Chief Executive Officer
Louis Ward, MHA

Mayers Memorial Hospital District

Board of Directors
Beatriz Vasquez, PhD, President
Abe Hathaway, Vice President
Laura Beyer, Secretary
Allen Albaugh, Treasurer
Jeanne Utterback, Director

Quality Committee
Meeting Agenda

November 13, 2019 1200
Boardroom: Fall River Mills

Attendees

Laura Beyer, Board Secretary
Jeanne Utterback, Director
Louis Ward, CEO
Jack Hathaway, Director of Quality

1	**CALL MEETING TO ORDER**		Chair Laura Beyer			
2	**CALL FOR REQUEST FROM THE AUDIENCE - PUBLIC COMMENTS OR TO SPEAK TO AGENDA ITEMS**					**Approx. Time Allotted**
3	**APPROVAL OF MINUTES**					
	3.1	Regular Meeting – October 16, 2019		Attachment A	**Action Item**	2 min.
4	**DEPARTMENT REPORTS**					
	4.1	Volunteer Services	Barbara Spalding	Attachment B	Report	10 min.
	4.2	Emergency Department	JD Phipps	Attachment C	Report	10 min.
	4.3	Hospice	Mary Ranquist		Report	10 min.
	4.4	Outpatient Services	Michelle Peterson	Attachment D	Report	10 min.
	4.5	Respiratory	Keith Earnest		Report	10 min.
	4.6	Med-Surg/Swing	Theresa Overton	Attachment E	Report	10 min.
	4.7	Med Staff	Pam Sweet	Attachment F	Report	10 min.
5	**QUARTERLY REPORTS**					
	5.1	Safety	Val Lakey	Attachment G	Report	10 min.
	5.2	CMS Core Measures	Jack Hathaway		Report	10 min.
	5.3	5-Star Rating Monitoring	Jack Hathaway		Report	10 min.
	5.4	Employee Health	Dawn Jacobson		Report	10 min.
6	**STANDING MONTHLY REPORTS**					
	6.1	Quality/Performance Improvement	Jack Hathaway		Report	10 min.
	6.2	PRIME	Jack Hathaway		Report	10 min.
	6.3	SNF Events/Survey	Candy Vculek		Report	10 min.
	6.4	Infection Control	Dawn Jacobson		Report	10 min.

7	**ADMINISTRATIVE REPORT**	Louis Ward	Report	10 min.
8	**OTHER INFORMATION/ANNOUNCEMENTS**		Information	5 min.
9	**ADJOURNMENT:** Next Regular Meeting – December 11, 2019 (Fall River Mills)			

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Board of Directors
Quality Committee
Minutes

October 16, 2019 11:00am
Boardroom (Fall River Mills)

Attachment A
DRAFT

These minutes are not intended to be a verbatim transcription of the proceedings and discussions associated with the business of the board's agenda; rather, what follows is a summary of the order of business and general nature of testimony, deliberations and action taken.

1 **CALL MEETING TO ORDER:** Board Chair Laura Beyer called the meeting to order at TIME on the above date.

BOARD MEMBERS PRESENT:
Laura Beyer, Secretary
Jeanne Utterback, Director

ABSENT:
Louis Ward, CEO
Jack Hathaway, DOQ

STAFF PRESENT:
Candy Vculek, CNO
Dawn Jacobson, Infection Preventionist
Lori Stephenson
Ryan Harris
Libby Mee
Pam Sweet, Board Clerk

2 **CALL FOR REQUEST FROM THE AUDIENCE – PUBLIC COMMENTS OR TO SPEAK TO AGENDA ITEMS**
None

3 **APPROVAL OF MINUTES**
3.1 A motion/second carried; committee members accepted the minutes of DATE Utterback/Mee **Approved All**

4 **DEPARTMENT REPORTS**

4.1 **Environmental Services**: Submitted written report.
Ryan Harris answered questions for Sherry Rodriguez.
Ryan is very pleased with the new laundry establishment and its staff. Very little turn over in staff.

4.2 **Cardiac Rehab:** Submitted written report.
Trudi Burns was not present to answer the committee's questions. Move to next meeting.

4.3 **Marketing:** Submitted written report.

4.4 **HIM:** Submitted written report.
OneContent went live on Monday. Working on solving the bugs now. System is more user friendly and staff is accepting it well. It will alleviate the need to index documents as it does that automatically as they are scanned in, but staff education is required as patient labels must be placed in a specific area of the document.

4.5 **Imaging:** No report. Move to next meeting

5 **QUARTERLY REPORTS**

5.1 **Workers Comp:** Submitted written report
Committee questioned why Libby thought our numbers are lower than average. Libby responded it is because of our consistent program, people being aware of the program and that departments works well together.

5.2 **Patient Safety First:** No Report. Move to next meeting

6 **STANDING MONTHLY REPORTS**

6.1 **Quality/Performance Improvement**: No Report

6.2 **PRIME**: No Report

6.3 **SNF Events/Survey**:
Had our annual CMS survey last week. It was not a licensing survey, but is probably the only survey we will have this year. The survey went very well. We had 5 or 6 lower level tags and no "harm" tags. Most worrisome of the tags were 2 missed potential reportings for patient abuse. Both complaints turned out to not have been abuse, but the reporting obligation was still there. Housekeeping, and Dietary had no tags.

6.4 **Infection Control**:
Trending norovirus in the community and among staff. Held an education yesterday on hand hygiene.
Talking with Shasta County Health about TB testing. We may be able to move to TB testing every 2 to 4 years. They do not recommend annual testing in a low risk environment, but the ED staff and the IC nurse should be tested annually. The CDC only recommends testing if symptomatic. State of CA requires testing every 4 years.

7 **ADMINISTRATIVE REPORT**: No Report

8 **NEW BUSINESS**: None

9 **OTHER INFORMATION/ANNOUNCEMENTS**: None

10 **ANNOUNCEMENT OF CLOSED SESSION**:

10.1 **STAFF STATUS CHANGE**

1. Beverly Chang, MD to Inactive

AHP APPOINTMENT

1. Jill Reed, MSW – Social Worker
2. Marchita Masters, PsyD

MEDICAL STAFF REAPPOINTMENT

1. Aaron Babb, MD – Family Medicine

A motion/second carried; committee members approved all credentials — Utterback/Beyer — Approved All Credentials

11 **RECONVENE OPEN SESSION**: Reported closed session action

12 **ADJOURNMENT:** 11:50am - Next Regular Meeting – November 13, 2019 (Fall River Mills)

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Attachment B

Board Quality Report Template

Name:

Barbara Spalding

Department:

Volunteer Services

Last Quality project reported:

To come up with a system to capture all volunteers in receiving required flu shots and TB tests annually.

Update on last Quality project reported:

Working with HR and Dawn Jacobson, Employee Health Nurse/Infection Control, we have come up with a program that would help make it much easier for volunteers to come in and get flu shots/TB tests.

Current report date to Board Quality:

Last report date to Board Quality:

What successes have you seen based on the outcome of previous Quality projects?

Having the volunteers come in during monthly employee physicals to get TB tests and during the flu season their flu shots has made the process a lot smoother. Communication is better coming to me from Dawn and then out to the volunteers.

What issues have come up in your department relating to Quality?

A large problem that came to light is having community members volunteering their time in our facility without being processed/vetted as a Mayers volunteer.

PLAN: What plan was implemented to address those issues?

I have been communicating with Department Managers and Leads to come up with a system to catch these folks and get them processed. This also would require staff to make sure that all people coming into our facility have the proper name badges or state their business for being there

DO: How did the implementation of that plan go?
We are slowly getting more of them processed but it is still ongoing.
STUDY: What kind of results did the implementation of the plan yield?
We have been receiving volunteer applications and conducting orientations.
ACT: What changes were made based on the results of the plan implementation?
The Activity Department staff have a new awareness of the processes for new volunteers and have been working with me to assure we are compliant.

Upcoming Quality Items:	Quality Related Goals for the Department:

Data/Graphics supporting project outcomes:

Attachment C

Board Quality Report Template

Name:

JD Phipps

Department:

Emergency Department

Last Quality project reported:

Documentation of vitals reassessment within 60min of discharge and Q2 hours while in the ED
Documentation of pain reassessment following administration of medication

Update on last Quality project reported:

Progress was made in consistency but still short of expectation. Due to early lack of progress, audit process was changed from representative samples to 100% audit. This allowed us to identify individual trends and provide individualized feedback and counseling to staff.

Current report date to Board Quality:

11/06/19

Last report date to Board Quality:

05/01/19

What successes have you seen based on the outcome of previous Quality projects?

The data improved in consistency as initial audits revealed dramatic fluctuations. Overall the data has improved.

What issues have come up in your department relating to Quality?

Lack of expected rapid improvement to pain and vitals compliance process.

PLAN: What plan was implemented to address those issues?

We implemented additional LEAN processes including daily shift audits. These tools are aimed at increasing compliance by creating a real time audit/feedback process that is driven by the staff rather than admin. We have started these additional steps on the vitals component and will transition to the pain process if needed. LEAN principles dictate starting one at a time.

DO: How did the implementation of that plan go?

We only have one full month of data available at this time.

STUDY: What kind of results did the implementation of the plan yield?

The data showed that the real time audit data was not as good as staff thought it was. This allowed us to provide specific feedback to staff that clarified expectations.

ACT: What changes were made based on the results of the plan implementation?

Still assessing as these changes are early.

Upcoming Quality Items:	Quality Related Goals for the Department:
Compliance - EMTALA transfers ED log accuracy	100% Compliance Pain/Vital reassessments

Data/Graphics supporting project outcomes:

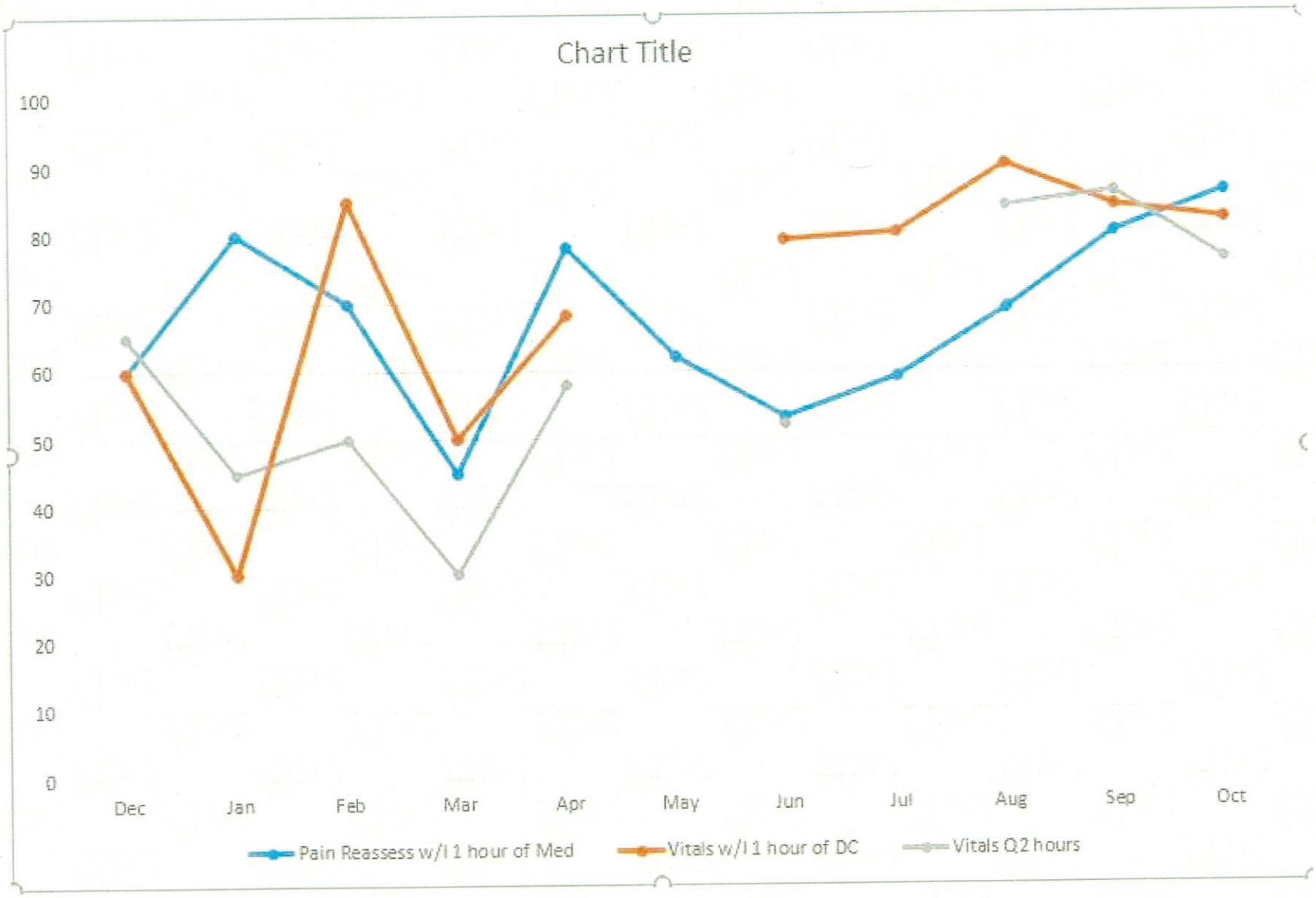
Chart Title
100
90
80
70
60
50
40
30
20
10
0
Dec
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
Pain Reassess w/I 1 hour of Med
Vitals w/I 1 hour of DC
Vitals Q2 hours

Attachment D

Board Quality Report Template

Name:

Michelle Peterson

Department:

Outpatient Medical Department (OPM)

Last Quality project reported:

05/08/19

Current report date to Board Quality:

11/13/19

Last report date to Board Quality:

05/08/19

Update on last Quality project reported:

Continue to work toward a better OPM EMR system that the physicians can chart in. Currently, paper charting on wound clinic days.

What successes have you seen based on the outcome of previous Quality projects?

Health Transportation Companies- now can transport Partnership patients to OPM appointments.

What issues have come up in your department relating to Quality?

Transportation is an issue getting patients to their appointments. We have a large no show no call rate, usually due to transportation issues.

PLAN: What plan was implemented to address those issues?

Health Transport Services- can transport Partnership patients to appointments.

DO: How did the implementation of that plan go?

So far, the transportation services has been helpful. The transport companies need to iron out the kinks. Sometimes they don't pick the patient up, and the patient calls stating nobody picked them up. Some patients are non compliant and the transportation company shows up at the patient home and they still don't come to their appointment.

STUDY: What kind of results did the implementation of the plan yield?

In October OPM saw 130 patients. From that sample 18% of those patients received rides from the transportation companies to their OPM appointment.

ACT: What changes were made based on the results of the plan implementation?

Michele King our OPM scheduler has more work on her plate to schedule rides for different patients. She often has to order rides online, and some companies require constant fax confirmation, and updates. Increase paperwork and coordination for the scheduler role.

Upcoming Quality Items:	Quality Related Goals for the Department:
Within the year OPM to provide-skin tear education for LTC and provide Vascular Access training for MMHD RN's	Fiscal year OPM- create skin tear class for LTC,OPM to attend Vascular Access Management training class at UCDavis

Data/Graphics supporting project outcomes:

Upcoming Quality Items:	Quality Related Goals for the Department:

Data/Graphics supporting project outcomes:

Attachment E

Board Quality Report Template

Name:

Theresa Overton

Department:

Acute

Current report date to Board Quality:

11/13/19

Last report date to Board Quality:

04/11/19

Last Quality project reported:

1. Short-staffed, Increased use of travelers. Lack of vested interest.
2. State Survey-Missed orders
3. State Survey-Noncompliance of "Reassessment of pain".

Update on last Quality project reported:

1. Continue with 2-travelers and intermittent use of registry. Bonus program not as successful for hire of full-time staff. Interviewed 4-RN's for Acute and all declined offer.
2. Compliance of missed orders with use of bedside reporting.
3. For a 4 month period (May-Aug 2019) 49% compliance. Inconsistency with registry.

What successes have you seen based on the outcome of previous Quality projects?

1. We have obtained 1-full time staff RN.
2. Bedside reporting successful for review of orders and chart check each shift.

What issues have come up in your department relating to Quality?

1. Shift assessments for recognition of change in condition to patient.
2. SBAR reporting to physician, supervisors, shift to shift ineffective regarding patients with change in condition and recognizing that change.

PLAN: What plan was implemented to address those issues?

1. Set a plan for use of a Daily Management Worksheet for shift assessments to be completed by 0800/2000 each shift by the RN/LVN's. The Daily Management Worksheet tracks compliance with an expectation of 90% assessments completed. The expectation is that the nurse is aware of any changes negative or positive in their patients and that they are able to communicate these changes to their supervisor or physician. The occurrence sheet tracks reasons as to why assessments not completed such as computer downtime or user error.
2. Developed SBAR for use by nurses to call physicians to report a Critical situation or Change in condition of the patient. This tool is to be used by nurses when communicating with physician, nursing supervisor and shift to shift.

DO: How did the implementation of that plan go?

1. The staff was educated as to the situation and rationale of the change. The staff starting working together as a team to assure compliance.

2. SBAR training conducted in the Sept. staff meeting for initiation to take place immediately.

STUDY: What kind of results did the implementation of the plan yield?

1. The first month of tracking went very well with 100% compliance within first 25 days. The staff was promised pizza if they had 100% which they received. There were problems with non-compliance the day after this due to computer glitches and new registry. The staff was coached once again regarding the importance of compliance for knowledge of their patients.

ACT: What changes were made based on the results of the plan implementation?

1. Spot audits are conducted and the staff RN's are educating new registry and working together to assure compliance.
2. Staff was asked to evaluate the process for which it was stated the physicians are inpatient with the SBAR reporting. One MD also interviewed as to the process who stated that it is appreciated. The other main physician will be interviewed.

Upcoming Quality Items:	Quality Related Goals for the Department:
Revise acuity system where assignments are done according to acuity for skill to match patient needs	Develop standard approach and methodology for patient assessment for high-level comprehensive nursing care.

Data/Graphics supporting project outcomes:

Attachment F

Board Quality Report Template

Name:

Pamela Sweet

Department:

Med. Staff

Current report date to Board Quality:

11/13/19

Last report date to Board Quality:

05/08/19

Last Quality project reported:

Policies and Procedures: 1,805 policies total; 412 are due or past due (Waiting on the manager to review and approve) 363 are currently in process (waiting on committees)
Practitioners – 63 practitioners

Update on last Quality project reported:

Policies and Procedures: 1797 policies total, 324 are due or past due, 159 are currently in process

Practitioners: 110 Practitioners, including 60 Telemedicine

What successes have you seen based on the outcome of previous Quality projects?

The total number of policies past due has dropped slightly and the number of policies waiting on committee approval has dropped by more than 50%

What issues have come up in your department relating to Quality?

The number of practitioners has increased significantly. Even though the increase is due to the number of telemedicine providers, the time required to manage them is the same as active providers.

PLAN: What plan was implemented to address those issues?

Discussing a provider management program with CNO

DO: How did the implementation of that plan go?
STUDY: What kind of results did the implementation of the plan yield?
ACT: What changes were made based on the results of the plan implementation?

Upcoming Quality Items:	**Quality Related Goals for the Department:**

Data/Graphics supporting project outcomes:

Upcoming Quality Items:	Quality Related Goals for the Department:

Data/Graphics supporting project outcomes:

Attachment G

Board Quality Departmental Report Template

Last Quality project reported: ICS 100/200 Training **Update on last Quality project reported:** Continue to train all staff on ICS100/200 - There are scheduled classes for this month.	**Current report date to Board Quality:** Nov. 13, 2019 **Last report date to Board Quality:** Feb. 12, 2019

What successes have you seen based on the outcome of previous Quality projects?
As an organization we are becoming more prepared for an emergency. We have identified areas that need improvement and have been working on remedies. The organization has a invested in supplies for each department and worked on improving communication abilities.

What issues have come up in your department relating to Quality?
No real issues - just managing the needed training for new staff. We also need to provide refresher training for employees. The nature of our business makes it hard for staff to be able to attend scheduled trainings and drills.

PLAN: What plan was implemented to address those issues?
We have a training plan as a part of orientation and re-orientation in the Relias program. We are also using Relias to put out other staff educations. Most recently, we did a review of the Code Binder for all staff.

DO: How did the implementation of that plan go?
It is working very well. We are able to educate, train and test and keep track of the progress.

STUDY: What kind of results did the implementation of the plan yield?
So far the results have been positive. We continue to identify ways to get the appropriate education to the appropriate staff.

ACT: What changes were made based on the results of the plan implementation?

None so far as we are still in the process.

Upcoming Quality Items:	Quality Related Goals for the Department:

Data/Graphics supporting project outcomes: