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

	Print Name	***Signature***
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		

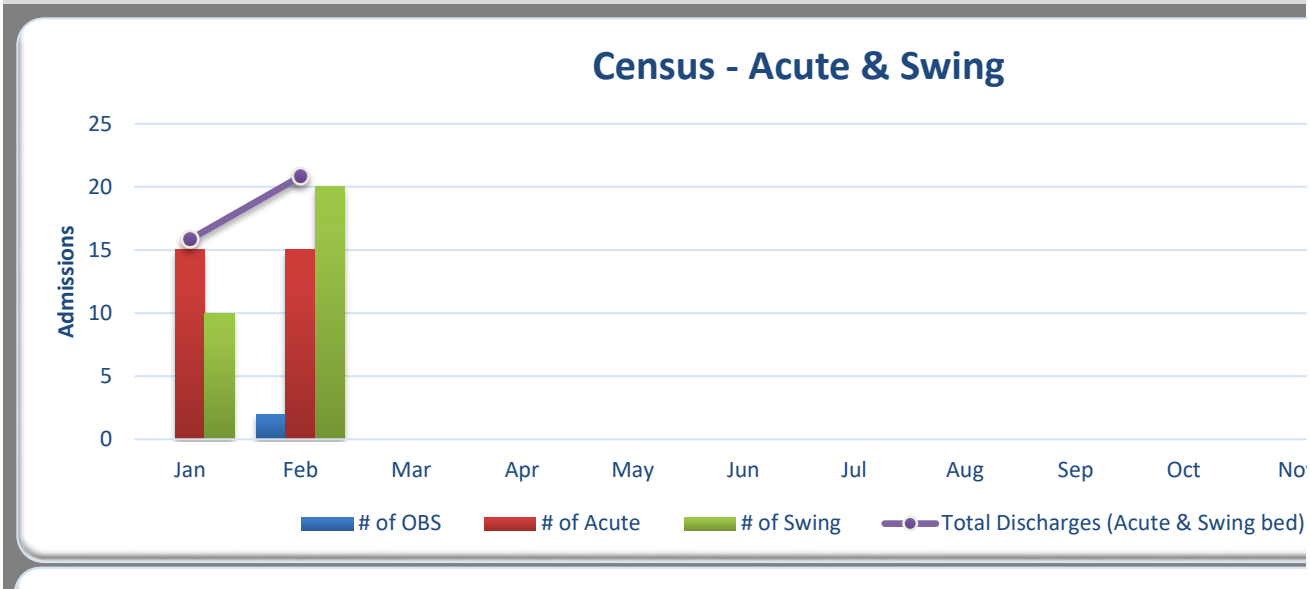
QUALITY CARE

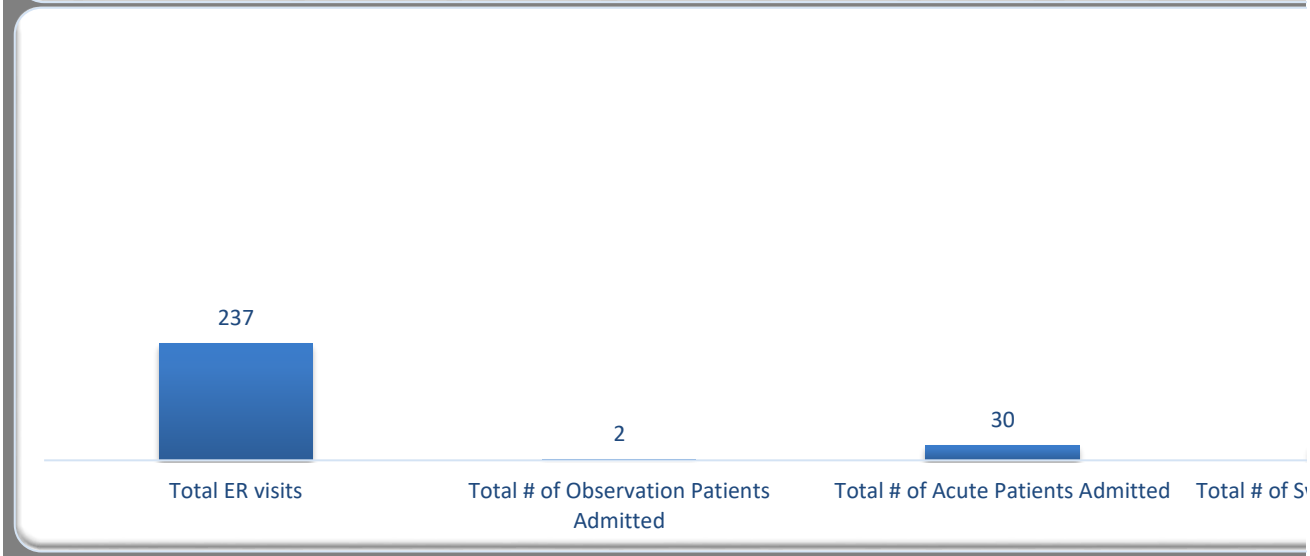
Name of Facility

QUALTIY ASSURANCE & PERFORMANCE IMPROVEMENT REPORT

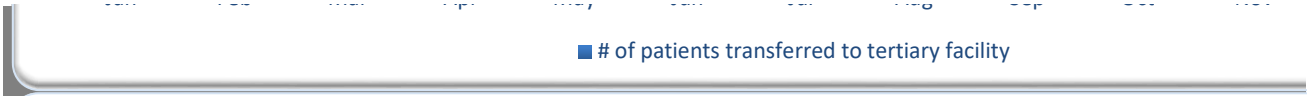
REPORTING PERIOD

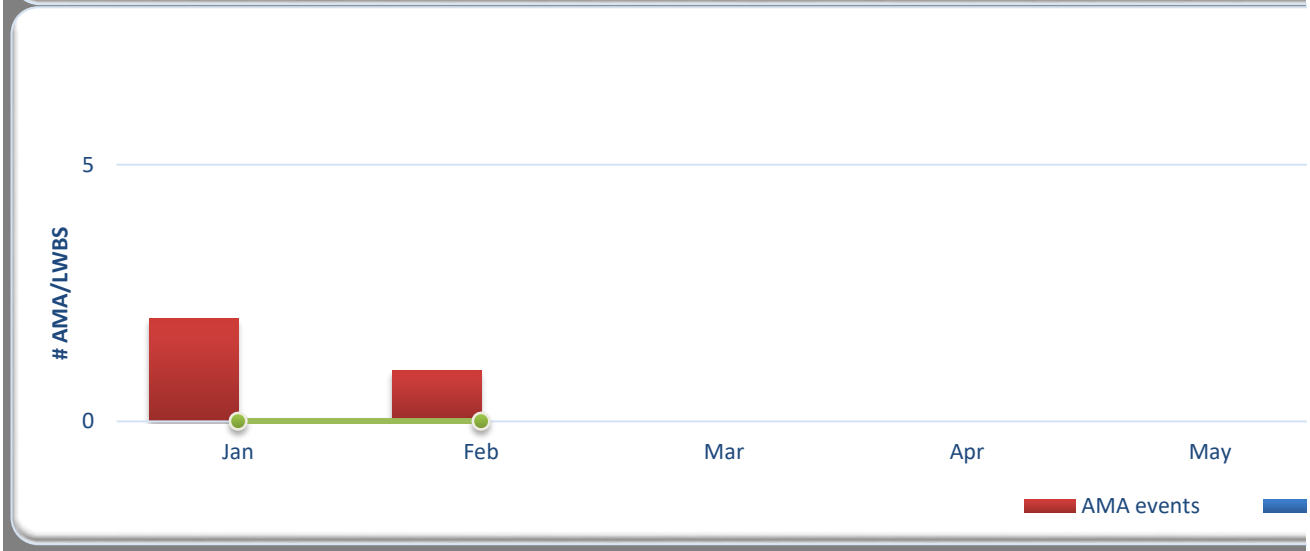
Date: Revised 2021

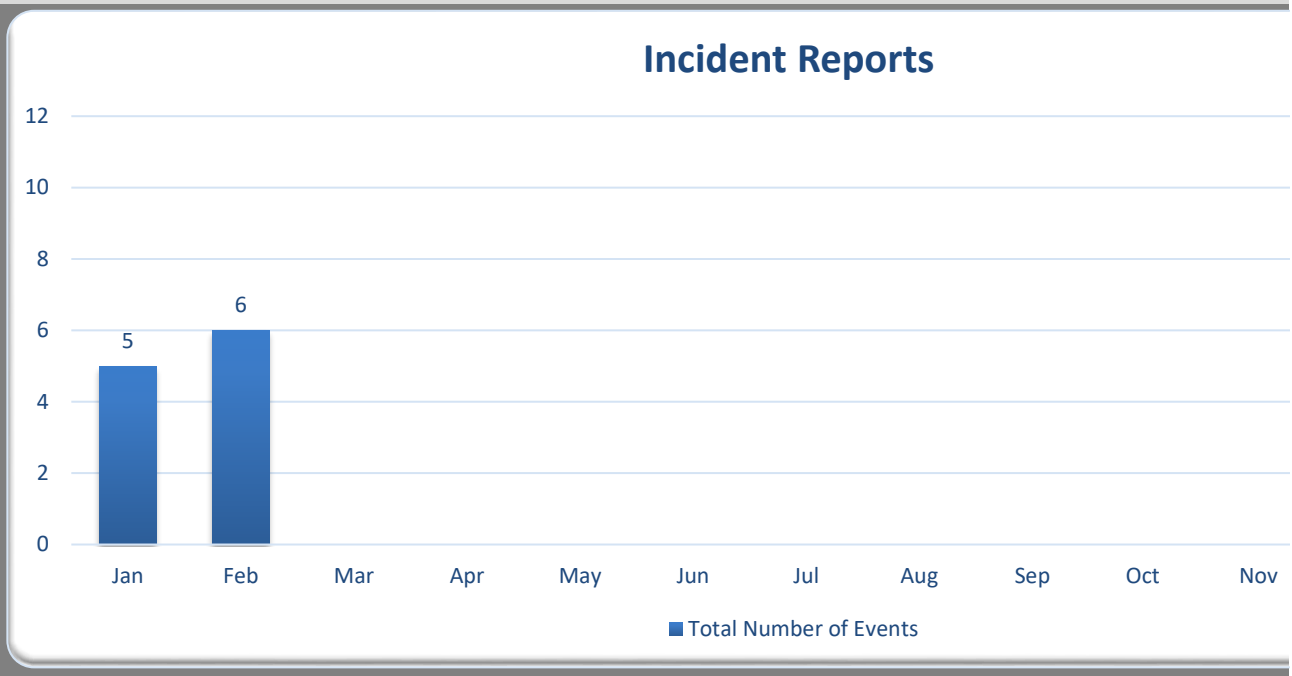

Census - Acute & Swing
25
20
15
10
5
0
Admissions
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
# of OBS
# of Acute
# of Swing
Total Discharges (Acute & Swing bed)

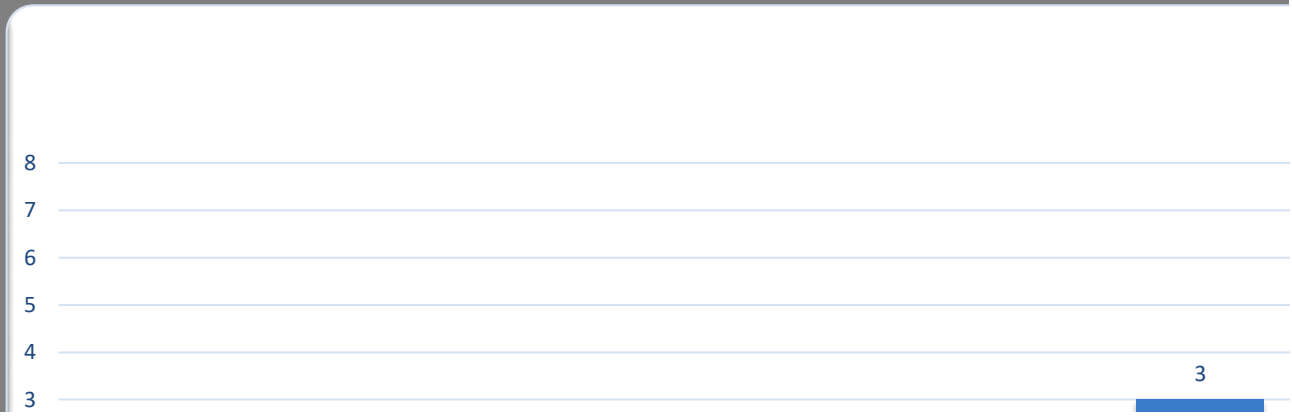

237
2
30
Total ER visits
Total # of Observation Patients Admitted
Total # of Acute Patients Admitted

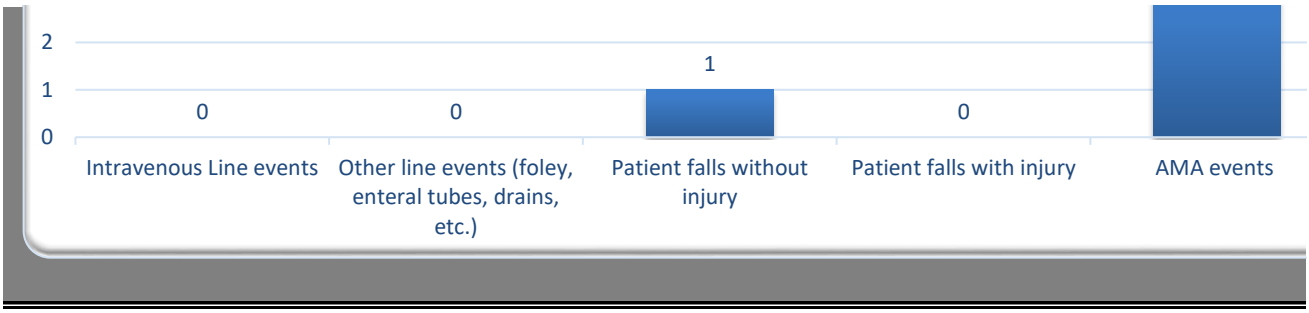

Transfers
5
0
1
1
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov

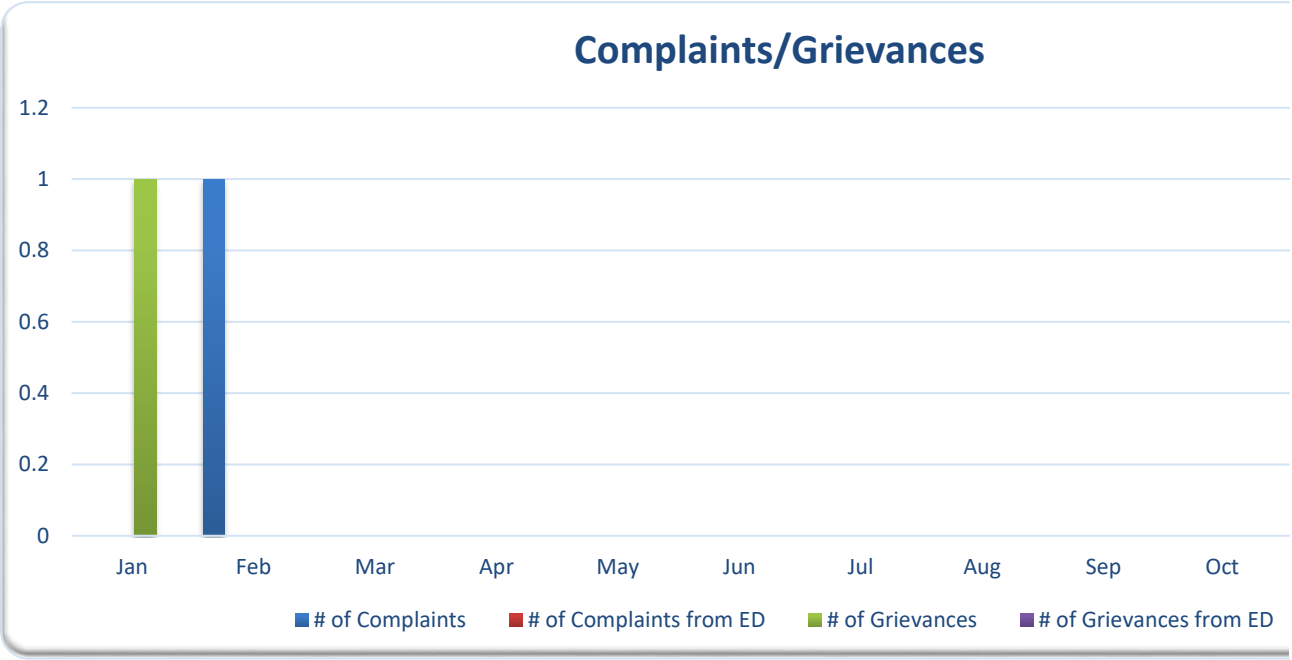

# of patients transferred to tertiary facility

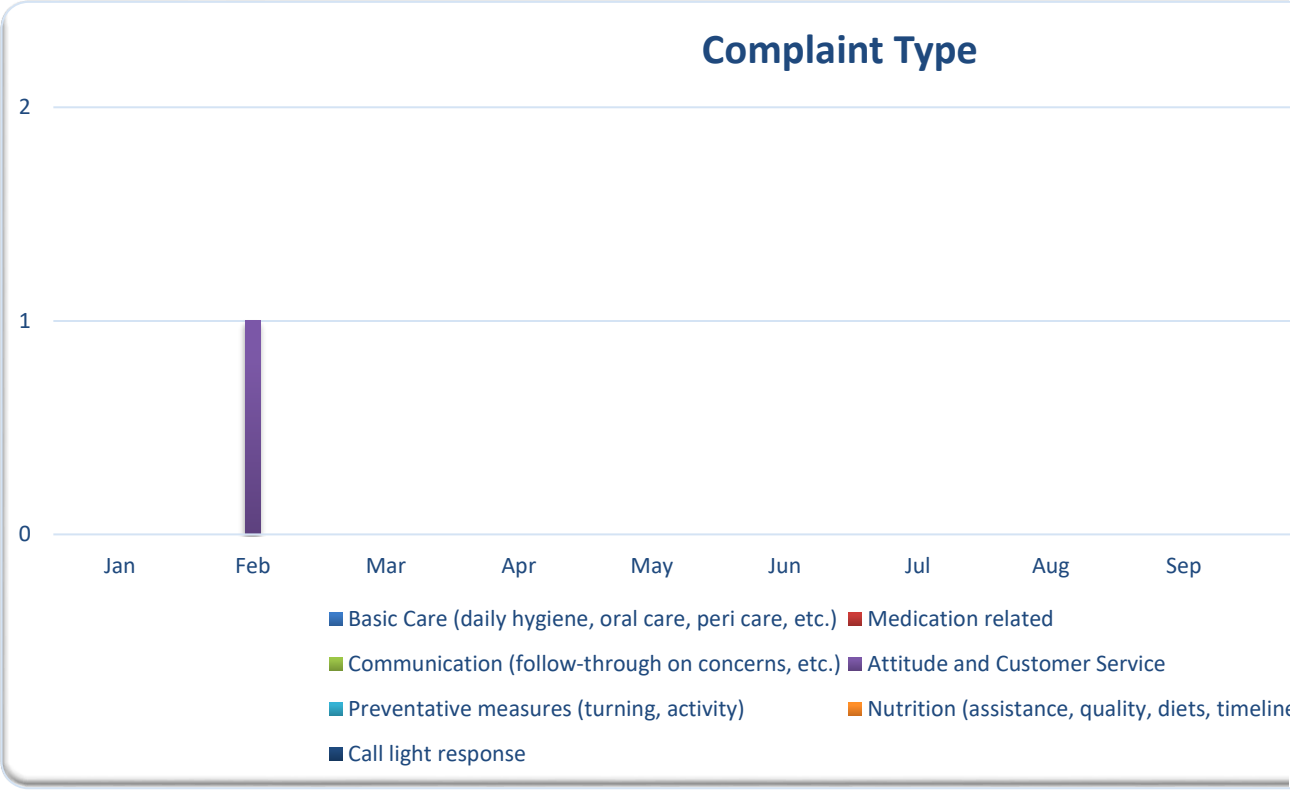

5
AMA/LWBS
0
Jan
Feb
Mar
Apr
May
AMA events

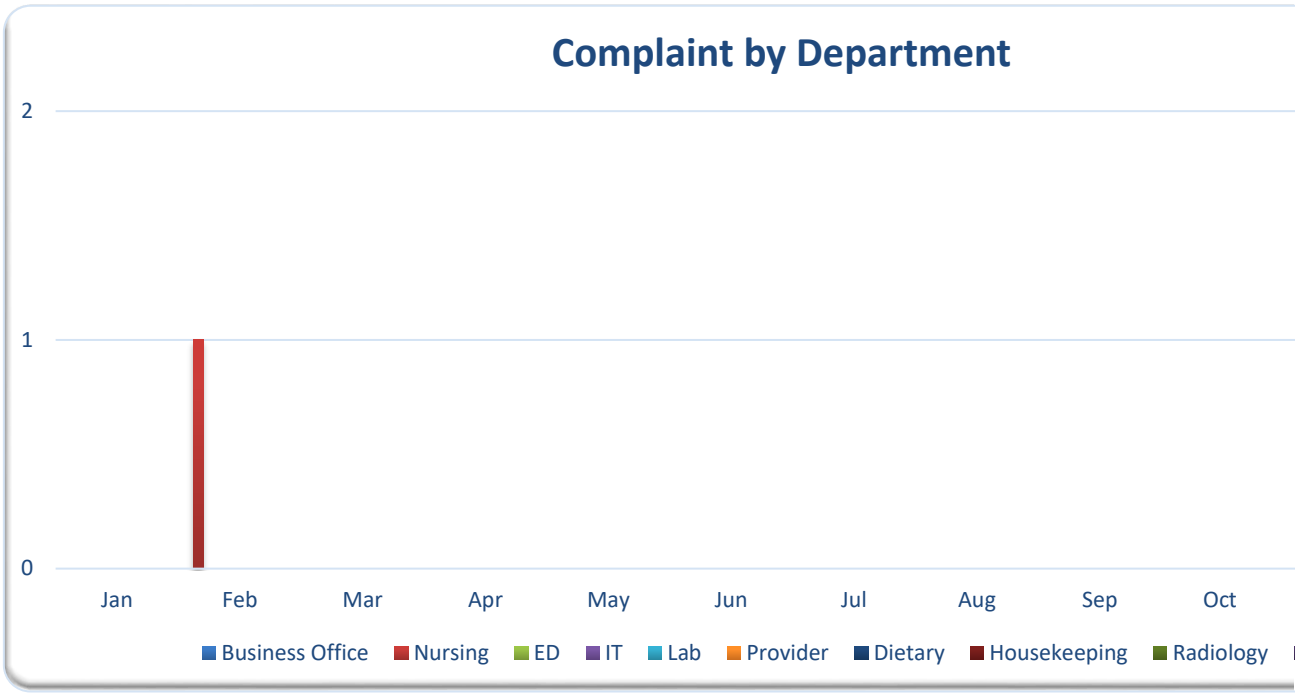

Incident Reports
12
10
8
6
4
2
0
5
6
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Total Number of Events


8
7
6
5
4
3
3

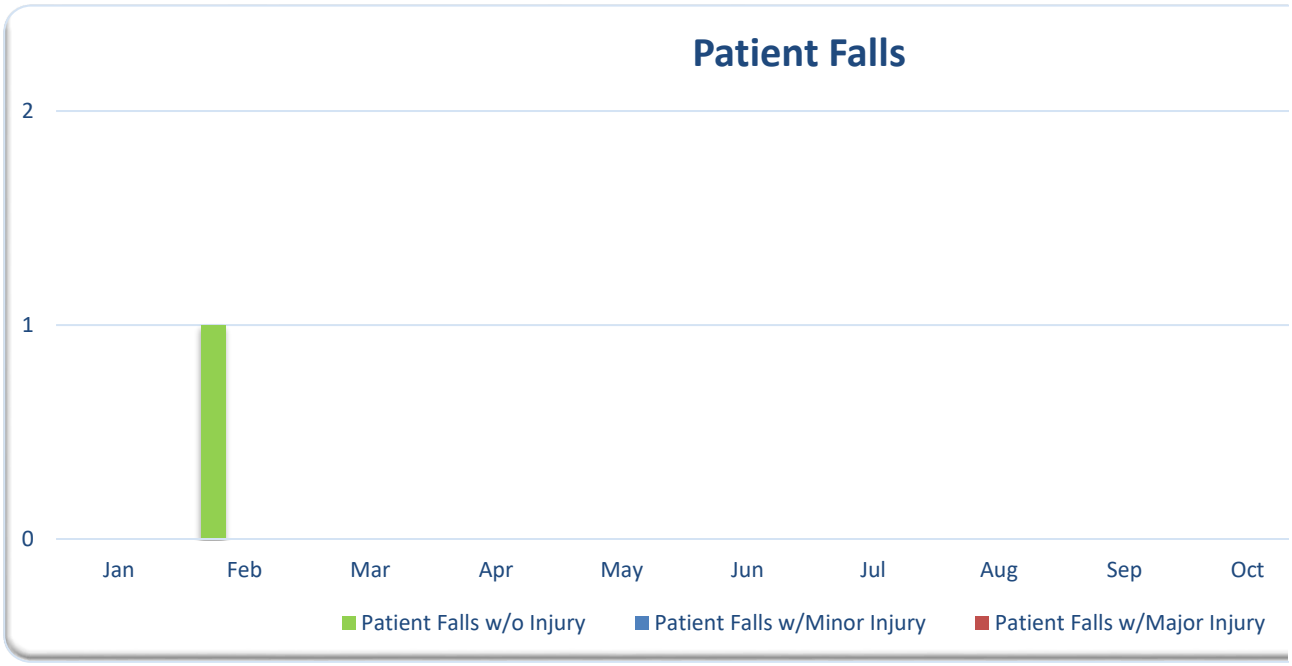

2
1
0
0
0
1
0
Intravenous Line events
Other line events (foley, enteral tubes, drains, etc.)
Patient falls without injury
Patient falls with injury
AMA events

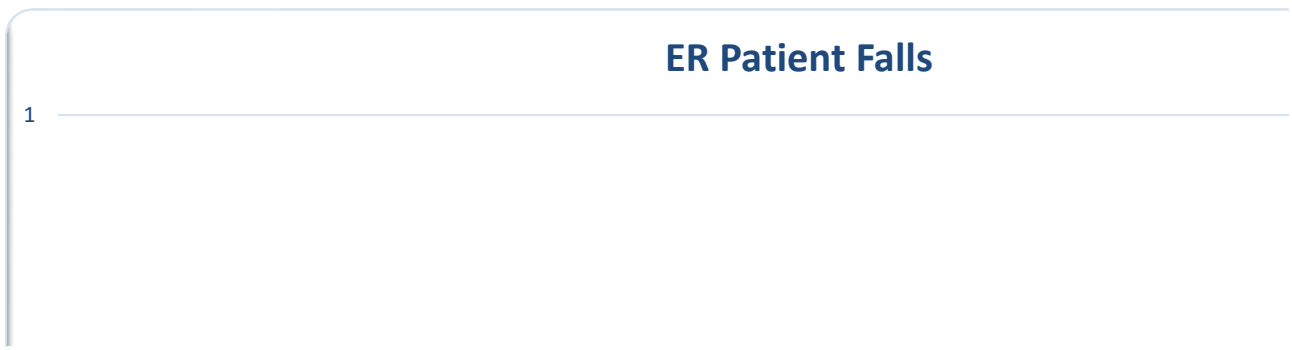

Complaints/Grievances
1.2
1
0.8
0.6
0.4
0.2
0
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
# of Complaints
# of Complaints from ED
# of Grievances
# of Grievances from ED


Complaint Type
2
1
0
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
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, timeline
Call light response

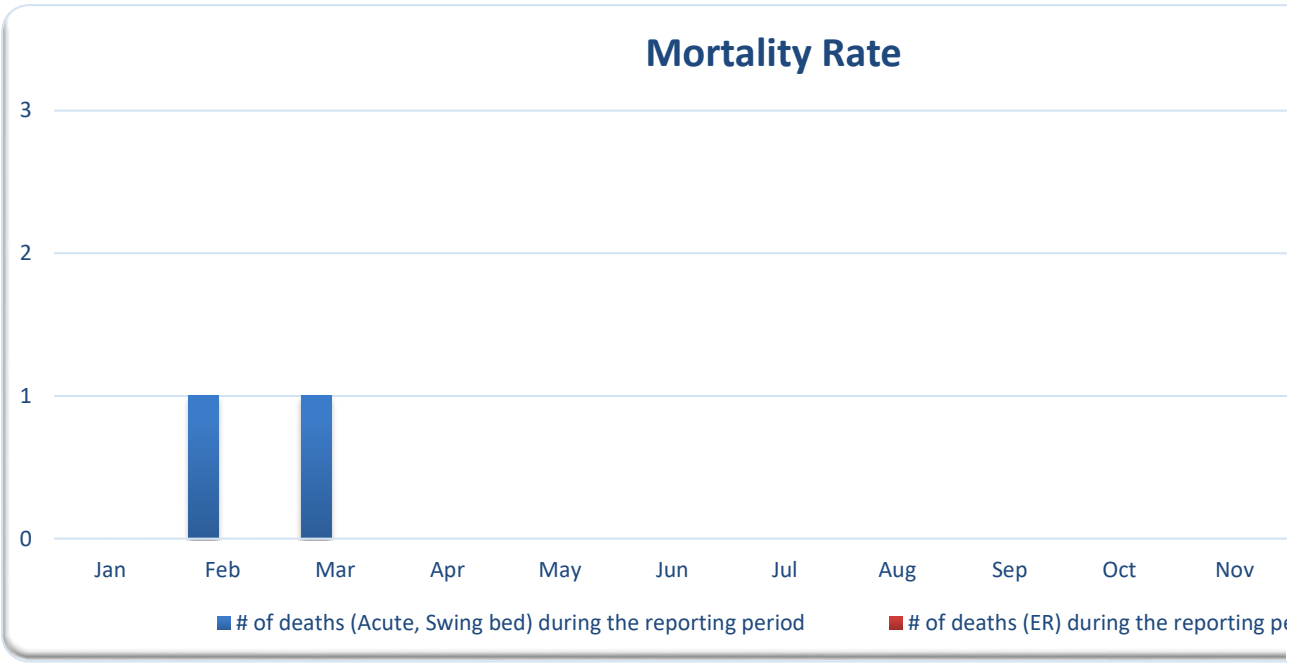


D. Patient Falls

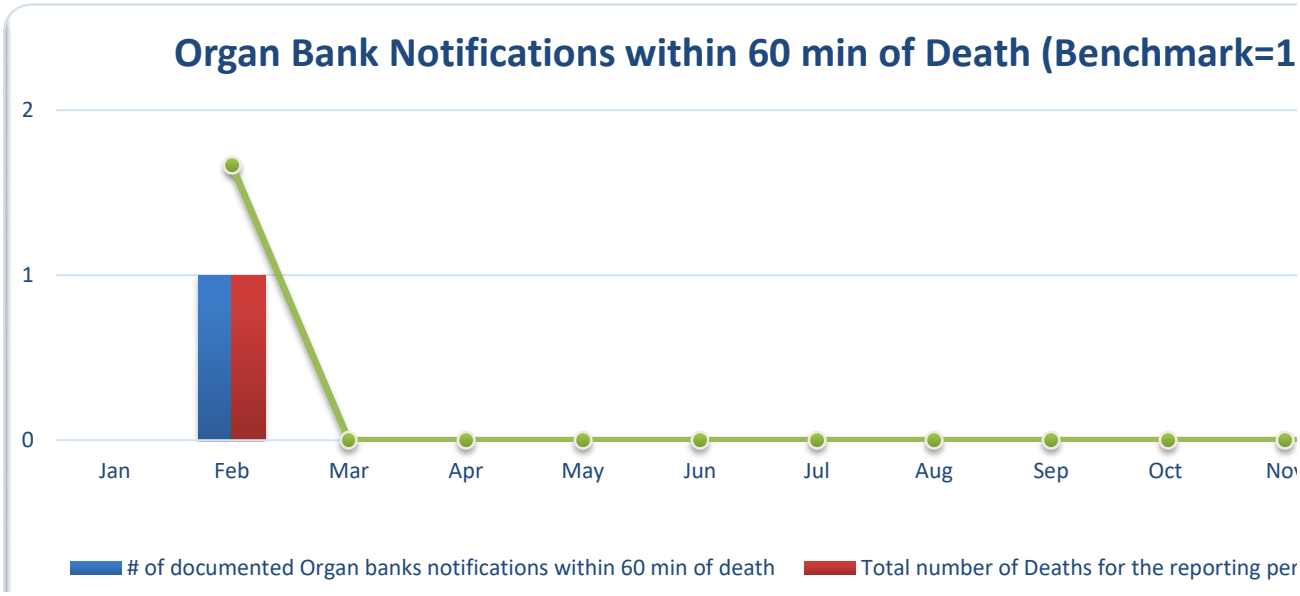




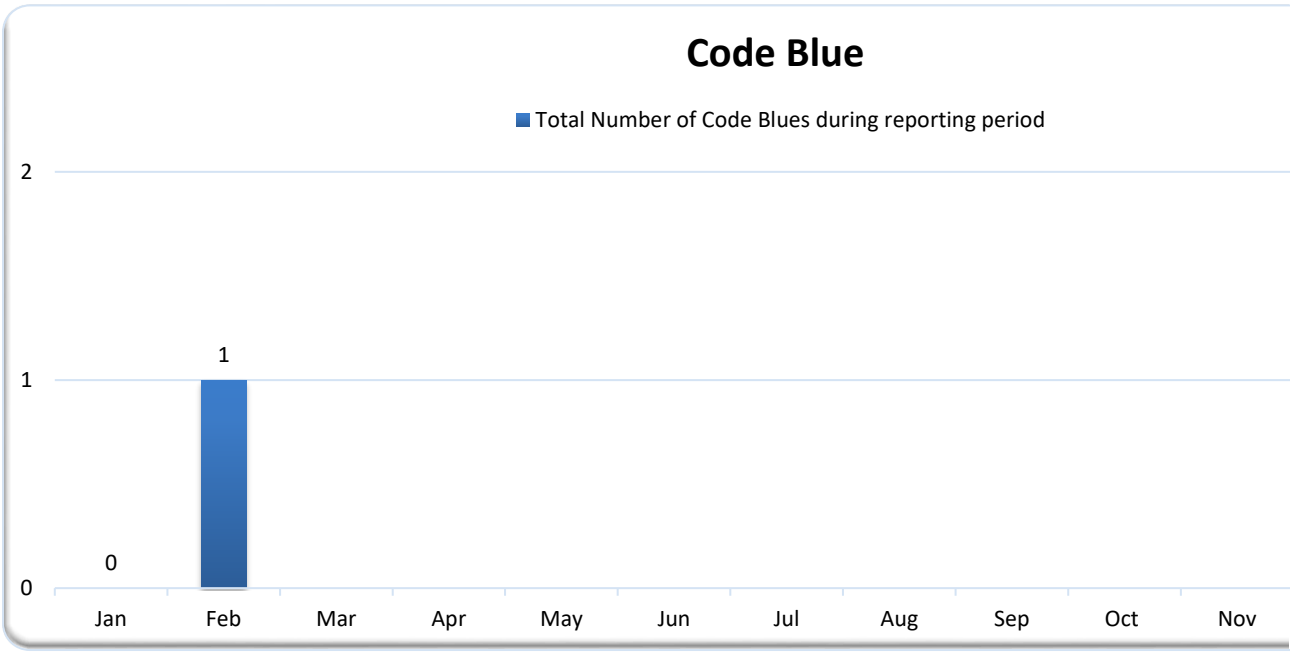
G. Mortality Rate



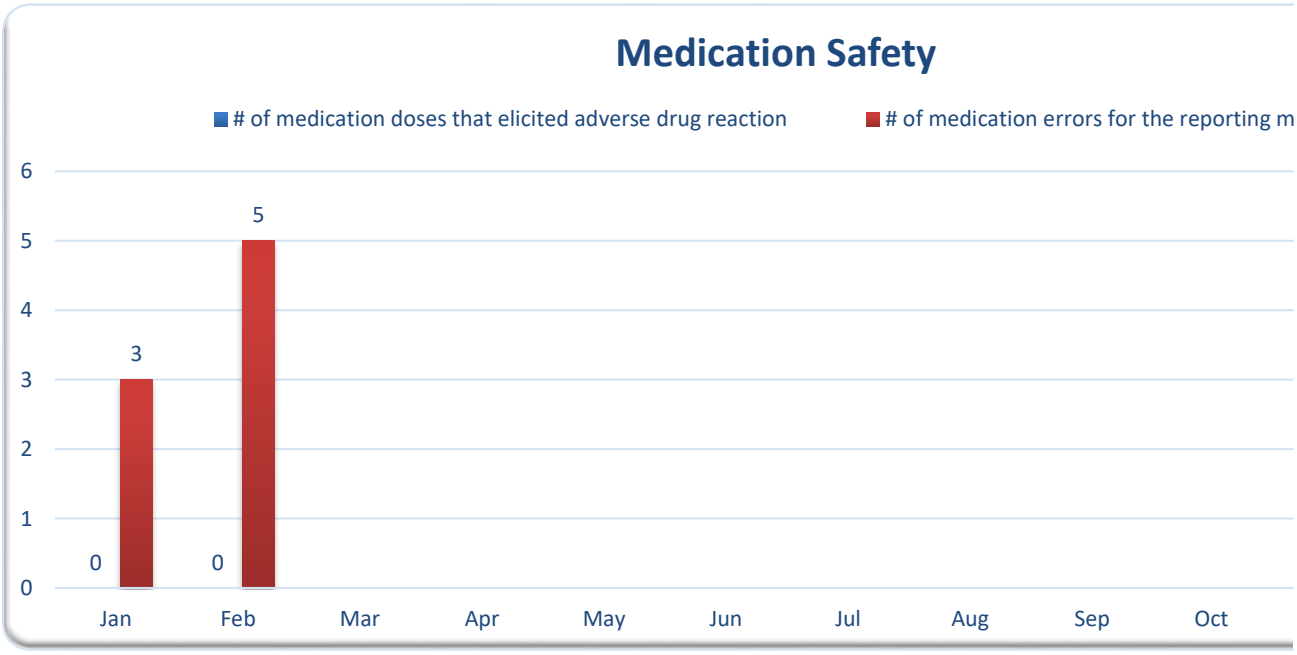
I. OPO



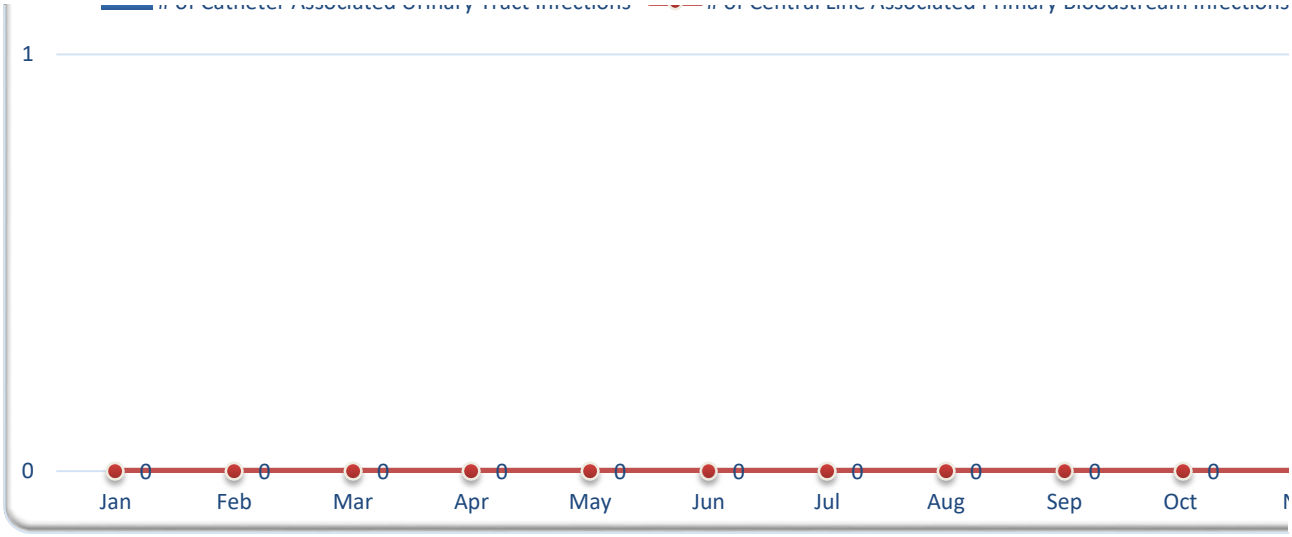
J. Code Blue Intervention



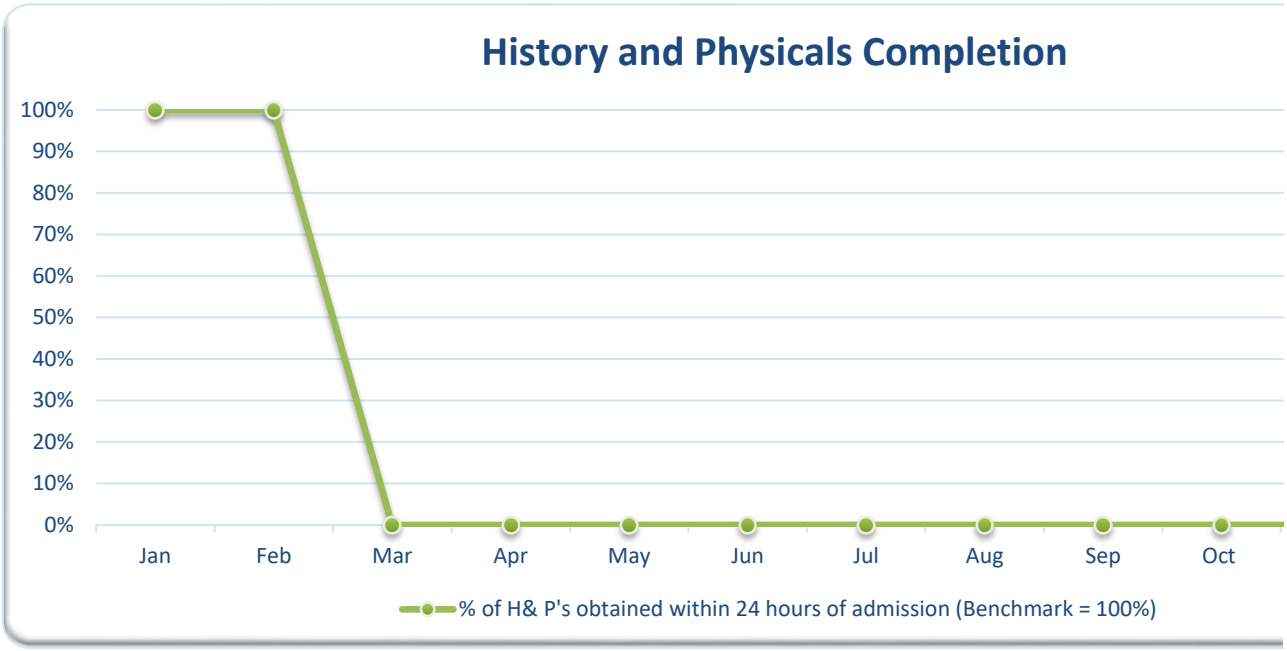
B. Med Errors

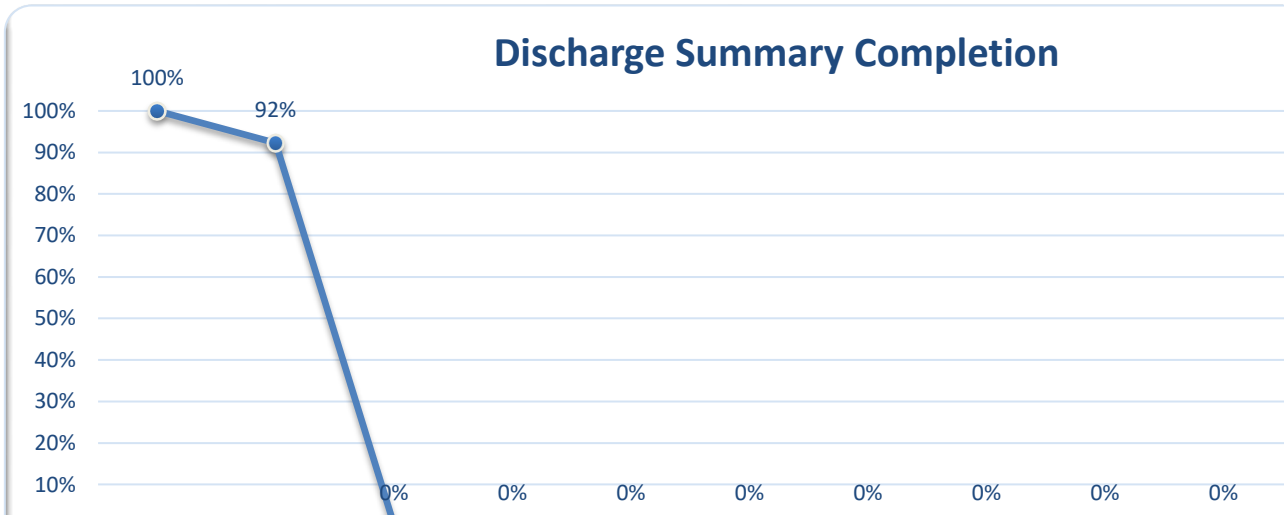


XIII. Infection Control & Prevention


1
0
0 0 0 0 0 0 0 0 0 0
Jan Feb Mar Apr May Jun Jul Aug Sep Oct

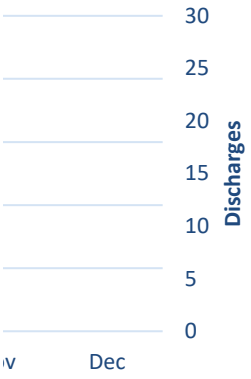
XIV. HIM

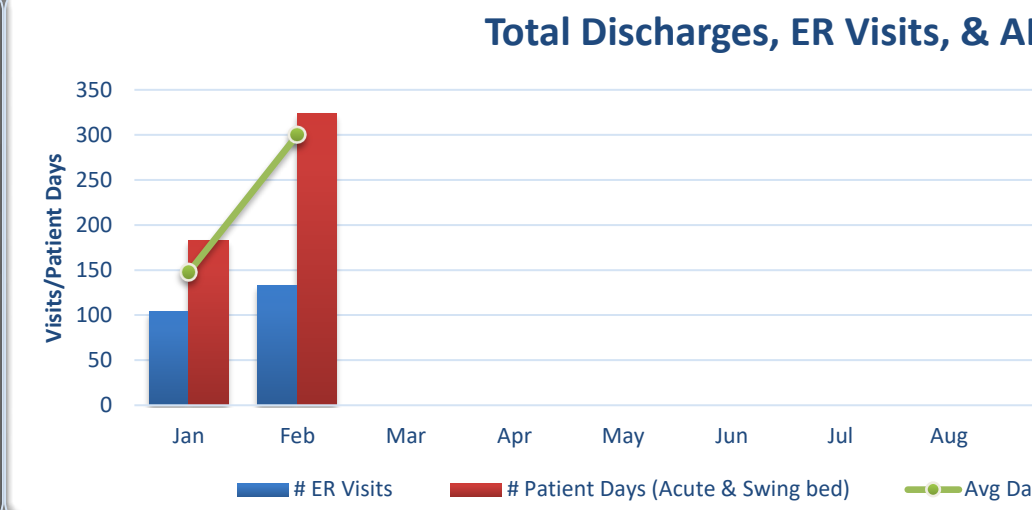

History and Physicals Completion
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Jan Feb Mar Apr May Jun Jul Aug Sep Oct
% of H& P's obtained within 24 hours of admission (Benchmark = 100%)

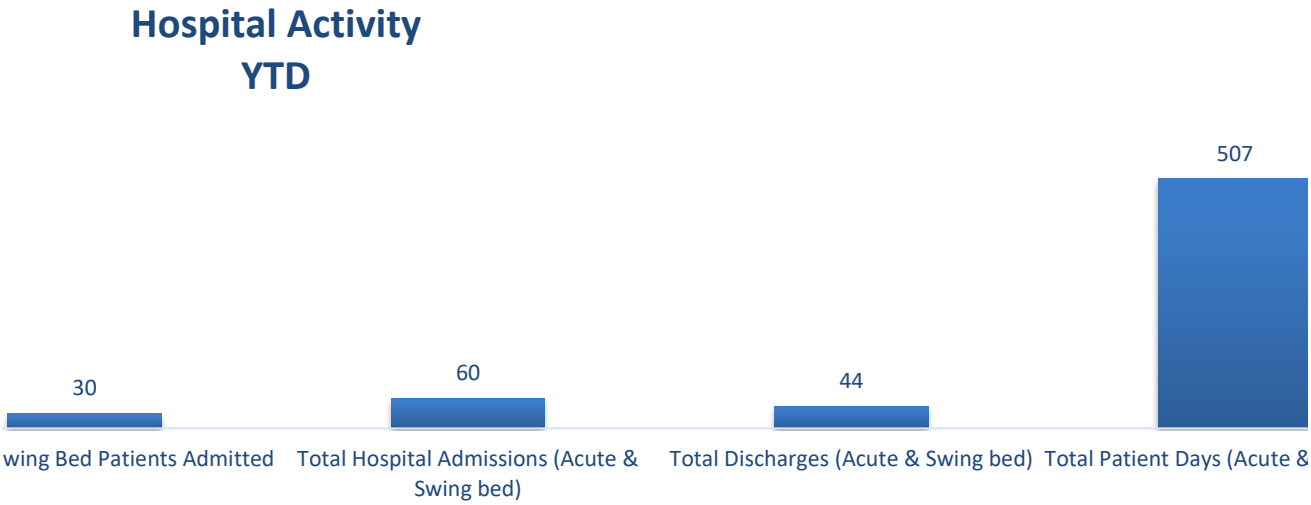

Discharge Summary Completion
100%
92%
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0% 0% 0% 0% 0% 0% 0% 0%


0%
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
% of Discharge Summaries completed within 48 hours of discharge (Benchmark=100%)

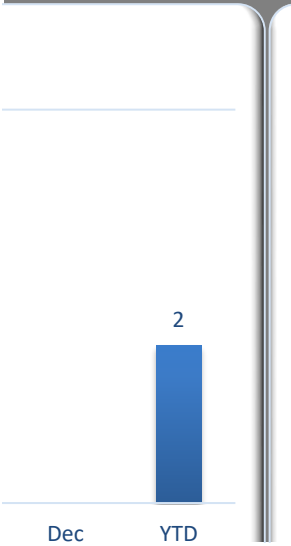
I. Volume & Utilization

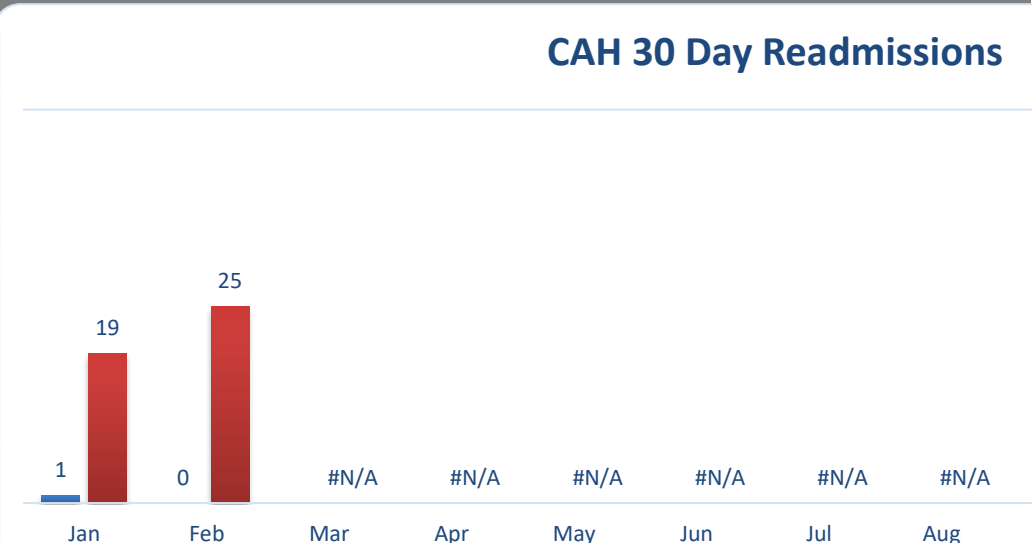


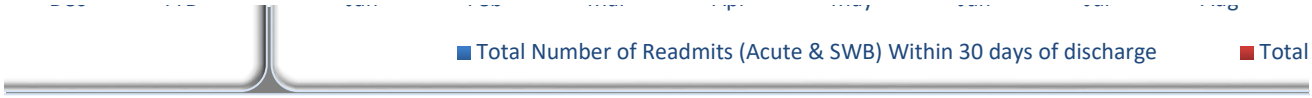




II. Care Management

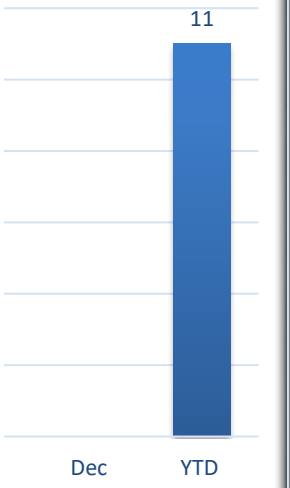




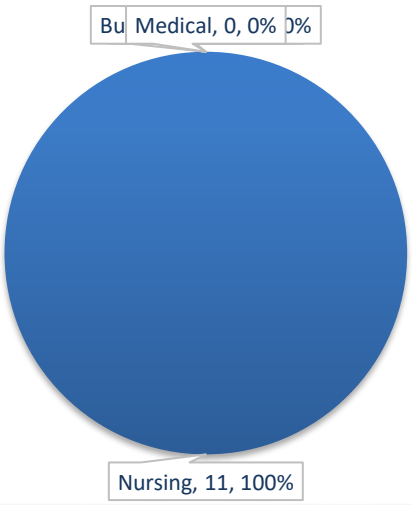


Hospital Activity
AMA/LWBS

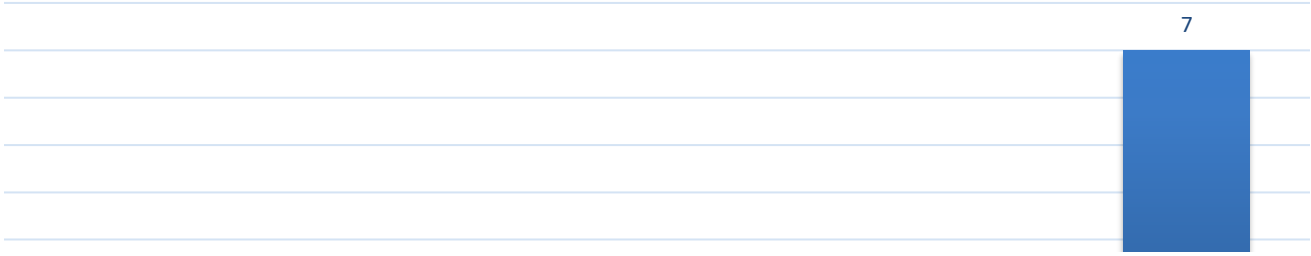
III. Risk Management

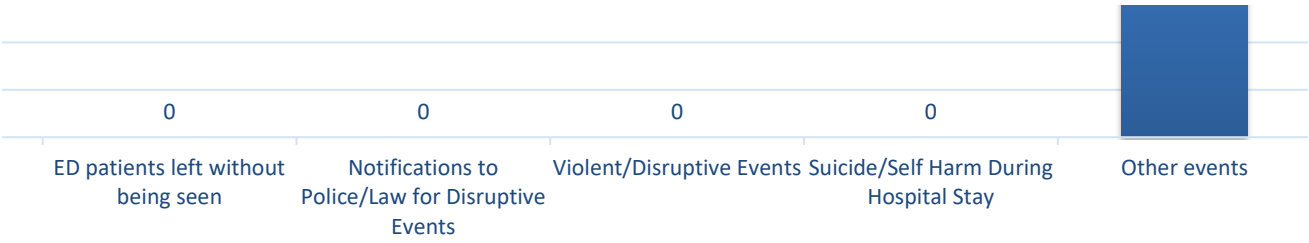


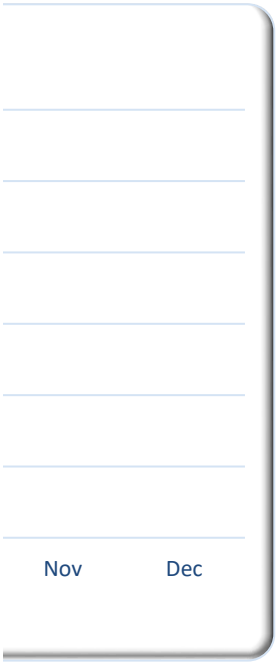
YTD
Incident by Department

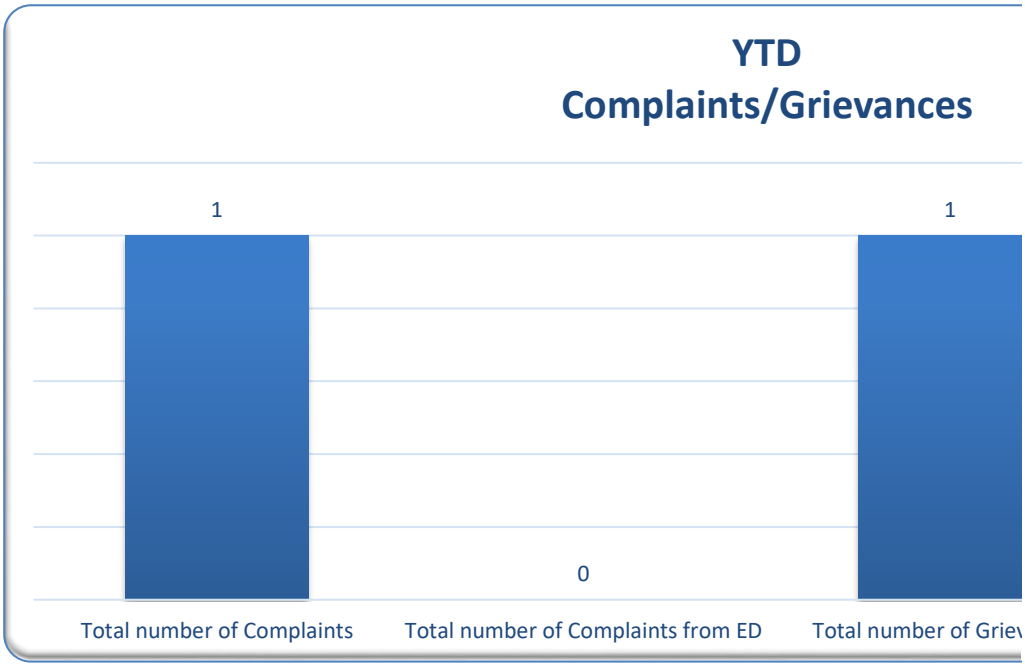


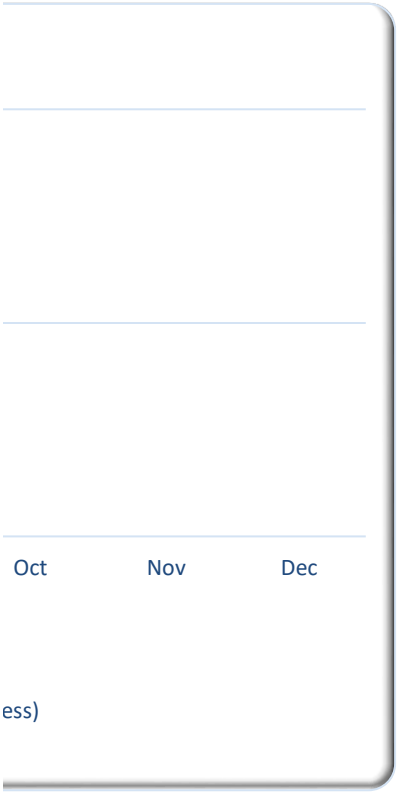
YTD
Incident Report Categories

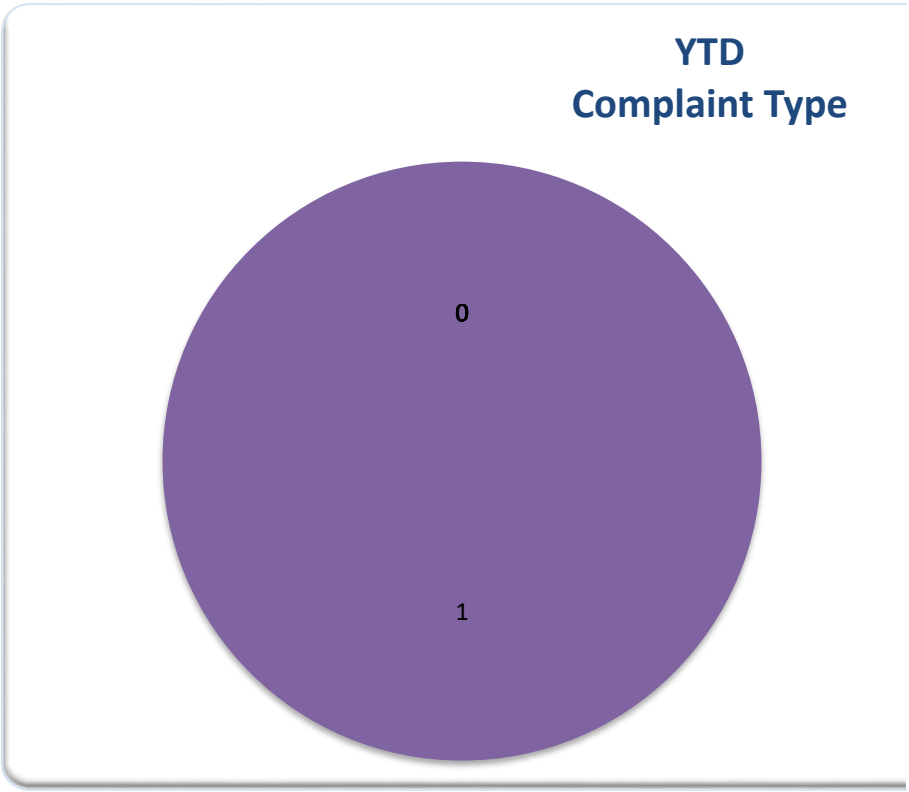


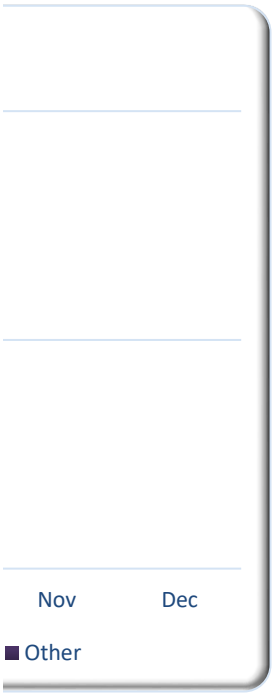

0
0
0
0
ED patients left without being seen
Notifications to Police/Law for Disruptive Events
Violent/Disruptive Events
Suicide/Self Harm During Hospital Stay
Other events

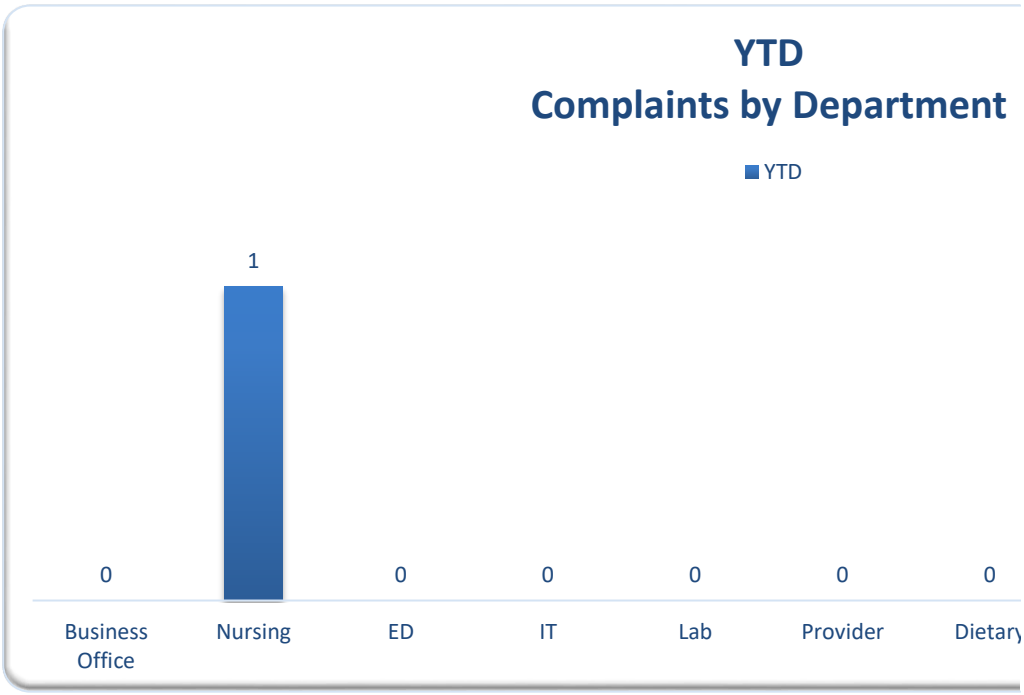

Nov
Dec

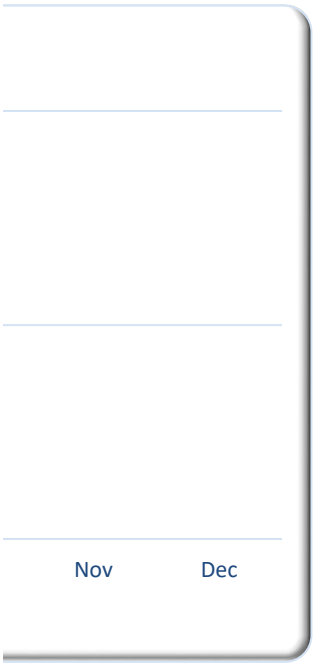

YTD
Complaints/Grievances
1
0
1
Total number of Complaints
Total number of Complaints from ED
Total number of Griev

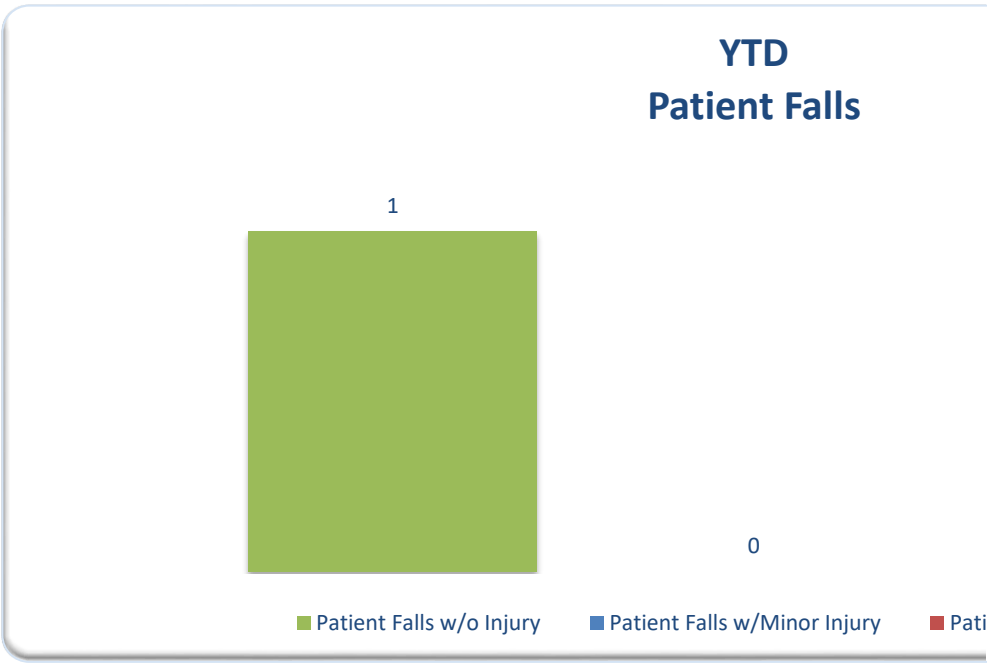

Oct
Nov
Dec
ess)

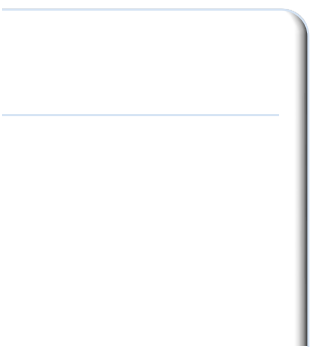

YTD
Complaint Type
0
1

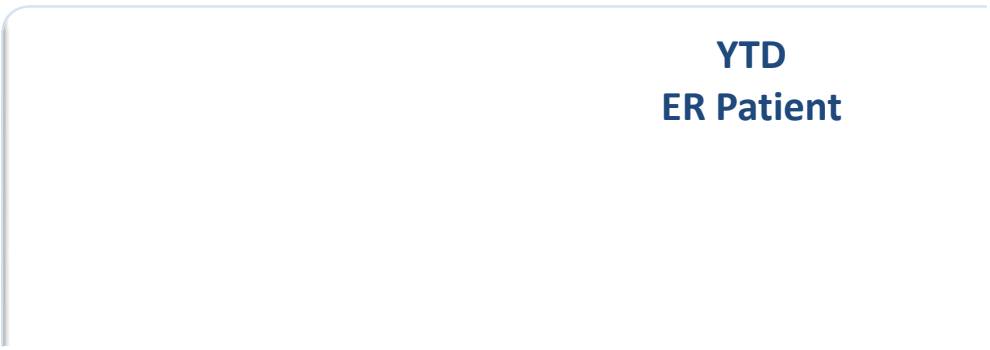

Nov
Dec
Other

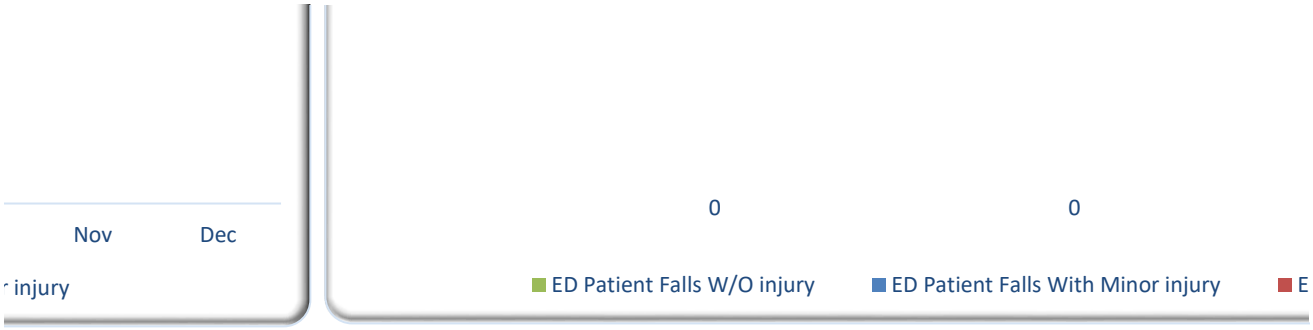

YTD
Complaints by Department
YTD
1
0
0
0
0
0
0
Business Office
Nursing
ED
IT
Lab
Provider
Dietary

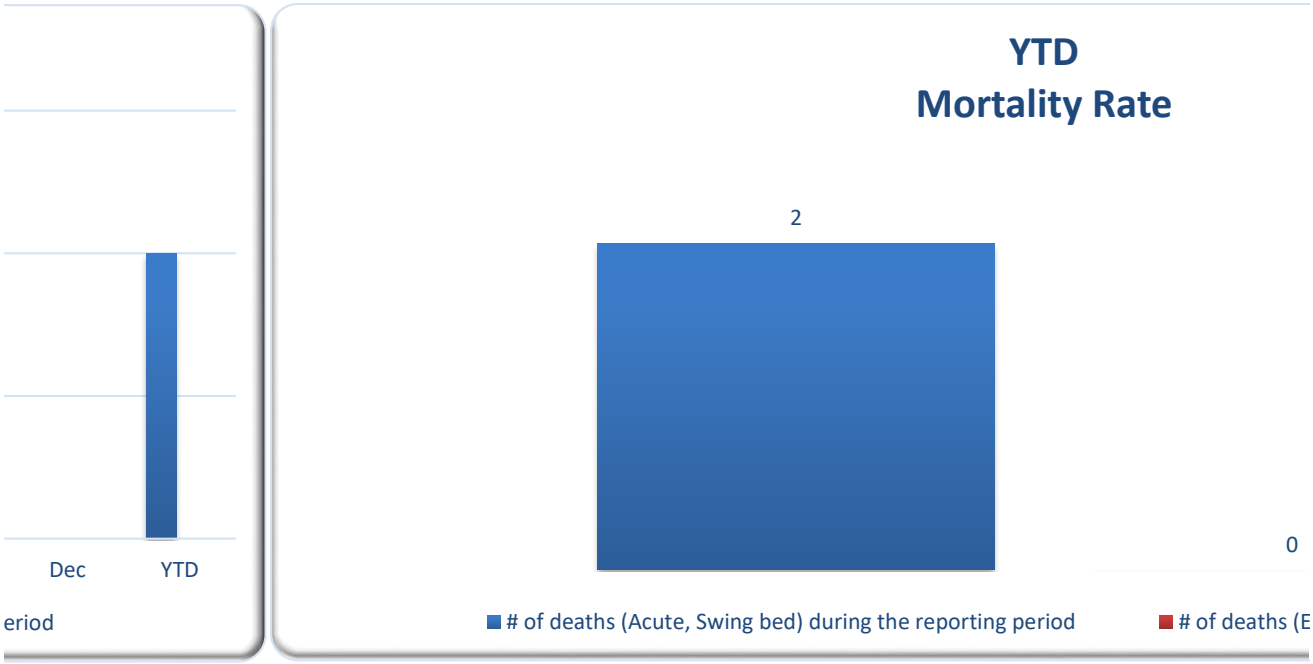

Nov
Dec

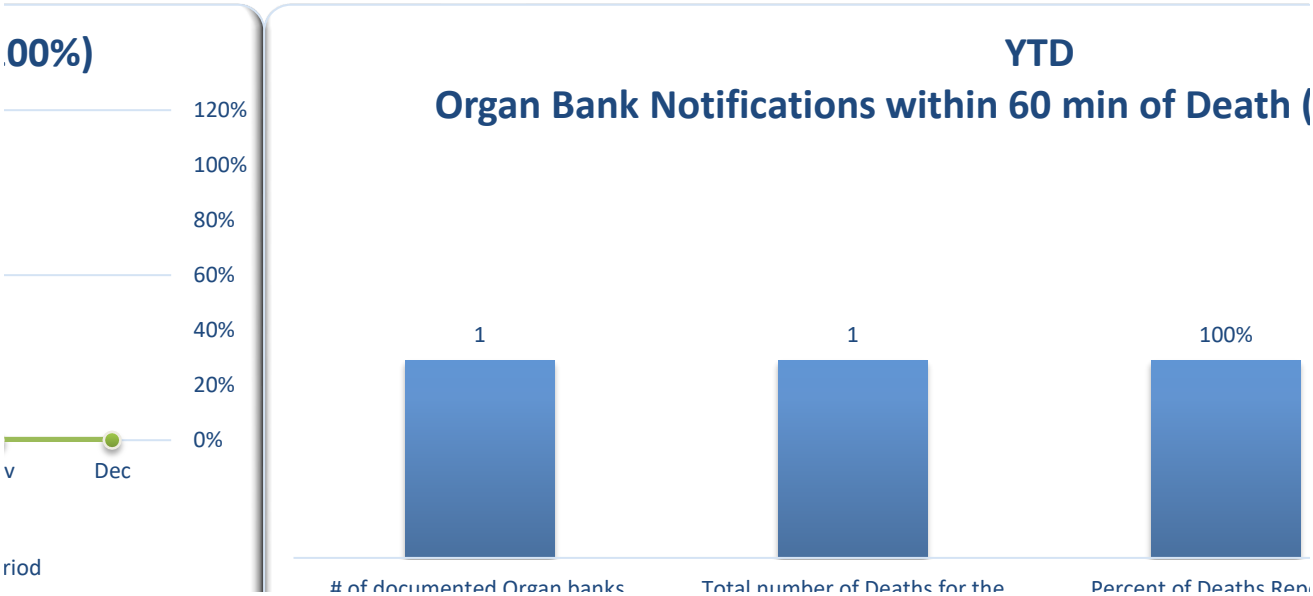

YTD
Patient Falls
1
0
Patient Falls w/o Injury
Patient Falls w/Minor Injury
Pati




YTD
ER Patient


Nov
Dec
injury
0
0
ED Patient Falls W/O injury
ED Patient Falls With Minor injury

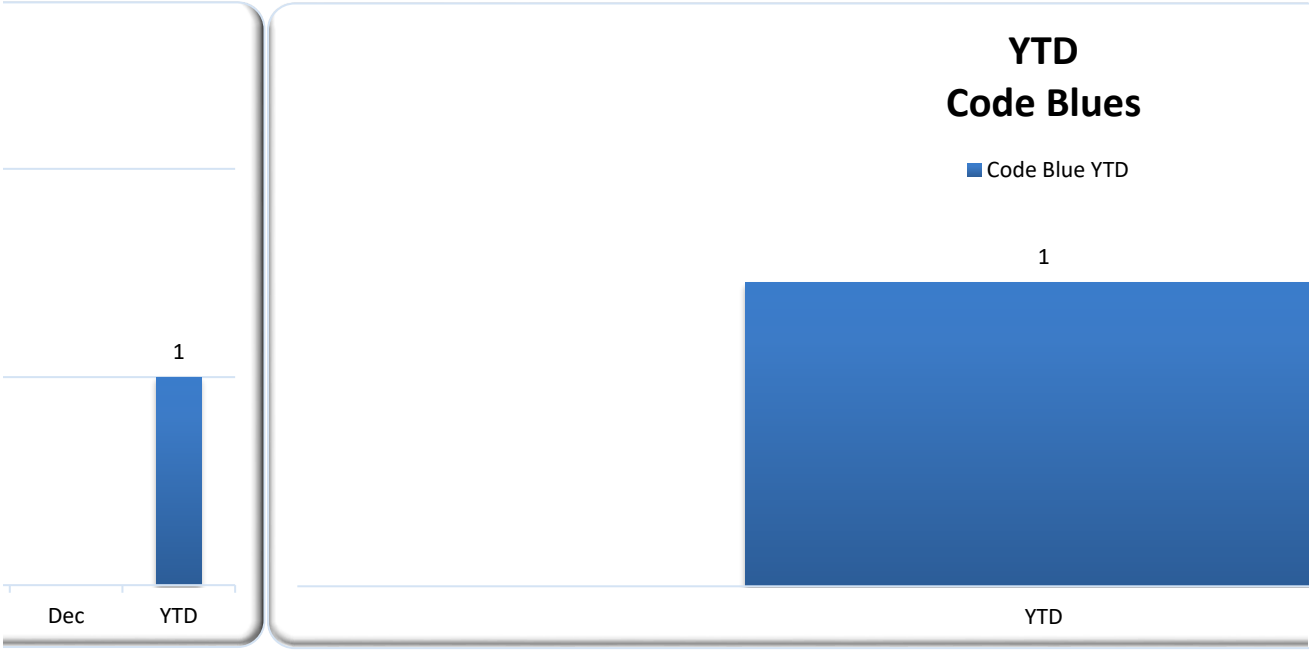

Dec
YTD
eriod
YTD
Mortality Rate
2
0
# of deaths (Acute, Swing bed) during the reporting period

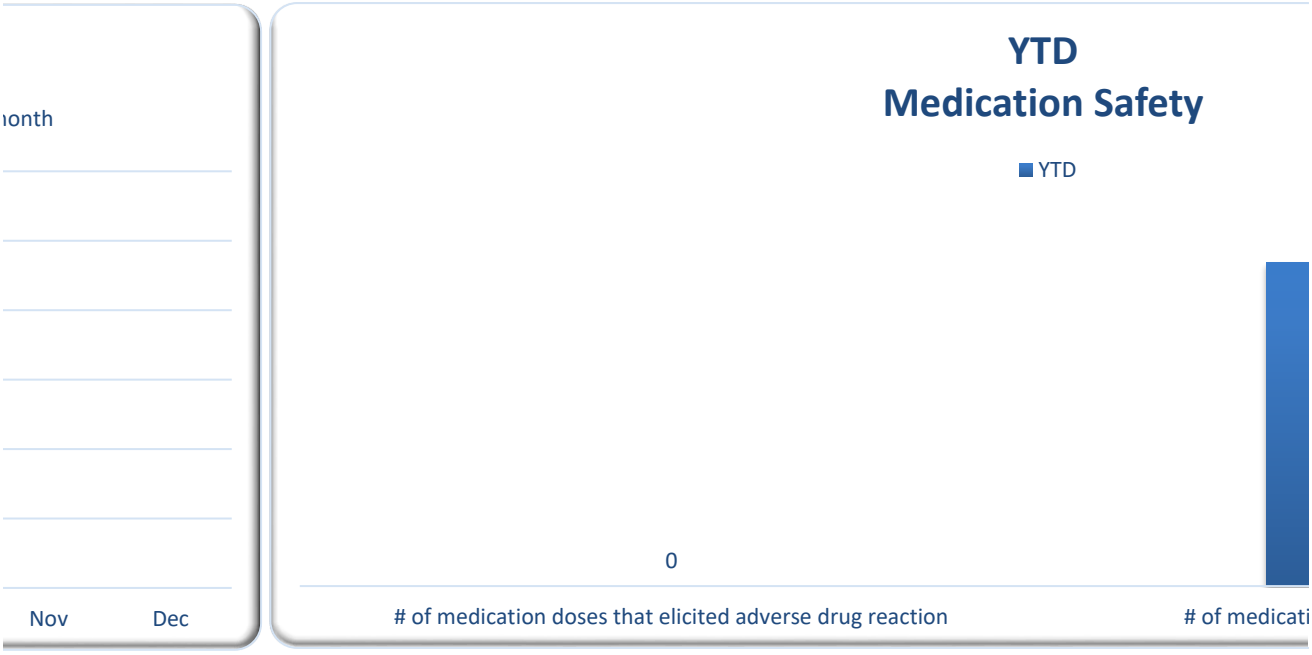

00%)
120%
100%
80%
60%
40%
20%
0%
v
Dec
riod
YTD
Organ Bank Notifications within 60 min of Death (
1
1
100%

notifications within 60 min of death

reporting period

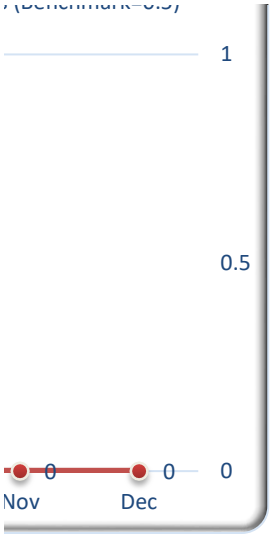
(Benchmark = 100%

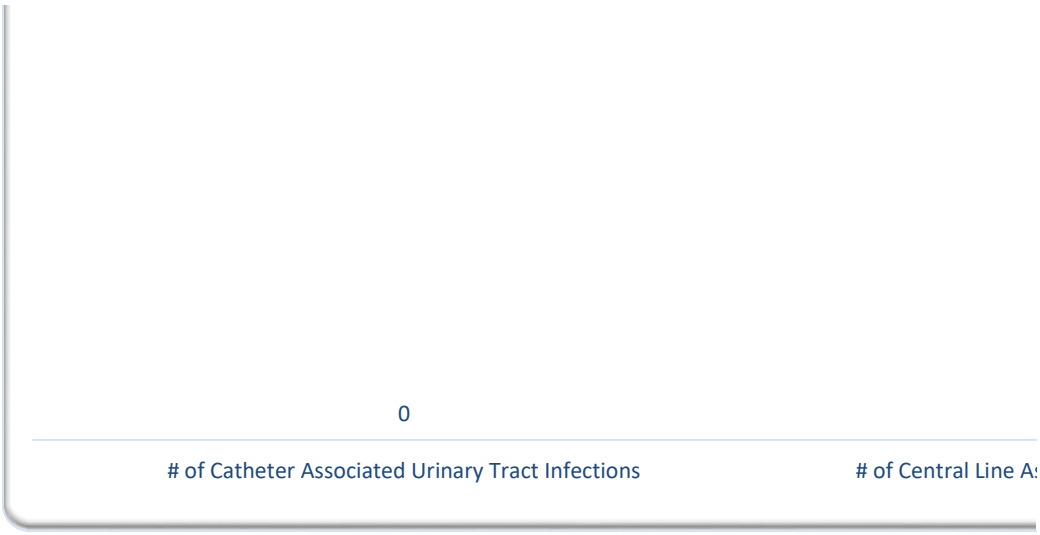


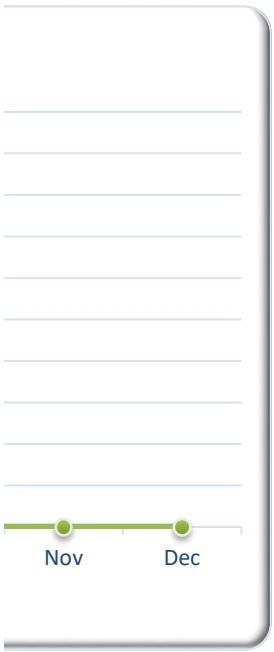


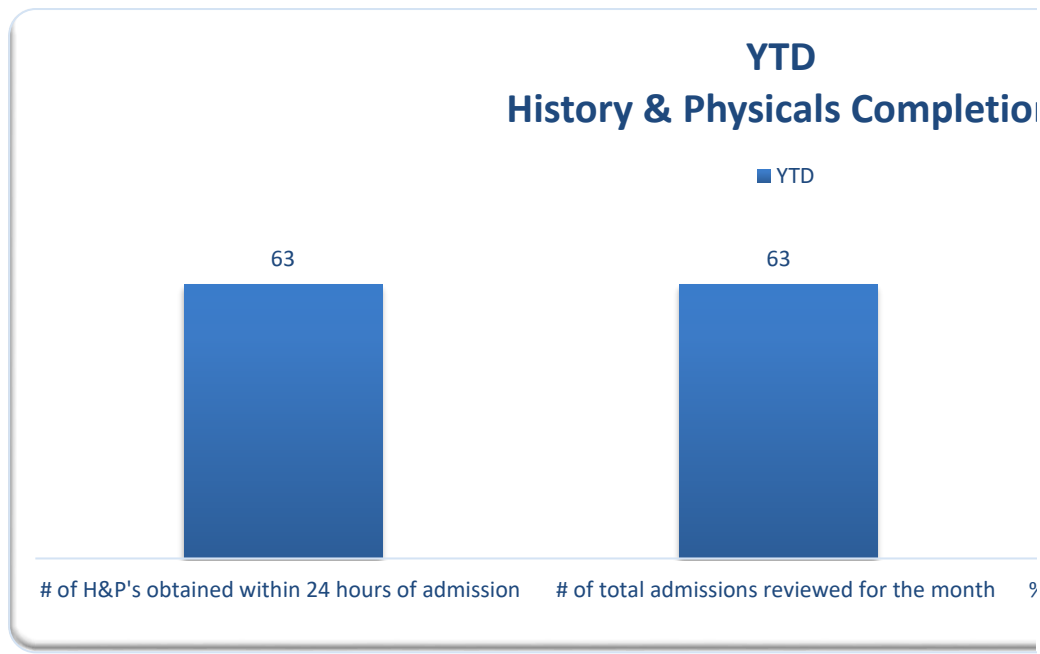
(Benchmark=0.5)

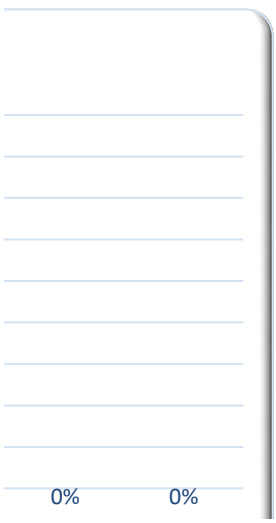
YTD
Infection Control and Preventio

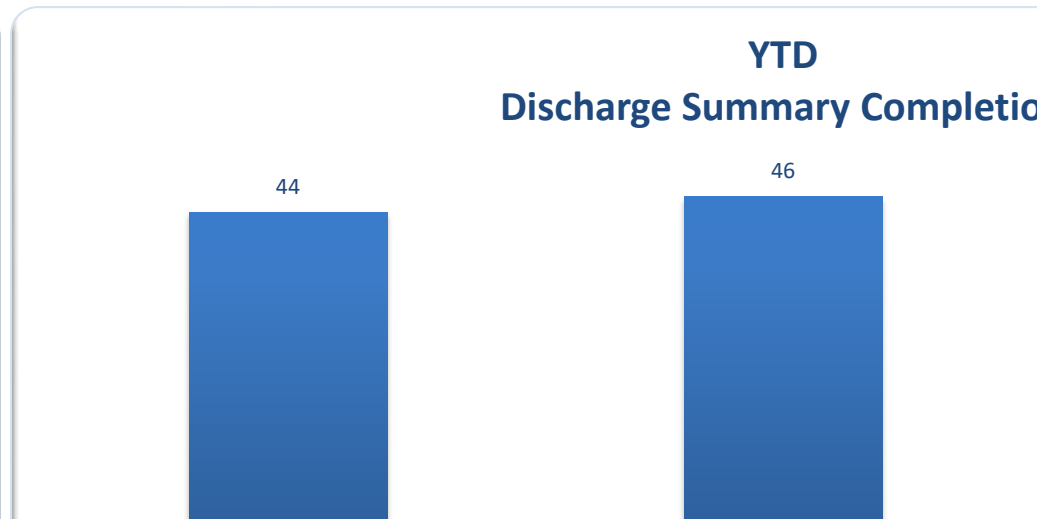

1
0.5
0
0
0
Nov
Dec

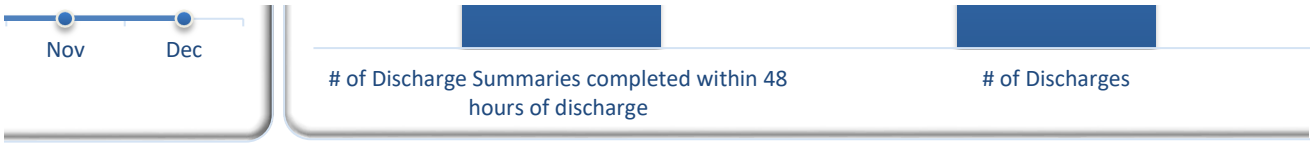

0
# of Catheter Associated Urinary Tract Infections
# of Central Line A

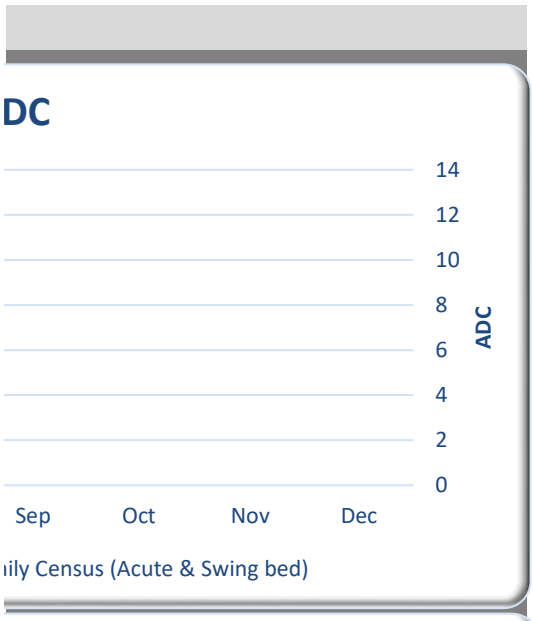

Nov
Dec

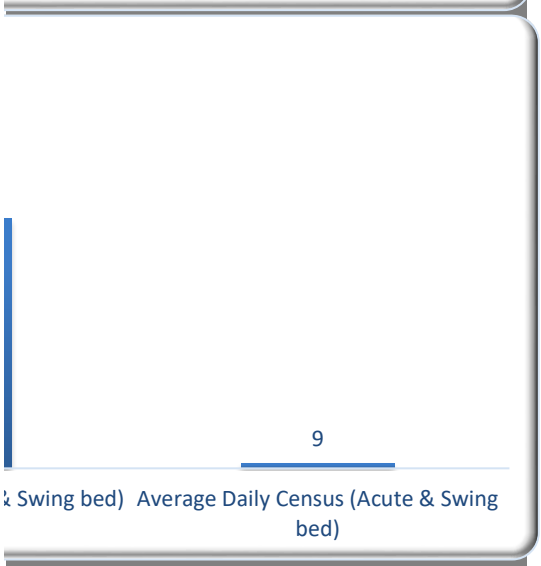

YTD
History & Physicals Completio
YTD
63
63
# of H&P's obtained within 24 hours of admission
# of total admissions reviewed for the month
%

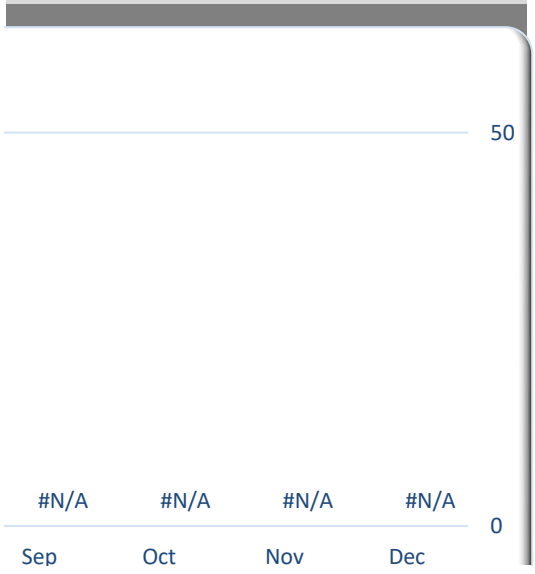

0%
0%


YTD
Discharge Summary Completio
44
46

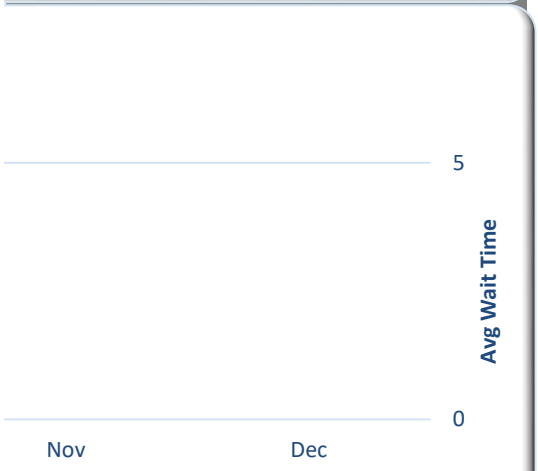

Nov
Dec
# of Discharge Summaries completed within 48 hours of discharge
# of Discharges

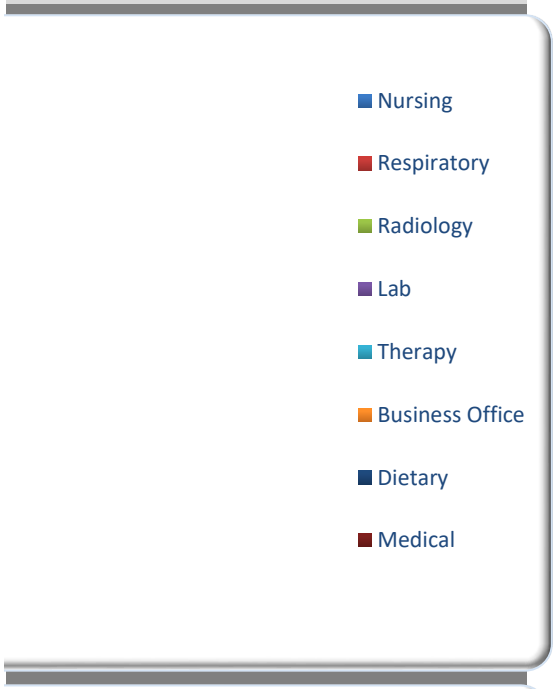

DC
14
12
10
8
6
4
2
0
ADC
Sep
Oct
Nov
Dec
ily Census (Acute & Swing bed)

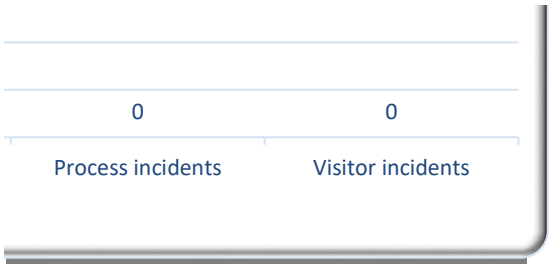

9
Swing bed)
Average Daily Census (Acute & Swing bed)


50
#N/A
#N/A
#N/A
#N/A
0
Sep
Oct
Nov
Dec

Discharges for the reporting month

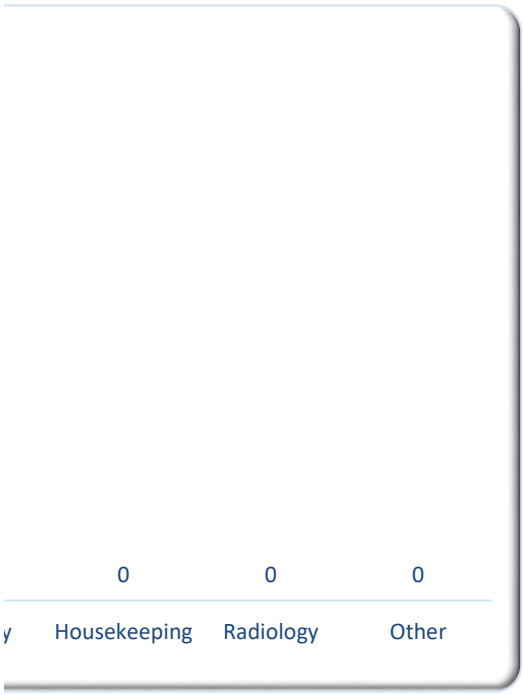


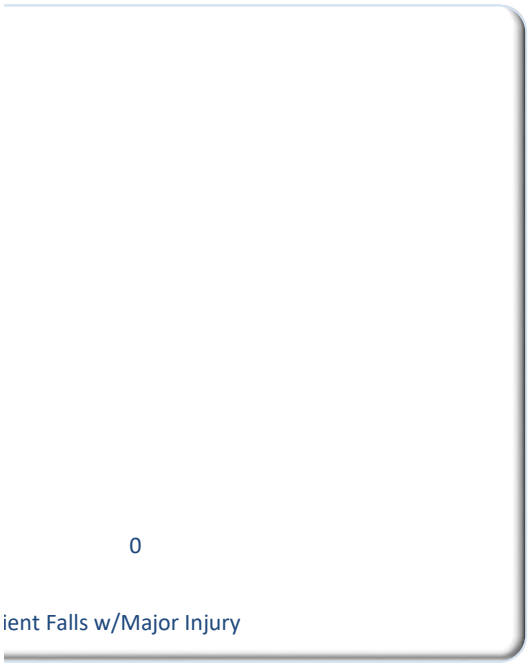


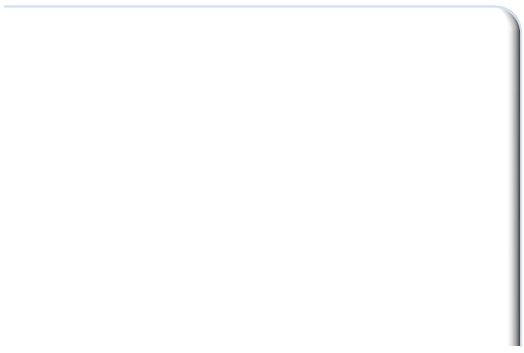

0
0
Process incidents
Visitor incidents


0
vances
Total number of Grievances from ED


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


0
0
0
y
Housekeeping
Radiology
Other


0
ient Falls w/Major Injury



0

D Patient Falls With Major injury

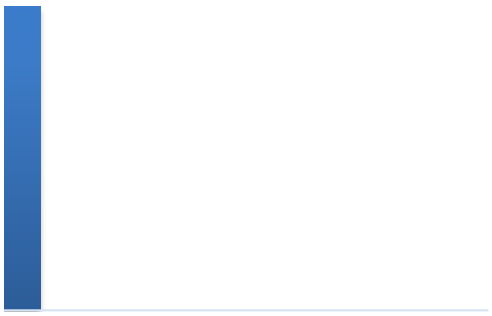
R) during the reporting period

(Benchmark=100%)

0

orted Tissue Donations

%)



8

ion errors for the reporting month

on

0

ssociated Primary Bloodstream Infections
(Benchmark=0.5)

n

100%

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

ɔn

96%

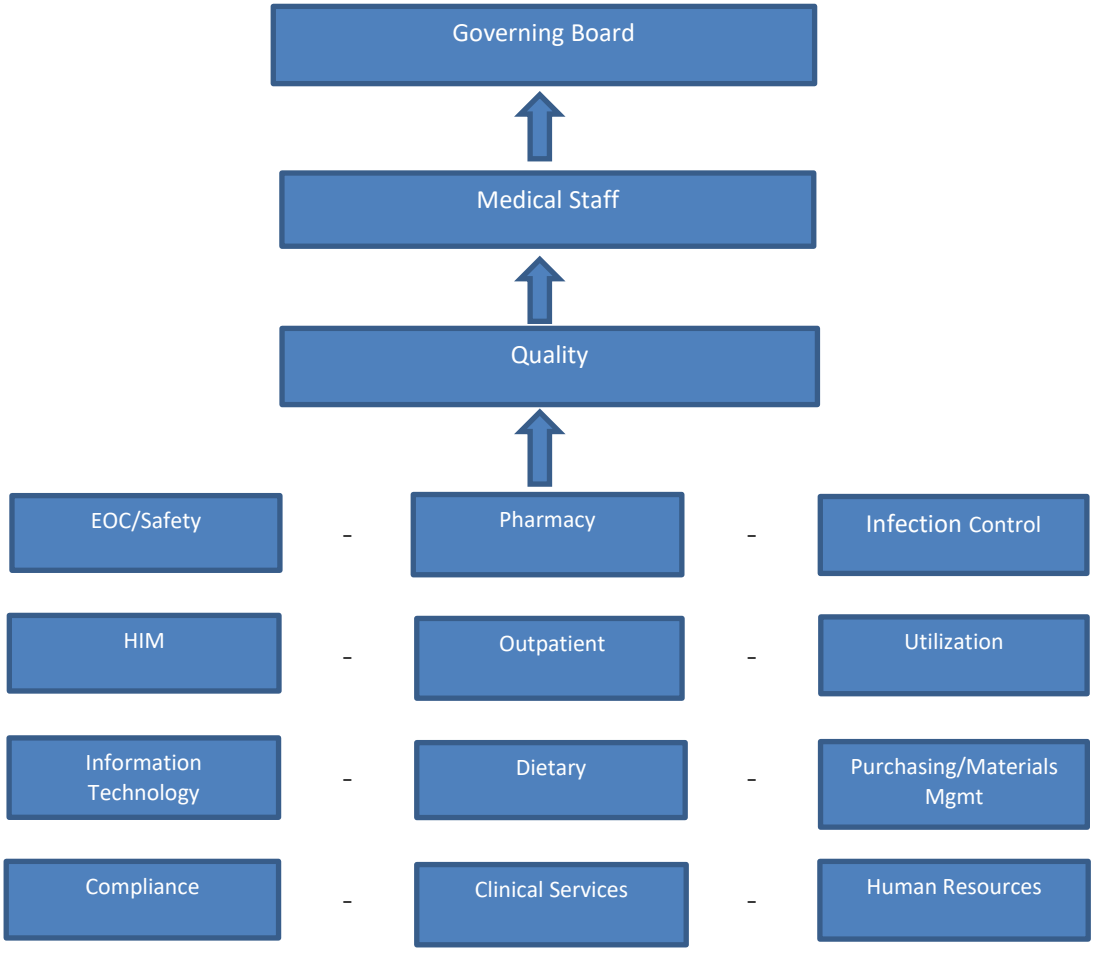
% of Discharge Summaries completed within 48 hours of discharge (Benchmark=100%)

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

Title of Meeting	***Frequency of Meeting***	***Attendees***
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

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 Screeing 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 (Dicharge/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

	Topic	*Responsible Party*
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**	
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 Admission	
I.	OPO/Tissue Donation	
J.	Patient Identifiers	
IV.	**Nursing**	
A.	Critical Tests/Labs	
B.	Restraints	
C.	RN Assessments	
D.	Code Blue	
V.	**Emergency Department**	
A.	ER Log & Visits	
B.	Medical Screening Exam	
C.	Provider Response Time	
D.	ED RN Assessment (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 Error Rate	
VII.	**Respiratory Care Services**	
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 Serviees

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
C. Master Treatment Plan
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 withoug 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

Care Management

A. 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 IVPB daily, LLE venous US	

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 ommission while doing QA checks of MARS. FSBS omitted by LPN. CCO interviewed LPN, LPN had inaccurate FSBS data. LPN given opportunity to correct the ommission. LPN entered inacurate 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 alaarm 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 cigerettes 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 cigerette 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 cigerettes. 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 cigerettes and lighter from purse and took it to the ward clerk to be stored for patient. CCO comunicated 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**

Incident Grouped by Department Involved													
Department	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**YTD**
Nursing	5	6											**11**
Respiratory	0	0											**0**
Radiology	0	0											**0**
Lab	0	0											**0**
Therapy	0	0											**0**
Business Office	0	0											**0**
Dietary	0	0											**0**
Medical	0	0											**0**

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 irriated 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 monthe 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

Complaint Grouped by Type													
Complaint Type	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**YTD**
Basic Care (daily hygiene, oral care, peri care, etc.)	0	0											**0**
Medication related	0	0											**0**
Communication (follow-through on concerns, etc.)	0	0											**0**
Attitude and Customer Service	0	1											**1**
Preventative measures (turning, activity)	0	0											**0**
Nutrition (assistance, quality, diets, timeliness)	0	0											**0**
Call light response	0	0											**0**

Complaint Grouped by Department													
Department	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**YTD**
Business Office	0	0											**0**
Nursing	0	1											**1**
ED	0	0											**0**
IT	0	0											**0**
Lab	0	0											**0**
Provider	0	0											**0**
Dietary	0	0											**0**
Housekeeping	0	0											**0**
Radiology	0	0											**0**
Other	0	0											**0**

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

Indicator	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Patient Falls with Minor 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 = 5 or less)	---	---	---	---	---	---	---	---	---	---	---	---	---
Indicator	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**YTD**
ED Patient Falls With Minor injury	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**
Percent of Total ED Patient Falls (Benchmark = 5 or less)	---	---	---	---	---	---	---	---	---	---	---	---	---

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**

Risk Management

G. 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 Identfiers

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**

Emergency Department

A. ER Log & Visits

Function: Outcome & Process Measure
Rationale: High Risk, Problem Prone
Data Source: Patient Records, ER Log PDSA
Sample Size: All ER patients During Reporting Period
Methodology: Patient Records, Audit Tool, PDSA
Inclusion Criteria: All ER Patients During Reporting Period

Indicators	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
ER Log Current & Complete (Each ER Visit)	104	133											**237**
Total number of ER Visits	104	133	0	0	0	0	0	0	0	0	0	0	**237**
Percent of Compliance (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**

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%**

Summary of Findings	Plan of Action
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 palpatations. 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**

December	
Summary of Findings	**Plan of Action**

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 end0organ 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 thrombolitic 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 inablility to heat Covid rooms at time of presentation. 9) Higher level of care needed. 10) Inability to keep at facility due to inablility 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

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
1	Stroke Log Completed	0%	%											**0%**
2	Door to EMS/Air Evac Notification < 15 Minutes	0	0											**0**
	Total # of Stroke Alerts	0	2											**2**
	Percentage of Compliance (Benchmark = 80%)	---	---	---	---	---	---	---	---	---	---	---	---	---
3	Door to Patient Transfer < 60 minutes	0	0											**0**
	Total # of Stroke Alerts	0	2											**2**
	Percentage of Compliance (Benchmark = 80%)	---	---	---	---	---	---	---	---	---	---	---	---	---
4	Door to Provider Evaluation < 15 minutes	0	2											**2**
	Total # of Stroke Alerts	0	2											**2**
	Percentage of Compliance (Benchmark = 80%)	---	**100%**	---	---	---	---	---	---	---	---	---	---	**100%**
5	Door to Stroke Center Notification < 20 minutes	0	0											**0**
	Total # of Stroke Alerts	0	2											**2**
	Percentage of Compliance (Benchmark = 80%)	---	---	---	---	---	---	---	---	---	---	---	---	---
6	Vital Signs Documented Every 15 minutes	0	1											**1**
	Total # of Stroke Alerts	0	2											**2**
	Percentage of Compliance (Benchmark = 80%)	---	**50%**	---	---	---	---	---	---	---	---	---	---	**50%**
7	Neurological Checks Documented Every 15 minutes	0	0											**0**
	Total # of Stroke Alerts	0	2											**2**
	Percentage of Compliance (Benchmark = 80%)	---	---	---	---	---	---	---	---	---	---	---	---	---
8	Total # of Stroke Patients	0	2											**2**
9	Total # of Acute Stroke Patients	0	2											**2**
10	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

Function: Outcome & Process Measure
Rationale: High Risk, Problem Prone
Sample Size: Minimum of 20 records per reporting period
Methodology: Medical records, Discharge reports, ED Log, PDSA
Inclusion Criteria: All ED patients

Indicator	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Door to Triage Level < 5 minutes	20	20											**40**
Total # of ED Patients Reviewed	20	20											**40**

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**

l. ED Nursing Assessment (Discharge/Transfer)

Function: Outcome & Process Measure
Rationale: High Risk, Problem Prone
Sample Size: Minimum of 20 records per reporting period
Methodology: Medical records, Discharge reports, ED Log, PDSA
Inclusion Criteria: All ED patients

Indicator	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
ED Nursing Assessment Completed Upon DC or Transfer	20	20											**40**
Total # of ED Patients Reviewed	20	20											**40**
Percentage of Compliance (Benchmark = 90%)	**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**

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 MedDispsense; 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 sysstem 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**

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**

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**

Radiology/Imaging Services

B. Imaging

Function: Outcome & Process Measure
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

Indicators	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Total Number of Contrast CT scans completed ***with reaction***	0	0											**0**
Total Number of Contrast CT scans completed	19	10											**29**
Percentage of CT scan reactions	**0%**	**0%**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**
Contrast CT scans with completed and signed consents	19	10											**29**
Total Number of Contrast CT scans	19	10											**29**
Percentage of Contrast CT scan consents	**100%**	**100%**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**100%**

January	
Summary of Findings	**Plan of Action**
No Reactions. All exams completed with signed consents.	no action needed.

February	
Summary of Findings	**Plan of Action**
No Reactions. All exams completed with signed consents.	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

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

Laboratory

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. Blood Culture Contaminations

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**

Infection Control and Prevention

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**

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**

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**

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	

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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**

Infection Control and Prevention

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

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 emial 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

Dietary Department

A.

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

Indicators	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**YTD**
Total number of PT treatment sessions performed	79	117											**196**
Total # of planned treatment sessions	0	4											**4**
Treatment Compliance (Benchmark = 85%)	**#DIV/0!**	**2925%**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**4900%**
Indicators	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**YTD**
Total number of OT treatment sessions performed	72	130											**202**
Total # of planned treatment sessions	3	144											**147**

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 particiation from patients this month.	Continue seeing patients that are well enough to participate.

February	
Summary of Findings	**Plan of Action**
Good particiation 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**

Human Resources

A. 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

Indicators	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Correct Insurance Plan (COB)	300	340											**640**
Primary Doctor	340	365											**705**
Insurance Verified	340	360											**700**
Correct Guarantor	315	350											**665**
HIPAA	340	367											**707**
Emergency Contact	340	340											**680**
Signed Documents	300	340											**640**
Total Number of Documents Completed	340	367											**707**
Total Number of Documents Audited	340	367											**707**
Percentage of Compliance (Benchmark = 90%)	**100%**	**100%**	######	######	######	######	######	######	######	######	######	######	**100%**

January	
Summary of Findings	**Plan of Action**
HAVE FOUND THAT HOSPITAL STAFF ARE STILL NOT PUTTING IN CORRECT INS INFO,CORRECT GUARANTOR, SIGNED DOCUMENTS	RCM MANAGER, CEO, RCM DIRECTOR ARE PUTTING AN AUDIT PROCESS IN PLACE TO MAKE SURE THESE THINGS ARE CAUGHT AND WILL BE AUDITED BY RCM MANGER, WILL CONTINUE TO MONITOR AND EDUCATE IN THE MEANTIME.
February	
Summary of Findings	**Plan of Action**
HAVE FOUND THAT HOSPITAL STAFF ARE STILL NOT PUTTING IN CORRECT INS INFO,CORRECT GUARANTOR, SIGNED DOCUMENTS	RCM MANAGER, CEO, RCM DIRECTOR ARE PUTTING AN AUDIT PROCESS IN PLACE TO MAKE SURE THESE THINGS ARE CAUGHT AND WILL BE AUDITED BY RCM MANGER, WILL CONTINUE TO MONITOR AND EDUCATE IN THE MEANTIME.
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**

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
Inclusion Criteria: Chargeable Items Exclusion Criteria: Non-Chargeable Criteria
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.

Indicators	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Percentage of Chargeable Items Correctly Labeled	100%	100%											**100%**
Percentage of Items Within Use Date (Benchmark = 90%)	100%	98%											**99%**
Percentage of Inventory Information Correct (Benchmark = 90%)	100%	100%											**100%**

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 istalled 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

Function: Process & Outcome Measure
Rational: High Risk, Problem Prone
Data Source: Patient Records, Patient Reports
Methodology: Patient Records, PDSA
Inclusion Criteria: All patients receiving outpatient therapy services
Exclusion Criteria: death, unplanned/unexpected discharge

Indicators	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Physician Signature on Initial Evaluations	1	0											**1**
Total # of Evaluations	1	0											**1**
Percentage of Compliance (Benchmark = 75%)	**100%**	---	---	---	---	---	---	---	---	---	---	---	**100%**
Total # Treatments Performed	12	9											**21**
Total # of Planned Patient Treatments	12	9											**21**
Percentage of Compliance (Benchmark = 70%)	**100%**	**100%**	---	---	---	---	---	---	---	---	---	---	**100%**
30-Day Progress Notes (performed on or before 30 days from initial evaluation)	0	0											**0**

Total Number of Progress Notes (all patients with therapy services greater than 30 days)	0	0											**0**
Percentage of Compliance (Benchmark = 95%)	---	---	---	---	---	---	---	---	---	---	---	---	---
Discharge Note Performed Within 72 Hours By PT (exclude weekends & holidays)	2	0											**2**
Total Number of Discharged Patients	2	0											**2**
Percentage of Compliance (Benchmark = 95%)	**100%**	---	---	---	---	---	---	---	---	---	---	---	**100%**
Total # of patients discharged with improved standardized assessment scores	2	0											**2**
Total # patients with documented standardized assessment score on admission	2	0											**2**
% of Functional Improvement (Benchmark=80%)	**100%**	---	---	---	---	---	---	---	---	---	---	---	**100%**

January	
Summary of Findings	**Plan of Action**
All paperwork written and received back in timely manner.	No changes needed at this time.

C. Outpatient Wound Services

Function: Process & Outcome Measure
Rational: High Risk, Problem Prone
Data Source: Patient Records, Patient Reports
Methodology: Patient Records, PDSA
Inclusion Criteria: All patients receiving outpatient therapy services

Indicators	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Total Number of Wound Debridements	4	4											**8**
Total Number of Consents Completed	2	2											**4**
Total Number of Consents Required	2	2											**4**
Percentage of Compliance (Benchmark = 100%)	**100%**	**100%**	---	---	---	---	---	---	---	---	---	---	**100%**
Total Number of Wounds Showing Improvement	2	2											**4**
Total Number of Wounds	2	2											**4**
Percentage of Compliance	**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
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

Function: Outcome Measure
Rationale: High Risk, Problem Prone
Data Source: Client Surveys
Sample Size: All discharged clients in program
Methodology: Client Surveys; PDCA
Inclusions: All clients in program discharged during reporting month
Formula: # of surveys completed/# of surveys returned

Indicators (Active Clients)	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Total number surveys returned													**0**
Total number of surveys distributed (active 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/active 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!**
Indicators (Discharged Clients)	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**YTD**
Total number surveys returned													**0**

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

Indicators	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Total number of clients with suicidal ideation													**0**
Total number of clients with treatment plan													**0**
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**									

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

Indicators	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Total number of missed appointments													**0**
Total number of scheduled appointments													**0**
Percentage of Missed Appointments (Benchmark=less than 10%)	**#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**									

Contract Services

Date	Name	Service	Date of Review	Renewed	Discontinued
01/14/21	Life Share Conctract/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/training/resources	3/1/2021 - 03/02/2022	Yes	
02/10/21	OFMQ Agreement	Peer review	2/23/2021 -	Yes	

MEC/GB Approval
Yes
Yes
Yes
Yes
Yes
Yes
Yes

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-Credentailing
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: 3/11/2021	**Time: 12:43**	**Recorder: Melissa Tunstall**	**Reporting Period Discussed: FEBRUARY 2021**

Members Present via Teams Meeting

Chairperson:		**CEO: Marie Harrington**			**Medical Representative: Dr. Chiaffitelli**		
Name	**Title**	**Name**	**Title**	**Name**	**Title**	**Name**	**Title**
Jennifer Waxell	Respiratory	Josey Kenmore	Materials Management	Amber Jackson	Clinic Manager	Tanya Knight	Lab Manager
Sarah Dillahunty	Dietary	Daniel Coffin	CCO	Kaye Hamilton	Credentialing	Sarah Cox	Infection
Zack Canaday	IT	Pamela Esparza	Radiology Manager	Jennifer Dreyer	HIM	Kasi HIlley	Business/RCM Director
Angela Williams	Corporate QM						

TOPIC	**FINDINGS/CONCLUSIONS**	**ACTIONS/RECOMMENDATIONS**	**FOLLOW-UP**
Call to Order	Melissa Tunstall and Daniel Coffin		
Review of Minutes	Pam Esparza		
Review of Committee Meetings			
A. EOC/Patient Safety Committee	Was not present for the meeting	Will report in March meeting	
B. Infection Control Committee	No CLABSI, CAUDIA, HAI. 100% hand hygene. Health stream.	Will continue to monitor	
C. Pharmacy & Therapeutics Committee	No data will have PNT meeting in April		
D. HIM/Credentials Committee	Discharge summary - 2 Consents missing 1-ER 3-acute 2-swingbed JANUARY - Consents had 1 missing out of swingbed. All others met benchmark	HIM emailed providers. K. Hamilton is going to call Physicians to get them to log on to get it complete Consents -. HIM manager sent emails and made phone calls. JANUARY - HIM will run a daily report for the charts to	
E. Utilization Review Committee	UR Mangager was not present for the meeting	Will report in March meeting	
F. Compliance Committee	No meetings started as of this time		
Old Business	Safety Officer has set up active shooter drill to be completed on March 11, 2021. Vaccine clinics are being held here at the hospital for the community to help get vaccinations to the public		
New Business	Electricion(Reyes Electric) came on 2/22/2021 to complete the rewiring of the Covid wing. It now has correct amperage to safely run ventilators and to heat and cool all of the rooms on that wing.		
Quality Assurance/Performance Improvement			
Volume & Utilization			
A. Hospital Activity			

B. Blood Utilization	1 Product was administered without problems	Will continue to monitor	
Care Management			
A. CAH/ER Re-Admits	0		
B. Acute Transfers	1		
C. Transition of Care			
D. Discharge Follow-Up Phone Calls			
E. Patient Discharge Safety Checklist	Implemented on 2/23/2021		
Risk Management			
A. Incidents	6 1-AMA 4 - Other events 1 - Patient fall w/o inj AMA Patient had an emergency at her home and had to leave.	AMA - Provider explained benefits of staying and the risks of leaving to the patient. Patient understood and still had to leave.	
B. Reported Complaints	1 Complaint for February.	CCO and QM visited with patient and found resolve at the bedside. Patient was happy with the decisions made.	
C. Reported Grievances			
D. Patient Falls Without Injury	1 Unassisted fall with no injury. Patient sustained no injuries. QM reviewed chart and incident report and found patient did not use the call	QM reviewed chart and incident report and found patient did not use the call light that was within reach. Nursing staff reeducated patient to call	
E. Patient Falls With Minor Injury			
F. Patient Falls With Major Injury			
G. Mortality Rate	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.	
H. Deaths Within 24 Hours of Admit			
I. OPO Notification/Tissue Donation	1 within the 60 minute time frame.		
J. Patient Identifiers			
Nursing			
A. Critical Tests/Labs	100% In addition to calling lab results to nursing staff, CCO is having the lab fax results and request signed acknowledgment from receiving nursing. Process has already made improvements.		
B. Restraints			
C. RN Assessments			

D. Code Blue	1 code blue. This was the mortality for February		
Emergency Department			
A. ER Log & Visits	133 Log book completed		
B. MSE			
C. Provider ER Response Time			
D. ED RN Assessment (Initial)			
E. ED Readmissions			
F. EMTALA Transfer Form			
G. ED Transfers	10 7 due to higher level of care 2 due to heat in covid wing 1	CCO has Electrician scheduled to fix the wiring to be able to accomodate	
H. Stroke Care	2 1 had completed paper work. 1 had imcomplete paperwork	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.	
I. Suicide Management	2 1. 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 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.	
J. Triage			
K. Stemi Care	1 Patient presented to ER with 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. Continue operating capacities for this CAH. No action required at this time.	
L. ED Nursing Assessment (Discharge/Transfer)			
Pharmacy & Medication Safety			
A. Pharmacy Utilization			
B. After Hours Access	133 times (22 times were unnecessary entrances. Meds were stocked in med dispense)	Refrigerator and med dispense locking system has been purchased to go in the nurses statioin. Awaiting installation. (This is expected to reduce the majority of after hours access)	

C. Adverse Drug Reactions			
D. Medication Errors	5 1) Nurse failed to administer IV antibiotics 2)Nurse failed to administer IV antibiotics 3) nurse failed to administer IV antibiotics 4) Nurse administered wrong solution of IV TPN 5) Nurse failed to properly mix IV TPN prior to administration.	1-4) CCO re-educated staff regarding 6 rights of medication adminstration. Staff acknowledged understanding via signature. 5) Nurse's agancy offered re-education and counseling to this nurse on an unrelated matter. Nurse terminated contract and will not be returning to MRMC.	
Respiratory Care Services			
A. Ventilator Days	10		
B. Ventilator Wean Rate			
C. Patient Self-Decannulation Rate			
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	1 Lab repeated/rejected sputum specimen received in lab w/wrong label	The respiratory stated that they would make sure the correct label would be applied before the specimen was collected.	
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	9 132 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.	
H. Patient Vaccinations			
I. Ventilator Associated Events			
J. Employee Health Summary	1 Light duty case continued; 2 employee injuries- sprain and contusion; 0 employee flu given; 0 TB screenings, 13 Covid vaccines given. 42 Lost work days: 1 GI, 5 URI, 1 Sore Throat/earache/fever, 1 Migraines/Bodyaches, 16 Covid-19 pending days, 1 positive Covid-19 with hospitalization- still out.		
HIM			
A. H&P's			
B. Discharge Summaries	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.	
C. Progress Notes (Swing bed & Acute)			

D. Consent to Treat	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 emial on 2/25/21 about consents and they still were not done.	
E. Swing bed Indicators			
F. E-prescribing System			
G. Legibility of Records			
Dietary			
A. Food Test Tray Eval			
B. Dietary Checklist Audit			
Therapy			
A. Therapy Indicators			
B. Therapy Visits			
C. Standardized Assessment Outcomes			
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	Oklahoma Blood Institute contract renewal		
Regulatory & Compliance			
A. OSDH & CMS Updates			
B. Surveys			
C. Product Recalls	None for facility		
D. FMEA			
E. RCA			
Policy & Procedure Review			
Policy & Procedure	Health Information Technology Policies and Procedures Manual		
Standing Agenda			
Credentialing/New Appointments			
A. Credentialing/New Appointment Updates	Benjamin Love, MD Courtesy Privileges William G. Morgan, MD Courtesy Privileges Kenna Wenthold, APRN Courtesy Privileges		
Education & Training			
A. Education & Training	ACLS to be done 3/4/2021 CCO will review with nursing staff and educate new policies and procedures 3/9 Basic life support classes will be held 3/18 Active shooter drill will be held 3/11.		
A. Department			
Other			
A. Other			
Adjournment			
A. Adjournment	1356	M. Tunstall and J. Kenmore	