulcer(s) during stay (Stage II or higher)	1%	<5%	0%	0% / 1 %
Number of wounds that showed improvement	63	----------	40	40/63
Number of initial wound patients with assessment/pictures completed within 24 hours of admission	100%	95%	100%	100% / 100%
Number of discharge wound patients with assessment/pictures completed at discharge	100%	95%	100%	100% / 100%

Medical Records

The Health Information Management (HIM) Department is responsible for overseeing the timely processing, completeness, and when necessary, the retrieval of all patients' medical records. The HIM Department staff ensure an accurate patient medical record through services including but not limited to processing and scanning, record retrieval and record abstraction and analysis. To ensure the quality of the patient's medical record the HIM Department measures the following quality measures including but not limited to H&Ps, Discharge Summary, Conditions of Admission, Electronic Prescribing and Legibility and reports these measures to the Quality Committee monthly.

Overall improvement in data for the year, closer monitoring, and communication with providers when documentation needs completed. Conditions of admission are a new indicator for the 2023 year. Electronic prescribing is down due to patient request for paper scripts at discharge.

Criteria	2022	Benchmark	2023	CY/PY
History & Physical (H&P) completion	99%	100%	100%	100% / 99%
Discharge Summary completion	95%	100%	100%	100% / 95%
Conditions of Admissions	N/A	100%	95%	95% / NA
Electronic Prescribing	99%	95%	97%	97% / 99%
Legibility	100%	95%	100%	100% /100%

Human Resources

The Human Resources Department is responsible for providing the right mix of staff for the Hospital that will be in line with the scope of services being provided to the Hospital. The Human Resources Department works in collaboration with Hospital leadership and Department Heads/Managers to select, train, and promote staff based on their relevant skills, talents and performance and provide training and development for all staff to enable them to achieve the highest level of skills possible thereby increasing quality and patient safety. To ensure quality the Human Resources Department analyzes and evaluates quality metrics that include but are not limited to the following: 90-Day staff competency check-off, new hire orientation compliance, annual education compliance, voluntary terminations, and involuntary terminations.

Staff competencies decreased with numerous HR change overs during 2023, improved with new HR director. Annual Education compliance numbers have improved with the new employee education system that was initiated in the first quarter of 2023. Voluntary terminations increased in 2023 due to personal growth opportunities, relocation, and competitive compensation opportunities.

Criteria	2022	Benchmark	2023	CY/PY
90-Day Staff Competency Staff Check-off Completed	100%	100%	97%	97% / 100%
New Hire Orientation Compliance	100%	100%	100%	100% / 100%
Annual Education Compliance	59%	100%	92%	92% / 59%
Voluntary Terminations	11		21	21/11
Involuntary Terminations	10		2	2/10

Life Safety and Emergency Preparedness

The Life Safety Program is vital to the safety of the Hospital and patients through minimizing the risks of a utility failure related to a utility system such as electrical, natural gas, medical gases, water, etc. and ensuring there are procedures in place in the event of such a failure; development of security procedures to protect patients, staff and visitors from harm during any type of security event; implementation of a fire management plan to minimize the risks of fire; and development and implementation of an equipment plan to manage the risk associated with the use of medical equipment.

The Emergency Preparedness Program is responsible for ensuring a timely, integrated, and coordinated response to a wide range of natural and man-made disasters that may disrupt normal operations and require a preplanned response. This is done in a manner that ensure protection, health and safety of patients, visitors and Hospital staff that is coordinated with the local community-wide response to a large-scale disaster.

Each program performs an analysis and evaluation of program specific quality measures to ensure patient safety and minimize risks to the Hospital that include but are not limited to monitoring fire drills, fire extinguisher checks and completion of emergency preparedness orientation education.

Fire drills and extinguisher checks remain at 100% for 2023. EP orientation decreased with HR change over and communication deficit with new employee education, HR and EP have resolved this issue.

Criteria	2022	Benchmark	2023	CY/PY
Number of fire drills completed	100%	100%	100%	100% / 100%
Number of monthly fire extinguisher checks completed	100%	100%	100%	100% / 100%
Number of new employees with documented completed EP orientation	100%	100%	87%	87% / 100%

Dietary

The Dietary Department is responsible for providing a program that meets the nutritional needs for all patients during their hospitalization while considering the patient's individual eating habits which are sometimes influenced by the patient's cultural or religious background. The Dietary Department collaborates with the Quality team to ensure food service quality measures are being appropriately assessed and measured. The dietary quality measures include but are not limited to the following: weekly and daily cleaning schedules, sanitizer logs and rinse temperatures.

Weekly cleaning schedules, daily cleaning schedules and PPM sanitizer log are new measures to 2023. Rinse temperatures are at 100% for the year.

Criteria	2022	Benchmark	2023	CY/PY
Weekly cleaning schedules completed and documented	N/A	100%	97%	97% / NA
Daily cleaning schedules completed and documented	N/A	100%	100%	100% / NA
PPM Sanitizer documented 3 times daily and logged	N/A	100%	100%	100% / NA
Rinse Temperatures documented	98%	100%	100%	100% / 98%

Respiratory Therapy

The Respiratory Therapy Department provides care and treatment for all patients in all stages of diseases and assists the patient and healthcare team with many different types of breathing disorders and problems. To ensure the safety of these patients the Respiratory Therapy Department develops and implements quality measures that includes but is not limited to the monitoring of ventilator days, patients who are on the ventilator at least seven (7) days in the weaning program and weaned a minimum of two (2) days prior to discharge, and the number of unplanned patients decannulations.

Ventilator days increased significantly for 2023 due to patients in the first half of the year requiring a ventilator, one patient was successfully weaned.

Criteria	2022	Benchmark	2023	CY/PY
Total number of ventilator days	9	----------	70	70/9
Number of patients on ventilator at least 7 days, in the weaning program & weaned a minimum of 2 days prior to discharge and at the time of discharge	0	----------	1	1/0
Number of unplanned patient decannulations	0	----------	0	0/0

Employee Health

Employee Health is dedicated to ensuring a culture of healthcare personnel (HCP) safety and the prevention of infectious disease transmission among healthcare personnel and patients in all healthcare settings. The Employee Health program is aimed at reducing risks for acquiring infections on the job (e.g., immunizing HCP, use of PPE, sharps safety) and managing HCP infectious exposures and illnesses that prevent the transmission of infectious diseases from potentially infectious HCP to patients, HCP, and others. As part of the quality program Employee Health monitors the quality of the Employee Health program through quality measures that include review of employee injuries, employee influenza vaccine compliance and employee COVID-19 vaccine compliance.

Employee injuries decreased by one in 2023, with continued education on workplace safety. Flu vaccine compliance remains the same through 2023. COVID vaccine compliance monitoring is no longer a requirement in 2023.

Criteria	2022	Benchmark	2023	CY/PY
Employee Injuries	9	----------	8	8/9
Employee Influenza Vaccine Compliance	51	----------	51	51/51
Employee COVID-19 Vaccinee Compliance	81%	100%	N/A	NA / 81%

Activities, Changes and/or Services Added During 2023

- Kelley Martinez CEO – June 27, 2023
- Nick Walker CNO – July 27, 2023

Policies

Date	Policy/Form#	Name of Policy/Form
01/2023		Respiratory Manuel (see TOC)
01/2023	FMCOM-002	Compliance Officer Appointment
01/2023	FMIC-001	Infection Preventionist Authority and Appointment Statement
01/2023	FMQM-002	Risk Manager Appointment
03/2023	380.0	Medical Records Policy
03/2023	FMEH-016	Respiratory Protection Program Hazard Assessment
03/2023		TB Risk Assessment for 2022
03/2023	BSO-0xx	Conditions of Admissions
03/2023	C-10A	HIPAA Privacy Officer Appointment
03/2023		Conditions of Admission Form
03/2023	HRD047	Social Media Policy
04/2023		AMA/LWBS Review Tool
05/2023	BSO-002	Employee VIP-Self Pay Discount Policy
05/2023	EHP-003	Employee Occupational Illness and Injury
05/2023	EHPR-001	Employee Health Standing Orders
05/2023	HIM-008	Scanning Documents into the EHR
05/2023	HIM-009	Access Maintenance HER
05/2023	HIM-015	Discharge Summary Contant Management
05/2023	HIM-016	Signing of a Death Certificate
05/2023	HIM-017	DC Record Reconciliation and Scanning
05/2023	HIM-018	Incomplete Records Policy
05/2023	HIM-024	Clinical Records Requirements, Standards and Content
05/2023	HIM-027	Location Security Maintance and Destruction of Medical Records
05/2023		INP Audit Sheet
05/2023		Mortality Review Tool
05/2023		OBS Audit Sheet
05/2023		Swing Bed Audit Sheet
06/2023		340B Drug Policy Reformatted
08/2023		Administration Policy Manuel (see TOC)
08/2023	FMDR-0xx	Immediate Use IV Compounding Skills Competency

08/2023	DRS-031	IV Compounding for Immediate Use and Preparation Area
08/2023	Lab 310	Critical Lab Value Sheet
08/2023		MRMC Generic Provider Time Sheet
08/2023		Provider Time Sheets Policy
09/2023		Corporate Cardholder Policy
09/2023		Corporate Cardholder Policy Attachment
09/2023	EHP-008	Staff Influenza Vaccine Program
09/2023		Corporate Credit Card Use Agreement
09/2023	ICP-015	Seasonal Influenza
09/2023		Hazard and Vulnerability Assessment
10/2023	DRS-015	Drug Diversion Policy
10/2023	FMDR-0xx	Behavioral Observation Checklist
10/2023	FMDR-0xx	Medication Error and Near Miss Report
10/2023	FMNR-0xx	Corporate Patient Belongings List
10/2023	FMNR-037	Patient Valuables Record Form
10/2023	FMNR-038	Lost and Found Property Report
10/2023	FMNR-039	Lost and Found Log
10/2023	FMNR-040	Temporary Absence Release Form
10/2023	NUR-028	Patient Belongings and Valuables
10/2023	NUR-029	Temporary Absence Release for Patients
10/2023	NUR-030	Intravenous Extravasation Management and Treatment
10/2023		Nursing Education – Personal Belonging and Valuables
10/2023		On Call and Call Back Responsibilities for Radiology

Contracted Services

In 2023, the Hospital had 71 active contracts and agreements. Through the contract review process 71contracts were reviewed, and 68 were retained by the Hospital. A central log is maintained of all contracts is maintained by Compliance and Administration. Following the review process, the contracts that were not retained in 2023 were the following:

- The Compliance Team Agreement - 3rd party Accredited RHC Survey for MFC
- InQDocs and InQuiSeek Agreement - RHC survey ready services and RHC policy management System for RHC
- Commercial Medical Electronics Maintenance Agreement

Education & Training

Date	Title/Main Objectives	Audience
1/17/23	PPE use, Hand-Hygiene, and Transmission-Based Precautions	CNAs
1/26/23	Collection of laboratory specimens in CPSI	Respiratory and Nursing
2/9/2023	Updated Covid-19 Medication and Treatment Guidelines	HCPs and Clinical Staff
2/10/2023	CareLearning online education program launched	All Staff

2/27/2023	EZ-IO inservice and training	Nursing, Respiratory therapy
3/30/2023	1st Quarter Mandatory Skills and Education modules: a. Foley Care and Maintenance/Preventing CAUTI. b. CVCs and PICC lines. c. Non-Ventilator Hospital-Acquired Pneumonia Vasopressors. d. Inotropic Agents.	Nursing
4/5/2023	a. New IUC securement devices to include use and rationale. b. New initiative: use of 2% CHG wipes for IUC care and rationale.	Nursing
4/11/2023	Active Shooter Training	All staff
4/25/2023	Lunch-n-Learn: Wound Care Essentials with Dianne	Nursing
5/15/2023	Ventilator & Respiratory Competencies New Admission Guidelines per Cohesive COVID-19 task force	Nursing
6/6/2023	Sepsis Care & Management for the Adult Patient	Nursing
6/15/2023	Dynamic Access PICC education ACLS/PALS	Nursing Nursing/Respiratory
6/16/2023	Electronic Devices policy (Read and Sign)	All Staff
6/21/2023	Lunch-n-Learn: UTI and Treatment with Dr. Rumsey	Nursing
7/24/2023	Q2 competencies and checkoffs: 1. Bolus/Gravity tube feeding 2. Continuous/Pump tube feeding 3. TPN/Lipids Administration 4. Transmission-based Precautions (test only) 5. PICC line displacement - what to do (Verbal) 6. IUC and CVC line necessity charting in CPSI (Verbal)	Nursing
9/28/2023	OHA Infection Prevention Bootcamp	IP
9/30/2023	Influenza and immunization education	All Staff
10/01/2023	ACLS/PALS	Nursing, Respiratory
10/11/2023	Hand hygiene/PPE	All Staff
12/5/2023- 12/7/2023	Nursing Skills fair: 1.) Blood transfusion 2.) Sepsis and CPSI documentation 3.) CAUTI Prevention 4.) PICC maintenance 5.) PPE/Hand Hygiene/Isolation 6.) Pharmacy IV compounding/Med Dispense	Nursing

Performance Improvement Projects

Problem/Opportunity	Improvements	Results
Stroke		
The Emergency Department will decrease the door to transfer time to < 60 minutes for all stroke patients who present to the Emergency Department at least 65% of the time or greater by December 2023.	Stroke documentation now in CPSI	Documentation improvements with EMR updates, delay in transfers remains an issue due to limited transportation/weather inhibiting ability to transportation
STEMI/CP		
The Emergency Department will decrease the door to transfer time to < 60 minutes for all STEMI patients who present to the Emergency Department at least 80% of the time or greater by December 2023.	CP documentation now in CPSI	Documentation improvements with EMR updates, delay in transfers remains an issue due to limited transportation/weather inhibiting ability to transportation

Surveys

Type of Survey	Results of Survey	Actions Taken
07/12/2023 – Pt care complaint	No findings	N/A
11/15/2023 – Life Safety Complaint	No findings	N/A

Root Cause Analysis

No RCAs were conducted in 2023.

Blood Utilization

Date	# of Transfusion Episodes	# of Blood Products	Transfusion Reaction
January 2023	None	None	None
February 2023	3	7	None
March 2023	2	2	None
April 2023	1	2	None
May 2023	2	4	None
June 2023	2	4	None
July 2023	5	10	1
August 2023	4	7	None
September 2023	3	11	None
October 2023	3	6	None
November 2023	0	0	None
December 2023	2	7	None

Facility/Equipment Issues/Concerns

Date	Brief Description of Issue	Action(s) Taken	PM Report Summary
01/2023	None		
02/2023	None		
03/2023	None		
04/2023	None		
05/2023	None		
06/2023	None		
07/2023	None		
08/2023	None		
09/2023	None		
10/2023	None		
11/2023	None		
12/2023	None		

Date	Type of Drill	Emergency Disaster Event
01/2023	None	
02/2023	None	Code Silver
03/18/2023	Fire Drill	
04/2023	None	
05/2023	None	
06/25/2023	Fire Drill	
07/2023	None	Power Outage
08/2023	None	Power Outage Internet Outage
09/28/2023	Fire Drill	
10/2023	None	
11/2023	None	MRSE Region 3 Drill
12/31/2023	Fire Drill	

03/30/2023 – Code Silver; initiated for patient safety. Areas of improvement; need for improved communication between team leaders and administrative staff. Staff how been educated on proper contact chain in the event of a patient safety event.

07/13/2023 – Power Outage; town/surrounding areas affected by outage, generator working for back up. Administration in contact with City for updates. Generator checks are done routinely in the event of unavoidable power outage.

08/11/2023 – Power Outage; town/surrounding areas affected by outage, generator working for back up. Administration in contact with City for updates. Generator checks are done routinely in the event of unavoidable power outage.

08/15/2023 – Internet Outage; began as a drill however internet would not return, documents for patient care are now printed for back up in the event of internet outage so as to not interrupt patient care.

Mandatory Routine Inspections

Date	Inspection Type	Results
1/29/23	Generator/Transfer Switch Check	Good
2/26/23	Generator/Transfer Switch Check	Good
3/31/23	Generator/Transfer Switch Check	Good
4/29/23	Generator/Transfer Switch Check	Good
5/27/23	Generator/Transfer Switch Check	Good
6/25/23	Generator/Transfer Switch Check	Good
7/22/23	Generator/Transfer Switch Check	Good
8/20/23	Generator/Transfer Switch Check	Good
9/24/23	Generator/Transfer Switch Check	Good
10/28/23	Generator/Transfer Switch Check	Good
11/26/23	Generator/Transfer Switch Check	Good
12/17/23	Generator/Transfer Switch Check	Good

Staffing

	New Employee	Voluntary Separations	Involuntary Separations	Open Positions
01/2023	3	2	0	8
02/2023	3	1	0	5
03/2023	3	3	0	8
04/2023	0	1	0	8
05/2023	3	5	0	8
06/2023	2	2	0	8
07/2023	4	1	0	6
08/2023	5	2	0	1
09/2023	1	1	0	0
10/2023	1	1	0	5
11/2023	2	1	1	5
12/2023	2	1	1	5

Medical Staff Appointments

Date	Credentialing Update	New Appointment
01/2023	Heartland Pathologist as follows: Mary Holmboe, MD Ruth Oneson, MD Ricky Reaves, MD Barry Rockler, MD Sherrita Wilson, MD	DIA – Associates as follows: Gregory Bradley, DO Nicholas Bull, DO Oliver Cvitanic, MD Frank Hebroni, MD Catherine Shaeffer, MD Natalia Solomon, MD Soumya Vempalle, MD
02/2023	Benjamin Love, MD Greg Morgan, MD	Amy Sims, APRN

	Kenna Wenthold, APRN	
03/2023	None	
04/2023	None	
05/2023	Suresh Chandrasekaran, MD	
06/2023	None	
07/2023	Jeff Brand, PA	
08/2023	None	
09/2023	Fei-Ling, Yeh, DO	
10/2023	None	
11/2023	Barry Davenport, MD Trent Elliott, DO	DIA-Associates, INC are as follows: Jeremiah Daniel, DO Nancy Emelife, MD Mehyar Hefazi-Torghabeh, MD Austin Marsh, MD Jessica Millslap, MD Aubrey Jade Slaughter, MD
12/2023	None	

Approval of 2023 Annual Quality Evaluation

_____ _____/_____/_____

Quality Manager *Date*

_____ _____/_____/_____

Medical Director *Date*

_____ _____/_____/_____

Governing Board Member *Date*